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SENATE BILL No. 400

Proposed Changes to February 28, 2023 printing by AM040014

DIGEST OF PROPOSED AMENDMENT

All payer claims data base. Amends the definition of "health payer" for the purposes of the all payer claims data base. Makes corresponding changes.

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

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

SECTION 1. IC 12-15-11-5, AS AMENDED BY P.L.195-2018, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. (a) A provider who participates in the Medicaid program must comply with the enrollment requirements that are established under rules adopted under IC 4-22-2 by the secretary.

(b) A provider who participates in the Medicaid program may be required to use the centralized credentials verification organization established in section 9 of this chapter.

SECTION 2. IC 12-15-11-9, AS AMENDED BY P.L.32-2021, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 9. (a) The office shall implement a centralized credentials verification organization and credentialing process that:

- (1) uses a common application, as determined by provider type;
- (2) issues a single eredentialing decision applicable to all Medicaid programs, except as determined by the office;
- (3) recredentials and revalidates provider information not less than once every three (3) years;
- (4) requires attestation of enrollment and credentialing information every six (6) months; and
- 20 (5) is certificated or accredited by the National Committee for

SB 400-LS 7336/DI 141



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1	Quality Assurance or its successor organization.	
2	(a) As used in this section, "clean credentialing application"	
3	means an application for network participation that:	
4	(1) is submitted by a provider under this section;	
5	(2) does not contain an error; and	
6	(3) may be processed by the managed care organization or	
7	contractor of the office without returning the application to	
8	the provider for a revision or clarification.	
9	(b) As used in this section, "credentialing" means a process by	
10	which a managed care organization or contractor of the office	
11	makes a determination that:	
12	(1) is based on criteria established by the managed care	
13	organization or contractor of the office; and	
14	(2) concerns whether a provider is eligible to:	
15	(A) provide health services to an individual eligible for	
16	Medicaid services; and	
17	(B) receive reimbursement for the health services;	
18	under an agreement that is entered into between the	
19	provider and managed care organization or contractor of the	
20	office.	
21	(c) As used in this section, "unclean credentialing application"	
22	means an application for network participation that:	
23	(1) is submitted by a provider under this section;	
24	(2) contains at least one (1) error; and	
25	(3) must be returned to the provider to correct the error.	
26	(d) This section applies to a managed care organization or a	
27	contractor of the office.	
28	(e) If the office or managed care organization issues a	
29	provisional credential to a provider under subsection (j), the office	
30	or a managed care organization shall:	_
31	(1) issue a final credentialing determination not later than	
32	sixty (60) calendar days after the date in which the provider	
33	was provisionally credentialed; and	
34	(2) except as provided in subsection (I), provide retroactive	
35	reimbursement under subsection (k).	
36	(f) The office shall prescribe the credentialing application form	
37	used by the Council for Affordable Quality Healthcare in	
38	electronic or paper format, which must be used by:	
39	(1) a provider who applies for credentialing by a managed	
40	care organization or a contractor of the office; and	
41	(2) a managed care organization or a contractor of the office	
42	that performs credentialing activities.	



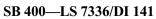
1	(g) A managed care organization or contractor of the office	
2	shall notify a provider concerning a deficiency on a completed	
3	unclean credentialing application form submitted by the provider	
4	not later than five (5) business days after the entity receives the	
5	completed unclean credentialing application form. A notice	
6	described in this subsection must:	
7	(1) provide a description of the deficiency; and	
8	(2) state the reason why the application was determined to be	
9	an unclean credentialing application.	
0	(h) A provider shall respond to the notification required under	
1	subsection (g) not later than five (5) business days after receipt of	
2	the notice.	
3	(i) A managed care organization or contractor of the office	
4	shall notify a provider concerning the status of the provider's	
5	completed clean credentialing application when:	
6	(1) the provider is provisionally credentialed; and	
7	(2) the entity makes a final credentialing determination	
8	concerning the provider.	
9	(j) If the managed care organization or contractor of the office	
0	fails to issue a credentialing determination within fifteen (15) days	
1	after receiving a completed clean credentialing application form	
2	from a provider, the managed care organization or contractor of	
.3	the office shall provisionally credential the provider in accordance	
4	with the standards and guidelines governing provisional	
.5	credentialing from the National Committee for Quality Assurance	
6	or its successor organization. The provisional credentialing license	
.7	is valid until a determination is made on the credentialing	-
8	application of the provider.	
9	(k) Once a managed care organization or the contractor of the	
0	office fully credentials a provider that holds provisional	_
1	credentialing and a network provider agreement has been	
2	executed, then reimbursement payments under the contract shall	
3	be paid retroactive to the later of the date the provider was	
4	provisionally credentialed or the effective date of the provider	
5	agreement. The managed care organization or contractor of the	
6	office shall reimburse the provider at the rates determined by the	
7	contract between the provider and the:	
8	(1) managed care organization; or	
9	(2) contractor of the office.	
0	(l) If a managed care organization or contractor of the office	
1	does not fully credential a provider that is provisionally	
2	credentialed under subsection (j), the provisional credentialing is	



1	terminated on the date the managed care organization or	
2	contractor of the office notifies the provider of the adverse	
3	credentialing determination. The managed care organization or	
4	contractor of the office is not required to reimburse for services	
5	rendered while the provider was provisionally credentialed.	
6	(b) (m) A managed care organization or contractor of the office	
7	may not require additional credentialing requirements in order to	
8	participate in a managed care organization's network. However, a	
9	contractor may collect additional information from the provider in	
10	order to complete a contract or provider agreement.	
11	(e) (n) A managed care organization or contractor of the office is	
12	not required to contract with a provider.	
13	(d) (o) A managed care organization or contractor of the office	
14	shall:	
15	(1) send representatives to meetings and participate in the	
16	credentialing process as determined by the office; and	
17	(2) not require additional credentialing information from a	
18	provider if a non-network credentialed provider is used.	
19	(e) (p) Except when a provider is no longer enrolled with the	
20	office, a credential acquired under this chapter is valid until	
21	recredentialing is required.	
22	(f) (q) An adverse action under this section is subject to IC 4-21.5.	
23	(g) (r) The office may adopt rules under IC 4-22-2 to implement	
24	this section.	
25	SECTION 3. IC 16-21-1-7.1 IS ADDED TO THE INDIANA	
26	CODE AS A NEW SECTION TO READ AS FOLLOWS	
27	[EFFECTIVE JULY 1, 2023]: Sec. 7.1. (a) A hospital's quality	
28	assessment and improvement program under 410 IAC 15-1.4-2	
29	must include a process for determining and reporting the	
30	occurrence of serious reportable events, as identified by the	
31	National Quality Forum.	
32	(b) The executive board may not require a hospital's quality	
33	assessment and improvement program to determine and report	
34	any other types of events that are not described in subsection (a).	
35	(c) The executive board may adopt rules under IC 4-22-2 to	
36	implement this section.	
37	SECTION 4. IC 16-21-1-7.2 IS ADDED TO THE INDIANA	
38	CODE AS A NEW SECTION TO READ AS FOLLOWS	
39	[EFFECTIVE JULY 1, 2023]: Sec. 7.2. (a) The medical staff (as	
40	described in IC 16-21-2-7) may make recommendations on the	
41	granting of clinical privileges or the appointment or reappointment	
42	of an applicant to the governing board of the hospital for a period	

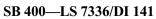


1	not to exceed thirty-six (36) months.	
2	(b) The executive board may adopt rules under IC 4-22-2 to	
3	implement this section.	
4	SECTION 5. IC 16-21-2-14.5 IS ADDED TO THE INDIANA	
5	CODE AS A NEW SECTION TO READ AS FOLLOWS	
6	[EFFECTIVE JULY 1, 2023]: Sec. 14.5. A hospital with an	
7	emergency department must have at least one (1) physician on site	
8	and on duty who is responsible for the emergency department at all	
9	times the emergency department is open.	
10	SECTION 6. IC 25-0.5-1-2.4 IS ADDED TO THE INDIANA	
11	CODE AS A NEW SECTION TO READ AS FOLLOWS	
12	[EFFECTIVE JULY 1, 2023]: Sec. 2.4. IC 25-1-1.1-4 applies to an	
13	individual licensed or certified under IC 25-4.5 (associate	
14	physicians).	
15	SECTION 7. IC 25-1-8-9 IS ADDED TO THE INDIANA CODE	
16	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY	
17	1, 2023]: Sec. 9. (a) The legislative services agency shall conduct an	
18	analysis of the fees established under section 2 of this chapter.	
19	(b) Not later than January 31, 2026, the legislative services	
20	agency shall submit a report to the budget committee in an	
21	electronic format under IC 5-14-6 containing the results of the	
22	analysis conducted under subsection (a). The report must include:	
23	(1) the amount of fees collected; and	
24	(2) a description of how the proceeds from the collected fees	
25	were used;	
26	during the two (2) most recent fiscal years.	
27	(c) This section expires July 1, 2026.	
28	SECTION 8. IC 25-1-9-23, AS AMENDED BY P.L.165-2022,	
29	SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
30	UPON PASSAGE]: Sec. 23. (a) This section does not apply to	
31	emergency services.	
32	(b) As used in this section, "covered individual" means an	
33	individual who is entitled to be provided health care services at a cost	
34	established according to a network plan.	
35	(c) As used in this section, "emergency services" means services	
36	that are:	
37	(1) furnished by a provider qualified to furnish emergency	
38	services; and	
39	(2) needed to evaluate or stabilize an emergency medical	
40	condition.	
41	(d) As used in this section, "in network practitioner" means a	
42	practitioner who is required under a network plan to provide health	



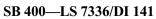


1	care services to covered individuals at not more than a preestablished	
2	rate or amount of compensation.	
3	(e) As used in this section, "network plan" means a plan under	
4	which facilities and practitioners are required by contract to provide	
5	health care services to covered individuals at not more than a	
6	preestablished rate or amount of compensation.	
7	(f) As used in this section, "out of network" means that the health	
8	care services provided by the practitioner to a covered individual are	
9	not subject to the covered individual's health carrier network plan.	
10	(g) As used in this section, "practitioner" means the following:	
11	(1) An individual who holds:	
12	(A) an unlimited license, certificate, or registration;	
13	(B) a limited or probationary license, certificate, or	
14	registration;	
15	(C) a temporary license, certificate, registration, or permit;	
16	(D) an intern permit; or	
17	(E) a provisional license;	
18	issued by the board (as defined in IC 25-0.5-11-1) regulating the	
19	profession in question.	
20	(2) An entity that:	
21	(A) is owned by, or employs; or	
22	(B) performs billing for professional health care services	
23	rendered by;	
24	an individual described in subdivision (1).	
25	The term does not include a dentist licensed under IC 25-14, an	
26	optometrist licensed under IC 25-24, or a provider facility (as defined	
27	in IC 25-1-9.8-10).	
28	(h) An in network practitioner who provides covered health care	
29	services to a covered individual may not charge more for the covered	
30	health care services than allowed according to the rate or amount of	
31	compensation established by the individual's network plan.	
32	(i) An out of network practitioner who provides health care	
33	services at an in network facility to a covered individual may not be	
34	reimbursed more for the health care services than allowed according to	
35	the rate or amount of compensation established by the covered	
36	individual's network plan unless all of the following conditions are met:	
37	(1) At least five (5) business days before the health care services	
38	are scheduled to be provided to the covered individual, the	
39	practitioner provides to the covered individual, on a form	
40	separate from any other form provided to the covered individual	
41	by the practitioner, a statement in conspicuous type that meets	
42	the following requirements:	





1	(A) Includes a notice reading substantially as follows:	
2	"[Name of practitioner] is an out of network practitioner	
3	providing [type of care] with [name of in network facility],	
4	which is an in network provider facility within your health	
5	carrier's plan. [Name of practitioner] will not be allowed to	
6	bill you the difference between the price charged by the	
7	practitioner and the rate your health carrier will reimburse	
8	for the services during your care at [name of in network	
9	facility] unless you give your written consent to the	
10	charge.".	
11	(B) Sets forth the practitioner's good faith estimate of the	
12	amount that the practitioner intends to charge for the health	
13	care services provided to the covered individual.	
14	(C) Includes a notice reading substantially as follows	
15	concerning the good faith estimate set forth under clause	
16	(B): "The estimate of our intended charge for [name or	
17	description of health care services] set forth in this	
18	statement is provided in good faith and is our best estimate	
19	of the amount we will charge. If our actual charge for [name	
20	or description of health care services] exceeds our estimate	
21	by the greater of:	
22	(i) one hundred dollars (\$100); or	
23 24	(ii) five percent (5%);	
2 4 25	we will explain to you why the charge exceeds the estimate.".	
25 26	(2) The covered individual signs the statement provided under	
27	subdivision (1), signifying the covered individual's consent to the	
28	charge for the health care services being greater than allowed	_
29 29	according to the rate or amount of compensation established by	
30	the network plan.	_
31	(j) If an out of network practitioner does not meet the requirements	
32	of subsection (i), the out of network practitioner shall include on any	
33	bill remitted to a covered individual a written statement in conspicuous	
34	type stating that the covered individual is not responsible for more than	
35	the rate or amount of compensation established by the covered	
36	individual's network plan plus any required copayment, deductible, or	
37	coinsurance.	_
38	(k) If a covered individual's network plan remits reimbursement to	
39	the covered individual for health care services subject to the	
40	reimbursement limitation of subsection (i), the network plan shall	
41	provide with the reimbursement a written statement in conspicuous	
1 2.	type that states that the covered individual is not responsible for more	

