SLS 20RS-346 **ORIGINAL**

2020 Regular Session

SENATE BILL NO. 292

BY SENATOR JACKSON

INSURANCE POLICIES. Provides relative to utilization reviews for health insurance policies. (8/1/20)

AN ACT

To amend and reenact R.S. 22:1016(A) and to enact Subpart P of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1260.41 through 1260.48, relative to health insurance; to provide for utilization reviews; to provide for definitions; to provide for documentation; to provide for decisions and notifications; to provide for reporting; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1016(A) is hereby amended and reenacted and Subpart P of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1260.41 through 1260.48 is hereby enacted to read as follows:

§1016. Regulation by the Department of Insurance and the Louisiana Department of Health of prepaid entities participating in the Louisiana Medicaid Program

A. Notwithstanding any law to the contrary, any prepaid entity that participates in the Louisiana Medicaid Program shall obtain an insurer license or certificate of authority from the Louisiana Department of Insurance. Any prepaid

entity participating in the Louisiana Medicaid Program shall be regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program, be regulated by the Louisiana Department of Health, subject to 42 USCA §1396 et seq., and all applicable federal and state laws, rules, and regulations relating to the Louisiana Medicaid Program. The Louisiana Department of Health shall have the authority to adopt and promulgate rules and regulations, including certification **requirements**, relating to the Louisiana Medicaid Program. Except for licensure**,** ~~and~~ financial solvency requirements, **and the provisions of Subpart P of Part III of Chapter 4 of this Title,** no other provisions of this Title shall apply to a prepaid entity with respect to the participation of the prepaid entity in the Louisiana Medicaid Program.

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SUBPART P. UTILIZATION REVIEW STANDARDS

§1260.41. Definitions

For purposes of this Part, the following terms have the following meanings unless the context clearly indicates otherwise:

(1) "Adverse determination" is a determination by a health insurance issuer or utilization review entity that an admission, availability of care, continued stay, or other healthcare service furnished or proposed to be furnished to an enrollee has been evaluated and, based upon the information provided, does not meet a health insurance issuer's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness, or is experimental or investigational, and the requested service is therefore denied, reduced, or terminated.

(2) "Ambulatory review" means a utilization review of healthcare services performed or provided in an outpatient setting.

(3) "Certification" means a determination by a health insurance issuer or a utilization review entity that an admission, availability of care, continued

stay, or other healthcare service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, healthcare setting, level of care, and effectiveness, and that payment will be made for that healthcare service, provided the patient is an enrollee of the health benefit plan at the time the service is provided.

(4) "Clinical review criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, decision abstracts, clinical protocols, medical protocols, practice guidelines, and any other criteria or rationales used by the health insurance issuer or utilization review entity to determine the necessity and appropriateness of healthcare services.

(5) "Commissioner" means the commissioner of the Louisiana Department of Insurance.

(6) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(7) "Department" means the Louisiana Department of Insurance.

(8) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, any other entity providing a plan of health insurance or health benefits, or a "managed care organization" as defined by 42 CFR 438.2.

(9) "Prior authorization" means a certification made pursuant to a prior authorization review or notice as required by a health insurance issuer prior to the provision of any healthcare service.

(10) "Prior authorization review" means a utilization review of medical

necessity conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, pre-treatment review, and case management.

(11) "Retrospective review" means a utilization review of medical necessity conducted after services have been provided to a patient but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(12) "Utilization review" means the application of a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of healthcare services, procedures, or settings. Techniques include but are not limited to ambulatory review, prior authorization review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. "Utilization review" shall not include elective clarification of coverage.

(13) "Utilization review entity" means an individual or entity that performs prior authorization examinations for a health insurance issuer. A health insurance issuer or healthcare provider is a utilization review entity if it directly performs prior authorization reviews.

§1260.42. Documented prior authorization program; general requirement

A. A health insurance issuer that requires the satisfaction of a utilization review as a condition of payment of a claim submitted by a healthcare provider shall maintain a documented prior authorization program that implements evidenced-based clinical review criteria. The prior authorization program shall include a method for reviewing and updating clinical review criteria.

