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 1260.48, 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 1260.48, 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. The provisions of this Chapter shall not apply to limited scope dental plans.

(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.

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

§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

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are additions.
specific item or service. 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. This
acknowledgment may be provided in electronic format.

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

§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,
or any item furnished as part of such surgical or invasive procedure, if such
procedure or item is furnished during the perioperative period of a procedure and
either of the following conditions is met:

(1) Prior authorization was received by the healthcare provider from the
health insurance issuer before the 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 any request requiring authorization by the requesting provider as being medically necessary for the treatment or management of an urgent condition 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 two business days 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 healthcare services requiring 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 all of the 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 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 business 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 three months.
§1260.48. Reviews for fraud, waste or abuse

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

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: ____________________

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