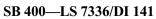




I	than the rate or amount of compensation established by the covered	
2	individual's network plan and that is included in the reimbursement	
3	plus any required copayment, deductible, or coinsurance.	
4	(1) If the charge of a practitioner for health care services provided	
5	to a covered individual exceeds the estimate provided to the covered	
6	individual under subsection (i)(1)(B) by the greater of:	
7	(1) one hundred dollars (\$100); or	
8	(2) five percent (5%);	
9	the facility or practitioner shall explain in a writing provided to the	
10	covered individual why the charge exceeds the estimate.	
11	(m) An in network practitioner is not required to provide a covered	
12	individual with the good faith estimate if the nonemergency health care	
13	service is scheduled to be performed by the practitioner within five (5)	
14	business days after the health care service is ordered.	
15	(n) The department of insurance shall adopt emergency rules	
16	under IC 4-22-2-37.1 to specify the requirements of the notifications	
17	set forth in subsections (j) and (k).	
18	(o) A practitioner may satisfy The requirements of this section by	
19	complying with the requirements set forth in Section 2799B-6 of the	
20	federal Public Health Service Act, as added by Public Law 116-260. do	
21	not apply to a practitioner that:	
22	(1) is required to comply with; and	
23	(2) is in compliance with;	
24	45 CFR Part 149, Subparts E and G, as may be enforced and	
25	amended by the federal Department of Health and Human	
26	Services.	
27	SECTION 9. IC 25-1-9.8-20, AS ADDED BY P.L.165-2022,	
28	SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
29	UPON PASSAGE]: Sec. 20. A practitioner may satisfy The	
30	requirements of this chapter by complying with the requirements set	
31	forth in Section 2799B-6 of the federal Public Health Service Act, as	
32	added by Public Law 116-260. do not apply to a practitioner that:	
33	(1) is required to comply with; and	
34	(2) is in compliance with;	
35	45 CFR Part 149, Subparts E and G, as may be enforced and	
36	amended by the federal Department of Health and Human	
37	Services.	
38	SECTION 10. IC 25-4.5 IS ADDED TO THE INDIANA CODE	
39	AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY	
40	1, 2023]:	
41	ARTICLE 4.5. ASSOCIATE PHYSICIANS	
42	Chapter 1. Definitions	D



1	Sec. 1. The definitions in this chapter apply throughout this	
2	article.	
3	Sec. 2. "Associate physician" means an individual who:	
4	(1) meets the qualifications under this article; and	
5	(2) is licensed under this article.	
6	Sec. 3. "Board" refers to the medical licensing board of	
7	Indiana.	
8	Sec. 4. "Collaborating physician" means a physician licensed	
9	by the board who collaborates with and is responsible for an	
10	associate physician.	
11	Sec. 5. (a) "Collaboration" means overseeing the activities of,	
12	and accepting responsibility for, the medical services rendered by	
13	an associate physician and that one (1) of the following conditions	
14	is met at all times that services are rendered or tasks are	
15	performed by the associate physician:	
16	(1) The collaborating physician or the physician designee is	
17	physically present at the location at which services are	
18	rendered or tasks are performed by the associate physician.	
19	(2) When the collaborating physician or the physician	
20	designee is not physically present at the location at which	
21	services are rendered or tasks are performed by the associate	
22	physician, the collaborating physician or the physician	
23	designee is able to personally ensure proper care of the	
24	patient and is:	
25	(A) immediately available through the use of	
26	telecommunications or other electronic means; and	
27	(B) able to see the person within a medically appropriate	
28	time frame;	
29	for consultation, if requested by the patient or the associate	
30	physician.	
31	(b) The term includes the use of protocols, guidelines, and	
32	standing orders developed or approved by the collaborating	
33	physician.	
34	Sec. 6. "Physician" means an individual who:	
35	(1) holds the degree of doctor of medicine or doctor of	
36	osteopathy, or an equivalent degree; and	
37	(2) holds an unlimited license under IC 25-22.5 to practice	
38	medicine or osteopathic medicine.	
39	Chapter 2. Licensure	
40	Sec. 1. (a) An individual must be licensed by the board before	
41	the individual may practice as an associate physician. The board	
42	may grant an associate physician license to an applicant who meets	D





1	the following requirements:	
2	(1) Submits an application on forms approved by the board.	
3	(2) Pays the fee established by the board.	
4	(3) Has:	
5	(A) successfully completed the academic requirements	
6	for the degree of doctor of medicine or doctor of	
7	osteopathy from a medical school approved by the	
8	board but has not completed an approved postgraduate	
9	residency; and	
10	(B) passed step two (2) of the United States Medical	
11	Licensing Examination, the Comprehensive Osteopathic	
12	Medical Licensing Exam, or an equivalent test approved	
13	by the board not more than three (3) years before	
14	graduating from a medical school and applying for	
15	licensure under this chapter.	
16	(4) Agrees to practice only primary care services:	
17	(A) in a medically underserved rural or urban area; or	
18	(B) at a rural health clinic (as defined in 42 U.S.C.	
19	1396d(l)(1));	
20	and under a collaborative agreement with a physician as	
21	required under this article.	
22	(5) Submits to the board any other information the board	
23	considers necessary to evaluate the applicant's qualifications.	
24	(6) Presents satisfactory evidence to the board that the	
25	individual has not been:	
26	(A) engaged in an act that would constitute grounds for	
27	a disciplinary sanction under IC 25-1-9; or	
28	(B) the subject of a disciplinary action by a licensing or	
29	certification agency of another state or jurisdiction on	
30	the grounds that the individual was not able to practice	-
31	as an associate physician without endangering the	
32	public.	
33	(7) Is a resident and citizen of the United States or is a	
34	lawfully admitted alien.	
35	(8) Is proficient in English.	
36	(9) Is of good moral character.	
37	(b) The board may not require an applicant or an individual	
38	licensed under this article to complete more continuing education	
39	than that required of a physician licensed under IC 25-22.5.	
40	Sec. 2. The board may refuse to issue a license or may issue a	
41	probationary license to an individual if:	
42	(1) the individual has been disciplined by an administrative	



1	agency in another jurisdiction or been convicted for a crime	
2	that has a direct bearing on the individual's ability to	
3	practice competently; and	
4	(2) the board determines that the act for which the individual	
5	was disciplined or convicted has a direct bearing on the	
6	individual's ability to practice as an associate physician.	
7	Sec. 3. (a) If the board issues a probationary license under	
8	section 2 of this chapter, the committee may require the individual	
9	who holds the probationary license to meet at least one (1) of the	
10	following conditions:	
11	(1) Report regularly to the board upon a matter that is the	
12	basis for the probation.	
13	(2) Limit practice to services prescribed by the board.	
14	(3) Continue or renew professional education.	
15	(4) Engage in community restitution or service without	
16	compensation for a number of hours specified by the board.	
17	(5) Submit to care, counseling, or treatment by a physician	
18	designated by the board for a matter that is the basis for the	
19	probation.	
20	(b) The board shall remove a limitation placed on a	
21	probationary license if after a hearing the committee finds that the	
22	deficiency that caused the limitation has been remedied.	
23	Sec. 4. (a) Subject to IC 25-1-2-6(e), a license issued by the	
24	board expires on a date established by the Indiana professional	
25	licensing agency under IC 25-1-5-4 and that does not exceed one (1)	
26	year from the date the license was issued.	
27	(b) An individual may renew a license:	
28	(1) not more than two (2) times; and	
29	(2) by paying a renewal fee on or before the expiration date	
30	of the license.	-
31	(c) If an individual fails to pay a renewal fee on or before the	
32	expiration date of a license, the license becomes invalid and must	
33	be returned to the board.	
34	(d) Before the board may issue a renewal license, the board	
35	shall ensure that the licensee is operating under a collaborative	
36	agreement as required by this article.	
37	Sec. 5. (a) If an individual surrenders a license to the board,	
38	the board may reinstate the license upon written request by the	
39	individual.	
40	(b) If the board reinstates a license, the board may impose	
41	conditions on the license appropriate to the reinstatement.	
42	(c) An individual may not surrender a license without written	



1	approval by the board if a disciplinary proceeding under this	
2	article is pending against the individual.	
3	Sec. 6. The board may do any of the following:	
4	(1) Suspend or revoke a license of a licensee who commits a	
5	serious violation of this article.	
6	(2) Discipline a licensee for a less severe violation of this	
7	chapter.	
8	Chapter 3. Collaborative Agreements	
9	Sec. 1. (a) In order to be licensed under this article, an	
.0	associate physician shall enter into a collaborative agreement with	
1	a physician licensed under IC 25-22.5. The associate physician may	
2	not practice independently from the collaborating physician.	
.3	(b) The collaborating physician is responsible at all times for	
4	the oversight of the activities of, and accepts responsibility for,	
.5	primary care services provided by the associate physician.	
.6	(c) Except in an emergency situation, an associate physician	
.7	shall clearly identify to a patient that the patient is being treated by	
.8	an associate physician.	
9	(d) If an associate physician determines that a patient needs to	
20	be examined by a physician, the associate physician shall	
21	immediately notify the collaborating physician or physician	
22	designee.	
23	(e) If an associate physician notifies the collaborating	
24	physician that the collaborating physician should examine a	
25	patient, the collaborating physician shall:	
26	(1) schedule an examination of the patient unless the patient	
27	declines; or	
28	(2) arrange for another physician to examine the patient.	
29	(f) A collaborating physician or an associate physician who	
80	does not comply with this section is subject to discipline under	-
31	IC 25-1-9.	
32	(g) An associate physician's collaborative agreement with a	
33	collaborating physician must:	
34	(1) be in writing;	
35	(2) include the services delegated to the associate physician	
86	by the collaborating physician and limited to those allowed	
37	under this article;	_
88	(3) set forth the collaborative agreement for the associate	
39	physician, including the emergency procedures that the	
10	associate physician must follow; and	
1	(4) specify the protocol the associate physician shall follow in	
12	prescribing a drug.	D



1	(h) The collaborating physician shall submit the collaborative	
2	agreement to the board. Any amendment to the collaborative	
3	agreement must be resubmitted to the board.	
4	(i) A collaborating physician or an associate physician who	
5	violates the collaborative agreement described in this section may	
6	be disciplined under IC 25-1-9.	
7	Sec. 2. (a) Collaboration by the collaborating physician or the	
8	physician's designee must be continuous but does not require the	
9	physical presence of the collaborating physician at the time and the	
10	place that the services are rendered.	
11	(b) A collaborating physician or physician's designee shall	
12	review patient encounters, including at least twenty percent (20%)	
13	of the charts in which the associate physician prescribes a	
14	controlled substance, not later than ten (10) business days, and	
15	within a reasonable time, as established in the collaborative	
16	agreement, after the associate physician has seen the patient, that	
17	is appropriate for the maintenance of quality medical care.	
18	Sec. 3. (a) A physician collaborating with an associate	
19	physician must meet the following requirements:	
20	(1) Be licensed under IC 25-22.5.	
21	(2) Register with the board the physician's intent to enter	
22	into a collaborative agreement with an associate physician.	
23	(3) Not have a disciplinary action restriction that limits the	
24	physician's ability to collaborate with an associate physician.	
25	(4) Maintain a written agreement with the associate	
26	physician that states the physician will:	
27	(A) work in collaboration with the associate physician in	
28	accordance with any rules adopted by the board; and	
29	(B) retain responsibility for the care rendered by the	
30	associate physician.	_
31	The collaborative agreement must be signed by the physician	
32	and the associate physician, updated annually, and made	
33	available to the board upon request.	
34	(b) Before initiating practice the collaborating physician and	
35	the associate physician must submit, on forms approved by the	
36	board, the following information:	
37	(1) The name, the business address, and the telephone	
38	number of the collaborating physician.	
39	(2) The name, the business address, and the telephone	
40	number of the associate physician.	
41	(3) A list of all the locations in which the collaborating	
42	physician authorizes the associate physician to prescribe.	