B. If a health insurance issuer engages a third-party utilization review entity to perform utilization reviews, the health insurance issuer shall be responsible for ensuring that the requirements of this Subpart and applicable rules and regulations are met by the third-party utilization review entity.

C. In addition to fulfilling the requirements of this Subpart, a prior authorization program shall meet standards set forth by a national accreditation organization including but not limited to the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care. A health insurance issuer or utilization review entity shall ensure that the utilization review program employs staff who are properly qualified, trained, supervised, and supported by explicit written current clinical review criteria and review procedures.

D. A health insurance issuer that requires utilization review for any service shall allow healthcare providers to submit requests for utilization review at any time, including outside normal business hours. Within twenty-four hours of receiving an oral or written request from a healthcare provider, the health insurance issuer shall provide the specific clinical review criteria used by the health insurance issuer to make a utilization review determination.

E.(1) A health insurance issuer shall maintain a system of recording information and supporting clinical documentation submitted by healthcare providers seeking utilization review. This information shall be maintained by the health insurance issuer until the claim has been paid or the claim appeals process has been exhausted unless the information is otherwise required to be retained for a longer period of time by state or federal law or regulation.

(2) A health insurance issuer shall provide a unique case number to a healthcare provider upon receipt from that provider of a request for utilization review. Except as otherwise requested by the healthcare provider in writing, the unique case number shall be transmitted or otherwise communicated through the same medium through which the request for utilization review was made.

(3) Upon request of the provider or facility, a health insurance issuer or a utilization review entity shall send to the provider or facility written acknowledgment of receipt of each document submitted by the provider or

facility during the processing of a prior authorization request.

(4) When the provider or facility transmits information by telephone, a health insurance issuer shall provide written acknowledgment of the information communicated by the provider or facility.

§1260.43. Single utilization review per episode of care

A health insurance issuer shall not impose any additional utilization review requirement with respect to any surgical or otherwise invasive procedure or any item furnished as part of that surgical or invasive procedure, if the procedure item is furnished during the perioperative period of a procedure when either of the following conditions is met:

(1) Prior authorization was received from the health insurance issuer before the procedure or item was furnished.

(2) Prior authorization was not required by the health insurance issuer.

§1260.44. Suspension of utilization review

In the event a hospital or healthcare provider has performed a procedure an average of thirty times per year over a period of two years and in a six-month time period has received certifications for ninety percent of the utilization reviews for that procedure, the health insurance issuer shall not require the hospital or healthcare provider to request utilization review for that procedure for the following six months. At the end of the six-month term, the suspension shall be reviewed prior to renewal. This suspension is subject to internal auditing at any time by the health insurance issuer and may be rescinded if the health insurance issuer determines the hospital or healthcare practitioner is not performing the procedure in conformity with the health insurance issuer's benefit plan.

§1260.45. Timeframes for decision

A. A health insurance issuer shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this Section,

"enrollee" includes the representative of an enrollee. A health insurance issuer or utilization review entity shall make a utilization review decision as expeditiously as the member's health condition requires, but in all cases no later than the time periods required in this Section.

B.(1) For utilization review determinations that are neither concurrent or retrospective review determinations, a health insurance issuer or utilization review entity shall make the determination within thirty-six hours of the initial request, which shall include one business day, of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination.

(2) The health insurance issuer shall give an initial notification of the decision to the requesting provider rendering the service by telephone or electronically within twenty-four hours of making the decision and provide written or electronic confirmation of the initial notification to the insured and the provider within three business days of making the decision.

(3) If a healthcare provider or facility believes that the time specifications provided in Paragraphs (1) and (2) of this Subsection are so long that they could seriously jeopardize the life or health of an insured or the insured's ability to attain, maintain, or regain maximum function, or that a delay in treatment would subject the insured to severe pain that could not be adequately managed without the service requested, the healthcare provider shall request an expedited review and the health insurance issuer shall make the determination within twenty-four hours of obtaining all necessary information from the provider or facility. The health insurance issuer shall give, either by telephone or electronically, an initial notification of the decision to the provider within twenty-four hours of the health insurance issuer making the decision and shall provide written confirmation of the decision within three business days of making the determination.

