

# SENATE BILL No. 156

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## DIGEST OF INTRODUCED BILL

**Citations Affected:** IC 27-8; IC 34-30-2-118.6.

**Synopsis:** External review of grievances. Requires a health care payor to establish a process for an external review of grievances after internal appeal procedures are exhausted. Provides for expedited and standard external reviews. Establishes requirements for independent review organizations to be certified by the department of insurance. Requires notice to a covered individual of the external review process.

**Effective:** July 1, 2000.

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January 10, 2000, read first time and referred to Committee on Health and Provider Services.

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Second Regular Session 111th General Assembly (2000)

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 1999 General Assembly.

# SENATE BILL No. 156



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

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

- 1 SECTION 1. IC 27-8-17-11 IS AMENDED TO READ AS
- 2 FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 11. A utilization review
- 3 agent must satisfy the following minimum requirements:
- 4 (1) Provide toll free telephone access at least forty (40) hours
- 5 each week during normal business hours.
- 6 (2) Maintain a telephone call recording system capable of
- 7 accepting or recording incoming telephone calls or providing
- 8 instructions during hours other than normal business hours.
- 9 (3) Respond to each telephone call left on the recording system
- 10 maintained under subdivision (2) within two (2) business days
- 11 after receiving the call.
- 12 (4) Protect the confidentiality of the medical records of covered
- 13 individuals.
- 14 (5) Within two (2) business days after receiving a request for a
- 15 utilization review determination that includes all information
- 16 necessary to complete the utilization review determination, notify
- 17 the enrollee ~~or~~ **and** the provider of record of the utilization review

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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.

SECTION 2. IC 27-8-17-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: Sec. 12. (a) A utilization review agent shall make available upon request a written description of the **following**:

**(1) The appeals procedure by which an enrollee or a provider of record may obtain a review of a utilization review determination by the utilization review agent.**

**(2) The external review process established by an enrollee's:**

**(A) health care payor under IC 27-8-17.1; or**

**(B) health maintenance organization under IC 27-13-10.1.**

(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

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1 by a health care provider licensed in the same discipline as the  
2 provider of record.

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

6 (A) the appeal is filed; and

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

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

14 (1) the appeal is initiated; and

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

17 **(d) A utilization review agent shall notify the covered individual**  
18 **in writing of the determination made by the utilization review**  
19 **agent regarding an appeal not later than five (5) business days**  
20 **after making the determination. The notice must include a written**  
21 **description of:**

22 **(1) the determination made by the utilization review agent;**

23 **(2) the reasons, policies, or procedures that are the basis of**  
24 **the determination;**

25 **(3) the right to further remedies allowed by law, including the**  
26 **right to review by an independent review organization under**  
27 **IC 27-8-17.1 or IC 27-13-10.1;**

28 **(4) the department, address, and telephone number through**  
29 **which a covered individual may contact a qualified**  
30 **representative to obtain additional information about the**  
31 **determination or the right to an appeal; and**

32 **(5) how to file a request for an external review under the**  
33 **external review process established by the covered**  
34 **individual's:**

35 **(A) health care payor under IC 27-8-17.1; or**

36 **(B) health maintenance organization under IC 27-13-10.1.**

37 SECTION 3. IC 27-8-17.1 IS ADDED TO THE INDIANA CODE  
38 AS NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY  
39 1, 2000]:

40 **Chapter 17.1 External Review of Grievances**

41 **Sec. 1. As used in this chapter, "appeal determination" means**  
42 **a determination that is made under an appeals procedure**

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1 established by a utilization review agent under IC 27-8-17-12  
 2 regarding an appeal of a utilization review determination made by  
 3 the utilization review agent.

4 **Sec. 2.** As used in this chapter, "covered individual" has the  
 5 meaning set forth in IC 27-8-17-1. However, the term:

6 (1) does not include an individual who has contracted for or  
 7 who participates in coverage under a health maintenance  
 8 organization (as defined in IC 27-13-1-19); and

9 (2) includes an individual who has contracted for or who  
 10 participates in coverage under a limited service health  
 11 maintenance organization (as defined in IC 27-13-34-4)  
 12 contract.