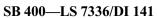
1	(4) A brief description of the setting in which the associate	
2	physician will practice.	
3	(5) A description of the associate physician's controlled	
4	substance prescriptive authority in collaboration with the	
5	collaborating physician, including a list of the controlled	
6	substances the collaborating physician authorizes the	
7	associate physician to prescribe and documentation that the	
8	authority is consistent with the education, knowledge, skill,	
9	and competence of both parties.	
.0	(6) Any other information required by the board.	
1	(c) An associate physician shall notify the board of any	
2	changes or additions in practice sites or collaborating physicians	
3	not more than thirty (30) days after the change or addition.	
4	Sec. 4. (a) An associate physician who is granted controlled	
.5	substances prescriptive authority by a collaborating physician	
.6	under this chapter may prescribe, if agreed to by the collaborating	
7	physician:	
8	(1) any controlled substance listed in Schedule III, Schedule	
9	IV, or Schedule V; and	
20	(2) a limited authority of Schedule II controlled substances	
21	and only if the Schedule II controlled substance contains	
22	hydrocodone.	
23	(b) The collaborating physician shall specify in the	
24	collaborative agreement whether the associate physician has	
25	authorization to prescribe a controlled substance and any	
26	limitations on the prescribing placed by the collaborating	
27	physician.	
28	(c) An associate physician with prescriptive authority for	
29	prescribing controlled substances shall register with the United	
0	States Drug Enforcement Administration and include the issued	_
31	registration number on prescriptions for controlled substances.	
32	(d) The board may adopt rules under IC 4-22-2 governing the	
3	prescribing of controlled substances by an associate physician.	
34	Sec. 5. If an associate physician is employed by a physician, a	
55	group of physicians, or another legal entity, the associate physician	
66	must be in collaboration with and be the legal responsibility of the	
37	collaborating physician. The legal responsibility for the associate	
8	physician's patient care activities are that of the collaborating	
9	physician, including when the associate physician provides care	
10	and treatment for patients in health care facilities.	
1	Sec. 6. A collaborating physician may not enter into a	
12	collaborative practice agreement with a total of more than six (6)	



associate physicians and physician assistants under IC 25-27.5.	
Sec. 7. The board may adopt rules under IC 4-22-2 specifying	
requirements and regulation of the use of collaborative agreements	
under this article.	
Chapter 4. Unauthorized Practice; Penalties; Sanctions	
Sec. 1. An individual may not:	
(1) profess to be an associate physician; or	
(2) use the title "associate physician";	
unless the individual is licensed under this article.	
Sec. 2. An individual who violates this chapter commits a Class	
B misdemeanor.	
Sec. 3. In addition to the penalty under section 2 of this	
chapter, an associate physician who violates this article is subject	
to the sanctions under IC 25-1-9.	
SECTION 11. IC 25-13-1-8, AS AMENDED BY P.L.78-2017,	
SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
JULY 1, 2023]: Sec. 8. (a) A license to practice dental hygiene in	
Indiana may be issued to candidates who pass an examination	
administered by an entity that has been approved by the board. Subject	
to IC 25-1-2-6(e), the license shall be valid for the remainder of the	
renewal period in effect on the date the license was issued.	
(b) Prior to the issuance of the license, the applicant shall pay a fee	
set by the board under section 5 of this chapter. Subject to	
IC 25-1-2-6(e), a license issued by the board expires on a date specified	
by the Indiana professional licensing agency under IC 25-1-5-4(l) of	
each even-numbered year.	
(c) Subject to IC 25-1-2-6(e), an applicant for license renewal	
must satisfy the following conditions:	
(1) Pay (A) the renewal fee set by the board under section 5 of	
this chapter on or before the renewal date specified by the	_
Indiana professional licensing agency in each even-numbered	
year. and	
(B) a compliance fee of twenty dollars (\$20) to be deposited	
in the dental compliance fund established by	
IC 25-14-1-3.7.	
(2) Subject to IC 25-1-4-3, provide the board with a sworn	
statement signed by the applicant attesting that the applicant has	
fulfilled the continuing education requirements under	
IC 25-13-2.	
(3) Be currently certified or successfully complete a course in	
basic life support through a program approved by the board. The	
board may waive the basic life support requirement for	0



1	applicants who show reasonable cause.	
2	(d) If the holder of a license does not renew the license on or	
3	before the renewal date specified by the Indiana professional licensing	
4	agency, the license expires and becomes invalid without any action by	
5	the board.	
6	(e) A license invalidated under subsection (d) may be reinstated	
7	by the board in three (3) years or less after such invalidation if the	
8	holder of the license meets the requirements under IC 25-1-8-6(c).	
9	(f) If a license remains invalid under subsection (d) for more than	
0	three (3) years, the holder of the invalid license may obtain a reinstated	
1	license by meeting the requirements for reinstatement under	
2	IC 25-1-8-6(d). The board may require the licensee to participate in	
3	remediation or pass an examination administered by an entity approved	
4	by the board.	
5	(g) The board may require the holder of an invalid license who	
6	files an application under this subsection to appear before the board	
7	and explain why the holder failed to renew the license.	
8	(h) The board may adopt rules under section 5 of this chapter	
9	establishing requirements for the reinstatement of a license that has	
0.	been invalidated for more than three (3) years.	
1	(i) The license to practice must be displayed at all times in plain	
2	view of the patients in the office where the holder is engaged in	
.3	practice. No person may lawfully practice dental hygiene who does not	
4	possess a license and its current renewal.	
.5	(j) Biennial renewals of licenses are subject to the provisions of	
6	IC 25-1-2.	
.7	SECTION 12. IC 25-14-1-3.7, AS AMENDED BY P.L.264-2013,	
8	SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
9	JULY 1, 2023]: Sec. 3.7. (a) The dental compliance fund is established	
0	to provide funds for administering and enforcing the provisions of this	
1	article, including investigating and taking enforcement action against	
2	violators of:	
3	(1) IC 25-1-9 concerning an individual licensed under IC 25-13	
4	or this article;	
5	(2) IC 25-13; and	
6	(3) this article.	
7	The fund shall be administered by the Indiana professional licensing	
8	agency.	
9	(b) The expenses of administering the fund shall be paid from the	
0	money in the fund. The fund consists of (1) compliance fees paid under	
1	IC 25-13-1-8 and section 10(a) of this chapter; and (2) fines and civil	
2	penalties collected through investigations of violations of:	

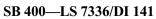




1	(A) (1) IC 25-1-9 concerning individuals licensed under	
2	IC 25-13 or this article;	
3	(B) (2) ☐IC 25-13; and	
4	(C) (3) this article;	
5	conducted by the board or the attorney general.	
6	(c) The treasurer of state shall invest the money in the fund not	
7	currently needed to meet the obligations of the fund in the same	
8	manner as other public money may be invested.	
9	(d) Money in the fund at the end of a state fiscal year does not	
10	revert to the state general fund.	
11	(e) The attorney general and the Indiana professional licensing	
12	agency shall enter into a memorandum of understanding to provide the	
13	attorney general with funds to conduct investigations and pursue	
14	enforcement action against violators of:	
15	(1) IC 25-1-9 if the individual is licensed under IC 25-13 or this	
16	article;	
17	(2) IC 25-13; and	
18	(3) this article.	
19	(f) The attorney general and the Indiana professional licensing	
20	agency shall present any memorandum of understanding under	
21	subsection (e) annually to the board for review.	
22	SECTION 13. IC 25-14-1-10, AS AMENDED BY P.L.78-2017,	
23	SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
24	JULY 1, 2023]: Sec. 10. (a) Subject to IC 25-1-2-6(e), unless renewed,	
25	a license issued by the board expires on a date specified by the agency	
26	under IC 25-1-5-4(l). An applicant for renewal shall pay the renewal	
27	fee set by the board under section 13 of this chapter on or before the	
28	renewal date specified by the agency. In addition to the renewal fee set	
29	by the board, an applicant for renewal shall pay a compliance fee of	
30	twenty dollars (\$20) to be deposited in the dental compliance fund	
31	established by section 3.7 of this chapter.	
32	(b) The license shall be properly displayed at all times in the office	
33	of the person named as the holder of the license, and a person may not	
34	be considered to be in legal practice if the person does not possess the	
35	license and renewal card.	
36	(c) If a holder of a dental license does not renew the license on or	
37	before the renewal date specified by the agency, without any action by	
38	the board the license together with any related renewal card is	
39	invalidated.	
40	(d) Except as provided in section 27.1 of this chapter, a license	
41	invalidated under subsection (c) may be reinstated by the board in three	_
42	(3) years or less after its invalidation if the holder of the license meets	



1	the requirements under IC 25-1-8-6(c).	
2	(e) Except as provided in section 27.1 of this chapter, if a license	
3	remains invalid under subsection (c) for more than three (3) years, the	
4	holder of the invalid license may obtain a reinstated license by	
5	satisfying the requirements for reinstatement under IC 25-1-8-6(d).	
6	(f) The board may require the holder of an invalid license who	
7	files an application under this subsection to appear before the board	
8	and explain why the holder failed to renew the license.	
9	(g) The board may adopt rules under section 13 of this chapter	
10	establishing requirements for the reinstatement of a license that has	
11	been invalidated for more than three (3) years. The fee for a duplicate	
12	license to practice as a dentist is subject to IC 25-1-8-2.	
13	(h) Biennial renewal of licenses is subject to IC 25-1-2.	
14	(i) Subject to IC 25-1-4-3, an application for renewal of a license	
15	under this section must contain a sworn statement signed by the	
16	applicant attesting that the applicant has fulfilled the continuing	
17	education requirements under IC 25-14-3.	
18	SECTION 14. IC 25-21.8-4-5, AS ADDED BY P.L.267-2017,	
19	SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
20	JULY 1, 2023]: Sec. 5. This article does not prohibit the following:	
21	(1) An individual who has a license, registration, certificate, or	
22	permit from the state from acting within the scope of the	
23	individual's license, registration, certificate, or permit.	
24	(2) An individual who participates in an approved training	
25	program for the purpose of acquiring a license, registration,	
26	certificate, or permit from the state from performing activities	
27	within the scope of the approved training program.	
28	(3) A student of an approved massage therapy school from	
29	performing massage therapy under the supervision of the	
30	approved massage therapy school, if the student does not profess	
31	to be a licensed massage therapist.	
32	(4) An individual's practice in one (1) or more of the following	
33	areas that does not involve intentional soft tissue manipulation:	
34	(A) Alexander Technique.	
35	(B) Feldenkrais.	
36	(C) Reiki.	
37	(D) Therapeutic Touch.	
38	(5) An individual's practice in which the individual provides	
39	service marked bodywork approaches that involve intentional	
40	soft tissue manipulation, including:	
41	(A) Rolfing;	
42	(B) Trager Approach;	





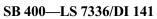
1	(C) Polarity Therapy;	
2	(D) Ortho-bionomy; and	
3	(E) Reflexology;	
4	if the individual is approved by a governing body based on a	
5	minimum level of training, demonstration of competency, and	
6	adherence to ethical standards.	
7	(6) The practice of massage therapy by a person either actively	
8	licensed as a massage therapist in another state or currently	
9	certified by the National Certification Board of Therapeutic	
10	Massage and Bodywork or other national certifying body if the	
11	person's state does not license massage therapists, if the	
12	individual is performing duties for a non-Indiana based team or	
13	organization, or for a national athletic event held in Indiana, so	
14	long as the individual restricts the individual's practice to the	
15	individual's team or organization during the course of the	
16	individual's or the individual's team's or the individual's	
17	organization's stay in Indiana or for the duration of the event.	
18	(7) Massage therapists from other states or countries providing	
19	educational programs in Indiana for a period not to exceed thirty	
20	(30) days within a calendar year.	
21	(8) An employee of a physician or a group of physicians from	
22	performing an act, a duty, or a function to which the exception	
23	described in IC 25-22.5-1-2(a)(20) IC 25-22.5-1-2(a)(21)	
24	applies.	
25	(9) An employee of a chiropractor from performing an act, duty,	
26	or function authorized under IC 25-10-1-13.	
27	(10) An employee of a podiatrist or a group of podiatrists from	
28	performing an act, duty, or function to which the exception	
29	described in IC 25-29-1-0.5(a)(13) applies.	
30	(11) A dramatic portrayal or some other artistic performance or	
31	expression involving the practice of massage therapy.	
32	(12) The practice of massage therapy by a member of an	
33	emergency response team during a period of active emergency	
34	response.	
35	SECTION 15. IC 25-22.5-1-2, AS AMENDED BY P.L.128-2022,	
36	SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
37	JULY 1, 2023]: Sec. 2. (a) This article, as it relates to the unlawful or	
38	unauthorized practice of medicine or osteopathic medicine, does not	
39	apply to any of the following:	
40	(1) A student in training in a medical school approved by the	
41	board, or while performing duties as an intern or a resident in a	
42	hospital under the supervision of the hospital's staff or in a	



