2023 Regular Session

HOUSE BILL NO. 468

BY REPRESENTATIVES PRESSLY, BAGLEY, BISHOP, BRYANT, DAVIS, FREEMAN, HORTON, LACOMBE, MAGEE, DUSTIN MILLER, CHARLES OWEN, ROBERT OWEN, SCHLEGEL, SELDERS, TURNER, VILLIO, AND ZERINGUE 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

AN ACT

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 1260.47, relative to health insurance; to provide with respect to health insurance issuers and healthcare providers; to provide for definitions; to provide for a documented prior authorization program; to provide for utilization review; to provide for certifications, determinations, and timeframes for notifications; to prohibit a claim denial or recoupment in certain circumstances; to provide for appeals; to provide for effectiveness; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. 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 1260.47, is hereby enacted to read as follows:

SUBPART P. UTILIZATION REVIEW STANDARDS

§1260.41. Definitions

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

(1) "Adverse determination" means 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 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.

(8) "Healthcare provider" or "provider" means an ambulance service as defined in R.S. 40:1131, a healthcare professional or a healthcare facility, or the agent or assignee of such professional or facility.

(9) "Healthcare services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(10) "Health insurance issuer" means the same as the term is defined in R.S. 22:1019.1. It shall also mean the administration of any self insured or self funded health plan.

(11) "Prior authorization" means a determination by a health insurance issuer or person contracting with a health insurance issuer that healthcare services ordered by the provider for an enrollee are medically necessary and appropriate.

(12) "Retrospective review" means a utilization review of medical necessity that is conducted after services have been provided to an enrollee, 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.

(13) "Utilization review" means 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 for application include but are not limited to ambulatory review, second opinion, certification, concurrent review, case management, discharge planning, reviews to determine prior authorization, and retrospective review. "Utilization review" does not include elective requests for clarification of coverage.

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

§1260.42. Documented prior authorization program; requirements

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 utilizes evidenced-based clinical review criteria. A health insurance issuer shall include a method for reviewing and updating clinical review criteria in its prior authorization program.

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

C. A health insurance issuer shall ensure that a prior authorization program meets the standards set forth by a national accreditation organization including but not limited to the National Committee for Quality Assurance, the Utilization Review Accreditation Commission, the Joint Commission, or the Accreditation Association for Ambulatory Health Care. A health insurance issuer or utilization review entity shall ensure that the utilization review program utilizes 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 a request for utilization review at any time, including outside normal business hours. Within seventy-two hours of receiving an oral or written request of a healthcare provider, a health insurance issuer shall provide to the healthcare provider the specific clinical review criteria used by the health insurance issuer to make its utilization review determination for the specific item or service for which the provider requested authorization. A health insurance issuer's referring of the provider to the specific criteria by electronic means is sufficient to meet the requirements of this Subsection.

E.(1) A health insurance issuer shall maintain a system of documenting information and supporting clinical documentation submitted by healthcare providers

seeking utilization review. A health insurance issuer shall maintain this information until the claim has been paid or the claim appeal process has been exhausted unless such 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 confirmation 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 confirmation number shall be communicated through the same medium through which the request for utilization review was made.

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

(4) When information is transmitted telephonically, a health insurance issuer shall provide written acknowledgment of the information communicated by the provider.

§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 procedure or otherwise invasive procedure, nor any item furnished as part of such surgical or invasive procedure, if such procedure item is furnished during the peroperative period of a procedure and either of the following conditions is met:

(1) Prior authorization was received by a healthcare provider from the health insurance issuer before any surgical procedure or item, as part of such surgical or otherwise invasive procedure, was furnished.

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

§1260.44. Timeframes for determinations; concurrent review; retrospective review; adverse determination

A.(1) A health insurance issuer or utilization review entity shall maintain written procedures for making utilization review determinations and for notifying

enrollees and providers acting on behalf of enrollees of its determination, and shall make a utilization review determination as expeditiously as the enrollee's health condition requires, but in all cases no later than the time periods set forth in this Section.

