SENATE BILL No. 237

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-1-37.5.

Synopsis: Prior authorization for health care services. Amends the law on health care service prior authorizations: (1) to establish a standard by which to determine whether a health care service is "medically necessary"; (2) to require that the medical review or utilization review practices of a health plan be governed by this standard of medical necessity; (3) to require a health plan to employ a medical director who is responsible for reviewing and approving the health plan's policies on responses to requests for prior authorization; (4) to require a health plan to establish clear written policies and procedures for prior authorization for health care services; (5) to restrict a health plan's prior authorization requirements applying to: (A) physical medicine or rehabilitation services for a covered individual diagnosed with chronic pain; and (B) rehabilitative or habilitative services, including physical therapy, occupational therapy, and chiropractic services; (6) to provide that, under certain circumstances (including the failure of a health plan to respond to a request within certain time limits), a request for prior authorization is conclusively considered to be approved by the health plan; (7) to require a health plan to provide a procedure under which providers and covered individuals may seek retroactive authorization for health care services that are medically necessary covered benefits; and (8) to prohibit a health plan from denying coverage for a health care service merely because prior authorization was not obtained for the health care service before it was provided to a covered individual if: (A) the health care service would have been a covered benefit if prior authorization had been obtained before the health care service was provided to the covered individual; (B) a determination of medical

(Continued next page)

Effective: July 1, 2024.

Messmer

January 10, 2024, read first time and referred to Committee on Health and Provider Services.

necessity can be made after the health care service is provided; and (C) it is determined that the health care service was medically necessary. Defines "medically necessary" for use in these provisions.

Introduced

Second Regular Session of the 123rd General Assembly (2024)

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 2023 Regular Session of the General Assembly.

SENATE BILL No. 237

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

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

SECTION 1. IC 27-1-37.5-5.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 5.6. For purposes of this chapter, a health care service is "medically necessary" if the health care service is provided to a covered individual for the purpose of preventing, diagnosing, or treating an illness, injury, or disease, or the symptoms of an illness, injury, or disease, in a manner that is:**

(1) consistent with generally accepted standards of medical practice;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the convenience of the covered individual or physician or other health care practitioner.

SECTION 2. IC 27-1-37.5-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2024]: **Sec. 8.2. The medical review or utilization review practices of a health plan must be governed by the standard of medical necessity set forth in section 5.6 of this chapter.**

SECTION 3. IC 27-1-37.5-8.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.4. (a) A health plan shall employ a medical director who is responsible for reviewing and approving the policies of the health plan governing the clinical aspects of responses to requests for prior authorization of health care services for covered individuals.**

(b) A health plan shall establish and make available to:

(1) participating providers;

(2) other health care providers; and

(3) covered individuals;

clear written policies and procedures under which prior authorization may be obtained for health care services for covered individuals.

SECTION 4. IC 27-1-37.5-8.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.6. (a) As used in this section, "chronic pain" means pain experienced by a covered individual that persists or recurs for a period of more than three (3) months.**

(b) The following apply to physical medicine or rehabilitation services for a covered individual who is diagnosed with chronic pain:

(1) A health plan shall not require prior authorization for the physical medicine or rehabilitation services provided to the covered individual during the first ninety (90) days after the covered individual is diagnosed with chronic pain.

(2) After the ninety (90) day period referred to in subdivision (1), a health plan shall not require prior authorization for the physical medicine or rehabilitation services provided to the covered individual more frequently than:

(A) once for every six (6) appointments in which the covered individual receives physical medicine or rehabilitation services for chronic pain; or

(B) once every thirty (30) days;

whichever period is longer.

SECTION 5. IC 27-1-37.5-8.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.8. (a) As used in this section,**

"rehabilitative or habilitative services" include the following:

(1) Physical therapy services within the scope of practice of a physical therapist under IC 25-27.

(2) Occupational therapy services within the scope of practice of an occupational therapist under IC 25-23.5.