1	program approved by the medical school.	
2	(2) A person who renders service in case of emergency where no	
3	fee or other consideration is contemplated, charged, or received.	
4	(3) A paramedic (as defined in IC 16-18-2-266), an advanced	
5	emergency medical technician (as defined in IC 16-18-2-6.5), an	
6	emergency medical technician (as defined in IC 16-18-2-112),	
7	or a person with equivalent certification from another state who	
8	renders advanced life support (as defined in IC 16-18-2-7), or	
9	basic life support (as defined in IC 16-18-2-33.5):	
10	(A) during a disaster emergency declared by the governor	
11	under IC 10-14-3-12 in response to an act that the governor	
12	in good faith believes to be an act of terrorism (as defined	
13	in IC 35-31.5-2-329); and	
14	(B) in accordance with the rules adopted by the Indiana	
15	emergency medical services commission or the disaster	
16	emergency declaration of the governor.	
17	(4) Commissioned medical officers or medical service officers	
18	of the armed forces of the United States, the United States Public	
19	Health Service, and medical officers of the United States	
20	Department of Veterans Affairs in the discharge of their official	
21	duties in Indiana.	
22	(5) An individual who is not a licensee who resides in another	
23	state or country and is authorized to practice medicine or	
24	osteopathic medicine there, who is called in for consultation by	
25	an individual licensed to practice medicine or osteopathic	
26	medicine in Indiana.	
27	(6) A person administering a domestic or family remedy to a	
28	member of the person's family.	
29	(7) A member of a church practicing the religious tenets of the	
30	church if the member does not make a medical diagnosis,	
31	prescribe or administer drugs or medicines, perform surgical or	
32	physical operations, or assume the title of or profess to be a	
33	physician.	
34	(8) A school corporation and a school employee who acts under	
35	IC 34-30-14 (or IC 34-4-16.5-3.5 before its repeal).	
36	(9) An associate physician practicing in compliance with	
37	IC 25-4.5 and under a collaborative agreement.	
38	(9) (10) A chiropractor practicing the chiropractor's profession	
39	under IC 25-10 or to an employee of a chiropractor acting under	
40	the direction and supervision of the chiropractor under	
41	IC 25-10-1-13.	
42	(10) (11) A dental hygienist practicing the dental hygienist's	



1	profession under IC 25-13.	
2	(11) (12) A dentist practicing the dentist's profession under	
3	IC 25-14.	
4	(12) (13) A hearing aid dealer practicing the hearing aid dealer's	
5	profession under IC 25-20.	
6	(13) (14) A nurse practicing the nurse's profession under	
7	IC 25-23. However, a certified registered nurse anesthetist (as	
8	defined in IC 25-23-1-1.4) may administer anesthesia if the	
9	certified registered nurse anesthetist acts under the direction of	
10	and in the immediate presence of a physician.	
11	(14) (15) An optometrist practicing the optometrist's profession	
12	under IC 25-24.	
13	(15) (16) A pharmacist practicing the pharmacist's profession	
14	under IC 25-26.	
15	(16) (17) A physical therapist practicing the physical therapist's	
16	profession under IC 25-27.	
17	(17) (18) A podiatrist practicing the podiatrist's profession under	
18	IC 25-29.	
19	(18) (19) A psychologist practicing the psychologist's profession	
20	under IC 25-33.	
21	(19) (20) A speech-language pathologist or audiologist	
22	practicing the pathologist's or audiologist's profession under	
23	IC 25-35.6.	
24	(20) (21) An employee of a physician or group of physicians who	
25	performs an act, a duty, or a function that is customarily within	
26	the specific area of practice of the employing physician or group	
27	of physicians, if the act, duty, or function is performed under the	
28	direction and supervision of the employing physician or a	
29	physician of the employing group within whose area of practice	
30	the act, duty, or function falls. An employee may not make a	
31	diagnosis or prescribe a treatment and must report the results of	
32	an examination of a patient conducted by the employee to the	
33	employing physician or the physician of the employing group	
34	under whose supervision the employee is working. An employee	
35	may not administer medication without the specific order of the	
36	employing physician or a physician of the employing group.	
37	Unless an employee is licensed or registered to independently	
38	practice in a profession described in subdivisions (9) (10)	
39	through (18) (19), nothing in this subsection grants the	
40	employee independent practitioner status or the authority to	
41	perform patient services in an independent practice in a	
42	profession.	





1	(21) (22) A hospital licensed under IC 16-21 or IC 12-25.	
2	(22) (23) A health care organization whose members,	
3	shareholders, or partners are individuals, partnerships,	
4	corporations, facilities, or institutions licensed or legally	
5	authorized by this state to provide health care or professional	
6	services as:	
7	(A) a physician;	
8	(B) a psychiatric hospital;	
9	(C) a hospital;	
10	(D) a health maintenance organization or limited service	
11	health maintenance organization;	
12	(E) a health facility;	
13	(F) a dentist;	
14	(G) a registered or licensed practical nurse;	
15	(H) a certified nurse midwife or a certified direct entry	
16	midwife;	
17	(I) an optometrist;	
18	(J) a podiatrist;	
19	(K) a chiropractor;	
20	(L) a physical therapist; or	
21	(M) a psychologist.	
22	(23) (24) A physician assistant practicing the physician assistant	
23	profession under IC 25-27.5.	
24	(24) (25) A physician providing medical treatment under section	
25	2.1 of this chapter.	
26	(25) (26) An attendant who provides attendant care services (as	
27	defined in IC 16-18-2-28.5).	
28	(26) (27) A personal services attendant providing authorized	
29	attendant care services under IC 12-10-17.1.	
30	(27) (28) A respiratory care practitioner practicing the	
31	practitioner's profession under IC 25-34.5.	
32	(b) A person described in subsection (a)(9) through (a)(18)	
33	(a)(19) _is not excluded from the application of this article if:	
34	(1) the person performs an act that an Indiana statute does not	
35	authorize the person to perform; and	
36	(2) the act qualifies in whole or in part as the practice of	
37	medicine or osteopathic medicine.	
38	(c) An employment or other contractual relationship between an	
39	entity described in subsection (a)(21) (a)(22) through (a)(23)[
40	and a licensed physician does not constitute the unlawful practice of	
41	medicine or osteopathic medicine under this article if the entity does	
42	not direct or control independent medical acts, decisions, or judgment	



1	of the licensed physician. However, if the direction or control is done	
2	by the entity under IC 34-30-15 (or IC 34-4-12.6 before its repeal), the	
3	entity is excluded from the application of this article as it relates to the	
4	unlawful practice of medicine or osteopathic medicine.	
5	(d) This subsection does not apply to a prescription or drug order	
6	for a legend drug that is filled or refilled in a pharmacy owned or	
7	operated by a hospital licensed under IC 16-21. A physician licensed	
8	in Indiana who permits or authorizes a person to fill or refill a	
9	prescription or drug order for a legend drug except as authorized in	
10	IC 16-42-19-11 through IC 16-42-19-19 is subject to disciplinary	
11	action under IC 25-1-9. A person who violates this subsection commits	
12	the unlawful practice of medicine or osteopathic medicine under this	
13	chapter.	
14	(e) A person described in subsection (a)(8) shall not be authorized	
15	to dispense contraceptives or birth control devices.	
16	(f) Nothing in this section allows a person to use words or	
17	abbreviations that indicate or induce an individual to believe that the	
18	person is engaged in the practice of medicine or osteopathic medicine.	
19	SECTION 16. IC 25-27.5-5-1, AS AMENDED BY P.L.247-2019,	
20	SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
21	JULY 1, 2023]: Sec. 1. (a) This chapter does not apply to the practice	
22	of other health care professionals set forth under IC 25-22.5-1-2(a)(1)	
23	through IC 25-22.5-1-2(a)(19). <u>IC</u> 25-22.5-1-2(a)(20).	
24	(b) This chapter does not exempt a physician assistant from the	
25	requirements of IC 16-41-35-29.	
26	SECTION 17. IC 25-27.5-5-2, AS AMENDED BY P.L.247-2019,	
27	SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
28	JULY 1, 2023]: Sec. 2. (a) A physician assistant:	
29	(1) must engage in a dependent practice with a collaborating	
30	physician; and	
31	(2) may not be independent from the collaborating physician,	
32	including any of the activities of other health care providers set	
33	forth under IC 25-22.5-1-2(a)(1) through IC 25-22.5-1-2(a)(19).	
34	IC 25-22.5-1-2(a)(20).	
35	A physician assistant may perform, under a collaborative agreement,	
36	the duties and responsibilities that are delegated by the collaborating	
37	physician and that are within the collaborating physician's scope of	
38	practice, including prescribing and dispensing drugs and medical	
39	devices. A patient may elect to be seen, examined, and treated by the	
40	collaborating physician.	



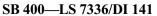
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(b) If a physician assistant determines that a patient needs to be

examined by a physician, the physician assistant shall immediately

1	notify the collaborating physician or physician designee.	
2	(c) If a physician assistant notifies the collaborating physician that	
3	the physician should examine a patient, the collaborating physician	
4	shall:	
5	(1) schedule an examination of the patient unless the patient	
6	declines; or	
7	(2) arrange for another physician to examine the patient.	
8	(d) A collaborating physician or physician assistant who does not	
9	comply with subsections (b) and (c) is subject to discipline under	
10	IC 25-1-9.	
11	(e) A physician assistant's collaborative agreement with a	
12	collaborating physician must:	
13	(1) be in writing;	
14	(2) include all the tasks delegated to the physician assistant by	
15	the collaborating physician;	
16	(3) set forth the collaborative agreement for the physician	
17	assistant, including the emergency procedures that the physician	
18	assistant must follow; and	
19	(4) specify the protocol the physician assistant shall follow in	
20	prescribing a drug.	
21	(f) The physician shall submit the collaborative agreement to the	
22	board. The physician assistant may prescribe a drug under the	
23	collaborative agreement unless the board denies the collaborative	
24	agreement. Any amendment to the collaborative agreement must be	
25	resubmitted to the board, and the physician assistant may operate under	
26	any new prescriptive authority under the amended collaborative	
27	agreement unless the agreement has been denied by the board.	
28	(g) A physician or a physician assistant who violates the	
29	collaborative agreement described in this section may be disciplined	
30	under IC 25-1-9.	
31	SECTION 18. IC 25-34.5-3-7, AS AMENDED BY THE	
32	TECHNICAL CORRECTIONS BILL OF THE 2023 GENERAL	
33	ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
34	JULY 1, 2023]: Sec. 7. This article does not affect the applicability of	
35	IC 25-22.5-1-2(a)(20). IC 25-22.5-1-2(a)(21).	
36	SECTION 19. IC 27-1-3-19 IS AMENDED TO READ AS	
37	FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 19. (a) Whenever the	
38	commissioner determines that any insurance company to which this	
39	article is applicable:	
40	(1) is conducting its business contrary to law or in an unsafe or	
41	unauthorized manner;	
42	(2) has had its capital or surplus fund impaired or reduced below	





(3) has failed, neglected, or refused to observe and comply with any law, order, or rule of the department or commissioner; then the commissioner may, by an order in writing addressed to the board of directors, board of trustees, attorney in fact, partners, or owners of or in any such insurance company, to direct the discontinuance of any such illegal, unauthorized, or unsafe practice, the restoration of an impairment to the capital or the surplus fund, or the compliance with any such law, order, or rule of the department or commissioner. The order shall be mailed to the last known principal office of the insurance company by certified or registered mail or delivered to an officer of the company and shall be considered to be received by the insurance company three (3) days after mailing or on the date of delivery. (b) If the insurance company fails, neglects, or refuses to comply with the terms of that order within thirty (30) days after its receipt by the insurance company, or within a shorter period set out in the order if the commissioner determines that an emergency exists, the commissioner may, in addition to any other remedy conferred upon the department or the commissioner by law, bring an action against any such insurance company, its officers, and agents to compel that compliance. (c) The action shall be brought by the commissioner in the Marion County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted. SECTION 20. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 6.2. (a) As used in this section, "domestic stock insurer" means a person that: (1) provides coverage under a health plan (as defined in IC 27-	1	the amount required by law; or	
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such insurance company, its officers, and agents to compel that compliance. (c) The action shall be brought by the commissioner in the Marion County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted. SECTION 20. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 6.2. (a) As used in this section, "domestic stock insurer" means a person that: (1) provides coverage under a health plan (as defined in IC 27-1-48-4); (2) is organized under the insurance laws of this state; and (3) is a publicly traded stock corporation. (b) A domestic stock insurer shall file the following with the department: (1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the	19	commissioner may, in addition to any other remedy conferred upon the	
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23 (c) The action shall be brought by the commissioner in the Marion 24 County circuit court. The action shall be commenced and prosecuted 25 in accordance with the Indiana Rules of Trial Procedure, and relief for 26 noncompliance of the order includes any remedy appropriate under the 27 facts, including injunction, preliminary injunction, and temporary 28 restraining order. In that action, a change of venue from the judge, but 29 no change of venue from the county, is permitted. 30 SECTION 20. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA 31 CODE AS A NEW SECTION TO READ AS FOLLOWS 32 [EFFECTIVE JULY 1, 2023]: Sec. 6.2. (a) As used in this section, 33 "domestic stock insurer" means a person that: 34 (1) provides coverage under a health plan (as defined in 35 IC 27-1-48-4); 36 (2) is organized under the insurance laws of this state; and 37 (3) is a publicly traded stock corporation. 38 (b) A domestic stock insurer shall file the following with the 39 department: 40 (1) Not later than March 1 of each calendar year, the 41 domestic stock insurer's annual financial statement from the	21	such insurance company, its officers, and agents to compel that	
County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted. SECTION 20. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 6.2. (a) As used in this section, "domestic stock insurer" means a person that: (1) provides coverage under a health plan (as defined in IC 27-1-48-4); (2) is organized under the insurance laws of this state; and (3) is a publicly traded stock corporation. (b) A domestic stock insurer shall file the following with the department: (1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the	22		
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34 (1) provides coverage under a health plan (as defined in IC 27-1-48-4); 36 (2) is organized under the insurance laws of this state; and 37 (3) is a publicly traded stock corporation. 38 (b) A domestic stock insurer shall file the following with the department: 40 (1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the	32		
35 IC 27-1-48-4); 36 (2) is organized under the insurance laws of this state; and 37 (3) is a publicly traded stock corporation. 38 (b) A domestic stock insurer shall file the following with the 39 department: 40 (1) Not later than March 1 of each calendar year, the 41 domestic stock insurer's annual financial statement from the	33	"domestic stock insurer" means a person that:	
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40 (1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the		· · ·	
domestic stock insurer's annual financial statement from the		1	
		· · · · · · · · · · · · · · · · · · ·	
42 previous calendar year.			
	42	previous calendar year.	



