2023 Regular Session

HOUSE BILL NO. 468

BY REPRESENTATIVES PRESSLY AND CHARLES OWEN AND SENATORS ROBERT MILLS AND MORRIS

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

INSURANCE/HEALTH: Provides relative to utilization review standards and approval procedures for healthcare service claims submitted by healthcare providers

1 AN ACT

2 To enact Subpart P of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of
3 1950, to be comprised of R.S. 22:1260.41 through 1260.47, relative to health
4 insurance; to provide with respect to health insurance issuers and healthcare
5 providers; to provide for definitions; to provide for a documented prior authorization
6 program; to provide for utilization review; to provide for certifications,
7 determinations, and timeframes for notifications; to prohibit a claim denial or
8 recoupment in certain circumstances; to provide for appeals; to provide for
9 effectiveness; and to provide for related matters.

10 Be it enacted by the Legislature of Louisiana:

11 Section 1. Subpart P of Part III of Chapter 4 of Title 22 of the Louisiana Revised
12 Statutes of 1950, comprised of R.S. 22:1260.41 through 1260.47, is hereby enacted to read
13 as follows:

14 SUBPART P. UTILIZATION REVIEW STANDARDS

15 §1260.41. Definitions

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

18 (1) "Adverse determination" means a determination by a health insurance
19 issuer or utilization review entity that an admission, availability of care, continued
20 stay, or other healthcare service furnished or proposed to be furnished to an enrollee

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

has been reviewed 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 utilization review for the requested service is therefore denied, reduced, or terminated.

(2) "Ambulatory review" means the same as the term is defined in R.S. 22:2392.

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

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

(6) "Healthcare facility" or "facility" means a facility or institution providing healthcare services including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting. A "healthcare facility" may include a base healthcare facility.

(7) "Healthcare professional" means the same as the term is defined in R.S. 22:2392.

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 (8) "Healthcare provider" or "provider" means a healthcare professional or
2 a healthcare facility or the agent or assignee of such professional or facility.
3 (9) "Healthcare services" means services, items, supplies, or drugs for the
4 diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury,
5 or disease.
6 (10) "Health insurance issuer" means the same as the term is defined in R.S.
7 22:1019.1.
8 (11) "Prior authorization" means a determination by a health insurance issuer
9 or person contracting with a health insurance issuer that healthcare services ordered
10 by the provider for an enrollee are medically necessary and appropriate.
11 (12) "Retrospective review" means a utilization review of medical necessity
12 that is conducted after services have been provided to an enrollee, but does not
13 include the review of a claim that is limited to an evaluation of reimbursement levels,
14 veracity of documentation, accuracy of coding, or adjudication for payment.
15 (13) "Utilization review" means a set of formal techniques designed to
16 monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or
17 efficiency of healthcare services, procedures, or settings. Techniques for application
18 include but are not limited to ambulatory review, second opinion, certification,
19 concurrent review, case management, discharge planning, reviews to determine prior
20 authorization, and retrospective review. "Utilization review" does not include
21 elective requests for clarification of coverage.
22 (14) "Utilization review entity" means an individual or entity that performs
23 reviews to determine prior authorization for a health insurance issuer. A health
24 insurance issuer or healthcare provider is a utilization review entity if it performs
25 utilization review.
26 §1260.42. Documented prior authorization program; requirements
27 A. A health insurance issuer that requires the satisfaction of a utilization
28 review as a condition of payment of a claim submitted by a healthcare provider shall
29 maintain a documented prior authorization program that utilizes evidenced-based

