Reprinted
February 4, 2020

SENATE BILL No. 243

DIGEST OF SB 243 (Updated February 3, 2020 3:40 pm - DI 104)

Citations Affected: IC 12-7; IC 12-15; IC 16-18; IC 16-51; IC 25-1; IC 27-8; IC 27-13.

Synopsis: Credentialing, billing, and employment contracts. Requires a provider to include the service facility location in order to obtain Medicaid reimbursement from the office of the secretary of family and social services or the managed care organization. Specifies requirements for credentialing a provider for: (1) the Medicaid program; (2) an accident and sickness insurance policy; and (3) a health maintenance organization contract. Sets forth provisional credential for reimbursement purposes until a decision is made on a provider's credentialing application and allows for retroactive reimbursement under specified circumstances. Specifies health care billing forms to be used in certain health care settings. Prohibits employment contracts between employers and practitioner employees to include non-compete agreements.

Effective: July 1, 2020.

Brown L, Charbonneau

January 9, 2020, read first time and referred to Committee on Health and Provider Services.
January 30, 2020, amended, reported favorably — Do Pass.
February 3, 2020, read second time, amended, ordered engrossed.

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February 4, 2020

Second Regular Session of the 121st General Assembly (2020)

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 2019 Regular Session of the General Assembly.

SENATE BILL No. 243

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

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

SECTION 1. IC 12-7-2-174.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 174.7. (a) "Service facility location", for purposes of IC 12-15-11, means the address where the services of a provider facility or practitioner were provided.**

(b) The term consists of exact address and place of service codes as required on CMS forms 1500 and 1450, including an office, on-campus location of a hospital, and off-campus location of a hospital.

SECTION 2. IC 12-15-11-5, AS AMENDED BY P.L.195-2018, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 5. (a) A provider who participates in the Medicaid program must comply with the enrollment requirements that are established under rules adopted under IC 4-22-2 by the secretary.

(b) A provider who participates in the Medicaid program may be required to ~~use the centralized credentials verification organization established in section 9 of this chapter.~~ **include the address of the**

service facility location in order to obtain Medicaid reimbursement for a claim for health care services from the office or a managed care organization.

(c) The office or a managed care organization is not required to accept a claim for health care services that does not contain the service facility location.

SECTION 3. IC 12-15-11-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 6. **(a)** After a provider signs a provider agreement under this chapter, the office may not exclude the provider from participating in the Medicaid program by entering into an exclusive contract with another provider or group of providers, except as provided under section 7 of this chapter.

(b) The office or a managed care organization contracting with the office may not prohibit a provider from participating in a network of another insurer, managed care organization, or health maintenance organization.

SECTION 4. IC 12-15-11-9, AS ADDED BY P.L.195-2018, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 9. (a) The office shall implement a centralized ~~credentials verification organization and~~ credentialing process that:

(1) uses a common application, as determined by provider type;

(2) issues a single credentialing decision applicable to all Medicaid programs, except as determined by the office, **not later than thirty (30) days from the date of application;**

(3) recredentials and revalidates provider information not less than once every three (3) years; **and**

~~(4) requires attestation of enrollment and credentialing information every six (6) months; and~~

~~(5)~~ **(4)** ~~is certificated or accredited by the National Committee for Quality Assurance or its successor organization.~~ **subject to subsection (h), provides retroactive reimbursement to the date of the credentialing application for a provider that is approved.**

(b) A managed care organization or contractor of the office may not require additional credentialing requirements in order to participate in a managed care organization's network. However, a contractor may collect additional information from the provider in order to complete a contract or provider agreement.

(c) A managed care organization or contractor of the office is not required to contract with a provider.

(d) A managed care organization or contractor of the office shall:

(1) send representatives to meetings and participate in the

credentialing process as determined by the office; and

(2) not require additional credentialing information from a provider if a non-network credentialed provider is used.

(e) Except when a provider is no longer enrolled with the office, a credential acquired under this chapter is valid until recredentialing is required.

(f) An adverse action under this section is subject to IC 4-21.5.

(g) The office may adopt rules under IC 4-22-2 to implement this section.

~~(h) The office may adopt emergency rules to implement this section. However, an emergency rule adopted under this section expires the earlier of:~~

~~(1) one (1) year after the rule was accepted for filing under IC 4-22-2-37.1(e); or~~

~~(2) June 30, 2019.~~

~~This subsection expires July 1, 2019.~~

~~(i) The office shall report the timeliness of determinations made under this section to the legislative council in an electronic format under IC 5-14-6 not later than December 31, 2018. This subsection expires January 1, 2019.~~

(h) A provider may receive reimbursement as of the date of the issuance of a provisional credentialing license under subsection (i) if the provider is not credentialed within thirty (30) days as required by subsection (a)(2). A provider that submits a credentialing application that includes incomplete or incorrect information is not eligible for retroactive reimbursement under subsection (a). A typographical error does not constitute incorrect information for purposes of this subsection.