	(2) Not later than May 15 of each calendar year, the domestic	
	stock insurer's first quarter financial statement from the	
	current calendar year.	
	(3) Not later than August 15 of each calendar year, the	
	domestic stock insurer's second quarter financial statement	
	from the current calendar year.	
	(4) Not later than November 15 of each calendar year, the	
	domestic stock insurer's third quarter financial statement	
	from the current calendar year.	
	(c) The department must post the information filed under	
9	ubsection (b) on the department's website on a single and easily	
2	accessible web page not later than ten (10) business days after	
1	receiving the information.	
	SECTION 21. IC 27-1-37.5-1, AS ADDED BY P.L.77-2018,	
	SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
	ULY 1, 2023]: Sec. 1. (a) Except as provided in sections 10, 11, 12,[
3	and 13, and 13.5 of this chapter, this chapter applies beginning	
-	September 1, 2018.	
	(b) This chapter does not apply to a step therapy protocol	
(exception procedure under IC 27-8-5-30 or IC 27-13-7-23.	
	(c) This chapter does not apply to a health plan that is offered by	
6	local unit public employer under a program of group health insurance	
	provided under IC 5-10-8-2.6.	
1	SECTION 22. IC 27-1-37.5-1.5 IS ADDED TO THE INDIANA	
(CODE AS A NEW SECTION TO READ AS FOLLOWS	
	EFFECTIVE JULY 1, 2023]: Sec. 1.5. As used in this chapter,	
•	'adverse determination' means a denial of a request for benefits	
	on the grounds that the health service or item:	_
•	(1) is not medically necessary, appropriate, effective, or	
	efficient;	_
	(2) is not being provided in or at an appropriate health care	
	setting or level of care; or	
	(3) is experimental or investigational.	
	SECTION 23. IC 27-1-37.5-1.7 IS ADDED TO THE INDIANA	
•	CODE AS A NEW SECTION TO READ AS FOLLOWS	
	EFFECTIVE JULY 1, 2023]: Sec. 1.7. As used in this chapter,	
	'clinical peer'' means a practitioner or other health care provider	
	vho either:	
1		
	(1) holds a current and valid license in any United States	
	jurisdiction; (2) has been granted regionality in the state if regionality	
	(2) has been granted reciprocity in the state, if reciprocity	
	exists; or	
	SD 400 I C 7226/DI 141	



I	(3) holds a license that is part of a compact in which the state	
2	has entered.	
3	SECTION 24. IC 27-1-37.5-11, AS ADDED BY P.L.77-2018,	
4	SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
5	JULY 1, 2023]: Sec. 11. (a) This section applies to a prior authorization	
6	request delivered to a health plan after December 31, 2019.	
7	(b) A health plan shall respond to a request delivered under	
8	section 10 of this chapter as follows:	
9	(1) If the request is delivered under section 10(b) of this chapter,	
10	the health plan shall immediately send to the requesting health	
11	care provider an electronic receipt for the request.	
12	(2) If the request is for an urgent care situation, the health plan	
13	shall respond with a prior authorization determination not more	
14	than seventy-two (72) forty-eight (48) hours after receiving the	
15	request.	
16	(3) If the request is for a nonurgent care situation, the health plan	
17	shall respond with a prior authorization determination not more	
18	than seven (7) five (5) business days after receiving the request.	
19	(c) If a request delivered under section 10 of this chapter is	
20	incomplete:	
21	(1) the health plan shall respond within the period required by	
22	subsection (b) and indicate the specific additional information	
23	required to process the request;	
24	(2) if the request was delivered under section 10(b) of this	
25	chapter, upon receiving the response under subdivision (1), the	
26	health care provider shall immediately send to the health plan an	
27	electronic receipt for the response made under subdivision (1);	
28	and	
29	(3) if the request is for an urgent care situation, the health care	
30	provider shall respond to the request for additional information	
31	not more than seventy-two (72) forty-eight (48) hours after the	
32	health care provider receives the response under subdivision (1).	
33	(d) If a request delivered under section 10 of this chapter is denied,	
34	the health plan shall respond within the period required by subsection	
35	(b) and indicate the specific reason for the denial in clear and easy to	
36	understand language.	
37	SECTION 25. IC 27-1-37.5-13.5 IS ADDED TO THE INDIANA	
38	CODE AS A NEW SECTION TO READ AS FOLLOWS	
39	[EFFECTIVE JULY 1, 2023]: Sec. 13.5. (a) This section applies only	
40	to the state employee health plan (as defined in IC 5-10-8-6.7(a)).	
41	(b) The state employee health plan may not require a	
12	participating provider to obtain prior authorization for the	
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1	following CPT codes:	
2	(1) 11200.	
3	(2) 11201.	
4	(3) 17311.	
5	(4) 17312.	
6	(5) 17313.	
7	(6) 17314.	
8 9	(7) 44140.	
10	(8) 44160. (9) 44970.	
10	(10) 49505.	
12	(11) 70450.	
13	(12) 70551.	
14	(13) 70552.	
15	(14) 70553.	
16	(15) 71250.	
17	(16) 71260.	
18	(17) 71275.	
19	(18) 72141.	
20	(19) 72148.	
21	(20) 72158.	
22	(21) 73221.	
23	(22) 73721.	
24	(23) 74150.	
25	(24) 74160.	
26	(25) 74176.	
27	(26) 74177.	
28	(27) 74178.	
29	(28) 74179.	
30	(29) 74181.	
31	(30) 74183.	
32	(31) 78452.	
33 34	(32) 92507.	
	(33) 92526.	
35 36	(34) 92609. (35) 93303.	
37	(36) 93306.	
38	(37) 95044.	
39	(38) 95806.	
40	(39) 95810.	
41	(40) 97110.	
42	(40) 97110. (41) 97112.	
12	(11) //112	
	SB 400—LS 7336/DI 141	



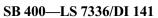
1	(42) 97116.	
2	(43) 97129.	
3	(44) 97130.	
4	(45) 97140.	
5	(46) 97530.	
6	(47) V5010.	
7	(48) V5256.	
8	(49) V5261.	
9	(50) V5275.	
10	(c) The state employee health plan may not issue a retroactive	
11	denial for a CPT code listed in subsection (b).	
12	(d) Before November 1, 2025, the:	
13	(1) interim study committee on public health, behavioral	
14	health, and human services; and	
15	(2) interim study committee on financial institutions and	
16	insurance;	
17	shall jointly review the impact of this section, including any relief	
18	on the administrative burdens to participating providers and any	
19	differences in utilization of the CPT codes listed in subsection (b).	
20	(e) This section expires June 30, 2026.	
21	SECTION 26. IC 27-1-37.5-17 IS ADDED TO THE INDIANA	
22	CODE AS A NEW SECTION TO READ AS FOLLOWS	
23	[EFFECTIVE JULY 1, 2023]: Sec. 17. (a) As used in this section,	
24	"necessary information" includes the results of any face-to-face	
25	clinical evaluation, second opinion, or other clinical information	
26	that is directly applicable to the requested service that may be	
27	required.	
28	(b) If a health plan makes an adverse determination on a prior	
29	authorization request by a covered individual's health care	
30	provider, the health plan must offer the covered individual's health	
31	care provider the option to request a peer to peer review by a	
32	clinical peer concerning the adverse determination.	
33	(c) A covered individual's health care provider may request a	
34	peer to peer review by a clinical peer either in writing or	
35	electronically.	
36	(d) If a peer to peer review by a clinical peer is requested	
37	under this section:	
38	(1) the health plan's clinical peer and the covered	
39	individual's health care provider or the health care	
40	provider's designee shall make every effort to provide the	
41	peer to peer review not later than seven (7) business days	
42	from the date of receipt by the health plan of the request by	



1 2 3	the covered individual's health care provider for a peer to peer review if the health plan has received the necessary information for the peer to peer review; and	
4	(2) the health plan must have the peer to peer review	
5	conducted between the clinical peer and the covered	
6	individual's health care provider or the provider's designee.	
7	SECTION 27. IC 27-1-44.5-2, AS AMENDED BY P.L.165-2022,	
8	SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
9	JULY 1, 2023]: Sec. 2. As used in this chapter, "health payer" includes	
10	the following:	
11	(1) Medicare.	
12	(2) Medicaid or a managed care organization (as defined in	
13	IC 12-7-2-126.9) that has contracted with Medicaid to provide	
14	services to a Medicaid recipient.	
15	(3) An insurer that issues a policy of accident and sickness	
16	insurance (as defined in IC 27-8-5-1), except for the following	
17	types of coverage:	
18	(A) Accident only, credit, dental, vision, long term care, or	
19	disability income insurance.	
20	(B) Coverage issued as a supplement to liability insurance.	
21	(C) Automobile medical payment insurance.	
22	(D) A specified disease policy.	
23	(E) A policy that provides indemnity benefits not based on	
24	any expense incurred requirements, including a plan that	
25	provides coverage for:	
26	(i) hospital confinement, critical illness, or intensive	
27	care; or	
28	(ii) gaps for deductibles or copayments.	
29	(F) Worker's compensation or similar insurance.	
30	(G) A student health plan.	
31	(H) A supplemental plan that always pays in addition to	
32	other coverage.	
33	(4) A health maintenance organization (as defined in	
34	IC 27-13-1-19).	
35	(5) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).	
36	(6) An administrator (as defined in IC 27-1-25-1).	
37	(7) A multiple employer welfare arrangement (as defined in	
38	IC 27-1-34-1).	
39	(8) [An] employee	
40	benefit plan that is subject to the federal Employee	
41	Retirement Income Security Act of 1974 (29 U.S.C. 1001 et	
42	seq.[), including a third party administrator of an employee	



benefit plan.	
(9) A state employee health plan (a	as defined in
IC 5-10-8-6.7(a)]).	
(8) (9) [10]) Any other person identified by the	
for participation in the data base described in the	_
SECTION 28. IC 27-1-44.5-5, AS AMENDED BY	
SECTION 6, IS AMENDED TO READ AS FOLLOW	
JULY 1, 2023]: Sec. 5. (a) A health payer shall begin required data in a format specified by the administrator	
not later than three (3) months from the first day	
declares the data base to be fully operational.	the departmen
(b) An employer may opt-in to share claims da	to with the dat
base.	ta with the data
(c) The state, the Indiana Medicaid state plan	- and Medicaio
managed care entities must submit data for the data b	
SECTION 2 (9). IC 27-1-45-10, AS	
P.L.165-2022, SECTION 9, IS AMENDED TO READ	
[EFFECTIVE UPON PASSAGE]: Sec. 10. A facility	or a practitione
may satisfy The requirements of this chapter by con	_
requirements set forth in Section 2799B-6 of the feder	al Public Healtl
Service Act, as added by Public Law 116-260. do	not apply to a
facility or practitioner that:	
(1) is required to comply with; and	
(2) is in compliance with;	
45 CFR Part 149, Subparts E and G, as may be	
amended by the federal Department of Healt	h and Humai
Services.	
SECTION 29 [30]. IC 27-1-46-18, AS	
P.L.165-2022, SECTION 10, IS AMENDED T	
FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec.	•
facility may satisfy The requirements of this chapter by	
the requirements set forth in Section 2799B-6 of the	
Health Service Act, as added by Public Law 116-260.	do not apply to
a facility or practitioner that:	
(1) is required to comply with; and	
(2) is in compliance with; 45 CFR Part 149, Subparts E and G, as may be	a anfarmed and
amended by the federal Department of Health	
Services.	ii aliu Hulliai
SECTION 3 (1). IC 27-1-48 IS ADDED TO	THE INDIANA
CODE AS A NEW CHAPTER TO READ A	
[EFFECTIVE JULY 1, 2023]:	.io i ollow

