RÉSUMÉ DIGEST

ACT 312 (HB 468) **2023 Regular Session** **Pressly**

New 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", "urgent condition", "utilization review", and "utilization review entity".

New 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.

New law authorizes a provider to submit to an issuer a request for utilization review for any service 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 a provider's oral or written request. Further authorizes an issuer to provide the notice in an electronic format.

New law requires an issuer to maintain a system of recording supporting clinical documents 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.

New law prohibits an issuer from imposing additional utilization review requirements with respect to any surgical or invasive procedure or any item furnished thereof.

Determinations based on expedited review. New law requires an issuer or entity to offer an expedited review of a provider's prior authorization request that is medically necessary for the treatment or management of a patient's urgent condition. Requires the issuer or entity to electronically communicate its decision to the provider as soon as possible, but not more than two business days 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 additional information.

New law provides that for any requests from a provider requiring prior authorization for which the provider does not request an expedited review, the issuer is required to communicate its decision on the prior authorization request no more than five business days from 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 five business days from receipt of the additional information.

Determinations for concurrent review. New 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, new 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 two business days of making the certification.

Determinations for retrospective review. New 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 three business days of making the retrospective review determination.

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

New 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 two business days to provide the necessary information to the issuer.

New 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 new law, the issuer is prohibited from denying a claim based on a lack of prior authorization.

New law requires an issuer to accept any evidence-based information, collect only the information necessary for authorization from a provider that will assist in the utilization review, and 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.

New 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, new law requires the issuer to give in the response all reasons for denial, including any clinical review criteria.

New 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 for the enrollee's use for an appeal.

New 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 practitioner's or specialist's training and experience to meet certain criteria with respect to the providing of treatment.

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

New 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.

New law requires an issuer's certification of prior authorization to remain valid for a minimum of three months from the date of certification.

New law does not prohibit a health insurance issuer from conducting investigations of possible fraud, waste, or abuse or from taking appropriate actions based upon the results of such investigations.

Effective January 1, 2024.

(Adds R.S. 22:1260.41-1260.48)