13 **Sec. 3.** As used in this chapter, "health care payor" means an  
 14 entity that provides coverage to an enrollee (as defined in  
 15 IC 27-8-17-3). However, the term:

16 (1) does not include a health maintenance organization (as  
 17 defined in IC 27-13-1-19); and

18 (2) includes a limited service health maintenance organization  
 19 (as defined in IC 27-13-34-4).

20 **Sec. 4.** As used in this chapter, "utilization review agent" has the  
 21 meaning set forth in IC 27-8-17-7.

22 **Sec. 5.** As used in this chapter, "utilization review  
 23 determination" has the meaning set forth in IC 27-8-17-8.

24 **Sec. 6.** A health care payor shall establish and maintain a  
 25 process for an external review of an adverse appeal determination  
 26 that is based on a determination:

27 (1) of medical necessity; or

28 (2) that a proposed service is experimental or investigational;  
 29 regarding a service that is the subject of the adverse appeal  
 30 determination.

31 **Sec. 7. (a)** An external review process established under section  
 32 6 of this chapter must:

33 (1) allow a covered individual or the covered individual's  
 34 representative to file a written request with the health care  
 35 payor for an external review of an adverse appeal  
 36 determination not later than forty-five (45) days after the  
 37 covered individual is notified of the adverse appeal  
 38 determination; and

39 (2) provide for:

40 (A) an expedited external review for a grievance related to  
 41 an illness, a disease, a condition, an injury, or a disability  
 42 that would seriously jeopardize the covered individual's:

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- 1 (i) life or health; or  
 2 (ii) ability to reach and maintain maximum function; or  
 3 (B) a standard external review for a grievance not  
 4 described in clause (A).

5 Under this chapter, a covered individual may not file more than  
 6 one (1) request for an external review of the same adverse appeal  
 7 determination.

8 (b) Subject to the requirements of subsection (d), when a request  
 9 is filed under subsection (a), the health care payor shall:

- 10 (1) select a different independent review organization for each  
 11 request for an external review filed under this chapter from  
 12 the list of independent review organizations that are certified  
 13 by the department under section 13 of this chapter; and  
 14 (2) rotate the choice of an independent review organization  
 15 among all certified independent review organizations before  
 16 repeating a selection.

17 (c) The independent review organization shall assign a medical  
 18 review professional who is board certified in the applicable  
 19 specialty for resolution of an external review.

20 (d) The independent review organization and the medical review  
 21 professional conducting the external review under this chapter  
 22 may not have a material professional, familial, financial, or other  
 23 affiliation with the following:

- 24 (1) The health care payor or utilization review agent.  
 25 (2) Any officer, director, or management employee of the  
 26 health care payor or utilization review agent.  
 27 (3) The health care provider or the health care provider's  
 28 professional group that is proposing the service.  
 29 (4) The facility at which the service would be provided.  
 30 (5) The development or manufacture of the principal drug,  
 31 device, procedure, or other therapy that is proposed by the  
 32 treating health care provider.

33 However, the medical review professional may have an affiliation  
 34 under which the medical review professional provides health care  
 35 services to covered individuals of the health care payor and may  
 36 have an affiliation that is limited to staff privileges at the health  
 37 facility if the affiliation is disclosed to the covered individual and  
 38 the health care payor before commencing the review, and neither  
 39 the covered individual nor the health care payor objects.

40 (e) The covered individual may be required to pay not more  
 41 than twenty-five dollars (\$25) of the costs associated with the  
 42 services of an independent review organization under this chapter.



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1 **All additional costs must be paid by the health care payor.**

2 **Sec. 8. (a) A covered individual who files a request for an**  
 3 **external review under this chapter shall:**

4 (1) not be subject to retaliation for exercising the covered  
 5 individual's right to an external review under this chapter;

6 (2) be permitted to use the assistance of other individuals,  
 7 including health care providers, attorneys, friends, and family  
 8 members throughout the review process;

9 (3) be permitted to submit additional information relating to  
 10 the proposed service throughout the review process; and

11 (4) cooperate with the independent review organization by:

12 (A) providing requested medical information; or

13 (B) authorizing the release of necessary medical  
 14 information.