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 clinical review criteria. A health insurance issuer shall include a method for
2 reviewing and updating clinical review criteria in its prior authorization program.
3 B. If a health insurance issuer utilizes a third-party utilization review entity
4 to perform utilization review, the health insurance issuer is responsible for ensuring
5 that the requirements of this Subpart and applicable rules and regulations are met by
6 the third-party utilization review entity.
7 C. A health insurance issuer shall ensure that a prior authorization program
8 meets the standards set forth by a national accreditation organization including but
9 not limited to the National Committee for Quality Assurance, the Utilization Review
10 Accreditation Commission, the Joint Commission, and the Accreditation Association
11 for Ambulatory Health Care. A health insurance issuer or utilization review entity
12 shall ensure that the utilization review program utilizes staff who are properly
13 qualified, trained, supervised, and supported by explicit written, current clinical
14 review criteria and review procedures.
15 D. A health insurance issuer that requires utilization review for any service
16 shall allow healthcare providers to submit a request for utilization review at any
17 time, including outside normal business hours. Within twenty-four hours of
18 receiving an oral or written request of a healthcare provider, a health insurance issuer
19 shall provide to the healthcare provider the specific clinical review criteria used by
20 the health insurance issuer to make a utilization review determination.
21 E.(1) A health insurance issuer shall maintain a system of documenting
22 information and supporting clinical documentation submitted by healthcare providers
23 seeking utilization review. A health insurance issuer shall maintain this information
24 until the claim has been paid or the claim appeal process has been exhausted unless
25 such information is otherwise required to be retained for a longer period of time by
26 state or federal law or regulation.
27 (2) A health insurance issuer shall provide a unique confirmation number to
28 a healthcare provider upon receipt from that provider of a request for utilization
29 review. Except as otherwise requested by the healthcare provider in writing, the

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 unique confirmation number shall be communicated through the same medium
2 through which the request for utilization review was made.
3 (3) Upon request of the provider, a health insurance issuer or a utilization
4 review entity shall remit to the provider written acknowledgment of receipt of each
5 document submitted by a provider during the processing of a utilization review.
6 (4) When information is transmitted telephonically, a health insurance issuer
7 shall provide written acknowledgment of the information communicated by the
8 provider.
9 §1260.43. Single utilization review per episode of care
10 A health insurance issuer shall not impose any additional utilization review
11 requirement with respect to any surgical procedure or otherwise invasive procedure,
12 nor any item furnished as part of such surgical or invasive procedure, if such
13 procedure item is furnished during the peroperative period of a procedure and either
14 of the following conditions is met:
15 (1) Prior authorization was received by a healthcare provider from the health
16 insurance issuer before any surgical procedure or item, as part of such surgical or
17 otherwise invasive procedure, was furnished.
18 (2) Prior authorization was not required by the health insurance issuer.
19 §1260.44. Timeframes for determinations; concurrent review; retrospective review;
20 adverse determination
21 A.(1) A health insurance issuer or utilization review entity shall maintain
22 written procedures for making utilization review determinations and for notifying
23 enrollees and providers acting on behalf of enrollees of its determination, and shall
24 make a utilization review determination as expeditiously as the enrollee's health
25 condition requires, but in all cases no later than the time periods set forth in this
26 Section.
27 (2) For purposes of this Section, "enrollee" includes the representative of an
28 enrollee.

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 B.(1) For utilization review determinations that are neither concurrent nor
2 retrospective review determinations, a health insurance issuer or utilization review
3 entity shall make the determination within thirty-six hours, which shall include one
4 business day, of obtaining all necessary information regarding a proposed admission,
5 procedure, or service requiring a review determination.
6 (2) The health insurance issuer shall provide an initial notification of its
7 determination to the provider rendering the service either by telephone or
8 electronically within twenty-four hours of making the determination, and shall
9 provide written or electronic confirmation of the initial notification to the enrollee
10 and the provider within three business days of making the determination.
11 (3)(a) If a healthcare provider believes that following the time specifications
12 set forth in this Subsection could seriously jeopardize the life or health of an
13 enrollee, or the enrollee's ability to attain, maintain, or regain maximum function, or
14 a delay in treatment would subject the enrollee to severe pain that could not be
15 adequately managed without the service requested, the healthcare provider shall
16 request an expedited review and the health insurance issuer shall make the
17 determination within twenty-four hours of obtaining all necessary information from
18 the provider or facility.
19 (b) The health insurance issuer shall provide an initial notification of the
20 determination to the provider either by telephone or electronically within twenty-four
21 hours of making the determination and shall provide written confirmation of the
22 determination within three business days of making the determination.
23 C.(1) For concurrent review determinations, a health insurance issuer or
24 utilization review entity shall make the determination within twenty-four hours of
25 obtaining all necessary information from the provider or facility.
26 (2) In the case of a determination to certify an extended stay or additional
27 services, the health insurance issuer or utilization review entity shall provide an
28 initial notification of its certification to the provider rendering the service either by
29 telephone or electronically within twenty-four hours of making the concurrent review

