[Ind. Code §§ 27-8-17-1 through 27-8-17-20.]

§§ 27-8-17-1 through 27-8-17-20: Life, Accident, and Health-- Health Care Utilization Review

§ 27-8-17-1. "Covered individual" defined
Sec. 1. As used in this chapter, "covered individual" means:

(1) an enrollee; or

(2) an eligible dependent of an enrollee.

§ 27-8-17-2. "Department" defined
Sec. 2. As used in this chapter, "department" refers to the department of insurance.

§ 27-8-17-3. "Enrollee" defined
Sec. 3. As used in this chapter, "enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy issued under insurance classes 1(b) and 2(a) of IC 27-1-5-1, health maintenance organization contract, or other benefit program providing payment, reimbursement, or indemnification for the costs of health care for:

(1) the individual;

(2) eligible dependents of the individual; or

(3) both the individual and the individual's eligible dependents.

§ 27-8-17-4. "Health maintenance organization" defined
Sec. 4. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

§ 27-8-17-5. "Provider of record" defined
Sec. 5. As used in this chapter, "provider of record" means the physician or other licensed practitioner identified to a utilization review agent as having primary responsibility for the care, treatment, and services rendered to a covered individual.

§ 27-8-17-6. "Utilization review" defined
Sec. 6. (a) As used in this chapter, "utilization review" means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual.

(b) The term does not include the following:

(1) Elective requests for clarification of coverage, eligibility, or benefits verification.

(2) Medical claims review (as defined in IC 27-8-16-4).

§ 27-8-17-7. "Utilization review agent" defined
Sec. 7. (a) As used in this chapter, "utilization review agent" means any entity performing utilization review, except the following:

(1) An agency of the state or federal government.

(2) An agent acting on behalf of the federal or state government.

(3) Entities conducting general in-house utilization review for hospitals, home health agencies, health maintenance organizations, preferred provider organizations or other managed care entities, clinics, private offices, or any other health facility, so long as the review does not result in the approval or denial of an enrollee's coverage for hospital or medical services.

(b) However, an agent described in subsection (a)(2) who performs utilization review for a person other than the federal or state government is a utilization review agent who is subject to the requirements of this chapter.

§ 27-8-17-8. "Utilization review determination" defined
Sec. 8. (a) As used in this chapter, "utilization review determination" means the rendering of a decision based on utilization review that denies or affirms either of the following:

(1) The necessity or appropriateness of the allocation of resources.

(2) The provision or proposed provision of health care services to a covered individual.

(b) The term does not include the identification of alternative, optional medical care that:

(1) requires the approval of the covered individual; and

(2) does not affect coverage or benefits if rejected by the covered individual.

§ 27-8-17-9. Certificate of registration; issuance to agent
Sec. 9. (a) A utilization review agent may not conduct utilization review in Indiana unless the utilization review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a utilization review agent must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the utilization review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the utilization review agent is capable of satisfying the minimum requirements set forth in section 11 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 10(a) of this chapter in the rules adopted under section 20 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out its responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a utilization review agent that satisfies the requirements of this section.

§ 27-8-17-10. Certificate of registration; renewal; transfer; notice of change in information
Sec. 10. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed annually. To obtain the renewal of a certificate of registration, a utilization review agent must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 9(d) of this chapter. The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the entity to whom the certificate is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the utilization review agent that submitted the application shall notify the department of the change in writing within thirty (30) days after the change.

§ 27-8-17-11. Minimum utilization review agent requirements
Sec. 11. A utilization review agent must satisfy the following minimum requirements:

(1) Provide toll free telephone access at least forty (40) hours each week during normal business hours.

(2) Maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours.

(3) Respond to each telephone call left on the recording system maintained under subdivision (2) within two (2) business days after receiving the call.

(4) Protect the confidentiality of the medical records of covered individuals.

(5) Within two (2) business days after receiving a request for a utilization review determination that includes all information necessary to complete the utilization review determination, notify the enrollee or the provider of record of the utilization review determination by mail or another means of communication.

(6) Include in the notification of a utilization review determination not to certify an admission, a service, or a procedure:

(A) if the determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination; and

(B) the procedures to initiate an appeal of the determination.

(7) Ensure that every utilization review determination as to the necessity or appropriateness of an admission, a service, or a procedure is:

(A) reviewed by a physician; or

(B) determined in accordance with standards or guidelines approved by a physician.

(8) Ensure that every physician making a utilization review determination for the utilization review agent has a current license issued by a state licensing agency in the United States.

(9) Provide a period of at least forty-eight (48) hours following an emergency admission, service, or procedure during which:

(A) an enrollee; or

(B) the representative of an enrollee;

may notify the utilization review agent and request certification or continuing treatment for the condition involved in the admission, service, or procedure.

(10) Provide an appeals procedure satisfying the requirements set forth in section 12 of this chapter.

(11) Develop a utilization review plan and file a summary of the plan with the department.

§ 27-8-17-12. Appeals procedure

Sec. 12. (a) A utilization review agent shall make available to an enrollee, and to a provider of record upon request, at the time an adverse utilization review determination is made:

(1) a written description of the appeals procedure by which an enrollee or a provider of record may appeal the utilization review determination by the utilization review agent; and

(2) in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under IC 27-8-28 or IC 27-13-10 and the toll free telephone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.

(b) The appeals procedure provided by a utilization review agent must meet the following requirements:

(1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.