(3) Chiropractic services within the scope of practice of a chiropractor under IC 25-10.

(b) For purposes of this section, the rehabilitative or habilitative services provided by a health care provider to a covered individual constitute a "new episode of care" if:

(1) the rehabilitative or habilitative services are provided to the covered individual for a new or recurring condition; and

(2) the covered individual has not received rehabilitative or habilitative services for the condition described in subdivison (1) for at least ninety (90) days.

(c) A health plan may not require prior authorization for the first twelve (12) appointments in a new episode of care in which a covered individual receives rehabilitative or habilitative services.

SECTION 6. IC 27-1-37.5-11, AS AMENDED BY P.L.190-2023, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 11. (a) This section applies to a prior authorization request delivered to a health plan after December 31, 2019.

(b) A health plan shall respond to a request delivered under section 10 of this chapter as follows:

(1) If the request is delivered under section 10(b) of this chapter, the health plan shall immediately send to the requesting health care provider an electronic receipt for the request.

(2) If the request is for an urgent care situation, the health plan shall respond with a prior authorization determination not more than forty-eight (48) hours after receiving the request.

(3) If the request is for a nonurgent care situation, the health plan shall respond with a prior authorization determination not more than five (5) business days after receiving the request.

(c) If a request delivered under section 10 of this chapter is incomplete:

(1) the health plan shall respond within the period required by subsection (b) and indicate the specific additional information required to process the request;

(2) if the request was delivered under section 10(b) of this chapter, upon receiving the response under subdivision (1), the health care provider shall immediately send to the health plan an electronic receipt for the response made under subdivision (1);

and

(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information not more than forty-eight (48) hours after the health care provider receives the response under subdivision (1).

(d) If a request delivered under section 10 of this chapter is denied, the health plan shall respond within the period required by subsection (b) and indicate the specific reason for the denial in clear and easy to understand language.

(e) Under any of the following circumstances, a request for prior authorization delivered under section 10 of this chapter is conclusively considered to be approved by the health plan:

(1) The health plan fails to respond to the request within the period allowed under:

(A) subsection (b)(2); or

(B) subsection (b)(3);

whichever applies.

(2) The health plan, through:

(A) an oral communication;

(B) information provided by the health plan by an Internet platform or program; or

(C) any information set forth in:

(i) the policy of accident and sickness insurance referred to in section 5(a)(1) of this chapter;

(ii) the health maintenance organization contract referred to in section 5(a)(2) of this chapter; or

(iii) any plan summary or other document that explains the health care services to which a covered individual is entitled by a Medicaid risk based managed care program referred to in section 5(a)(3) of this chapter;

states that prior authorization is not required under the circumstances applying to the covered individual.

SECTION 7. IC 27-1-37.5-13, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 13. (a) This section applies to a claim filed after December 31, 2018, for a medically necessary health care service rendered by a participating provider, the necessity of which:

(1) is not anticipated at the time prior authorization is obtained for another health care service; and

(2) is determined at the time the other health care service is rendered.

(b) The health plan shall not deny a claim described in subsection

(a) based solely on lack of prior authorization for the unanticipated health care service.

(c) The health plan:

(1) shall not deny payment for a health care service that is rendered in accordance with:

(A) a prior authorization; and

(B) all terms and conditions of the participating provider's agreement or contract with the health plan; and

(2) may:

(A) require retrospective review of; and

(B) withhold payment for;

an unanticipated health care service described in subsection (a).

(d) A health plan shall provide a procedure under which participating providers and covered individuals may seek retroactive authorization for health care services.

(e) A health plan shall not deny coverage for a health care service merely because prior authorization was not obtained for the health care service before the health care service was provided to a covered individual if:

(1) the health care service would have been a covered benefit if prior authorization had been obtained for the health care service before it was provided to the covered individual;

(2) a determination of medical necessity can be made after the health care service is provided to the covered individual; and

(3) it is determined after the health care service is provided to the covered individual that the health care service was medically necessary.