DIGEST

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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.