[Ind. Code §§ 25-1-9.1-1 through 25-1-9.1-12.]

§§ 25-1-9.1-1 through 25-1-9.1-12: Out of Network Provider Referrals

§ 25-1-9.1-1. Application of chapter

Sec. 1. (a) This chapter applies to a referral made after December 31, 2017.

(b) This chapter does not apply to the following:

(1) A referral for treatment of an emergency medical condition.

(2) A referral made:

(A) immediately following treatment of an emergency medical condition; and

(B) by the provider that rendered the treatment of the emergency medical condition.

(3) A referral for medically or psychologically necessary therapeutic services rendered to an admitted patient in:

(A) a hospital; or

(B) another facility to which a patient may be admitted for more than twenty-four (24) hours.

§ 25-1-9.1-2. "Affiliated"

Sec. 2. As used in this chapter, "affiliated" refers to a provider that is a member of the same provider group as another provider.

§ 25-1-9.1-3. "Covered individual"

Sec. 3. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

§ 25-1-9.1-4. "Emergency medical condition"

Sec. 4. As used in this chapter, "emergency medical condition" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's (including, with respect to a pregnant woman, her unborn child's) health in serious jeopardy;

(2) result in serious impairment to the individual's (including, with respect to a pregnant woman, her unborn child's) bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual (including, with respect to a pregnant woman, her unborn child).

§ 25-1-9.1-5. "Health plan"

Sec. 5. (a) As used in this chapter, "health plan" means:

(1) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(2) an individual contract or a group contract with a health maintenance organization under IC 27-13; or

(3) another plan or program that provides payment, reimbursement, or indemnification for the costs of health care items or services;

that conditions the payment of benefits, in whole or in part, on a covered individual's use of providers that have agreed to be part of a network.

(b) The term does not include the following:

(1) Worker's compensation or similar insurance.

(2) Benefits provided under a certificate of exemption issued by the worker's compensation board under IC 22-3-2-5.

(3) Medicaid (IC 12-15).

§ 25-1-9.1-6. "Network"

Sec. 6. As used in this chapter, "network" means a group of two (2) or more providers that have entered into:

(1) an agreement with an insurer under IC 27-8-11-3;

(2) a participating provider contract with a health maintenance organization under IC 27-13; or

(3) an agreement with another person specifying terms and conditions of the providers' rendering of health care items or services to covered individuals.

§ 25-1-9.1-7. "Network provider"

Sec. 7. As used in this chapter, "network provider" means a provider described in section 6 of this chapter.

§ 25-1-9.1-8. "Out of network provider"

Sec. 8. As used in this chapter, "out of network provider" means a provider that is not described in section 6 of this chapter.

IC 25-1-9.1-9. "Provider"

Sec. 9. (a) As used in this chapter, "provider" means a practitioner described in IC 25-1-9-2(1).

(b) The term does not include an individual who holds a license, certification, registration, or permit issued under the following:

(1) IC 25-19.

(2) IC 25-38.1.

(c) The term includes a provider group.

§ 25-1-9.1-10. "Provider group"

Sec. 10. As used in this chapter, "provider group" means a legal entity:

(1) that is owned by or employs one (1) or more providers; and

(2) through which billing is performed for health care items and services rendered by the providers.

§ 25-1-9.1-11. "Referral"

Sec. 11. (a) As used in this chapter, "referral" means a recommendation or direction made by a provider to a covered individual that the covered individual receive a health care item or service rendered by another provider that is not affiliated with the first provider.

(b) The term does not include a recommendation or direction made by a provider to a covered individual that the covered individual receive a health care item or service rendered by another provider that is:

(1) affiliated with; or

(2) not specifically identified by name by;

the first provider.

§ 25-1-9.1-12. Notice to covered individual upon referral; notice for telephone referral

Sec. 12. (a) This section does not apply to a referral made by a provider that has confirmed that the provider to which a covered individual is referred is a network provider with respect to the covered individual's health plan.

(b) A provider that makes a referral shall provide to the covered individual an electronic or paper copy of written notice that states all of the following:

(1) That an out of network provider may be called upon to render health care items or services to the covered individual during the course of treatment.

(2) That an out of network provider described in subdivision (1) is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.

(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out of network provider described in subdivision (1):

(A) to obtain a list of network providers that may render the health care items or services; and

(B) for additional assistance.

(c) A provider that makes a referral via telephone to a patient of record shall provide to the covered individual all of the following information:

(1) That an out of network provider may be called upon to render health care items or services to the covered individual during the course of treatment.

(2) That an out of network provider described in subdivision (1) is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.

(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out of network provider described in subdivision (1):

(A) to obtain a list of network providers that may render the health care items or services; and

(B) for additional assistance.

(4) The provider shall note in the covered individual's medical chart:

(A) the name of the provider to whom the covered individual was referred; and

(B) that the referral was made via telephone.