C.(1) For concurrent review determinations, a health insurance issuer

or utilization review entity shall make the determination within twenty-four hours of obtaining all necessary information from the provider or facility.

(2) In the case of a determination to certify an extended stay or additional services, the health insurance issuer shall give an initial notification of the decision to the provider rendering the service either by telephone or electronically within twenty-four hours of making the decision, and provide written confirmation to the enrollee and the provider within three working days after the certification. The initial and written notifications shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(3) In the case of an adverse determination, the health insurance issuer shall make an initial notification to the provider by telephone or electronically within twenty-four hours of making the adverse determination and provide written or electronic notification to the enrollee and the provider within three working days of making the adverse determination.

D. For retrospective review determinations, a health insurance issuer shall make the determination within thirty working days of receiving all necessary information. A health insurance issuer shall provide notice in writing of the issuer's determination to an enrollee within ten working days of making the determination.

E. For purposes of this Section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. If the request for utilization review from the participating provider or facility is not accompanied by all necessary information required by the health insurance issuer, the health insurance issuer shall have one calendar day to inform the provider or facility what additional information is necessary to make the determination and shall allow a provider or facility no less than two business days to provide the necessary information to the health insurance issuer. In cases where the provider or an enrollee will not release necessary

information, the health insurance issuer may deny certification of an admission, procedure, or service.

F. A written notification of an adverse determination shall include the principal reason or reasons for the determination including the clinical rationale and the instructions for initiating an appeal or reconsideration of the determination. A health insurance issuer shall provide the clinical rationale for an adverse determination in writing, including the clinical review criteria used to make that determination, to the healthcare provider and to any party who received notice of the adverse determination.

G. If a health insurance issuer fails to make a determination within the timeframes required in this Section, the health insurance issuer shall be prohibited from denying the claim based upon a lack of prior authorization.

§1260.46. Documentation

A health insurance issuer, when conducting a utilization review determination, shall:

(1) Accept any evidence-based information from a provider or facility that will assist in the authorization process.

(2) Collect only the information necessary to authorize the service and maintain a process for the provider or facility to submit any records.

(3) If medical records are requested, require only the portion of the medical record necessary in that specific case to determine medical necessity or appropriateness of the service to be delivered, to include admission or extension of stay, and frequency or duration of service.

(4) Base review determinations on the medical information in the enrollee's records and obtained by the health insurance issuer up to the time of the review determination.

§1260.47. Utilization review decisions

A. When a healthcare provider or facility makes a request for the utilization review, the response from the health insurance issuer shall state if it

is certified or denied. If the request is denied, the response shall give the specific reason for the denial in clear and simple language. If the reason for the denial is based on clinical review criteria, the specific criteria shall be provided. A denial of a utilization review request shall include the department and credentials of the individual who has the authority to approve or deny the request. A denial shall also include a phone number to contact the authorizing entity and a notice regarding the enrollee's appeal rights and process. If a request for utilization review is denied by the health insurance issuer and the healthcare provider requests an appeal by peer review of the decision to deny, the peer review shall be with a healthcare practitioner similar in specialty, education, and background. The health insurance insurer's medical director has the ultimate authority regarding the appeal determination, and the healthcare provider has the option to consult with the medical director after the peer-to-peer consultation. Timeframes for completion of this appeal process shall take no longer than thirty days.

B. Provided the patient is an enrollee of the health benefit plan, a health insurance issuer shall be prohibited from revoking, limiting, conditioning, or otherwise restricting a utilization review certification within forty-five working days of the date the healthcare provider receives the utilization review certification.

§1260.48. Utilization review reporting

A.(1) A health insurance issuer shall on an annual basis and at a time and in a manner specified by the commissioner submit to the department the following information:

(a) A list of all items and services subject to a utilization review requirement under each health benefit plan offered by the health insurance issuer.

(b) The percentage of utilization review requests approved during the previous plan year by the health insurance issuer with respect to each item and

service.

