



Reprinted
February 1, 2000

SENATE BILL No. 156

DIGEST OF SB 156 (Updated January 31, 2000 4:42 PM - DI 97)

Citations Affected: IC 27-8; IC 34-30; noncode.

Synopsis: External review of appeal determinations. Requires a health care payor to establish a process for an external review of appeal determinations 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.

Gard

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

January 27, 2000, amended, reported favorably — Do Pass.

January 31, 2000, read second time, amended, ordered engrossed.

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SB 156—LS 6515/DI 97+



Reprinted
February 1, 2000

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 Appeal Determinations**

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 does not
 6 include an individual who has contracted for or who participates
 7 in coverage under the following:

8 (1) A health maintenance organization (as defined in
 9 IC 27-13-1-19) contract.

10 (2) A limited service health maintenance organization (as
 11 defined in IC 27-13-34-4) contract.

12 (3) Accident-only, credit, dental, vision, Medicare supplement,
 13 long term care, or disability income insurance.

14 (4) Coverage issued as a supplement to liability insurance.

15 (5) Worker's compensation or similar insurance.

16 (6) Automobile medical payment insurance.

17 (7) A specified disease policy issued as an individual policy.

18 (8) A limited benefit health insurance policy issued as an
 19 individual policy.

20 (9) A short term insurance plan that:

21 (A) may not be renewed; and

22 (B) has a duration of not more than six (6) months.

23 (10) A policy that provides a stipulated daily, weekly, or
 24 monthly payment to an insured during hospital confinement,
 25 without regard to the actual expense of the confinement.

26 **Sec. 3.** As used in this chapter, "health care payor" means an
 27 entity that provides coverage to an enrollee (as defined in
 28 IC 27-8-17-3). However, the term does not include an entity that
 29 provides coverage to an enrollee under the following:

30 (1) A health maintenance organization (as defined in
 31 IC 27-13-1-19) contract.

32 (2) A limited service health maintenance organization (as
 33 defined in IC 27-13-34-4) contract.

34 (3) Accident-only, credit, dental, vision, Medicare supplement,
 35 long term care, or disability income insurance.

36 (4) Coverage issued as a supplement to liability insurance.

37 (5) Worker's compensation or similar insurance.

38 (6) Automobile medical payment insurance.

39 (7) A specified disease policy issued as an individual policy.

40 (8) A limited benefit health insurance policy issued as an
 41 individual policy.

42 (9) A short term insurance plan that:

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(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(10) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

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

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

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

- (1) of medical necessity; or
- (2) that a proposed service is experimental or investigational; regarding a service that is the subject of the adverse appeal determination.

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

- (1) allow a covered individual or the covered individual's representative to file a written request with the health care payor for an external review of an adverse appeal determination not later than forty-five (45) days after the covered individual is notified of the adverse appeal determination; and
- (2) provide for:
 - (A) an expedited external review of an adverse appeal determination related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's:
 - (i) life or health; or
 - (ii) ability to reach and maintain maximum function; or
 - (B) a standard external review of an adverse appeal determination not described in clause (A).

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

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

- (1) select a different independent review organization for each request for an external review filed under this chapter from the list of independent review organizations that are certified

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1 by the department under section 13 of this chapter; and
 2 (2) rotate the choice of an independent review organization
 3 among all certified independent review organizations before
 4 repeating a selection.

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

8 (d) The independent review organization and the medical review
 9 professional conducting the external review under this chapter
 10 may not have a material professional, familial, financial, or other
 11 affiliation with the following:

- 12 (1) The health care payor or utilization review agent.
- 13 (2) Any officer, director, or management employee of the
 14 health care payor or utilization review agent.
- 15 (3) The health care provider or the health care provider's
 16 professional group that is proposing the service.
- 17 (4) The facility at which the service would be provided.
- 18 (5) The development or manufacture of the principal drug,
 19 device, procedure, or other therapy that is proposed by the
 20 treating health care provider.

21 However, the medical review professional may have an affiliation
 22 under which the medical review professional provides health care
 23 services to covered individuals of the health care payor and may
 24 have an affiliation that is limited to staff privileges at the health
 25 facility if the affiliation is disclosed to the covered individual and
 26 the health care payor before commencing the review, and neither
 27 the covered individual nor the health care payor objects.

