

ACT No. 312

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, MORRIS, AND SMITH

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 1260.48, 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 1260.48, 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:

1 (1) "Adverse determination" means a determination by a health insurance
2 issuer or utilization review entity that an admission, availability of care, continued
3 stay, or other healthcare service furnished or proposed to be furnished to an enrollee
4 has been reviewed and, based upon the information provided, does not meet a health
5 insurance issuer's requirements for medical necessity, appropriateness, healthcare
6 setting, level of care or effectiveness, or is experimental or investigational, and the
7 utilization review for the requested service is therefore denied, reduced, or
8 terminated.

9 (2) "Ambulatory review" means the same as the term is defined in R.S.
10 22:2392.

11 (3) "Certification" means a determination by a health insurance issuer or a
12 utilization review entity that an admission, availability of care, continued stay, or
13 other healthcare service has been reviewed and, based on the information provided,
14 satisfies the health insurance issuer's requirements for medical necessity,
15 appropriateness, healthcare setting, and level of care and effectiveness, and that
16 payment will be made for that healthcare service provided the patient is an enrollee
17 of the health benefit plan at the time the service is provided.

18 (4) "Clinical review criteria" means the written policies or screening
19 procedures, drug formularies or lists of covered drugs, determination rules, decision
20 abstracts, clinical protocols, medical protocols, practice guidelines, and any other
21 criteria or rationale used by the health insurance issuer or utilization review entity
22 to determine the necessity and appropriateness of healthcare services.

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

25 (6) "Healthcare facility" or "facility" means a facility or institution providing
26 healthcare services including but not limited to a hospital or other licensed inpatient
27 center, ambulatory surgical or treatment center, skilled nursing facility, inpatient
28 hospice facility, residential treatment center, diagnostic, laboratory, or imaging

1 center, or rehabilitation or other therapeutic health setting. A "healthcare facility"
2 may include a base healthcare facility.

3 (7) "Healthcare professional" means the same as the term is defined in R.S.
4 22:2392.

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

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

11 (10) "Health insurance issuer" means the same as the term is defined in R.S.
12 22:1019.1. The provisions of this Chapter shall not apply to limited scope dental
13 plans.

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

17 (12) "Retrospective review" means a utilization review of medical necessity
18 that is conducted after services have been provided to an enrollee, but does not
19 include the review of a claim that is limited to an evaluation of reimbursement levels,
20 veracity of documentation, accuracy of coding, or adjudication for payment.

21 (13) "Utilization review" means a set of formal techniques designed to
22 monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or
23 efficiency of healthcare services, procedures, or settings. Techniques for application
24 include but are not limited to ambulatory review, second opinion, certification,
25 concurrent review, case management, discharge planning, reviews to determine prior
26 authorization, and retrospective review. "Utilization review" does not include
27 elective requests for clarification of coverage.

28 (14) "Utilization review entity" means an individual or entity that performs
29 reviews to determine prior authorization for a health insurance issuer. A health

1 insurance issuer or healthcare provider is a utilization review entity if it performs
2 utilization review.

3 (15) "Urgent condition" means a condition which could immediately and
4 seriously jeopardize the life or health of the patient or the patient's ability to attain,
5 maintain, or regain maximum function.

6 §1260.42. Documented prior authorization program; requirements

7 A. A health insurance issuer that requires the satisfaction of a utilization
8 review as a condition of payment of a claim submitted by a healthcare provider shall
9 maintain a documented prior authorization program that utilizes evidenced-based
10 clinical review criteria. A health insurance issuer shall include a method for
11 reviewing and updating clinical review criteria in its prior authorization program.

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

16 C. A health insurance issuer shall ensure that a prior authorization program
17 meets the standards set forth by a national accreditation organization including but
18 not limited to the National Committee for Quality Assurance, the Utilization Review
19 Accreditation Commission, the Joint Commission, or the Accreditation Association
20 for Ambulatory Health Care. A health insurance issuer or utilization review entity
21 shall ensure that the utilization review program utilizes staff who are properly
22 qualified, trained, supervised, and supported by explicit written, current clinical
23 review criteria and review procedures.

24 D. A health insurance issuer that requires utilization review for any service
25 shall allow healthcare providers to submit a request for utilization review at any
26 time, including outside normal business hours. Within seventy-two hours of
27 receiving an oral or written request of a healthcare provider, a health insurance issuer
28 shall provide to the healthcare provider the specific clinical review criteria used by
29 the health insurance issuer to make its utilization review determination for the

1 specific item or service. A health insurance issuer's referring of the provider to the
2 specific criteria by electronic means is sufficient to meet the requirements of this
3 Subsection.

4 E.(1) A health insurance issuer shall maintain a system of documenting
5 information and supporting clinical documentation submitted by healthcare providers
6 seeking utilization review. A health insurance issuer shall maintain this information
7 until the claim has been paid or the claim appeal process has been exhausted unless
8 such information is otherwise required to be retained for a longer period of time by
9 state or federal law or regulation.

