Indiana

I. Scope and Applicability

A. Who is subject to the state's utilization management regulations? Any entity performing utilization review. Ind. Code Ann. § 27-8-17-9(a)

1. **HMOs?** Yes.
2. **Insurers?** Yes.
3. **Utilization Review Organizations?** Yes.
4. **ACOs?** Yes, if the ACO is acting as a utilization review agent or performing utilization review.
5. **PPOs?** Yes.
6. **Third Party Administrators?** Yes.

B. What term does the state use to refer to regulated entities? A utilization review agent is any entity performing utilization review. Ind. Code Ann. § 27-8-17-7(a)

C. What activities does the state include in its definition of utilization management (aka utilization review)? Utilization review is defined as "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." The term does not include "Elective requests for clarification of coverage, eligibility, or benefits verification" or "Medical claims review." Ind. Code Ann. § 27-8-17-6 Utilization review determination means the rendering of a decision based on utilization review that denies or affirms either the necessity or appropriateness of the allocation of resources, or the provision or proposed provision of health care services to a covered individual. The term does not include the identification of alternative, optional medical care that requires the approval of the covered individual, and does not affect coverage or benefits if rejected by the covered individual. Ind. Code Aann. § 27-8-17-8(a) and (b)

D. What exemptions are provided? There are exceptions for an agency of the state or federal government, an agent acting on behalf of the federal or state government, 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, as long as such review does not result in the approval or denial of an enrollee's coverage for hospital or medical services. Ind. Code Ann. § 27-8-17-7(a) However, an agent acting on behalf of the federal or state government who performs utilization review for a person other than the federal or state government is a utilization review agent and subject to the requirements of this chapter. Ind. Code Ann. § 27-8-17-7(b)

II. Regulatory Information

A. Responsible State Agency (which agency oversees UM?) Indiana Department of Insurance.

B. Contact Information for the State Agency:

1. **Name and Title:** Rebecca Vaughan, Manager, UR, IRO, MCR & DMPO Licensing; Stephen W. Robertson, Commissioner
2. **Address:** Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787
3. **Phone and Facsimile:** (317) 232-2187; Facsimile (317) 232-5251.
4. **E-mail:** rvaughan@idoi.in.gov
5. **Website:** www.in.gov/idoi/2351.htm

III. Licensure/Certification Requirements

A. What entities are required to obtain a license? 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 of Insurance. Ind. Code Ann. § 27-8-17-9(a)

B. Renewal period? Annually. Ind. Code Ann. § 27-8-17-10(a)

C. Licensure fees? The application for registration must be accompanied by the fee: $150 for initial and $100 for renewal. Ind. Code Ann. § 27-8-17-10(a); Ind. Admin. Code Tit. 760, r. 1-46-11 If not received prior to license expiration date, must submit a new application with new application fee of $150. Ind. Admin. Code Tit. 760, r. 1-46-3(g)

D. Licensure documentation when applying or upon renewal? An application containing the name, address, telephone number, and normal business hours of the utilization review agent, the name and telephone number of a person that the department may contact concerning the information in the application, and all documentation necessary for the department to determine that the utilization review agent is capable of satisfying the minimum statutory requirements. Ind. Code Ann. § 27-8-17-9(b) Further, an application submitted under this section must be signed and verified by the applicant, accompanied by an application fee and provided with 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. Ind. Code Ann. § 27-8-17-9(c) and Ind. Code Ann. § 27-8-17-13. *See also* Ind. Admin. Code Tit. 760, r. 1-46-3(c) An application for certification of a utilization review agent must be filed with the Department of Insurance at 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204. A copy may be obtained from the Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204. Ind. Admin. Code Tit. 760, r. 1-46-3(a) & (b)

E. Accreditation waiver or "deemed" status? There is no waiver, but companies with the approval or accreditation of a utilization review accreditation organization are considered to have met most of the state's requirements for utilization review. *See* Ind. Code Ann. § 27-8-17-14(a) However, all utilization review agents must submit an annual licensure application and fee to the Department of Insurance.