(i) If the office of a managed care organization fails to issue a credentialing determination within thirty (30) days as required by subsection (a)(2), the office and the managed care organization shall issue a provisional credentialing license to a provider upon the submission by the provider of a complete credentialing application and verification by the office or the managed care organization that the provider holds a valid license in Indiana for the profession for which the provider is seeking to be credentialed. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

SECTION 5. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-1.**

SECTION 6. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 167.8. "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

SECTION 7. IC 16-18-2-188.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 188.4. "Individual provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.**

SECTION 8. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.7. "Institutional provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 9. IC 16-18-2-190.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.8. "Institutional provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.**

SECTION 10. IC 16-18-2-190.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.9. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 11. IC 16-18-2-254.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 254.7. "Office setting", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 12. IC 16-18-2-295, AS AMENDED BY P.L.161-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 295. (a) "Provider", for purposes of IC 16-21-8, has the meaning set forth in IC 16-21-8-0.2.

(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7), and IC 16-41-1 through IC 16-41-9, means any of the following:

(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:

(A) A physician.

(B) A psychotherapist.

(C) A dentist.

(D) A registered nurse.
(E) A licensed practical nurse.
(F) An optometrist.
(G) A podiatrist.
(H) A chiropractor.
(I) A physical therapist.
(J) A psychologist.
(K) An audiologist.
(L) A speech-language pathologist.
(M) A dietitian.
(N) An occupational therapist.
(O) A respiratory therapist.
(P) A pharmacist.
(Q) A sexual assault nurse examiner.

(2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.

(3) A health facility licensed under IC 16-28-2.

(4) A home health agency licensed under IC 16-27-1.

(5) An employer of a certified emergency medical technician, a certified advanced emergency medical technician, or a licensed paramedic.

(6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.

(c) "Provider", for purposes of IC 16-39-7-1, has the meaning set forth in IC 16-39-7-1(a).

(d) "Provider", for purposes of IC 16-48-1, has the meaning set forth in IC 16-48-1-3.

(e) "Provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-8.

SECTION 13. IC 16-51 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Billing

Sec. 1. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 2. As used in this chapter, "health maintenance

organization" has the meaning set forth in IC 27-13-1-19.

Sec. 3. (a) As used in this chapter, "individual provider form" means a medical claim form that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by individual providers or groups of providers; and

(2) includes a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The CMS-1500 form.

(2) The HCFA-1500 form.

Sec. 4. As used in this chapter, "institutional provider" means any of the following:

(1) A hospital.

(2) A skilled nursing facility.

(3) An end stage renal disease provider.

(4) A home health agency.

(5) A hospice organization.

(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.

(7) A comprehensive outpatient rehabilitation facility.

(8) A community mental health center.

(9) A critical access hospital.

(10) A federally qualified health center.

(11) A histocompatibility laboratory.

(12) An Indian health service facility.

(13) An organ procurement organization.

(14) A religious nonmedical health care institution.

(15) A rural health clinic.

Sec. 5. (a) As used in this chapter, "institutional provider form" means a medical claim form that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by institutional providers; and

(2) does not include a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The 8371 Institutional form.

(2) The CMS-1450 form.

(3) The UB-04 form.

Sec. 6. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 7. As used in this chapter, "office setting" means a location, whether or not physically located within the facility of an institutional provider, where a provider routinely provides health examinations and diagnosis and treatment of illness or injury on an ambulatory basis.

Sec. 8. As used in this chapter, "provider" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 9. (a) A bill for health care services provided by a provider in an office setting:

(1) must not be submitted on an institutional provider form; and

(2) must be submitted on an individual provider form.

(b) An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services provided by a provider in an office setting is not required to accept a bill for the health care services that is submitted on an institutional provider form.

Sec. 10. The state department shall adopt rules under IC 4-22-2 for the enforcement of this chapter.

SECTION 14. IC 25-1-9.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 9.9. Practitioner Employment Contracts And Non-Compete Agreements

Sec. 1. This chapter applies to an employment contract entered into, modified, renewed, or extended after June 30, 2020.