10 (2) A health insurance issuer shall provide a unique confirmation number to
11 a healthcare provider upon receipt from that provider of a request for utilization
12 review. Except as otherwise requested by the healthcare provider in writing, the
13 unique confirmation number shall be communicated through the same medium
14 through which the request for utilization review was made.

15 (3) Upon request of the provider, a health insurance issuer or a utilization
16 review entity shall remit to the provider written acknowledgment of receipt of each
17 document submitted by a provider during the processing of a utilization review. This
18 acknowledgment may be provided in electronic format.

19 (4) When information is transmitted telephonically, a health insurance issuer
20 shall provide written acknowledgment of the information communicated by the
21 provider. This acknowledgment may be provided in electronic format.

22 §1260.43. Single utilization review per episode of care

23 A health insurance issuer shall not impose any additional utilization review
24 requirement with respect to any surgical procedure or otherwise invasive procedure,
25 nor any item furnished as part of such surgical or invasive procedure, if such
26 procedure or item is furnished during the perioperative period of a procedure and
27 either of the following conditions is met:

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

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

2 §1260.44. Timeframes for determinations; concurrent review; retrospective review;
3 adverse determination

4 A.(1) A health insurance issuer or utilization review entity shall maintain
5 written procedures for making utilization review determinations and for notifying
6 enrollees and providers acting on behalf of enrollees of its determination, and shall
7 make a utilization review determination as expeditiously as the enrollee's health
8 condition requires, but in all cases no later than the time periods set forth in this
9 Section.

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

12 B.(1) For any request requiring authorization by the requesting provider as
13 being medically necessary for the treatment or management of an urgent condition
14 a health insurance issuer or utilization review entity shall offer an expedited review
15 by electronic means to the provider requesting prior authorization. When such a
16 request is made by the provider, the health insurance issuer shall electronically
17 communicate its decision to the provider as soon as possible, but not more than two
18 business days from receipt of the request. If additional information is needed and
19 requested for the health insurance issuer or utilization review entity to make its
20 determination, the issuer or entity shall electronically communicate its decision to
21 the provider as soon as possible, but not more than forty-eight hours from receipt of
22 the required additional information.

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

1 decision to the provider no more than five business days from receipt of the
2 additional information.

3 (3) The health insurance issuer shall provide an initial notification of its
4 determination to the provider rendering the service either by telephone or
5 electronically within twenty-four hours of making the determination.

6 C.(1) For concurrent review determinations, a health insurance issuer or
7 utilization review entity shall make the determination within twenty-four hours of
8 obtaining all necessary information from the provider or facility.

9 (2) In the case of a determination to certify an extended stay or additional
10 services, the health insurance issuer or utilization review entity shall provide an
11 initial notification of its certification to the provider rendering the service either by
12 telephone or electronically within twenty-four hours of making the concurrent review
13 certification, and shall provide written confirmation to the enrollee and the provider
14 within three business days of making the certification. The health insurance issuer
15 shall include in the initial and written notifications the number of extended days or
16 the next review date, the new total number of days or services approved, and the date
17 of admission or initiation of services.

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

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

28 (2) A health insurance issuer shall include in its written or electronic
29 notification of an adverse determination all of the reasons for the determination,

1 including the clinical rationale, and the instructions for initiating an appeal or
 2 reconsideration of the determination.

3 F. For purposes of this Section, "necessary information" includes the results
 4 of any face-to-face clinical evaluation or second opinion that may be required. If the
 5 request for utilization review from the provider is not accompanied by all necessary
 6 information required by the health insurance issuer, the health insurance issuer has
 7 one calendar day to inform the provider of the particular additional information
 8 necessary to make the determination, and shall allow the provider at least two
 9 business days to provide the necessary information to the health insurance issuer. In
 10 cases where the provider or an enrollee will not release necessary information, the
 11 health insurance issuer may deny certification of an admission, procedure, or service.

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

15 §1260.45. Documentation

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

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

20 (2) Collect only the information necessary to authorize the service and
 21 maintain a process for the provider to submit such records.

22 (3) If medical records are requested, require only the portion of the medical
 23 record necessary in that specific case to determine medical necessity or
 24 appropriateness of the service to be delivered, including admission or extension of
 25 stay, frequency, or duration of service.

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

1 §1260.46. Utilization review; determinations; appeals

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

6 B. In the denial of a utilization review request, a health insurance issuer shall
 7 include the department and credentials of the individual authorized to approve or
 8 deny the request, a phone number to contact the authorizing authority, and a notice
 9 regarding the enrollee's right to appeal.

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

16 (a) Treating the condition.

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

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

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

26 §1260.47. Prior authorization; denial of claims

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

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

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

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

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

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

17 (a) Another payor is responsible for the payment.

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

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

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

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

1 §1260.48. Reviews for fraud, waste or abuse

2 Nothing in this Subpart shall preclude a health insurance issuer from
3 conducting investigations of possible fraud, waste, or abuse or taking appropriate
4 actions based upon the results of such investigations.

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

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____