

2022 Regular Session

SENATE BILL NO. 112

BY SENATOR ROBERT MILLS

HEALTH/ACC INSURANCE. Requires health insurers that utilize prior authorization to reduce burdensome delays in approving and in making payments for covered healthcare services. (8/1/22)

1 AN ACT  
2 To enact Subpart A-4 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes  
3 of 1950, comprised of R.S. 22:1020.61 through 1020.73 and R.S. 22:1964(31),  
4 relative to health insurance; to provide for prior authorization for health insurance  
5 claims related to certain healthcare procedures; to provide for legislative intent and  
6 purposes; to provide for definitions; to provide for exemptions from prior  
7 authorization requirements related to certain healthcare services performed by certain  
8 healthcare providers; to provide for the duration of an exemption; to provide for  
9 denial or rescission of prior authorization exemption; to provide for an independent  
10 review of the elimination of certain exemptions; to provide for appeals; to provide  
11 for renewal of eligibility of an exemption; to provide for penalties; to define certain  
12 practices as unfair deceptive insurance practices; to provide for the promulgation of  
13 rules; and to provide for related matters.  
14 Be it enacted by the Legislature of Louisiana:  
15 Section 1. Subpart A-4 of Part III of Chapter 4 of Title 22 of the Louisiana Revised  
16 Statutes of 1950, comprised of R.S. 22:1020.61 through 1020.73, and R.S. 22:1964(31) are  
17 hereby enacted to read as follows:

1                    SUBPART A-4. REDUCING ADMINISTRATIVE BURDENS

2                                    IN HEALTH INSURANCE

3                    §1020.61. Legislative intent and purpose

4                                    A. The intent of this Subpart is to reduce or eliminate cumbersome prior  
5                                    authorizations that unnecessarily delay the start or continuation of necessary  
6                                    medical treatment. Reducing or eliminating unnecessary delays in starting or  
7                                    continuing necessary medical treatment will reduce negative patient outcomes.

8                                    B. The purpose of this Subpart is to provide for the following:

9                                    (1) To require health insurance issuers that choose to utilize prior  
10                                    authorization to subsequently pay claims timely and without delay once the  
11                                    covered healthcare service has been performed.

12                                    (2) To require health insurance issuers that choose to utilize prior  
13                                    authorization to alleviate unnecessary delays in patient access to necessary  
14                                    medical treatment by exempting certain procedures performed by healthcare  
15                                    providers who have historically established themselves as high quality  
16                                    healthcare providers with regard to that particular medical procedure.

17                    §1020.62. Definitions

18                                    Wherever used in this Subpart and unless the context otherwise  
19                                    indicates, the following terms shall have the following meanings:

20                                    (1) "Covered healthcare services" means healthcare procedures or  
21                                    treatments that are covered and payable under the terms of the health benefit  
22                                    plan issued by the health insurance issuer. "Covered healthcare services" shall  
23                                    not mean a treatment or procedure which is performed that is either not  
24                                    payable or not covered under the health benefit plan.

25                                    (2) "Covered person" shall have the same meaning as provided in R.S.  
26                                    22:1019.1.

27                                    (3) "Exemption" means an exception granted to a prior authorized  
28                                    healthcare provider related to a particular covered healthcare service for which  
29                                    a prior authorized healthcare provider is not required to obtain permission in

1 advance to perform the covered healthcare service on a covered person in order  
2 to be paid under the terms of the health benefit plan.

3 (4) "Health benefit plan" shall have the same meaning as provided in  
4 R.S. 22:1019.1.

5 (5) "Health insurance issuer" shall have the same meaning as provided  
6 in R.S. 22:1019.1 except, as used in this Subpart, a "health insurance issuer"  
7 shall not include the Office of Group Benefits.

8 (6) "Healthcare provider" or "provider" means a healthcare  
9 professional licensed pursuant to Title 37 of the Louisiana Revised Statutes of  
10 1950 or a healthcare facility licensed by the Louisiana Department of Health  
11 and subject to the provisions of R.S. 40:2006.

12 (7) "Prior authorization" or "prior authorized claim" means a  
13 determination by a health insurance issuer, or person contracting with a health  
14 insurance issuer, that covered healthcare services proposed to be provided to  
15 a covered person are medically necessary and appropriate.

16 (8) "Prior authorized healthcare provider" means a healthcare provider  
17 who has obtained the prior authorization of claims for not less than eighty  
18 percent of all prior authorization requests submitted for a particular covered  
19 healthcare service to the health insurance issuer in the prior twelve month  
20 period so that the provider need not submit a claim for prior authorization to  
21 receive payment under the health benefit plan for that particular covered  
22 healthcare service performed on the covered person.

23 §1020.63. Prior authorization of a claim, information required, limitations on  
24 denial of claim

25 A. If a health insurance issuer chooses to utilize prior authorization of  
26 a claim in the processing of health insurance claims, the health insurance issuer  
27 shall timely, and without delay, pay for the covered healthcare services once the  
28 services have been performed by the healthcare provider.

29 B.(1) A health insurance issuer shall not require any information to be

1 submitted with a request for a prior authorization of a claim unless that same  
2 information is required for submission of a claim for a covered healthcare  
3 service.

4 (2) For all healthcare procedures and treatments subjected to prior  
5 authorization by a health insurance issuer, the health insurance issuer shall  
6 conduct all eligibility and other medical policy coverage determinations for the  
7 prior authorization process for a covered person.