Sec. 2. As used in this chapter, "employee" means a practitioner (as defined in IC 25-1-9-2) employed by an employer for wages or salary. The term includes an individual who has received an offer of employment from a prospective employer.

Sec. 3. As used in this chapter, "employer" means an individual, corporation, partnership, limited liability company, or any other legal entity that has at least one (1) employee and is legally doing business in Indiana.

Sec. 4. As used in this chapter, "non-compete agreement" means a contractual provision by which an employer attempts to limit an employee's ability to seek future employment or engage in future business activity after the employment relationship has terminated.

Sec. 5. An employment contract entered into by an employer and employee may not contain a non-compete agreement.

Sec. 6. A non-compete agreement in an employment contract in

violation of this chapter is unenforceable and void.

SECTION 15. IC 27-8-11-7, AS AMENDED BY P.L.195-2018, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and

(2) an insurer that performs credentialing activities.

(c) An insurer shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than ~~thirty (30)~~ **fifteen (15)** business days after the insurer receives the completed credentialing application form.

(d) An insurer shall notify a provider concerning the status of the provider's completed credentialing application not later than

~~(1) sixty (60)~~ **thirty (30)** days after the insurer receives the completed credentialing application form. ~~and~~

~~(2) every thirty (30) days after the notice is provided under subdivision (1), until the insurer makes a final credentialing determination concerning the provider.~~

(e) ~~Notwithstanding subsection (d),~~ If an insurer fails to issue a credentialing determination within thirty (30) days after receiving a completed credentialing application form from a provider, the insurer shall provisionally credential the provider if the provider meets the following criteria:

(1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the insurer.

(2) The provider was previously credentialed by the insurer in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.

(3) The provider is a member of a provider group that is credentialed and a participating provider with the insurer.

(4) The provider is a network provider with the insurer.

(f) The criteria for issuing provisional credentialing under subsection (e) may not be less stringent than the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization.

(g) ~~Once~~ **If** an insurer ~~fully credentials~~ **fails to meet the thirty (30) day credentialing requirement under subsection (d), in addition to**

issuing to a provider ~~that holds~~ provisional credentialing **under subsection (e), the insurer shall provide the provider with** reimbursement payments under the contract **that** shall be retroactive to the date of the provisional credentialing. The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

(h) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (e), the provisional credentialing **and reimbursement** is terminated on the date the insurer notifies the provider of the adverse credentialing determination. ~~The insurer is not required to reimburse for services rendered while the provider was provisionally credentialed.~~

SECTION 16. IC 27-13-43-2, AS AMENDED BY P.L.1-2006, SECTION 489, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 2. (a) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

(1) a provider who applies for credentialing by a health maintenance organization; and

(2) a health maintenance organization that performs credentialing activities.

(b) A health maintenance organization shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than ~~thirty (30)~~ **fifteen (15)** business days after the health maintenance organization receives the completed credentialing application form.

(c) A health maintenance organization shall notify a provider concerning the status of the provider's completed credentialing application not later than

~~(1)~~ ~~sixty (60)~~ **thirty (30)** days after the health maintenance organization receives the completed credentialing application form. ~~and~~

~~(2) every thirty (30) days after the notice is provided under subdivision (1), until the health maintenance organization makes a final credentialing determination concerning the provider.~~

SECTION 17. IC 27-13-43-3, AS ADDED BY P.L.195-2018, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 3. (a) ~~Notwithstanding section 2 of this chapter,~~ If a health maintenance organization fails to issue a credentialing determination within thirty (30) days after receiving a completed credentialing application form from a provider, the health maintenance

organization shall provisionally credential the provider if the provider meets the following criteria:

(1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the health maintenance organization.

(2) The provider was previously credentialed by the health maintenance organization in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.

(3) The provider is a member of a provider group that is credentialed and a participating provider with the health maintenance organization.

(4) The provider is a network provider with the health maintenance organization.

(b) The criteria for issuing provisional credentialing under subsection (a) may not be less stringent than the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization.

(c) ~~Once~~ **If** a health maintenance organization ~~fully credentials~~ **fails to meet the thirty (30) day credentialing requirement under section 2 of this chapter, in addition to issuing to** a provider ~~that holds~~ provisional credentialing **under subsection (a), the health maintenance organization shall provide the provider with** reimbursement payments under the contract **that** shall be retroactive to the date of the provisional credentialing. The health maintenance organization shall reimburse the provider at the rates determined by the contract between the provider and the health maintenance organization.

