
DIGEST

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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 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)