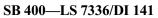




1	Chapter 48. Health Plan Notices	
2	Sec. 1. As used in this chapter, "covered individual" means an	
3	individual who is entitled to coverage under a health plan.	
4	Sec. 2. As used in this chapter, "CPT code" refers to the	
5	medical billing code that applies to a specific health care service,	
6	as published in the Current Procedural Terminology code set	
7	maintained by the American Medical Association.	
8	Sec. 3. (a) As used in this chapter, "health care service" means	
9	a health care related service or product rendered or sold by a	
10	health care provider within the scope of the health care provider's	
11	license or legal authorization, including hospital, medical, surgical,	
12	mental health, and substance abuse services or products.	
13	(b) The term does not include the following:	
14	(1) Dental services.	
15	(2) Vision services.	
16	(3) Long term rehabilitation treatment.	
17	(4) Pharmaceutical services or products.	
18	Sec. 4. (a) As used in this chapter, "health plan" means any of	
19	the following that provides coverage for health care services:	
20	(1) A policy of accident and sickness insurance (as defined in	
21	IC 27-8-5-1). However, the term does not include the	
22	coverages described in IC 27-8-5-2.5(a).	
23	(2) A contract with a health maintenance organization (as	
24	defined in IC 27-13-1-19) that provides coverage for basic	
25	health care services (as defined in IC 27-13-1-4).	
26	(3) The Medicaid risk based managed care program under	
27	IC 12-15.	
28	(b) The term includes a person that administers any of the	
29	following:	
30	(1) A policy described in subsection (a)(1).	-
31	(2) A contract described in subsection (a)(2).	
32	(3) Medicaid risk based managed care.	
33	Sec. 5. As used in this chapter, "participating provider" refers	
34	to the following:	
35	(1) A health care provider that has entered into an	
36	agreement with an insurer under IC 27-8-11-3.	
37	(2) A participating provider (as defined in IC 27-13-1-24).	
38	Sec. 6. As used in this chapter, "prior authorization" means a	
39	practice implemented by a health plan through which coverage of	
40	a health care service is dependent on the covered individual or	
41	health care provider obtaining approval from the health plan	
42	before the health care service is rendered. The term includes	
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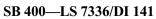


1	prospective or utilization review procedures conducted before a	
2	health care service is rendered.	
3	Sec. 7. A health plan must:	
4	(1) offer an alternative method for submission of a claim for	
5	when the health plan has technical difficulties with the health	
6	plan's claims submission system; and	
7	(2) post notice of the alternative method for claims	
8	submission on the health plan's website.	
9	Sec. 8. (a) Not later than February 1 of each calendar year, a	
0	health plan must post on the health plan's website:	
1	(1) the thirty (30) most frequently submitted CPT codes that	
2	were submitted by participating providers for prior	
3	authorization during the previous calendar year; and	
4	(2) the percentage of the thirty (30) most frequently	
5	submitted CPT codes that were approved in the previous	
6	calendar year, disaggregated by CPT code.	
7	(b) A health plan must maintain the information required	
8	under subsection (a) on the health plan's website, organized by	
)	year and on a single and easily accessible web page.	
\mathbf{C}	SECTION $3 \stackrel{\longleftarrow}{\longleftrightarrow} [2]$. IC 27-8-5-1.5, AS AMENDED BY	
1	P.L.124-2018, SECTION 76, IS AMENDED TO READ AS	
2	FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1.5. (a) This section	
3	applies to a policy of accident and sickness insurance issued on an	
1	individual, a group, a franchise, or a blanket basis, including a policy	
5	issued by an assessment company or a fraternal benefit society.	
5	(b) As used in this section, "commissioner" refers to the insurance	
7	commissioner appointed under IC 27-1-1-2.	
3	(c) As used in this section, "grossly inadequate filing" means a	
9	policy form filing:	
)	(1) that fails to provide key information, including state specific	-
1	information, regarding a product, policy, or rate; or	
2	(2) that demonstrates an insufficient understanding of applicable	
3	legal requirements.	
1	(d) As used in this section, "policy form" means a policy, a	
5	contract, a certificate, a rider, an endorsement, an evidence of	
6	coverage, or any amendment that is required by law to be filed with the	
7	commissioner for approval before use in Indiana.	
3	(e) As used in this section, "type of insurance" refers to a type of	
)	coverage listed on the National Association of Insurance	
)	Commissioners Uniform Life, Accident and Health, Annuity and Credit	
1	Product Coding Matrix under the heading "Continuing Care Retirement	
2	Communities", "Health", "Long Term Care", or "Medicare	
-	Communico, ficular, Long form Care, or medicare	





1	Supplement".	
2	(f) Each person having a role in the filing process described in	
3	subsection (i) shall act in good faith and with due diligence in the	
4	performance of the person's duties.	
5	(g) A policy form, including a policy form of a policy, contract,	
6	certificate, rider, endorsement, evidence of coverage, or amendment	
7	that is issued through a health benefit exchange (as defined in	
8	IC 27-19-2-8), may not be issued or delivered in Indiana unless the	
9	policy form has been filed with and approved by the commissioner.	
10	(h) The commissioner shall do the following:	
11	(1) Create a document containing a list of all product filing	
12	requirements for each type of insurance, with appropriate	
13	citations to the law, administrative rule, or bulletin that specifies	
14	the requirement, including the citation for the type of insurance	
15	to which the requirement applies.	
16	(2) Make the document described in subdivision (1) available on	
17	the department of insurance Internet site.	
18	(3) Update the document described in subdivision (1) at least	
19	annually and not more than thirty (30) days following any	
20	change in a filing requirement.	
21	(i) The filing process is as follows:	
22	(1) A filer shall submit a policy form filing that:	
23	(A) includes a copy of the document described in	
24	subsection (h);	
25	(B) indicates the location within the policy form or	
26	supplement that relates to each requirement contained in the	
27	document described in subsection (h); and	
28	(C) certifies that the policy form meets all requirements of	
29	state law.	
30	(2) The commissioner shall review a policy form filing and, not	
31	more than thirty (30) days after the commissioner receives the	
32	filing under subdivision (1):	
33	(A) approve the filing; or	
34	(B) provide written notice of a determination:	
35	(i) that deficiencies exist in the filing; or	
36	(ii) that the commissioner disapproves the filing.	
37	A written notice provided by the commissioner under clause (B)	
38	must be based only on the requirements set forth in the	
39	document described in subsection (h) and must cite the specific	
40	requirements not met by the filing. A written notice provided by	
41	the commissioner under clause (B)(i) must state the reasons for	
42	the commissioner's determination in sufficient detail to enable	D





1	the filer to bring the policy form into compliance with the	
2	requirements not met by the filing.	
3	(3) A filer may resubmit a policy form that:	
4	(A) was determined deficient under subdivision (2) and has	
5	been amended to correct the deficiencies; or	
6	(B) was disapproved under subdivision (2) and has been	
7	revised.	
8	A policy form resubmitted under this subdivision must meet the	
9	requirements set forth as described in subdivision (1) and must	
10	be resubmitted not more than thirty (30) days after the filer	
11	receives the commissioner's written notice of deficiency or	
12	disapproval. If a policy form is not resubmitted within thirty (30)	
13	days after receipt of the written notice, the commissioner's	
14	determination regarding the policy form is final.	
15	(4) The commissioner shall review a policy form filing	
16	resubmitted under subdivision (3) and, not more than thirty (30)	
17	days after the commissioner receives the resubmission:	
18	(A) approve the resubmitted policy form; or	
19	(B) provide written notice that the commissioner	
20	disapproves the resubmitted policy form.	
21	A written notice of disapproval provided by the commissioner	
22	under clause (B) must be based only on the requirements set	
23	forth in the document described in subsection (h), must cite the	
24	specific requirements not met by the filing, and must state the	
25	reasons for the commissioner's determination in detail. The	
26	commissioner's approval or disapproval of a resubmitted policy	
27	form under this subdivision is final, except that the	
28	commissioner may allow the filer to resubmit a further revised	
29	policy form if the filer, in the filer's resubmission under	
30	subdivision (3), introduced new provisions or materially	
31	modified a substantive provision of the policy form. If the	
32	commissioner allows a filer to resubmit a further revised policy	
33	form under this subdivision, the filer must resubmit the further	
34	revised policy form not more than thirty (30) days after the filer	
35	receives notice under clause (B), and the commissioner shall	
36	issue a final determination on the further revised policy form not	
37	more than thirty (30) days after the commissioner receives the	
38	further revised policy form.	
39	(5) If the commissioner disapproves a policy form filing under	
40	this subsection, the commissioner shall notify the filer, in	
41	writing, of the filer's right to a hearing as described in subsection	
42	(m). (r). A disapproved policy form filing may not be used for a	



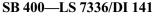
1	policy of accident and sickness insurance unless the disapproval	
2	is overturned in a hearing conducted under this subsection.	
3	(6) If the commissioner does not take any action on a policy form	
4	that is filed or resubmitted under this subsection in accordance	
5	with any applicable period specified in subdivision (2), (3), or	
6	(4), the policy form filing is considered to be approved.	
7	(j) Except as provided in this subsection, the commissioner may	
8	not disapprove a policy form resubmitted under subsection (i)(3) or	
9	(i)(4) for a reason other than a reason specified in the original notice of	
.0	determination under subsection (i)(2)(B). The commissioner may	
1	disapprove a resubmitted policy form for a reason other than a reason	
2	specified in the original notice of determination under subsection (i)(2)	
3	if:	
4	(1) the filer has introduced a new provision in the resubmission;	
.5	(2) the filer has materially modified a substantive provision of	
.6	the policy form in the resubmission;	
7	(3) there has been a change in requirements applying to the	
8	policy form; or	
9	(4) there has been reviewer error and the written disapproval	
20	fails to state a specific requirement with which the policy form	
21	does not comply.	
22	(k) The commissioner may return a grossly inadequate filing to the	
23	filer without triggering a deadline set forth in this section.	
24	(1) The commissioner may disapprove a policy form if:	
25	(1) the benefits provided under the policy form are not	
26	reasonable in relation to the premium charged; or	
27	(2) the policy form contains provisions that are unjust, unfair,	
28	inequitable, misleading, or deceptive, or that encourage	
29	misrepresentation of the policy.	
30	(m) Before approving or disapproving a premium rate	
31	increase or decrease, the commissioner shall consider the	
32	following:	
33	(1) The products affected, by line of business.	
34	(2) The number of covered lives affected.	
35	(3) Whether the product is open or closed to new members in	
86	the product block.	
37	(4) Applicable median cost sharing for the product, as	
88	allowed by state or federal law.	
39	(5) The benefits provided and the underlying costs of the	
10	health services rendered.	
1	(6) The implementation date of the increase or decrease.	
12	(7) The overall percent premium rate increase or decrease	



1	that is requested.	
2	(8) The actual percent premium rate increase or decrease to	
3	be approved.	
4	(9) Incurred claims paid each year for the past three (3)	
5	years, if applicable.	
6	(10) Earned premiums for each of the past three (3) years, if	
7	applicable.	
8	(11) Projected medical cost trends in the geographic service	
9	region, if the product for which a rate increase or decrease	
10	is requested is not a product offered statewide.	
11	(12) If applicable, historical rebates paid to the policyholder	
12	from the most recent health plan year under the federal	
13	Patient Protection and Affordable Care Act (P.L. 111-148),	
14	as amended by the federal Health Care and Education	
15	Reconciliation Act of 2010 (P.L. 111-152).	
16	(13) The median cost sharing amount for an individual	
17	covered by the product, or the actuarial value information as	
18	required under the Patient Protection and Affordable Care	
19	Act, if applicable.	
20	(n) The commissioner shall not approve a new product unless	
21	the commissioner has, at a minimum, considered the matters set	
22	forth in subsection (m)(1) through (m)(13).	
23	(o) The information compiled, prepared, and considered by the	
24	commissioner under subsection (m)(1) through (m)(13) is subject	
25	to the requirements of IC 5-14-3. However, the commissioner's	
26	approval of a new product or a rate increase or decrease may take	
27	effect before the information compiled, prepared, and considered	
28	by the commissioner under subsection (m)(1) through (m)(13) is	
29	made accessible to the public under IC 5-14-3.	
30	(p) When considering whether to approve a premium rate	_
31	increase, the commissioner shall consider whether the current rate	
32	is appropriate for achieving the insurer's target loss ratio.	
33	(q) To the extent authorized by the Patient Protection and	
34	Affordable Care Act and other federal law, the commissioner,	
35	under this section, may:	
36	(1) consider network adequacy;	
37	(2) conduct form review to ensure:	
38	(A) minimum essential health benefits; and	
39	(B) nondiscriminatory benefit design;	
40	(3) perform accreditation confirmation; and	
41	(4) confirm quality measures.	
42	(m) (r) Upon disapproval of a filing under this section, the	

