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)