IV. Program Requirements

A. Clinical review requirements? Each utilization review agent must use written screening criteria and review procedures. Criteria for review determinations must be developed and periodically updated with input from appropriate health care providers and approved by a physician. Criteria shall be available for inspection by the Department of Insurance. Tit. 760 Ind. Admin. Code 1-46-4(2) Every utilization review determination as to the necessity or appropriateness of an admission, a service, or a procedure must be reviewed by a physician, or determined in accordance with standards or guidelines approved by a physician. Ind. Code Ann. § 27-8-17-11(7) *See also* Ind. Code Ann. § 27-8-17-13 Utilization review plan must provide a period of at least 48 hours following an emergency admission, service, or

procedure during which an enrollee, or the representative of an enrollee, may notify the utilization review agent and request certification or continuing treatment. Ind. Code Ann. § 27-8-17-11(9)

B. Financial incentives prohibition? Compensation to utilization review agents may not be based on the extent to which certifications are denied or the amount by which claims are reduced for payment. Ind. Code Ann § 27-8-17-19

C. Telephone access standards? Utilization review agents must provide toll free telephone access at least 40 hours each week during normal business hours. They must maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours. Response to recorded messages is to be within 2 business days after receiving the call. Ind. Code Ann. § 27-8-17-11-(1), (2) and (3); Ind. Admin. Code Tit. 760, r. 1-46-7

D. Quality assurance programs required? No provision specifically for utilization review agents. However, a health maintenance organization shall establish procedures based on professionally recognized standards to assess and monitor the health care services provided to enrollees of the organization. *See* Ind. Code Ann. § 27-13-6-1 and Ind. Code Ann. § 27-13-6-2 (Internal Quality Management Program), Ind. Code Ann. § 27-13-6-3 (Program Requirements).

E. UM delegation oversight requirements? No provision.

F. Confidentiality provisions (beyond HIPAA)? Utilization review agents must protect the confidentiality of individual medical records in accordance with state and federal laws; must be used for purposes of utilization review, quality assurance, discharge planning, and catastrophic case management; shared with only those agencies that have authority to receive such information; must, when contacting a health care provider's office or hospital, provide its certification number and the caller's name to the provider's named utilization review representative in the health care provider's office. Medical records must be kept in a secure area with access limited only to utilization review personnel. Information generated and obtained shall be retained for at least 2 years. Ind. Code Ann. § 27-8-17-11 (4); Ind. Admin. Code Tit. 760, r. 1-46-8; Ind. Admin. Code Tit. 760, r. 1-46-3(c)(3); Ind. Admin. Code Tit. 760, r. 1-46-4(1)(H)

G. Timeframe for initial determination? No provision.

V. Reviewer Qualifications

A. UM reviewer requirements? All utilization review determinations must be reviewed by a licensed physician or determined in accordance with standards or guidelines approved by a physician. On appeal, a health care provider licensed in the same discipline as the treating provider must consider the adverse determination. Ind. Code Ann. § 27-8-17-11(7); Ind. Code Ann. § 27-8-17-12(B)(1)

B. Medical director requirements? No provision.

C. Same-state licensure requirements? 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. Ind. Code Ann. § 27-8-17-11(8)

D. Offshore reviews permitted? No provision.

VI. Appeals

A. Appeal Overview

HEALTH UM INDIANA

1. **Internal Appeals**
   a. **General overview.** A utilization review agent shall make available to an enrollee, and to a provider of record upon request, at the time an adverse determination is made: 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 in case of an enrollee covered under an accident an sickness policy or a health maintenance organization contract, notice the enrollee has the right to appeal the utilization review determination 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. Ind. Code Ann. § 27-8-17-12(a)
   b. **Are there any requirements based upon UM types (e.g., medical vs administrative)?** No difference in how appeals are conducted, however the different forms of utilization review is noted in its definition.
2. **External Appeals**
   a. **General overview.** An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding an adverse determination of appropriateness, medical necessity or that a proposed service is experimental or investigational or an insurer's decision to rescind an accident and sickness insurance policy. Ind. Code Ann. § 27-8-29-12
   b. **Any requirements based upon external review types?** No provision.