(c) The percentage of requests for utilization review for the previous plan year that were initially denied and that were subsequently appealed, and the percentage of appealed requests that were overturned, with respect to each item and service.

(d) The average and the median amount of time, in hours, that elapsed during the previous plan year between the submission of a request for a utilization review to the health insurance issuer and a determination by the plan with respect to that request for each item and service, excluding any requests that did not contain all information required to be submitted by the health insurance issuer.

(e) Such other information as the commissioner determines appropriate after consultation with and comment from stakeholders.

(2) The commissioner shall submit an annual report to the House and Senate committees on insurance containing the information submitted to the department pursuant to Subsection A of this Section.

B. A health insurance issuer annually and before open enrollment shall publish a list of all items and services that are subject to a prior authorization requirement under each health benefit plan on a publicly available website, shall provide the address of the website in any enrollment materials distributed by the plan, and shall update the website in a timely manner.

C. A health insurance issuer shall provide, along with contract materials for any provider or supplier who seeks to participate under a health benefit plan, a list of all items and services that are subject to a prior authorization requirement under the plan and any policies or procedures used by the plan for making determinations with respect to prior authorization requests.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl B. Cooper.

DIGEST

SB 292 Original 2020 Regular Session Jackson

Proposed law provides definitions including "utilization review" which is the application of a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of healthcare services, procedures, or settings. Provides for techniques that include but are not limited to ambulatory review, prior authorization review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

Proposed law requires a health insurer that demands a review as a condition of payment of a claim submitted by a healthcare provider to maintain a documented prior authorization program that utilizes evidenced-based clinical review criteria.

Proposed law requires a prior authorization program to meet standards set forth by a national accreditation organization including but not limited to the National Committee for Quality Assurance, the Utilization Review Accreditation Commission, and the Accreditation Association for Ambulatory Health Care.

Proposed law allows a healthcare provider to submit a request for utilization review for any service at all times including outside normal business hours. Provides that within 24 hours of receiving either an oral or written request from a healthcare provider, the health insurance issurer shall provide the specific clinical review criteria used by the health insurance issuer to make a utilization review determination.

Proposed law requires a health insurance issuer to maintain a system of recording information and supporting clinical documentation submitted by healthcare providers seeking a utilization review. Requires a health insurance issuer to provide a unique case number to a healthcare provider upon receipt from that provider of a request for utilization review.

Proposed law prohibits a health insurance issuer from imposing any additional utilization review requirements with respect to any surgical or otherwise invasive procedure and any item furnished as part of a surgical or invasive procedure under certain conditions.

Proposed law provides in the event a hospital or healthcare provider has performed a procedure an average of 30 times per year for two years and in a six-month time period has received certifications for 90% of the utilization reviews, the health insurance issuer shall not require the hospital or healthcare provider to request utilization review for the procedure for the following six months.

Proposed law provides for utilization review determinations that are neither concurrent nor retrospective review determinations, a health insurance issuer or utilization review entity shall make the determination within 36 hours, which shall include one business day, of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a utilization review determination. Requires the health insurance issuer to make an initial notification to the requesting provider rendering the service of the decision by telephone or electronically within 24 hours of making the decision and to provide written or electronic confirmation of the initial notification to the insured and the provider within three business days of making the certification.

Proposed law requires in the case of concurrent review determinations, a health insurance issuer or utilization review entity shall make the determination within 24 hours of obtaining all necessary information from the provider or facility.

Proposed law requires a written notification of an adverse determination to include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an appeal or reconsideration of the determination.

Proposed law provides for the required documentation a health insurance issuer must provide when conducting a utilization review determination.

Proposed law details the requirements for the response from the health insurance issuer in the event of a request for the utilization review by a healthcare provider or facility.

Proposed law requires a health insurance issuer, on an annual basis, and at a time and in a manner determined by the commissioner, to submit to the department specific information regarding utilization reviews. Requires the commissioner to submit to the House and Senate committees on insurance an annual report of the information submitted by a health insurance issuer.

Effective August 1, 2020.

(Amends R.S. 22:1016(A); adds R.S. 22:1260.41-22:1260.48)