28 (e) The covered individual may be required to pay not more
 29 than twenty-five dollars (\$25) of the costs associated with the
 30 services of an independent review organization under this chapter.
 31 All additional costs must be paid by the health care payor.

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

- 34 (1) not be subject to retaliation for exercising the covered
 35 individual's right to an external review under this chapter;
- 36 (2) be permitted to use the assistance of other individuals,
 37 including health care providers, attorneys, friends, and family
 38 members throughout the review process;
- 39 (3) be permitted to submit additional information relating to
 40 the proposed service throughout the review process; and
- 41 (4) cooperate with the independent review organization by:
 42 (A) providing requested medical information; or



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1 **(B) authorizing the release of necessary medical**
 2 **information.**

3 **(b) A health care payor and utilization review agent shall**
 4 **cooperate with an independent review organization selected under**
 5 **section 7 of this chapter by promptly providing information**
 6 **requested by the independent review organization.**

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

8 **(1) for an expedited external review filed under section**
 9 **7(a)(2)(A) of this chapter, not later than seventy-two (72)**
 10 **hours after the request for an external review is filed; or**

11 **(2) for a standard external review filed under section**
 12 **7(a)(2)(B) of this chapter, not later than fifteen (15) business**
 13 **days after the request for an external review is filed;**

14 **make a determination to uphold or reverse the adverse appeal**
 15 **determination based on information gathered from the covered**
 16 **individual or the covered individual's designee, the health care**
 17 **payor, the utilization review agent, the treating health care**
 18 **provider, and any additional information that the independent**
 19 **review organization considers necessary and appropriate.**

20 **(b) When making the determination under this section, the**
 21 **independent review organization shall apply:**

22 **(1) standards of decision making that are based on objective**
 23 **clinical evidence; and**

24 **(2) the terms of the covered individual's benefit policy,**
 25 **contract, or program.**

26 **(c) The independent review organization shall notify the health**
 27 **care payor, the utilization review agent, and the covered individual**
 28 **of the determination made under this section:**

29 **(1) for an expedited external review filed under section**
 30 **7(a)(2)(A) of this chapter, not later than twenty-four (24)**
 31 **hours after making the determination; or**

32 **(2) for a standard external review filed under section**
 33 **7(a)(2)(B) of this chapter, not later than seventy-two (72)**
 34 **hours after making the determination.**

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

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

42 **(1) the health care payor or the utilization review agent shall**

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1 reconsider the adverse appeal determination; and

2 (2) the independent review organization shall cease the
3 external review process until the reconsideration under
4 subsection (b) is completed.

5 (b) If a covered individual submits information under
6 subsection (a), the health care payor or the utilization review agent
7 shall reconsider the adverse appeal determination based on the
8 information and notify the covered individual and the health care
9 payor or the utilization review agent of the reconsideration
10 decision:

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

15 (A) life or health; or

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

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

19 (1).

20 (c) If the decision reached under subsection (b) is adverse to the
21 covered individual, the covered individual may request that the
22 independent review organization resume the external review under
23 this chapter.

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

28 **Sec. 13.** (a) The department shall establish and maintain a
29 process for annual certification of independent review
30 organizations.

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

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

36 (1) Medical review professionals assigned by the independent
37 review organization to perform external reviews under this
38 chapter:

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

41 (B) must be knowledgeable about a proposed service
42 through actual clinical experience;



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- 1 (C) must hold an unlimited license to practice in a state of
 2 the United States; and
 3 (D) must have no history of disciplinary actions or
 4 sanctions including:
 5 (i) loss of staff privileges; or
 6 (ii) restriction on participation;
 7 taken or pending by any hospital, government, or
 8 regulatory body.
- 9 (2) The independent review organization must have a quality
 10 assurance mechanism to ensure the:
 11 (A) timeliness and quality of reviews;
 12 (B) qualifications and independence of medical review
 13 professionals;
 14 (C) confidentiality of medical records and other review
 15 materials; and
 16 (D) satisfaction of covered individuals with the procedures
 17 used by the independent review organization, including the
 18 use of covered individual satisfaction surveys.
- 19 (3) The independent review organization must file with the
 20 department the following information before March 1 of each
 21 year:
 22 (A) The number and percentage of determinations that
 23 reverse an adverse appeal determination.
 24 (B) The number and percentage of determinations that
 25 affirm an adverse appeal determination.
 26 (C) The average time to process a determination.
 27 (D) Any other information required by the department.
- 28 The information required under this subdivision must be
 29 specified for each health care payor and utilization review
 30 agent for which the independent review organization
 31 performed reviews during the reporting year.
- 32 (4) Additional requirements established by the department.
- 33 (d) The department may not certify an independent review
 34 organization that is one (1) of the following:
 35 (1) A professional or trade association of health care
 36 providers, or a subsidiary or an affiliate of a professional or
 37 trade association of health care providers.
 38 (2) A health care payor, utilization review agent, or health
 39 plan association, or a subsidiary or an affiliate of a health care
 40 payor, utilization review agent, or health plan association.
 41 (e) The department may suspend or revoke an independent
 42 review organization's certification if the department finds that the