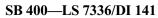


commissioner shall provide written notice to the filer or insurer of the	
right to a hearing within twenty (20) days of a request for a hearing.	
(n) (s) Unless a policy form approved under this chapter contains	
a material error or omission, the commissioner may not:	
(1) retroactively disapprove the policy form; or	
(2) examine the filer of the policy form during a routine or	
targeted market conduct examination for compliance with a	
policy form filing requirement that was not in existence at the	
time the policy form was filed.	
SECTION $3 \stackrel{\frown}{\longrightarrow} [3]$. IC 27-8-5.7-2.5 IS ADDED TO THE	
INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS	
[EFFECTIVE JULY 1, 2023]: Sec. 2.5. As used in this chapter, "CPT	
code" refers to the medical billing code that applies to a specific	
health care service, as published in the Current Procedural	
Terminology code set maintained by the American Medical	
Association.	
SECTION $3 \stackrel{\blacktriangleleft}{\longleftrightarrow} [4]$. IC 27-8-5.7-5 IS AMENDED TO READ AS	
FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. (a) An insurer shall	
pay or deny each clean claim in accordance with section sections 6 and	
6.5 of this chapter.	
(b) An insurer shall notify a provider of any deficiencies in a	
submitted claim not more than:	
(1) thirty (30) days for a claim that is filed electronically; or	
(2) forty-five (45) days for a claim that is filed on paper;	
and describe any remedy necessary to establish a clean claim.	
(c) Failure of an insurer to notify a provider as required under	
subsection (b) establishes the submitted claim as a clean claim.	
SECTION 3-4-[5]. IC 27-8-5.7-6.5 IS ADDED TO THE	
INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS	
[EFFECTIVE JULY 1, 2023]: Sec. 6.5. (a) An insurer may not:	-
(1) alter the CPT code submitted for a clean claim; and	
(2) pay for a CPT code of lesser monetary value;	
unless the medical record of the clean claim has been reviewed by	
an employee of the insurer who is licensed under IC 25-22.5.	
(b) An insurer may not alter a clean claim to only pay for the	
CPT codes necessary for an individual's final diagnosis, if the CPT	
codes billed were deemed medically necessary to reach the final	
diagnosis.	
SECTION 3 (6). IC 27-8-11-3 IS AMENDED TO READ AS	
FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) An insurer may:	
(1) enter into agreements with providers relating to terms and	
conditions of reimbursement for health care services that may be	
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1	rendered to insureds of the insurer, including agreements	
2	relating to the amounts to be charged the insured for services	
3	rendered or the terms and conditions for activities intended to	
4	reduce inappropriate care;	
5	(2) issue or administer policies in this state that include	
6	incentives for the insured to utilize the services of a provider that	
7	has entered into an agreement with the insurer under subdivision	
8	(1); and	
9	(3) issue or administer policies in this state that provide for	
10	reimbursement for expenses of health care services only if the	
11	services have been rendered by a provider that has entered into	
12	an agreement with the insurer under subdivision (1).	
13	(b) Before entering into any agreement under subsection (a)(1), an	
14	insurer shall establish terms and conditions that must be met by	
15	providers wishing to enter into an agreement with the insurer under	
16	subsection (a)(1). These terms and conditions may not discriminate	
17	unreasonably against or among providers. For the purposes of this	
18	subsection, neither differences in prices among hospitals or other	
19	institutional providers produced by a process of individual negotiation	
20	nor price differences among other providers in different geographical	
21	areas or different specialties constitutes unreasonable discrimination.	
22	Upon request by a provider seeking to enter into an agreement with an	
23	insurer under subsection (a)(1), the insurer shall make available to the	
24	provider a written statement of the terms and conditions that must be	
25	met by providers wishing to enter into an agreement with the insurer	
26	under subsection (a)(1).	
27	(c) No hospital, physician, pharmacist, or other provider	
28	designated in IC 27-8-6-1 willing to meet the terms and conditions of	
29	agreements described in this section may be denied the right to enter	
30	into an agreement under subsection (a)(1). When an insurer denies a	
31	provider the right to enter into an agreement with the insurer under	
32	subsection (a)(1) on the grounds that the provider does not satisfy the	
33	terms and conditions established by the insurer for providers entering	
34	into agreements with the insurer, the insurer shall provide the provider	
35	with a written notice that:	
36	(1) explains the basis of the insurer's denial; and	
37	(2) states the specific terms and conditions that the provider, in	
38	the opinion of the insurer, does not satisfy.	
39	(d) In no event may an insurer deny or limit reimbursement to an	
40	insured under this chapter on the grounds that the insured was not	
41	referred to the provider by a person acting on behalf of or under an	
42	agreement with the insurer.	

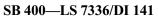




1	(e) No cause of action shall arise against any person or insurer for:	
2	(1) disclosing information as required by this section; or	
3	(2) the subsequent use of the information by unauthorized	
4	individuals.	
5	Nor shall such a cause of action arise against any person or provider for	
6	furnishing personal or privileged information to an insurer. However,	
7	this subsection provides no immunity for disclosing or furnishing false	
8	information with malice or willful intent to injure any person, provider,	
9	or insurer.	
10	(f) Nothing in this chapter abrogates the privileges and immunities	
11	established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).	
12	(g) This subsection does not apply to a rate schedule	
13	maintained by state or federal government payers. An insurer that	
14	enters into an agreement with a provider under subsection (a)(1)	
15	must provide the provider a current reimbursement rate schedule:	
16	(1) every two (2) years; and	
17	(2) when three (3) or more CPT code (as defined in	
18	IC 27-1-37.5-3) rates under the agreement are changed in a	
19	twelve (12) month period.	
20	SECTION $3 \stackrel{\longleftarrow}{\longleftrightarrow} [7]$. IC 27-8-11-7, AS AMENDED BY	
21	P.L.195-2018, SECTION 18, IS AMENDED TO READ AS	
22	FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 7. (a) This section	
23	applies to an insurer that issues or administers a policy that provides	
24	coverage for basic health care services (as defined in IC 27-13-1-4).	
25	(b) As used in this section, "clean credentialing application"	
26	means an application for network participation that:	
27	(1) is submitted by a provider under this section;	
28	(2) does not contain an error; and	
29	(3) may be processed by the insurer without returning the	
30	application to the provider for a revision or clarification.	
31	(c) As used in this section, "credentialing" means a process by	
32	which an insurer makes a determination that:	
33	(1) is based on criteria established by the insurer; and	
34	(2) concerns whether a provider is eligible to:	
35	(A) provide health services to an individual eligible for	
36	coverage; and	
37	(B) receive reimbursement for the health services;	
38	under an agreement that is entered into between the	
39	provider and the insurer.	
40	(d) As used in this section, "unclean credentialing application"	
41	means an application for network participation that:	
42	(1) is submitted by a provider under this section;	



1	(2) contains at least one (1) error; and	
2	(3) must be returned to the provider to correct the error.	
3	(b) (e) The department of insurance shall prescribe the	
4	credentialing application form used by the Council for Affordable	
5	Quality Healthcare (CAQH) in electronic or paper format, which must	
6	be used by:	
7	(1) a provider who applies for credentialing by an insurer; and	
8	(2) an insurer that performs credentialing activities.	
9	(c) An insurer shall notify a provider concerning a deficiency on	
10	a completed credentialing application form submitted by the provider	
11	not later than thirty (30) business days after the insurer receives the	
12	completed credentialing application form.	
13	(d) An insurer shall notify a provider concerning the status of the	
14	provider's completed credentialing application not later than:	
15	(1) sixty (60) days after the insurer receives the completed	
16	credentialing application form; and	
17	(2) every thirty (30) days after the notice is provided under	
18	subdivision (1), until the insurer makes a final credentialing	
19	determination concerning the provider.	
20	(e) Notwithstanding subsection (d), if an insurer fails to issue a	
21	credentialing determination within thirty (30) days after receiving a	
22	completed credentialing application form from a provider, the insurer	
23	shall provisionally credential the provider if the provider meets the	
24	following criteria:	
25	(1) The provider has submitted a completed and signed	
26	credentialing application form and any required supporting	
27	material to the insurer.	
28	(2) The provider was previously credentialed by the insurer in	
29	Indiana and in the same scope of practice for which the provider	
30	has applied for provisional credentialing.	
31	(3) The provider is a member of a provider group that is	
32	credentialed and a participating provider with the insurer.	
33	(4) The provider is a network provider with the insurer.	
34	(f) The criteria for issuing provisional credentialing under	
35	subsection (e) may not be less stringent than the standards and	
36	guidelines governing provisional credentialing from the National	
37	Committee for Quality Assurance or its successor organization.	
38	(g) Once an insurer fully credentials a provider that holds	
39	provisional credentialing, reimbursement payments under the contract	
40	shall be retroactive to the date of the provisional eredentialing. The	
41	insurer shall reimburse the provider at the rates determined by the	
42	contract between the provider and the insurer.	h

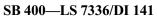




1	(h) If an insurer does not fully eredential a provider that is	
2	provisionally credentialed under subsection (e), the provisional	
3	credentialing is terminated on the date the insurer notifies the provider	
4	of the adverse credentialing determination. The insurer is not required	
5	to reimburse for services rendered while the provider was provisionally	
6	credentialed.	
7	(f) An insurer shall notify a provider concerning a deficiency	
8	on a completed unclean credentialing application form submitted	
9	by the provider not later than five (5) business days after the entity	
10	receives the completed unclean credentialing application form. A	
11	notice described in this subsection must:	
12	(1) provide a description of the deficiency; and	
13	(2) state the reason why the application was determined to be	
14	an unclean credentialing application.	
15	(g) A provider shall respond to the notification required under	
16	subsection (f) not later than five (5) business days after receipt of	
17	the notice.	
18	(h) An insurer shall notify a provider concerning the status of	
19	the provider's completed clean credentialing application when:	
20	(1) the provider is provisionally credentialed; and	
21	(2) the insurer makes a final credentialing determination	
22	concerning the provider.	
23	(i) If the insurer fails to issue a credentialing determination	
24	within fifteen (15) days after receiving a completed clean	
25	credentialing application form from a provider, the insurer shall	
26	provisionally credential the provider in accordance with the	
27	standards and guidelines governing provisional credentialing from	
28	the National Committee for Quality Assurance or its successor	
29	organization. The provisional credentialing license is valid until a	
30	determination is made on the credentialing application of the	
31	provider.	
32	(j) Once an insurer fully credentials a provider that holds	
33 34	provisional credentialing and a network provider agreement has	
	been executed, then reimbursement payments under the contract	
35	shall be paid retroactive to the later of: (1) the date the provider was provisionally credentialed; or	
36 37	(1) the date the provider was provisionally credentialed; or (2) the effective date of the provider agreement.	
38	The insurer shall reimburse the provider at the rates determined	
39	by the contract between the provider and the insurer.	
40	(k) If an insurer does not fully credential a provider that is	
1 0 41	provisionally credentialed under subsection (i), the provisional	
+1 42	credentialing is terminated on the date the insurer notifies the	
14	creachdaining is terminated on the date the insurer notifies the	



provider of the adverse credentialing determination. The insurer	
is not required to reimburse for services rendered while the	
provider was provisionally credentialed.	
SECTION 3 [←] [8]. IC 27-13-15-1 IS AMENDED TO READ AS	
FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1. (a) A contract	
between a health maintenance organization and a participating provider	
of health care services:	
(1) must be in writing;	
(2) may not prohibit the participating provider from disclosing:	
(A) the terms of the contract as it relates to financial or	
other incentives to limit medical services by the	
participating provider; or	
(B) all treatment options available to an insured, including	
those not covered by the insured's policy;	
(3) may not provide for a financial or other penalty to a provider	
for making a disclosure permitted under subdivision (2); and	
(4) must provide that in the event the health maintenance	
organization fails to pay for health care services as specified by	
the contract, the subscriber or enrollee is not liable to the	
participating provider for any sums owed by the health	
maintenance organization.	
(b) An enrollee is not entitled to coverage of a health care service	
under a group or an individual contract unless that health care service	
is included in the enrollee's contract.	
(c) A provider is not entitled to payment under a contract for	
health care services provided to an enrollee unless the provider has a	
contract or an agreement with the carrier.	
(d) This section applies to a contract entered, renewed, or modified	
after June 30, 1996.	
(d) This subsection does not apply to a rate schedule	
maintained by state or federal government payers. A health	
maintenance organization that enters into a contract with a	
participating provider must provide the participating provider	
with a current reimbursement rate schedule:	
(1) every two (2) years; and	
(2) when three (3) or more CPT code (as defined in	
IC 27-1-37.5-3) rates under the contract change in a twelve	
(12) month period.	
SECTION 3 (8) [9]. IC 27-13-20-1.5 IS ADDED TO THE	
INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS	
[EFFECTIVE JULY 1, 2023]: Sec. 1.5. (a) Before approving or	
disapproving an increase or decrease in the rates to be used by a	

