January 28, 2011

HOUSE BILL No. 1171

DIGEST OF HB 1171 (Updated January 26, 2011 5:17 pm - DI 77)

Citations Affected: IC 12-15.

Synopsis: Medicaid verification and claims. Requires the office of Medicaid policy and planning (office) and a contractor of the office to operate a single electronic eligibility verification system. Updates claims processing forms under the Medicaid program. Requires the office to use the most current forms for claims that the office processes within 90 days after the effective date of the new form.

Effective: July 1, 2011.

Brown T, Welch

January 10, 2011, read first time and referred to Committee on Public Health.
January 27, 2011, amended, reported — Do Pass.

January 28, 2011

First Regular Session 117th General Assembly (2011)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2010 Regular Session of the General Assembly.

HOUSE BILL No. 1171

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-1-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 21. Beginning January 1, 2012, the office and a contractor of the office shall operate a single electronic eligibility verification system that would allow the determination of whether an individual is participating in the state Medicaid program.**

SECTION 2. IC 12-15-13-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 7. (a) The office and an entity with which the office contracts for the payment of claims shall accept claims submitted on any of the following forms by an individual or organization that is a contractor or subcontractor of the office:

~~(1) HCFA-1500.~~

(1) CMS-1500 or its subsequent form.

~~(2) HCFA-1450 (UB92).~~

(2) CMS-1450 (UB04) or its subsequent form.

(3) American Dental Association (ADA) claim form.

(4) Pharmacy and compound drug form.

(b) The office and an entity with which the office contracts for the payment of claims:

(1) may designate as acceptable claim forms other than a form listed in subsection (a); and

(2) may not mandate the use of a crossover claim form.

SECTION 3. IC 12-15-13-7.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 7.2. (a) As used in this section, "provider" has the meaning set forth in IC 27-8-11-1.

(b) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) the office shall **for all purposes** begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the office ~~pays~~ **processes** claims for services provided under the Medicaid program; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for services provided under the Medicaid program.

(c) If a provider provides services that are covered under the Medicaid program:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (b); and

(2) before the office begins using the most current version of the diagnostic or procedure code;

the office shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1171, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-15-1-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 21. Beginning January 1, 2012, the office and a contractor of the office shall operate a single electronic eligibility verification system that would allow the determination of whether an individual is participating in the state Medicaid program.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1171 as introduced.)

BROWN T, Chair

Committee Vote: yeas 12, nays 0.