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 certification, and shall provide written confirmation to the enrollee and the provider
2 within three business days of making the certification. The health insurance issuer
3 shall include in the initial and written notifications the number of extended days or
4 the next review date, the new total number of days or services approved, and the date
5 of admission or initiation of services.
6 D. For retrospective review determinations, a health insurance issuer shall
7 make the determination within thirty business days of receiving all necessary
8 information. A health insurance issuer shall provide notice of the determination in
9 writing to the enrollee and provider within three business days of making the
10 retrospective review determination.
11 E.(1) In the case of an adverse determination, the health insurance issuer
12 shall provide an initial notification to the provider rendering the service either by
13 telephone or electronically within twenty-four hours of making the adverse
14 determination and shall provide written or electronic notification to the enrollee and
15 the provider within three business days of making the adverse determination.
16 (2) A health insurance issuer shall include in its written notification of an
17 adverse determination the principal reasons for the determination, including the
18 clinical rationale, and the instructions for initiating an appeal or reconsideration of
19 the determination. A health insurance issuer shall provide the clinical rationale in
20 writing for an adverse determination, including the clinical review criteria used to
21 make that determination, to the healthcare provider and any party who received
22 notice of the adverse determination.
23 F. For purposes of this Section, "necessary information" includes the results
24 of any face-to-face clinical evaluation or second opinion that may be required. If the
25 request for utilization review from the participating provider is not accompanied by
26 all necessary information required by the health insurance issuer, the health
27 insurance issuer has one calendar day to inform the provider of the particular
28 additional information necessary to make the determination, and shall allow the
29 provider at least two business days to provide the necessary information to the health

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 insurance issuer. In cases where the provider or an enrollee will not release
2 necessary information, the health insurance issuer may deny certification of an
3 admission, procedure, or service.
4 G. If a health insurance issuer fails to make a determination of a claim within
5 the timeframes set forth in this Section, the health insurance issuer shall not deny the
6 claim based upon a lack of prior authorization.
7 §1260.45. Documentation
8 When conducting a utilization review, a health insurance issuer shall do all
9 of the following:
10 (1) Accept any evidence-based information from a provider that will assist
11 in the utilization review.
12 (2) Collect only the information necessary to authorize the service and
13 maintain a process for the provider to submit such records.
14 (3) If medical records are requested, require only the portion of the medical
15 record necessary in that specific case to determine medical necessity or
16 appropriateness of the service to be delivered, including admission or extension of
17 stay, frequency, or duration of service.
18 (4) Base review determinations on the medical information in the enrollee's
19 records obtained by the health insurance issuer up to the time of the review
20 determination.
21 §1260.46. Utilization review; determinations; appeals
22 A. When a healthcare provider makes a request for a utilization review, the
23 health insurance issuer shall state if its response to the request is to certify or deny
24 the request. If the request is denied, the health insurance issuer shall provide in the
25 response the specific reason for the denial in clear and simple language. If the reason
26 for the denial is based on clinical review criteria, the health insurance issuer shall
27 provide the specific criteria.
28 B. In the denial of a utilization review request, a health insurance issuer shall
29 include the department and credentials of the individual authorized to approve or