(2) For purposes of this Section, "enrollee" includes the authorized representative of an enrollee.

B.(1) For prior authorization determinations, a health insurance issuer or utilization review entity shall offer an expedited review by electronic means to the provider requesting prior authorization. When such a request is made by the provider, the health insurance issuer shall electronically communicate its decision to the provider as soon as possible, but not more than forty-eight hours from receipt of the request. If additional information is needed and requested for the health insurance issuer or utilization review entity to make its determination, the issuer or entity shall electronically communicate its decision to the provider as soon as possible, but not more than forty-eight hours from receipt of the required additional information.

(2) For any requests from a provider for prior authorization for which the health insurance issuer does not receive a request for expedited review, the health insurance issuer shall communicate its decision on the prior authorization request no more than five business days from the receipt of the request. If additional information is needed and requested for the health insurance issuer to make its determination, the health insurance issuer shall communicate its decision to the provider no more than five business days from receipt of the additional information.

(3) The health insurance issuer shall provide an initial notification of its determination to the provider rendering the service either by telephone or electronically within twenty-four hours 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 or utilization review entity shall provide an initial notification of its certification to the provider rendering the service either by telephone or electronically within twenty-four hours of making the concurrent review certification, and shall provide written confirmation to the enrollee and the provider within three business days of making the certification. The health insurance issuer shall include in the initial and written notifications the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

D. For retrospective review determinations, a health insurance issuer shall make the determination within thirty business days of receiving all necessary information. A health insurance issuer shall provide notice of the determination in writing to the enrollee and provider within three business days of making the retrospective review determination.

E.(1) In the case of an adverse determination, the health insurance issuer shall provide an initial notification to the provider rendering the service either by telephone or electronically within twenty-four hours of making the adverse determination and shall provide written or electronic notification to the enrollee and the provider within three business days of making the adverse determination.

(2) A health insurance issuer shall include in its written or electronic notification of an adverse determination the principal reasons for the determination, including the clinical rationale, and the instructions for initiating an appeal or reconsideration of the determination.

F. 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 is not accompanied by all necessary information required by the health insurance issuer, the health insurance issuer has one calendar day to inform the provider of the particular additional information necessary to make the determination, and shall allow the

provider at least 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.

G. If a health insurance issuer fails to make a determination within the timeframes set forth in Subsection B of this Section, the health insurance issuer shall not deny a claim based upon a lack of prior authorization.

§1260.45. Documentation

When conducting a utilization review, a health insurance issuer shall do all of the following:

(1) Accept any evidence-based information from a provider that will assist in the utilization review.

(2) Collect only the information necessary to authorize the service and maintain a process for the provider to submit such 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, including admission or extension of stay, frequency, or duration of service.

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

§1260.46. Utilization review; determinations; appeals

A. When a healthcare provider makes a request for a utilization review, the health insurance issuer shall state if its response to the request is to certify or deny the request. If the request is denied, the health insurance issuer shall provide the information required in R.S. 22:1260.44(E).

B. In the denial of a utilization review request, a health insurance issuer shall include the department and credentials of the individual authorized to approve or

deny the request, a phone number to contact the authorizing authority, and a notice regarding the enrollee's right to appeal.

C.(1) If a health insurance issuer denies a request for utilization review and the healthcare provider requests a peer review of the determination to deny, the health insurance issuer shall appoint a licensed healthcare practitioner similar in education and background or a same-or-similar specialist to conduct the peer review with the requesting provider. To be considered a same-or-similar specialist, the reviewing specialist's training and experience shall meet the following criteria:

(a) Treating the condition.

(b) Treating complications that may result from the service or procedure.

(2) The criteria set forth in Paragraph (1) of this Subsection are sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. For the purpose of this Subsection, "training and experience" refers to the practitioner's clinical training and experience.

(3) When the peer review is requested by a physician, the health insurance issuer shall appoint a physician to conduct the review. The health insurance issuer shall notify the physician of its peer review determination within two days of the date of the peer review.

