

## **IC 27-13-36**

Chapter 36. Patient Protection; Clinical Decision Making; Access to Personnel and Facilities

### **IC 27-13-36-1**

#### **Medical director; individual to develop treatment policies and consult with treating providers**

Sec. 1. (a) Each health maintenance organization shall appoint a medical director who has an unlimited license to practice medicine under IC 25-22.5 or an equivalent license issued by another state.

(b) The medical director is responsible for oversight of treatment policies, protocols, quality assurance activities, and utilization management decisions of the health maintenance organization.

(c) A health maintenance organization shall contract with or employ at least one (1) individual who holds an unlimited license to practice medicine under IC 25-22.5 to do the following:

(1) Develop, in consultation with a group of appropriate providers, the health maintenance organization's treatment policies, protocols, and quality assurance activities.

(2) Consult with the treating provider before an adverse utilization review decision is made.

(d) Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.

*As added by P.L.69-1998, SEC.14.*

### **IC 27-13-36-2**

#### **Sufficient number and type of primary care providers**

Sec. 2. Beginning July 1, 1999, each health maintenance organization shall include a sufficient number and type of primary care providers and other appropriate providers throughout the health maintenance organization's service area to:

(1) meet the needs of; and

(2) provide a choice of primary care providers and other appropriate providers to;

enrollees and subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.

*As added by P.L.69-1998, SEC.14.*

### **IC 27-13-36-2.5**

#### **Discrimination on basis of provider's license or certification prohibited**

Sec. 2.5. (a) A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to:

(1) participation;

(2) reimbursement;

(3) indemnification; or  
(4) scope of care;  
solely on the basis of the provider's license or certification.

(b) This section does not require a health maintenance organization to enter into a contract with a provider that would allow the provider to enter the health maintenance organization network.  
*As added by P.L.233-1999, SEC.13.*

### **IC 27-13-36-3**

#### **Adequate number of services and providers within reasonable proximity of subscribers**

Sec. 3. (a) The provisions of this section do not apply until July 1, 1999.

(b) Each health maintenance organization shall demonstrate to the department that the health maintenance organization offers an adequate number of:

- (1) acute care hospital services;
- (2) primary care providers; and
- (3) other appropriate providers;

that are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.

(c) If a health maintenance organization provides coverage for:

- (1) specialty medical services, including physical therapy, occupational therapy, and rehabilitation services;
- (2) mental and behavioral care services; or
- (3) pharmacy services;

the health maintenance organization shall demonstrate to the department that the offered services are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.

*As added by P.L.69-1998, SEC.14.*

### **IC 27-13-36-4**

#### **Specialty areas of primary care providers**

Sec. 4. Beginning July 1, 1999, primary care providers shall include licensed physicians who practice in one (1) or more of the following areas:

- (1) Family practice.
- (2) General practice.
- (3) Internal medicine.
- (4) As a woman's health care provider, in compliance with IC 27-8-24.7.
- (5) Pediatrics.

*As added by P.L.69-1998, SEC.14.*

### **IC 27-13-36-5**

#### **Referrals to out of network providers**

Sec. 5. (a) The provisions of the section do not apply until July 1, 1999.

(b) When an enrollee's primary care provider determines that the enrollee needs a particular health care service and the health maintenance organization determines that the type of health care service needed by the enrollee to treat a specific condition:

- (1) is a covered service; and
- (2) is not available from the health maintenance organization's network of participating providers;

the primary care provider and the health maintenance organization shall refer the enrollee to an appropriate provider who is not a participating provider within a reasonable amount of time and within a reasonable proximity of the enrollee.

(c) When an enrollee receives health care services from a provider to whom the enrollee was referred as described in subsection (b), the health maintenance organization shall pay the out of network provider the lesser of the following:

- (1) The usual, customary, and reasonable charge in the health maintenance organization's service area for the health care services provided by the out of network provider.
- (2) An amount agreed to between the health maintenance organization and the out of network provider.

The enrollee's treating provider may collect from the enrollee only the deductible or copayment, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider. The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider as provided in this subsection.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a determination allowed under subsection (b).

*As added by P.L.69-1998, SEC.14.*

### **IC 27-13-36-6**

#### **Continuation of care provisions**

Sec. 6. (a) A health maintenance organization shall include provisions in the health maintenance organization's contracts with providers to provide for continuation of care in the event that a provider's contract with the health maintenance organization is terminated, provided that the termination is not due to a quality of care issue.