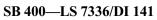




1	health maintenance organization, the commissioner shall review	
2	the following:	
3	(1) The products affected, by line of business.	
4	(2) The number of covered lives affected.	
5	(3) Whether the product is open or closed to new members in	
6	the product block.	
7	(4) Applicable median cost sharing for the product, as	
8	allowed by state or federal law.	
9	(5) The benefits provided and the underlying costs of the	
10	health services rendered.	
11	(6) The implementation date of the increase or decrease.	
12	(7) The overall percent premium rate increase or decrease	
13	that is requested.	
14	(8) The actual percent premium rate increase or decrease to	
15	be approved.	
16	(9) Incurred claims paid each year for the past three (3)	
17	years, if applicable.	
18	(10) Earned premiums for each of the past three (3) years, if	
19	applicable.	
20	(11) Projected medical cost trends in the geographic service	
21	region, if the product for which a rate increase or decrease	
22	is requested is not a product offered statewide.	
23	(12) If applicable, historical rebates paid to the enrollee from	
24	the most recent health plan year under the federal Patient	
25	Protection and Affordable Care Act (P.L. 111-148), as	
26	amended by the federal Health Care and Education	
27	Reconciliation Act of 2010 (P.L. 111-152).	
28	(13) The median cost sharing amount for a member enrolled	
29	in the product, or the actuarial value information as	
30	required under the Patient Protection and Affordable Care	-
31	Act, if applicable.	
32	(b) The commissioner shall not approve a rate increase or	
33	decrease for an existing product unless the commissioner has, at a	
34	minimum, considered the matters set forth in subsection (a)(1)	
35	through (a)(13).	
36	(c) The information compiled, prepared, and considered by the	
37	commissioner under subsection (a)(1) through (a)(13) is subject to	
38	the requirements of IC 5-14-3. However, the commissioner's	
39	approval of a rate increase or decrease may take effect before the	
40	information compiled, prepared, and considered by the	
41	commissioner under subsection (a)(1) through (a)(13) is made	
42	accessible to the public under IC 5-14-3.	



increase, the commissioner shall consider whether the current rate is appropriate for achieving the target loss ratio of the health maintenance organization. (e) To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner, under this section, may: (1) consider network adequacy;	
maintenance organization. (e) To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner, under this section, may:	
(e) To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner, under this section, may:	
Affordable Care Act and other federal law, the commissioner, under this section, may:	
under this section, may:	
, ,	
(1) consider notwork adequates	
(1) consider network adequacy;	
(2) conduct form review to ensure:	
(A) minimum essential health benefits; and	
(B) nondiscriminatory benefit design;	
(3) perform accreditation confirmation; and	
(4) confirm quality measures.	
SECTION <39>[40]. IC 27-13-36.2-4.5 IS ADDED TO THE	
INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS	
[EFFECTIVE JULY 1, 2023]: Sec. 4.5. (a) A health maintenance	
organization may not:	
(1) alter the CPT code (as defined in IC 27-1-37.5-3)	
submitted for a clean claim; and	
(2) pay for a CPT code (as defined in IC 27-1-37.5-3) of lesser	
monetary value;	
unless the medical record of the clean claim has been reviewed by	
an employee of the health maintenance organization who is	
licensed under IC 25-22.5.	
(b) A health maintenance organization may not alter a clean	
claim to only pay for the CPT codes (as defined in IC 27-1-37.5-3)	
necessary for an individual's final diagnosis, if the CPT codes (as	
defined in IC 27-1-37.5-3) billed were deemed medically necessary	
to reach the final diagnosis.	
SECTION 4 (1) IC 27-13-43-2, AS AMENDED BY	
P.L.1-2006, SECTION 489, IS AMENDED TO READ AS FOLLOWS	
[EFFECTIVE JULY 1, 2023]: Sec. 2. (a) As used in this section,	
"clean credentialing application" means an application for	
network participation that:	
(1) is submitted by a provider under this section;	
(2) does not contain an error; and	
(3) may be processed by the health maintenance organization	
without returning the application to the provider for a	
revision or clarification.	
(b) As used in this section, "credentialing" means a process by	
which a health maintenance organization makes a determination	
that:	





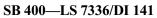
1	(1) is based on criteria established by the health maintenance	
2	organization; and	
3	(2) concerns whether a provider is eligible to:	
4	(A) provide health services to an individual eligible for	
5	coverage; and	
6	(B) receive reimbursement for the health services;	
7	under an agreement that is entered into between the	
8	provider and the health maintenance organization.	
9	(c) As used in this section, "unclean credentialing application"	
10	means an application for network participation that:	
11	(1) is submitted by a provider under this section;	
12	(2) contains at least one (1) error; and	
13	(3) must be returned to the provider to correct the error.	
14	(a) (d) The department shall prescribe the credentialing	
15	application form used by the Council for Affordable Quality Healthcare	
16	(CAQH) in electronic or paper format. The form must be used by:	
17	(1) a provider who applies for credentialing by a health	
18	maintenance organization; and	
19	(2) a health maintenance organization that performs	
20	credentialing activities.	
21	(b) A health maintenance organization shall notify a provider	
22	concerning a deficiency on a completed credentialing application form	
23	submitted by the provider not later than thirty (30) business days after	
24	the health maintenance organization receives the completed	
25	credentialing application form.	
26	(c) A health maintenance organization shall notify a provider	
27	concerning the status of the provider's completed credentialing	
28	application not later than:	
29	(1) sixty (60) days after the health maintenance organization	
30	receives the completed credentialing application form; and	
31	(2) every thirty (30) days after the notice is provided under	
32	subdivision (1), until the health maintenance organization makes	
33	a final credentialing determination concerning the provider.	
34	(e) An insurer shall notify a provider concerning a deficiency	
35	on a completed unclean credentialing application form submitted	
36	by the provider not later than five (5) business days after the entity	
37	receives the completed unclean credentialing application form. A	
38	notice described in this subsection must:	
39	(1) provide a description of the deficiency; and	
40	(2) state the reason why the application was determined to be	
41	an unclean credentialing application.	
42	(f) A provider shall respond to the notification required under	



1	subsection (e) not later than five (5) business days after receipt of	
2	the notice.	
3	(g) An insurer shall notify a provider concerning the status of	
4	the provider's completed clean credentialing application when:	
5	(1) the provider is provisionally credentialed; and	
6	(2) the insurer makes a final credentialing determination	
7	concerning the provider.	
8	(h) If the insurer fails to issue a credentialing determination	
9	within fifteen (15) days after receiving a completed clean	
10	credentialing application form from a provider, the insurer shall	
11	provisionally credential the provider in accordance with the	
12	standards and guidelines governing provisional credentialing from	
13	the National Committee for Quality Assurance or its successor	
14	organization. The provisional credentialing license is valid until a	
15	determination is made on the credentialing application of the	
16	provider.	
17	(i) Once an insurer fully credentials a provider that holds	
18	provisional credentialing and a network provider agreement has	
19	been executed, then reimbursement payments under the contract	
20	shall be paid retroactive to the later of:	
21	(1) the date the provider was provisionally credentialed; or	
22	(2) the effective date of the provider agreement.	
23	The insurer shall reimburse the provider at the rates determined	
24	by the contract between the provider and the insurer.	
25	(j) If an insurer does not fully credential a provider that is	
26	provisionally credentialed under subsection (h), the provisional	
27	credentialing is terminated on the date the insurer notifies the	
28	provider of the adverse credentialing determination. The insurer	
29	is not required to reimburse for services rendered while the	
30	provider was provisionally credentialed.	
31	SECTION 4<1>[2]. IC 27-13-43-3 IS REPEALED [EFFECTIVE	
32	JULY 1, 2023]. Sec. 3. (a) Notwithstanding section 2 of this chapter,	
33	if a health maintenance organization fails to issue a credentialing	
34	determination within thirty (30) days after receiving a completed	
35	credentialing application form from a provider, the health maintenance	
36	organization shall provisionally credential the provider if the provider	
37	meets the following criteria:	
38	(1) The provider has submitted a completed and signed	
39	eredentialing application form and any required supporting	
40	material to the health maintenance organization.	
41	(2) The provider was previously credentialed by the health	
42	maintenance organization in Indiana and in the same scope of	D
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1	practice for which the provider has applied for provisional	
2	credentialing.	
3	(3) The provider is a member of a provider group that is	
4	credentialed and a participating provider with the health	
5	maintenance organization.	
6	(4) The provider is a network provider with the health	
7	maintenance organization.	
8	(b) The criteria for issuing provisional credentialing under	
9	subsection (a) may not be less stringent than the standards and	
10	guidelines governing provisional credentialing from the National	
11	Committee for Quality Assurance or its successor organization.	
12	(c) Once a health maintenance organization fully credentials a	
13	provider that holds provisional credentialing, reimbursement payments	
14	under the contract shall be retroactive to the date of the provisional	
15	eredentialing. The health maintenance organization shall reimburse the	
16	provider at the rates determined by the contract between the provider	
17	and the health maintenance organization.	
18	(d) If a health maintenance organization does not fully credential	
19	a provider that is provisionally credentialed under subsection (a), the	
20	provisional credentialing is terminated on the date the health	
21	maintenance organization notifies the provider of the adverse	
22	credentialing determination. The health maintenance organization is	
23	not required to reimburse for services rendered while the provider was	
24	provisionally eredentialed.	
25	SECTION $4 \rightleftharpoons [3]$. IC 35-52-25-2.8 IS ADDED TO THE	
26	INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS	
27	[EFFECTIVE JULY 1, 2023]: Sec. 2.8. IC 25-4.5-4-2 defines a crime	
28	concerning associate physicians.	
29	SECTION $4 \Leftrightarrow \boxed{4}$. [EFFECTIVE JULY 1, 2023] (a) 410	
30	IAC 15-1.4-2.2(a) is void. The publisher of the Indiana	
31	Administrative Code and Indiana Register shall remove this	
32	subsection from the Indiana Administrative Code.	
33	(b) The Indiana department of health shall amend 410	
34	IAC 15-1.4-2.2 to conform to this act.	
35	(c) In amending the rule as required by this SECTION, the	
36	Indiana department of health may adopt an emergency rule in the	
37	manner provided by IC 4-22-2-37.1.	
38	(d) Notwithstanding IC 4-22-2-37.1(g), an emergency rule	
39	adopted by the Indiana department of health under this SECTION	
40	expires on the date on which a rule that supersedes the emergency	
41	rule is adopted by the Indiana department of health under	
42	IC 4-22-2-24 through IC 4-22-2-36.	D





1	(e) This SECTION expires July 1, 2024.	
2	SECTION $4 \stackrel{\longleftarrow}{\longleftrightarrow} [5]$. [EFFECTIVE JULY 1, 2023] (a) 410	
3	IAC 15-1.5-5(a)(3) is void. The publisher of the Indiana	
4	Administrative Code and Indiana Register shall remove this	
5	subdivision from the Indiana Administrative Code.	
6	(b) This SECTION expires July 1, 2025.	
7	SECTION 4 <5> [6]. [EFFECTIVE UPON PASSAGE] (a) The	
8	legislative council is urged to assign to the appropriate interim	
9	study committee the task of studying the issue of whether a health	
10	insurer or a health maintenance organization should be required	
11	to exempt a participating health care provider from needing to	
12	receive prior authorization on a particular health care service if	
13	the participating health care provider has continuously received	_
14	approval for the health care service for a determined number of	
15	months.	
16	(b) This SECTION expires January 1, 2024.	
17	SECTION 4 <6> [7]. [EFFECTIVE UPON PASSAGE] (a) The	
18	legislative council is urged to assign to the appropriate interim	
19	study committee the task of studying the issue of whether Indiana	
20	should adopt an interstate mobility of occupational licensing to	
21	allow individuals who hold current and valid occupational licenses	
22	or government certifications in another state in a lawful occupation	
23	with a similar scope of practice as Indiana to practice in Indiana	
24	under certain conditions.	
25	(b) This SECTION expires January 1, 2024.	
26	SECTION 4 [8]. An emergency is declared for this act.	-
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