15 (b) A health care payor and utilization review agent shall  
 16 cooperate with an independent review organization selected under  
 17 section 7 of this chapter by promptly providing information  
 18 requested by the independent review organization.

19 **Sec. 9. (a) An independent review organization shall:**

20 (1) for an expedited external review filed under section  
 21 7(a)(2)(A) of this chapter, not later than seventy-two (72)  
 22 hours after the request for an external review is filed; or

23 (2) for a standard external review filed under section  
 24 7(a)(2)(B) of this chapter, not later than fifteen (15) business  
 25 days after the request for an external review is filed;

26 make a determination to uphold or reverse the adverse appeal  
 27 determination based on information gathered from the covered  
 28 individual or the covered individual's designee, the health care  
 29 payor, the utilization review agent, the treating health care  
 30 provider, and any additional information that the independent  
 31 review organization considers necessary and appropriate.

32 (b) When making the determination under this section, the  
 33 independent review organization shall apply:

34 (1) standards of decision making that are based on objective  
 35 clinical evidence; and

36 (2) the terms of the covered individual's benefit policy,  
 37 contract, or program.

38 (c) The independent review organization shall notify the health  
 39 care payor, the utilization review agent, and the covered individual  
 40 of the determination made under this section:

41 (1) for an expedited external review filed under section  
 42 7(a)(2)(A) of this chapter, not later than twenty-four (24)

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1 hours after making the determination; or  
 2 (2) for a standard external review filed under section  
 3 7(a)(2)(B) of this chapter, not later than seventy-two (72)  
 4 hours after making the determination.

5 **Sec. 10.** A determination made under section 9 of this chapter is  
 6 binding on the health care payor.

7 **Sec. 11. (a)** If, at any time during an external review performed  
 8 under this chapter, the covered individual submits information to  
 9 the health care payor or the utilization review agent that is  
 10 relevant to the adverse appeal determination and that was not  
 11 considered by the utilization review agent:

12 (1) the health care payor or the utilization review agent shall  
 13 reconsider the adverse appeal determination; and

14 (2) the independent review organization shall cease the  
 15 external review process until the reconsideration under  
 16 subsection (b) is completed.

17 (b) If a covered individual submits information under  
 18 subsection (a), the health care payor or the utilization review agent  
 19 shall reconsider the adverse appeal determination based on the  
 20 information and notify the covered individual and the health care  
 21 payor or the utilization review agent of the reconsideration  
 22 decision:

23 (1) not later than seventy-two (72) hours after the information  
 24 is submitted for a reconsideration related to an illness, a  
 25 disease, a condition, an injury, or a disability that would  
 26 seriously jeopardize the covered individual's:

27 (A) life or health; or

28 (B) ability to reach and maintain maximum function; or

29 (2) not later than fifteen (15) days after the information is  
 30 submitted for a reconsideration not described in subdivision

31 (1).

32 (c) If the decision reached under subsection (b) is adverse to the  
 33 covered individual, the covered individual may request that the  
 34 independent review organization resume the external review under  
 35 this chapter.

36 **Sec. 12.** This chapter does not add to or change the terms of  
 37 coverage included in a health care payor's policy, contract, or  
 38 program under which a covered individual receives health care  
 39 benefits.

40 **Sec. 13. (a)** The department shall establish and maintain a  
 41 process for annual certification of independent review  
 42 organizations.



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1           (b) The department shall certify a number of independent  
2 review organizations determined by the department to be sufficient  
3 to fulfill the purposes of this chapter.

4           (c) An independent review organization shall meet the following  
5 minimum requirements for certification by the department:

6           (1) Medical review professionals assigned by the independent  
7 review organization to perform external reviews under this  
8 chapter:

9           (A) must be board certified in the specialty in which a  
10 covered individual's proposed service would be provided;

11           (B) must be knowledgeable about a proposed service  
12 through actual clinical experience;

13           (C) must hold an unlimited license to practice in a state of  
14 the United States; and

15           (D) must have no history of disciplinary actions or  
16 sanctions including:

17           (i) loss of staff privileges; or

18           (ii) restriction on participation;

19           taken or pending by any hospital, government, or  
20 regulatory body.