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1 independent review organization is not in substantial compliance
2 with the certification requirements under this section.

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

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

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

- 11 (1) the total number of external reviews handled through the
- 12 process during the preceding calendar year;
- 13 (2) a compilation of the causes underlying those external
- 14 reviews; and
- 15 (3) a summary of the final disposition of those external
- 16 reviews;

17 for each independent review organization used by the health care
18 payor during the reporting year.

19 (b) The commissioner shall:

- 20 (1) make the information required to be filed under this
- 21 section available to the public; and
- 22 (2) prepare an annual compilation of the data required under
- 23 subsection (a) that allows for comparative analysis.

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

27 Sec. 15. Except as provided in sections 13(g) and 14 of this
28 chapter, documents and other information created or received by
29 the independent review organization or the medical review
30 professional in connection with an external review under this
31 chapter:

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

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

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

42 Sec. 17. (a) An independent review organization is immune from

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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 determination under Medicare (42 U.S.C. 1395 et seq.), the covered individual may not request an external review of the same determination 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 December 31, 2000.

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 156, 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 4, line 5, before ":" insert "**does not include an individual who has contracted for or who participates in coverage under the following**".

Page 4, line 6, delete "does not include an individual who has contracted for or" and insert "A".

Page 4, line 7, delete "who participates in coverage under a".

Page 4, line 8, delete "; and" and insert "**contract**".

Page 4, line 9, delete "includes an individual who has contracted for or who" and insert "A".

Page 4, line 10, delete "participates in coverage under a".

Page 4, between lines 12 and 13, begin a new line block indented and insert:

(3) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(4) Coverage issued as a supplement to liability insurance.

(5) Worker's compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) A specified disease policy issued as an individual policy.

(8) A limited benefit health insurance policy issued as an individual policy.

(9) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(10) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement."

Page 4, line 15, before ":" insert "**does not include an entity that provides coverage to an enrollee under the following**".

Page 4, line 16, delete "does not include a" and insert "A".

Page 4, line 17, delete "; and" and insert "**contract**".

Page 4, line 18, delete "includes a" and insert "A".

Page 4, line 19, before "." insert "**contract**".

Page 4, between lines 19 and 20, begin a new line block indented and insert:

(3) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.



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- (4) Coverage issued as a supplement to liability insurance.
- (5) Worker's compensation or similar insurance.
- (6) Automobile medical payment insurance.
- (7) A specified disease policy issued as an individual policy.
- (8) A limited benefit health insurance policy issued as an individual policy.
- (9) A short term insurance plan that:
 - (A) may not be renewed; and
 - (B) has a duration of not more than six (6) months.
- (10) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement."

Page 10, line 32, delete "January 1, 2001" and insert "**December 31, 2000**".

and when so amended that said bill do pass.

(Reference is to SB 156 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 8, Nays 0.

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SENATE MOTION

Mr. President: I move that Senate Bill 156 be amended to read as follows:

Page 3, line 40, delete "Grievances" and insert "**Appeal Determinations**".

Page 5, line 11, after "determination" insert ", **including an adverse appeal determination**".

Page 5, line 26, delete "for a grievance" and insert "**of an adverse appeal determination**".

Page 5, line 31, delete "for a grievance" and insert "**of an adverse appeal determination**".

Page 10, line 9, delete "grievances" and insert "**external reviews**".

Page 10, line 11, delete "grievances" and insert "**external reviews**".

Page 10, line 13, delete "grievances" and insert "**external reviews**".

Page 11, line 7, delete "grievance" and insert "**determination**".

Page 11, line 9, delete "grievance" and insert "**determination**".

(Reference is to SB 156 as printed January 28, 2000.)

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