B. Internal Appeal Requirements

1. **Initial requirements?**
   a. **Does the state specify any initial UM appeal notice requirements to patients/providers?** Upon request, the utilization review agent shall make available to an enrollee, and to a provider of record, at the time of an adverse utilization review determination, a written description of the appeals procedure by which an enrollee or a provider of record may appeal the utilization review agent; and in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract notice that the enrollee has the right to appeal the utilization review determination, and the toll free telephone number and the enrollee may call to request a review of the determination or obtain further information about the right to appeal. Ind. Code Ann. § 27-8-17-12(a) HMOs must also provide timely, adequate, and appropriate notice to each enrollee or subscriber of the grievance procedure. Ind. Code Ann. § 27-13-10-4
   b. **What information must be included in the adverse determination notice?**
      i. **Notice of appeal rights** Yes. Ind. Code. Ann. § 27-8-28-16(a)
      ii. **Appeal requirements** Yes. Ind. Code Ann. § 27-8-28-16 (a)
      iii. **Rights to follow-up and/or external appeals?** Yes. Ind. Code Ann. § 27-13-10-4
      iv. **Is there a second level of appeals and are they different?** No provision.
   c. **How must the notice be communicated?** Information must be communicated either orally or in writing. Ind. Code Ann. § 27-8-28-16
2. **What are the filing requirements?**
   a. **What information must be filed by the patient/provider?** A covered individual may file a grievance orally or in writing. All

reasonably necessary information to complete the review. Ind. Code Ann. § 27-8-28-14(a), Ind. Code Ann. § 27-8-28-16

b. Can the UM appeal filing deadline be extended? No provision.

3. What timeframe must be followed?

a. For standard appeals? The utilization agent must complete the determination of the appeal within 30 days after the appeal is filed and all necessary information necessary to complete the appeal is received. An acknowledgement of the receipt of the grievance, given orally or in writing, to the covered individual within 5 business days. A grievance must be resolved within 20 business days after the insurer receives all information reasonably necessary to complete the review. The insurer must notify the insured if the determination cannot be made within the 20 days and may have an additional 10 business days to complete the determination. The insurer must notify the covered individual within 5 business days after the determination is made. Ind. Code Ann. § 27-8-28-16, Ind. Code Ann. § 27-8-17-12(b)

b. For expedited appeals? For emergency or life threatening situations the utilization review agent shall provide an expedited appeals process. A physician must make the determination within 48 hours after the appeal is filed and all information necessary to complete the appeal is received. Ind. Code Ann. § 27-8-17-12(c)

4. What are the final notification requirements? An insurer shall notify a covered individual in writing of the resolution of a grievance within 5 business days of completing the investigation. The grievance notice must include a statement of the decision reached by the insurer; a statement of the reasons, policies, and procedures that are the basis of the decision; a notice of the covered individual's right to appeal the decision and the department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal. Ind. Code Ann. § 27-8-28-16(d)

5. Is there more key information? A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance. Ind. Code Ann. § 27-8-28-15(b)

C. External Appeals

1. Does the state have external appeal after the UM appeals process is complete? Yes.

2. Statutory/Regulator Reference

a. Ind. Code Aann. § 27-8-29-13(a)

b. Ind. Code Ann. § 27-8-29-15.

c. Ind. Code Ann. § 27-8-29-17

d. Ind. Code Ann. § 27-13-10.1 through § 27-13-10.1-12

3. Note: See RegQuest External Review Module for specific details.

Regulator reviewed on September 27, 2017.

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