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 deny the request, a phone number to contact the authorizing authority, and a notice
2 regarding the enrollee's right to appeal.
3 C.(1) If a health insurance issuer denies a request for utilization review and
4 the healthcare provider requests an appeal by peer review of the determination to
5 deny, the health insurance issuer shall appoint a Louisiana licensed healthcare
6 practitioner similar in specialty, education, and background practicing in this state
7 to conduct the provider's appeal by peer review. The health insurance issuer's
8 medical director shall issue the ultimate decision regarding the appeal determination
9 and the healthcare provider may then consult with the medical director after the
10 appeal by peer review.
11 (2) The timeframe for the appeal described in this Subsection shall not
12 exceed thirty days from the date the provider makes the written request for appeal
13 by peer review to the health insurance issuer.
14 §1260.47. Prior authorization; denial of claims
15 A. A health insurance issuer shall not deny any claim subsequently
16 submitted for healthcare services specifically included in a prior authorization unless
17 at least one of the following circumstances applies for each healthcare service
18 denied:
19 (1)(a) Benefit limitations, such as annual maximums and frequency
20 limitations not applicable at the time of prior authorization, have been reached due
21 to utilization subsequent to the issuance of the prior authorization and the health
22 insurance issuer provides notification to the provider prior to healthcare services
23 being rendered.
24 (b) In the event of the service being rendered prior to notification, the health
25 insurance issuer shall pay the provider and recoup such payment from the enrollee.
26 (2) The documentation for the claim provided by the provider clearly fails
27 to support the claim as originally certified.
28 (3) If, subsequent to the issuance of the prior authorization, new services are
29 provided to the enrollee or a change in the enrollee's condition occurs indicating that

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

1 the prior authorized service would no longer be considered medically necessary,
2 based on the prevailing standard of care.
3 (4) If, subsequent to the issuance of the prior authorization, new services are
4 provided to the enrollee or a change in the enrollee's condition occurs indicating that
5 the prior authorized service would at that time require disapproval in accordance
6 with the terms and conditions for coverage under the enrollee's plan in effect at the
7 time the prior authorization was certified.
8 (5) The health insurance issuer's denial is due to one of the following:
9 (a) Another payor is responsible for the payment.
10 (b) The healthcare provider has already been paid for the healthcare services
11 identified on the claim.
12 (c) The claim was submitted fraudulently or the prior authorization was
13 based in whole or material part on erroneous information provided to the health
14 insurance issuer by the healthcare provider, enrollee, or the enrollee's representative.
15 (d) The person receiving the service was not eligible to receive the
16 healthcare service on the date of service and the health insurance issuer did not know
17 and, with the exercise of reasonable care, could not have known of the person's
18 ineligibility status.
19 B. A health insurance issuer's certification of prior authorization is valid for
20 a minimum of six months.
21 Section 2. This Act shall become effective upon signature of the governor or, if not
22 signed by the governor, upon expiration of the time for bills to become law without signature
23 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
24 vetoed by the governor and subsequently approved by the legislature, this Act shall become
25 effective the day following such approval.

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 468 Original 2023 Regular Session Pressly

Abstract: Requires standards for prior authorization and approval procedures, including timeframes, for health insurance issuers to determine healthcare service claims submitted by healthcare providers.

Proposed law defines "adverse determination", "ambulatory review", "certification", "clinical review criteria", "concurrent review", "healthcare facility", "healthcare professional", "healthcare provider", "healthcare services", "health insurance issuer", "prior authorization", "retrospective review", "utilization review", and "utilization review entity".

Proposed law requires a health insurance issuer (issuer) that mandates a satisfactory utilization review as a condition of payment for the claim of a healthcare provider (provider) to maintain a documented prior authorization program that utilizes evidenced-based clinical review criteria. Authorizes an issuer to employ a third-party utilization review entity to perform utilization review and requires a prior authorization program to meet standards set forth by a national accreditation organization.

Proposed law authorizes a provider to submit a request for utilization review for any service to an issuer at any time, including outside normal business hours. Requires an issuer to notify the provider of the specific clinical review criteria to be used for its utilization review determination within 24 hours of receiving either an oral or written request from a provider.