(d) If a health maintenance organization does not fully credential a provider that is provisionally credentialed under subsection (a), the provisional credentialing **and reimbursement** is terminated on the date the health maintenance organization notifies the provider of the adverse credentialing determination. ~~The health maintenance organization is not required to reimburse for services rendered while the provider was provisionally credentialed.~~

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 243, has had the same under consideration and begs leave to report the same back to the Senate 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 12-7-2-174.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 174.7. (a) "Service facility location", for purposes of IC 12-15-11, means the address where the services of a provider facility or practitioner were provided.**

(b) The term consists of exact address and place of service codes as required on CMS forms 1500 and 1450, including an office, on-campus location of a hospital, and off-campus location of a hospital.".

Page 1, line 8, delete "where the" and insert "**of the service facility location in order to obtain Medicaid reimbursement for a claim for health care services from the office or a managed care organization.**

(c) The office or a managed care organization is not required to accept a claim for health care services that does not contain the service facility location.".

Page 1, delete lines 9 through 10.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 243 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 11, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 243 be amended to read as follows:

Page 3, line 21, after "(h)" insert "**A provider may receive reimbursement as of the date of the issuance of a provisional**

credentialing license under subsection (i) if the provider is not credentialed within thirty (30) days as required by subsection (a)(2).".

Page 3, line 26, delete "The" and insert "**If the office of a managed care organization fails to issue a credentialing determination within thirty (30) days as required by subsection (a)(2), the**".

Page 3, between lines 33 and 34, begin a new paragraph and insert:

"SECTION 5. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-1.**

SECTION 6. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 167.8. "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

SECTION 7. IC 16-18-2-188.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 188.4. "Individual provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.**

SECTION 8. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.7. "Institutional provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 9. IC 16-18-2-190.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.8. "Institutional provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.**

SECTION 10. IC 16-18-2-190.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 190.9. "Insurer", for purposes OF IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 11. IC 16-18-2-254.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 254.7. "Office setting", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 12. IC 16-18-2-295, AS AMENDED BY P.L.161-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 295. (a) "Provider", for purposes of IC 16-21-8,

has the meaning set forth in IC 16-21-8-0.2.

(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7), and IC 16-41-1 through IC 16-41-9, means any of the following:

(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:

(A) A physician.
(B) A psychotherapist.
(C) A dentist.
(D) A registered nurse.
(E) A licensed practical nurse.
(F) An optometrist.
(G) A podiatrist.
(H) A chiropractor.
(I) A physical therapist.
(J) A psychologist.
(K) An audiologist.
(L) A speech-language pathologist.
(M) A dietitian.
(N) An occupational therapist.
(O) A respiratory therapist.
(P) A pharmacist.
(Q) A sexual assault nurse examiner.

(2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.

(3) A health facility licensed under IC 16-28-2.

(4) A home health agency licensed under IC 16-27-1.

(5) An employer of a certified emergency medical technician, a certified advanced emergency medical technician, or a licensed paramedic.

(6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.

(c) "Provider", for purposes of IC 16-39-7-1, has the meaning set forth in IC 16-39-7-1(a).

(d) "Provider", for purposes of IC 16-48-1, has the meaning set forth in IC 16-48-1-3.

(e) "Provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-8.

SECTION 13. IC 16-51 IS ADDED TO THE INDIANA CODE AS

A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Billing

Sec. 1. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 2. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 3. (a) As used in this chapter, "individual provider form" means a medical claim form that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by individual providers or groups of providers; and

(2) includes a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The CMS-1500 form.

(2) The HCFA-1500 form.

Sec. 4. As used in this chapter, "institutional provider" means any of the following:

(1) A hospital.

(2) A skilled nursing facility.

(3) An end stage renal disease provider.

(4) A home health agency.

(5) A hospice organization.

(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.

(7) A comprehensive outpatient rehabilitation facility.

(8) A community mental health center.

(9) A critical access hospital.

(10) A federally qualified health center.

(11) A histocompatibility laboratory.

(12) An Indian health service facility.

(13) An organ procurement organization.

(14) A religious nonmedical health care institution.

(15) A rural health clinic.

Sec. 5. (a) As used in this chapter, "institutional provider form" means a medical claim form that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by institutional providers; and

(2) does not include a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The 8371 Institutional form.

(2) The CMS-1450 form.

(3) The UB-04 form.

Sec. 6. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 7. As used in this chapter, "office setting" means a location, whether or not physically located within the facility of an institutional provider, where a provider routinely provides health examinations and diagnosis and treatment of illness or injury on an ambulatory basis.

Sec. 8. As used in this chapter, "provider" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 9. (a) A bill for health care services provided by a provider in an office setting:

(1) must not be submitted on an institutional provider form; and

(2) must be submitted on an individual provider form.