§1260.47. Prior authorization; denial of claims

A. A health insurance issuer shall not deny any claim subsequently submitted for healthcare services specifically included in a prior authorization unless at least one of the following circumstances applies for each healthcare service denied:

(1) Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of prior authorization, have been reached due to utilization subsequent to the issuance of the prior authorization and the health insurance issuer provides notification to the provider prior to healthcare services being rendered.

(2) The documentation for the claim provided by the provider clearly fails to support the claim as originally certified.

(3) If, subsequent to the issuance of the prior authorization, new services are provided to the enrollee or a change in the enrollee's condition occurs indicating that the prior authorized service would no longer be considered medically necessary, based on the prevailing standard of care.

(4) If, subsequent to the issuance of the prior authorization, new services are provided to the enrollee or a change in the enrollee's condition occurs indicating that the prior authorized service would at that time require disapproval in accordance with the terms and conditions for coverage under the enrollee's plan in effect at the time the prior authorization was certified.

(5) The health insurance issuer's denial is due to one of the following:

(a) Another payor is responsible for the payment.

(b) The healthcare provider has already been paid for the healthcare services identified on the claim.

(c) The claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the health insurance issuer by the healthcare provider, enrollee, or the enrollee's representative.

(d) The person receiving the service was not eligible to receive the healthcare service on the date of service and the health insurance issuer did not know and, with the exercise of reasonable care, could not have known of the person's ineligibility status.

B. A health insurance issuer's certification of prior authorization is valid for a minimum of six months.

Section 2. This Act shall become effective on January 1, 2024.

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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)]

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HB 468 Reengrossed 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 (entity) to perform utilization review and requires a prior authorization program to meet standards set forth by a national accreditation organization. Further authorizes an issuer to refer the provider to the specific criteria by electronic means.

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 the specific item or service in its utilization review determination within 72 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 based on exigency. Proposed law requires an issuer or entity to offer an expedited review by electronic means to the provider requesting prior authorization. Requires the issuer to electronically communicate its decision to the provider as soon as possible, but not more than 48 hours from receipt of the request. Further provides that if additional information is needed, the issuer or entity is required to electronically communicate its decision to the provider as soon as possible, but not more than 48 hours from receipt of the required additional information.

Proposed law provides that for any requests from a provider for prior authorization for which the issuer does not receive a request for expedited review, the issuer is required to communicate its decision on the prior authorization request no more than 5 business days from the receipt of the request. Further provides that if the issuer needs and requests additional information to make its determination, the issuer is required to communicate its decision to the provider no more than 5 business days from receipt of the additional information.

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 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 a peer review of the determination to deny, the issuer is required to appoint a licensed healthcare practitioner similar in education and background or a same-or-similar specialist to conduct the peer review with the requesting provider. Requires the reviewing same-or-similar specialist's training and experience to meet certain criteria with respect to the providing of treatment.

Proposed law requires an issuer to appoint a physician to conduct the review and to notify the requesting physician of its peer review determination within 2 days of the date of the peer review.

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 on Jan, 1, 2024.

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

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Insurance to the original bill:

1. Make technical changes.

The House Floor Amendments to the engrossed bill:

1. Provide that a "health insurance issuer" means the administration of any self-insured or self-funded health plan.

2. Provide that a "healthcare provider" means an ambulance service as defined in present law.

3. Change the timeframe for which a health insurance issuer is required to notify the provider of the specific clinical review criteria to be used for its utilization review determination from within 24 hours to within 72 hours of receiving either an oral or written request from a provider. Authorize an issuer to electronically refer the provider to the specific criteria.

4. Require a health insurance issuer or utilization review entity to offer an expedited review by electronic means and to communicate its decision to the provider as soon as possible, but not more than 48 hours from receipt of the request.

5. Require a health insurance issuer to communicate to the provider its decision on non-expedited prior authorization requests within 5 business days from the receipt of the request.

6. Remove a health insurance issuer's right to recoup payment from enrollees.

7. Make changes with respect to peer review and qualifications of reviewing specialists.

8. Change the effective date from the date of the governor's signature to Jan. 1, 2024.

9. Make technical changes.