Proposed law requires an issuer to maintain a system of recording supporting clinical documentation submitted by providers seeking utilization review. Requires an issuer to assign a unique case number upon receipt of the provider's request for utilization review.

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

Determinations that are neither concurrent or retrospective review. Proposed law requires an issuer or utilization review entity to make a utilization review determination within 36 hours, including 1 business day, of obtaining all necessary information regarding a proposed admission, procedure, or service. Requires the issuer to provide initial notification of its determination to the requesting provider by telephone or electronically within 24 hours of making the determination, with written or electronic confirmation of the initial notification to the enrollee and provider within 3 business days of making the determination.

Determinations based on exigency. When the needs of the enrollee permit, proposed law requires the provider to request an expedited review and requires the issuer to make a determination within 24 hours of obtaining all necessary information from the provider or facility. Requires the issuer to provide initial notification of its determination to the provider by telephone or electronically within 24 hours of making the determination, with written confirmation of the determination within 3 business days of making the determination.

Determinations for concurrent review. Proposed law requires an issuer to make a determination within 24 hours of obtaining all necessary information from the provider or facility. If the determination is to extend a patient's stay or certify additional services, proposed law requires the issuer or utilization review entity to provide an initial notification of its certification to the provider by telephone or electronically within 24 hours of making

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

the certification. Further requires the issuer to provide written or electronic confirmation of the initial notification to the enrollee and the provider within 3 business days of making the certification.

Determinations for retrospective review. Proposed law requires an issuer to make the determination within 30 business days of receiving all necessary information. Requires the issuer to provide notice of the determination in writing to the enrollee and provider within 3 business days of making the retrospective review determination.

For adverse determinations, proposed law requires an issuer to provide an initial notification to the provider by telephone or electronically within 24 hours of making the adverse determination. Requires the issuer to provide written or electronic notification to the enrollee and the provider within 3 business days of making the adverse determination.

Proposed law describes the necessary information required by a provider or enrollee for submission to an issuer. Prescribes that if a provider's request for utilization review does not provide all necessary information, the issuer has 1 calendar day to inform the provider of the particular additional necessary information needed for determination, and the provider has at least 2 business days to provide the necessary information to the issuer.

Proposed law authorizes an issuer to deny certification of an admission, procedure, or service if the provider or enrollee will not release necessary information, but if the issuer fails to make a determination within the timeframes prescribed in proposed law, the issuer is prohibited from denying a claim based on a lack of prior authorization.

Proposed law requires an issuer to accept any evidence-based information and to collect only the information necessary for authorization from a provider that will assist in the utilization review, and to base its review determinations on the medical information in the enrollee's records obtained by the issuer up to the time of the review determination.

Proposed law requires an issuer to state if its response to a provider's request for utilization review is to certify or deny the request. If the request is denied, proposed law requires the issuer to give in the response the specific reason for the denial in clear and simple language, including any clinical review criteria that was the basis for denial.

Proposed law requires an issuer's denial of a utilization review request to include the department and credentials of the individual authorized to approve or deny the request, including the phone number of the authorizing authority regarding the enrollee's right to appeal.

Proposed law provides that if a provider requests an appeal by peer review of the determination to deny, the issuer is required to appoint a healthcare practitioner licensed in this state of similar specialty, education, and background. Requires the issuer's medical director to issue the ultimate decision regarding the appeal determination, at which time the provider may then consult with the medical director concerning the appeal by peer review.

Proposed law provides for the timeframe for the appeal by peer review to not exceed 30 days from the date the provider makes the written request for appeal to the issuer.

Proposed law prohibits an issuer from denying any claim subsequently submitted by a healthcare provider for healthcare services specifically included in a prior authorization unless certain circumstances apply. Further requires an issuer's certification of prior authorization to remain valid for a minimum of 6 months.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Adds R.S. 22:1260.41-1260.47)