21           (2) The independent review organization must have a quality  
22 assurance mechanism to ensure the:

23           (A) timeliness and quality of reviews;

24           (B) qualifications and independence of medical review  
25 professionals;

26           (C) confidentiality of medical records and other review  
27 materials; and

28           (D) satisfaction of covered individuals with the procedures  
29 used by the independent review organization, including the  
30 use of covered individual satisfaction surveys.

31           (3) The independent review organization must file with the  
32 department the following information before March 1 of each  
33 year:

34           (A) The number and percentage of determinations that  
35 reverse an adverse appeal determination.

36           (B) The number and percentage of determinations that  
37 affirm an adverse appeal determination.

38           (C) The average time to process a determination.

39           (D) Any other information required by the department.

40           The information required under this subdivision must be  
41 specified for each health care payor and utilization review  
42 agent for which the independent review organization

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1 performed reviews during the reporting year.

2 (4) Additional requirements established by the department.

3 (d) The department may not certify an independent review  
4 organization that is one (1) of the following:

5 (1) A professional or trade association of health care  
6 providers, or a subsidiary or an affiliate of a professional or  
7 trade association of health care providers.

8 (2) A health care payor, utilization review agent, or health  
9 plan association, or a subsidiary or an affiliate of a health care  
10 payor, utilization review agent, or health plan association.

11 (e) The department may suspend or revoke an independent  
12 review organization's certification if the department finds that the  
13 independent review organization is not in substantial compliance  
14 with the certification requirements under this section.

15 (f) The department shall make available to health care payors  
16 a list of all certified independent review organizations.

17 (g) The department shall make the information provided to the  
18 department under subsection (c)(3) available to the public in a  
19 format that does not identify specific covered individuals.

20 **Sec. 14. (a)** A health care payor shall, on or before March 1 of  
21 each year, file with the commissioner a description of the external  
22 review process under this chapter, including:

23 (1) the total number of grievances handled through the  
24 process during the preceding calendar year;

25 (2) a compilation of the causes underlying those grievances;  
26 and

27 (3) a summary of the final disposition of those grievances;  
28 for each independent review organization used by the health care  
29 payor during the reporting year.

30 (b) The commissioner shall:

31 (1) make the information required to be filed under this  
32 section available to the public; and

33 (2) prepare an annual compilation of the data required under  
34 subsection (a) that allows for comparative analysis.

35 (c) The commissioner may require any additional reports as are  
36 necessary and appropriate for the commissioner to carry out the  
37 commissioner's duties under this chapter.

38 **Sec. 15.** Except as provided in sections 13(g) and 14 of this  
39 chapter, documents and other information created or received by  
40 the independent review organization or the medical review  
41 professional in connection with an external review under this  
42 chapter:

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- (1) are not public records;
- (2) may not be disclosed under IC 5-14-3; and
- (3) must be treated in accordance with confidentiality requirements of state and federal law.

**Sec. 16. (a)** A health care payor shall provide notice to each covered individual of the external review process and how to file a request for an external review under this chapter.

(b) A health care payor shall prominently display on all notices to covered individuals the telephone number and address at which a request for an external review may be filed.

**Sec. 17. (a)** An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy any party's burden of proof or persuasion concerning any material issue of fact or law.

**Sec. 18.** If a covered individual has the right to an external review of a grievance under Medicare (42 U.S.C. 1395 et seq.), the covered individual may not request an external review of the same grievance under this chapter.

**Sec. 19.** The department may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 4. IC 34-30-2-118.6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]: **Sec. 118.6. IC 27-8-17.1 (Concerning independent review organizations.)**

SECTION 5. [EFFECTIVE JULY 1, 2000] **IC 27-8-17.1, as added by this act, applies to adverse appeal determinations made after January 1, 2001.**

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