(b) The contract provisions under subsection (a) shall require that the provider, upon the request of the enrollee, continue to treat the enrollee for up to sixty (60) days following the termination of the provider's contract with the health maintenance organization or, in

the case of a pregnant enrollee in the third trimester of pregnancy, throughout the term of the enrollee's pregnancy. If the provider is a hospital, the contract shall provide for continuation of treatment until the earlier of the following:

- (1) Sixty (60) days following the termination of the provider's contract with the health maintenance organization.
- (2) The enrollee is released from inpatient status at the hospital.
- (c) During a continuation period under this section, the provider:
  - (1) shall agree to continue accepting the contract terms and conditions, together with applicable deductibles and copayments, as payment in full; and
  - (2) is prohibited from billing the enrollee for any amounts in excess of the enrollee's applicable deductible or copayment.

*As added by P.L.69-1998, SEC.14.*

#### **IC 27-13-36-7**

##### **Telephone access for authorization of care**

Sec. 7. Each health maintenance organization shall provide the following:

- (1) Telephone access to the health maintenance organization during business hours to ensure enrollee access for routine care.
- (2) Twenty-four (24) hour telephone access to either:
  - (A) a representative of the health maintenance organization;
  - or
  - (B) a participating provider;for authorization for care.

*As added by P.L.69-1998, SEC.14.*

#### **IC 27-13-36-8**

##### **Guidelines for establishing reasonable periods for appointments**

Sec. 8. (a) Each health maintenance organization shall establish guidelines for establishing reasonable periods of time within which an enrollee must be given an appointment with a participating provider, except as provided in section 9 of this chapter regarding emergency services.

(b) The guidelines described in subsection (a) must include appointment scheduling guidelines based on the type of health care services most often requested, including the following:

- (1) Prenatal care appointments.
- (2) Well-child visits and immunizations.
- (3) Routine physicals.
- (4) Adult preventive services.
- (5) Urgent visits.

*As added by P.L.69-1998, SEC.14.*

#### **IC 27-13-36-9**

##### **Coverage and reimbursement for expenses for care obtained in an emergency**

Sec. 9. (a) As used in this section, "care obtained in an emergency" means, with respect to an enrollee, covered services that

are:

- (1) furnished by a provider within the scope of the provider's license and as otherwise authorized under law; and
- (2) needed to evaluate or stabilize an individual in an emergency.

(b) As used in this section, "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

- (1) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.
- (2) The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility.
- (3) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

(c) As described in subsection (d), each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:

- (1) prior authorization; or
- (2) regard to the contractual relationship between:
  - (A) the provider who provided health care services to the enrollee in an emergency; and
  - (B) the health maintenance organization;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention. The emergency care obtained by an enrollee under this section includes care for the alleviation of severe pain, which is a symptom of an emergency as provided in IC 27-13-1-11.7.

(d) Each health maintenance organization shall cover and reimburse expenses for emergency services at a rate equal to the lesser of the following:

- (1) The usual, customary, and reasonable charge in the health maintenance organization's service area for health care services provided during the emergency.
- (2) An amount agreed to between the health maintenance organization and the out of network provider.

A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible. Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency. *As added by P.L.69-1998, SEC.14.*

### **IC 27-13-36-10**

**Access plan to meet needs of vulnerable, underserved, and non-English speaking enrollees**

Sec. 10. Each health maintenance organization shall demonstrate to the commissioner that the health maintenance organization has developed an access plan to meet the needs of the health maintenance organization's enrollees, including vulnerable and underserved enrollees and enrollees from major population groups who speak a primary language other than English.

*As added by P.L.69-1998, SEC.14.*

#### **IC 27-13-36-11**

##### **Standards for continuity of care**

Sec. 11. The health maintenance organization shall develop standards for continuity of care following enrollment, including sufficient information on how to access care within the health maintenance organization.

*As added by P.L.69-1998, SEC.14.*

#### **IC 27-13-36-12**

##### **Payment to enrollee for service rendered by nonparticipating provider; requirements**

Sec. 12. (a) As used in this section, "nonparticipating provider" means a provider that has not entered into an agreement with a health maintenance organization to serve as a participating provider.

(b) After September 30, 2009, if a health maintenance organization makes a payment to an enrollee for a health care service rendered by a nonparticipating provider, the health maintenance organization shall include with the payment instrument written notice to the enrollee that includes the following:

- (1) A statement specifying the claims covered by the payment instrument.
- (2) The name and address of the provider submitting each claim.
- (3) The amount paid by the health maintenance organization for each claim.
- (4) Any amount of a claim that is the enrollee's responsibility.
- (5) A statement in at least 24 point bold type that:
  - (A) instructs the enrollee to use the payment to pay the nonparticipating provider if the enrollee has not paid the nonparticipating provider in full;
  - (B) specifies that paying the nonparticipating provider is the enrollee's responsibility; and
  - (C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

*As added by P.L.144-2009, SEC.3.*