(2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection shall be made by a physician and completed within forty-eight (48) hours after:

(1) the appeal is initiated; and

(2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy (as defined in IC 27-8-28-1) or a contract issued by a health maintenance organization (as defined in IC 27-13-1-19), the enrollee's exclusive right to appeal a utilization review determination is provided under IC 27-8-28 or IC 27-13-10, respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent.

§ 27-8-17-13. Physician's statement; documentation of review agent capability

Sec. 13. To provide documentation demonstrating that a utilization review agent is capable of satisfying the requirement of section 11(7) of this chapter, as required by section 9(b)(3) of this chapter, the utilization

review agent may provide a signed statement of a physician employed by or under contract to the utilization review agent verifying that determinations made by the utilization review agent as to the necessity or appropriateness of admissions, services, and procedures are reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.

§ 27-8-17-14. Accreditation and approval of review agent; determination; new certificate of registration; order to cease activities

Sec. 14. (a) The department may, according to the rules adopted under section 20 of this chapter, determine that a utilization review agent satisfies the requirements set forth in section 11 of this chapter if the utilization review agent:

(1) has, at the time of issuance of the agent's certificate of registration, received; and

(2) maintains;

the approval or accreditation of a utilization review accreditation organization that has been approved by the department for the purposes of this section. The department may not make a determination under this subsection before July 1, 1993.

(b) If a utilization review agent:

(1) is determined to satisfy the requirements of section 11 of this chapter by obtaining accreditation from a utilization review accreditation organization; and

(2) subsequently loses the accreditation from the accrediting organization;

the utilization review agent must, within sixty (60) days after losing its accreditation, obtain a new certificate of registration under this chapter to continue to conduct utilization review in Indiana. During the sixty (60) day period, the utilization review agent may continue to conduct utilization review subject to all other requirements of this chapter, unless ordered to cease under subsection (c).

(c) If the department determines, before the expiration of the sixty (60) day period referred to in subsection (b), that the utilization review agent cannot satisfy the requirements for issuance of a certificate of registration under this chapter, the department shall order the utilization review agent to immediately cease all utilization review activities in Indiana.

§ 27-8-17-15. Certification of admission, service, or procedure; enrollee request; notice and information; assistance; denial under terms of benefit program

Sec. 15. (a) The following requirements apply to an enrollee's request for certification by a utilization review agent of an admission, a service, or a procedure:

(1) In the absence of contractual terms to the contrary, the enrollee is responsible for notifying the utilization review agent of the admission, service, or procedure in a timely manner and for obtaining certification of health care services.

(2) A utilization review agent shall allow the provider of record or a responsible patient representative, including a family member, to assist the enrollee in fulfilling the enrollee's responsibility under subdivision (1).

(3) The provider of record shall, within a reasonable time, provide to the utilization review agent all relevant information necessary to certify the admission, service, or procedure. For an emergency admission or procedure, the information shall be provided within two (2) business days after the emergency admission or procedure. For an elective admission, procedure, or treatment, the information shall be provided not later than two (2) business days before the admission or the provision of the procedure or treatment.

(b) The failure to provide the information required by this section may result in the denial of certification in accordance with the terms of the enrollee's insurance policy, health maintenance organization contract, or other benefit program.

§ 27-8-17-16. Fraudulent or misleading information; penalties
Sec. 16. A provider of record, an enrollee, or the agent of a provider of record or an enrollee who provides fraudulent or misleading information is subject to appropriate administrative, civil, and criminal penalties, including the penalty for deception under IC 35-43-5-3.

§ 27-8-17-17. Violations; notice to agent; cease and desist orders; penalties; revocation or suspension of registration; review
Sec. 17. (a) If the department believes that a utilization review agent has violated this chapter, the department shall notify the utilization review agent of the alleged violation.

(b) The utilization review agent shall respond to a notice given under subsection (a) within thirty (30) days after receiving the notice.

(c) If the department:

(1) believes that a utilization review agent has violated this chapter; and

(2) is not satisfied, based on the response given by the utilization review agent under subsection (b), that the violation has been corrected;

the department shall order the utilization review agent under IC 4-21.5-3-6 to cease all utilization review activities in Indiana.

(d) If the department determines that a utilization review agent has violated this chapter, the department:

(1) shall order the utilization review agent to cease and desist from engaging in the violation; and

(2) may do either or both of the following:

(A) Order the utilization review agent to pay a civil penalty of not more than five thousand dollars ($5,000) if the utilization review agent has committed violations with a frequency that indicates a general business practice.

(B) Suspend or revoke the certificate of registration of the utilization review agent.

(e) Any order issued or ruling made by the department under this section is subject to review under IC 4-21.5.

§ 27-8-17-18. Confidential information
Sec. 18. (a) This chapter does not require a utilization review agent to disclose information that is proprietary.

(b) Any:

(1) information concerning standards, criteria, or medical protocols used by a utilization review agent in conducting utilization review; or

(2) other proprietary information concerning utilization review conducted by a utilization review agent;

that is disclosed to the department of insurance under this chapter is confidential for the purposes of IC 5-14-3-4(a)(1) and may not be disclosed by the department.

§ 27-8-17-19. Prohibited bases for compensation of agent
Sec. 19. The compensation of a utilization review agent for the performance of utilization review may not be based on:

(1) the extent to which certifications are denied; or

(2) the amount by which subsequent claims are reduced for payment.

§ 27-8-17-20. Rules
Sec. 20. The department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.