(b) An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services provided by a provider in an office setting is not required to accept a bill for the health care services that is submitted on an institutional provider form.

Sec. 10. The state department shall adopt rules under IC 4-22-2 for the enforcement of this chapter.".

Page 4, after line 14, begin a new paragraph and insert:

"SECTION 15. IC 27-8-11-7, AS AMENDED BY P.L.195-2018, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and

(2) an insurer that performs credentialing activities.

(c) An insurer shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than ~~thirty (30)~~ **fifteen (15)** business days after the insurer receives the completed credentialing application form.

(d) An insurer shall notify a provider concerning the status of the provider's completed credentialing application not later than

~~(1) sixty (60)~~ **thirty (30)** days after the insurer receives the completed credentialing application form. ~~and~~

~~(2) every thirty (30) days after the notice is provided under subdivision (1), until the insurer makes a final credentialing determination concerning the provider.~~

(e) ~~Notwithstanding subsection (d),~~ If an insurer fails to issue a credentialing determination within thirty (30) days after receiving a completed credentialing application form from a provider, the insurer shall provisionally credential the provider if the provider meets the following criteria:

(1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the insurer.

(2) The provider was previously credentialed by the insurer in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.

(3) The provider is a member of a provider group that is credentialed and a participating provider with the insurer.

(4) The provider is a network provider with the insurer.

(f) The criteria for issuing provisional credentialing under subsection (e) may not be less stringent than the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization.

(g) ~~Once~~ **If** an insurer ~~fully credentials~~ **fails to meet the thirty (30) day credentialing requirement under subsection (d), in addition to issuing to** a provider ~~that holds~~ provisional credentialing **under subsection (e), the insurer shall provide the provider with** reimbursement payments under the contract **that** shall be retroactive to the date of the provisional credentialing. The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

(h) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (e), the provisional credentialing **and reimbursement** is terminated on the date the insurer notifies the provider of the adverse credentialing determination. ~~The insurer is not required to reimburse for services rendered while the~~

~~provider was provisionally credentialed.~~

SECTION 16. IC 27-13-43-2, AS AMENDED BY P.L.1-2006, SECTION 489, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 2. (a) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

(1) a provider who applies for credentialing by a health maintenance organization; and

(2) a health maintenance organization that performs credentialing activities.

(b) A health maintenance organization shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than ~~thirty (30)~~ **fifteen (15)** business days after the health maintenance organization receives the completed credentialing application form.

(c) A health maintenance organization shall notify a provider concerning the status of the provider's completed credentialing application not later than

~~(1) sixty (60)~~ **thirty (30)** days after the health maintenance organization receives the completed credentialing application form. ~~and~~

~~(2) every thirty (30) days after the notice is provided under subdivision (1), until the health maintenance organization makes a final credentialing determination concerning the provider.~~

SECTION 17. IC 27-13-43-3, AS ADDED BY P.L.195-2018, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: Sec. 3. (a) ~~Notwithstanding section 2 of this chapter,~~ If a health maintenance organization fails to issue a credentialing determination within thirty (30) days after receiving a completed credentialing application form from a provider, the health maintenance organization shall provisionally credential the provider if the provider meets the following criteria:

(1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the health maintenance organization.

(2) The provider was previously credentialed by the health maintenance organization in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.

(3) The provider is a member of a provider group that is credentialed and a participating provider with the health

maintenance organization.

(4) The provider is a network provider with the health maintenance organization.

(b) The criteria for issuing provisional credentialing under subsection (a) may not be less stringent than the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization.

(c) ~~Once~~ **If** a health maintenance organization ~~fully credentials~~ **fails to meet the thirty (30) day credentialing requirement under section 2 of this chapter, in addition to issuing to** a provider ~~that holds~~ provisional credentialing **under subsection (a), the health maintenance organization shall provide the provider with** reimbursement payments under the contract **that** shall be retroactive to the date of the provisional credentialing. The health maintenance organization shall reimburse the provider at the rates determined by the contract between the provider and the health maintenance organization.

(d) If a health maintenance organization does not fully credential a provider that is provisionally credentialed under subsection (a), the provisional credentialing **and reimbursement** is terminated on the date the health maintenance organization notifies the provider of the adverse credentialing determination. ~~The health maintenance organization is not required to reimburse for services rendered while the provider was provisionally credentialed.~~".

Renumber all SECTIONS consecutively.

(Reference is to SB 243 as printed January 31, 2020.)

BROWN L