8 C. Once a health insurance issuer has issued a prior authorization for  
9 a particular covered healthcare service or once a particular covered healthcare  
10 service has been deemed prior authorized as provided for in R.S. 22:1020.64,  
11 the health insurance issuer shall not deny any claim subsequently submitted for  
12 healthcare services included in the prior authorization unless one of the  
13 following circumstances applies:

14 (1) The health insurance issuer's policy has a benefit limitation, like an  
15 annual maximum or a frequency limit, that was exhausted between the time of  
16 the prior authorization was granted and the date on which the service was  
17 performed by the healthcare provider.

18 (2) The documentation for the claim provided by the healthcare provider  
19 clearly fails to support the claim that was the subject of the prior authorized  
20 claim request.

21 (3) The covered healthcare service is provided to the patient when the  
22 patient's condition has changed to the degree that the prior authorized medical  
23 procedure or treatment is no longer considered medically necessary at the time  
24 it is performed. A healthcare service is considered medically necessary when  
25 based upon the prevailing standard of care at the time the medical procedure  
26 or treatment is performed.

27 (4) If, at the time the medical procedure or treatment is provided to a  
28 patient, the patient's condition has changed to the degree that if the prior  
29 authorization of a claim sought on the date that the procedure or treatment was

1 performed, it would have been denied under the terms and conditions for  
2 coverage under the patient's health benefit plan in effect at time of the granting  
3 of the prior authorization.

4 (5) Another payer is primarily responsible for payment under the terms  
5 and conditions for coverage under the patient's health insurance plan for which  
6 prior authorization of a claim is sought.

7 (6) The healthcare provider has already been paid for the covered  
8 healthcare service identified on the claim.

9 (7) The claim was submitted fraudulently or the prior authorization of  
10 a claim was based in whole or in part on erroneous information provided to the  
11 health insurance issuer by the healthcare provider, the patient, or other person  
12 not related to the health insurance issuer.

13 (8) The patient receiving the procedure or treatment was not eligible to  
14 receive the procedure or service on the date of service and the health insurance  
15 issuer did not know, and with the exercise of reasonable care could not have  
16 known, that the patient was ineligible under the health benefit plan.

17 §1020.64. Prior authorized healthcare provider; exemptions; expedited  
18 approval procedures

19 A. If a health insurance issuer utilizes prior authorization in the course  
20 and scope of approving payments for covered healthcare services, the health  
21 insurance issuer shall not require prior authorization for a particular covered  
22 healthcare service if provided by a prior authorized healthcare provider, as  
23 defined in R.S. 22:1020.62.

24 B. If a particular covered healthcare service is performed by a prior  
25 authorized healthcare provider, the covered healthcare service shall be deemed  
26 prior authorized under the terms of the health benefit plan and subject to the  
27 provisions of this Subpart.

28 C.(1) Once a healthcare provider has met the criteria and is determined  
29 to be a prior authorized healthcare provider as is defined in R.S. 22:1020.62, a

1 health insurance issuer may evaluate whether a provider continues to qualify  
2 to be exempt under this Section to be exempt from obtaining prior  
3 authorization for a particular covered healthcare service, as long as an  
4 evaluation is made no more often than annually.

5 (2) Nothing in this Section requires a health insurance issuer to  
6 reevaluate a prior authorized healthcare provider for a particular evaluation  
7 period and a health insurance issuer may continue an exemption without  
8 evaluating or reevaluating a prior authorized healthcare provider.

9 D. A healthcare provider is not required to request an exemption from  
10 the prior authorization process in order to qualify as a prior authorized  
11 healthcare provider. The designation as a prior authorized healthcare provider  
12 shall be based upon whether the healthcare provider meets the definition  
13 pursuant to R.S. 22:1020.62.

14 §1020.65. Duration of prior authorization exemption

15 A. An exemption from requirements of a prior authorization of a claim  
16 shall remain in effect and not be rescinded until one of the following takes place,  
17 whichever is later:

18 (1) The thirtieth day after the date the health insurance issuer notifies  
19 the provider of the health insurance issuer's determination to rescind the  
20 exemption or designation if the provider does not appeal the health insurance  
21 issuer's determination.

22 (2) If the provider appeals the determination, pursuant to R.S.  
23 22:1020.66, then the fifth day after the date the independent review organization  
24 confirms in writing the health insurance issuer's determination to rescind the  
25 exemption or designation and written notice is given to the provider.

26 B. If a health insurance issuer does not finalize a rescission  
27 determination as specified in Subsection A of this Section, the provider is  
28 considered to have satisfied the criteria to continue to qualify for the exemption.

29 §1020.66. Denial or rescission of prior authorization exemption

1           A. A health insurance issuer may rescind an exemption from prior  
2 authorized healthcare provider upon satisfaction of all of the following items:

3           (1) Rescission shall only occur in January of each year.

4           (2) The health insurance issuer makes a determination, on the basis of  
5 a retrospective review of a random sample of not fewer than five and no more  
6 than twenty claims submitted by the provider during the most recent annual  
7 evaluation period, that less than eighty percent of the claims for the particular  
8 covered healthcare service satisfies the medical necessity criteria that would  
9 have been used by the health insurance issuer when conducting prior  
10 authorization review for the particular covered healthcare service during the  
11 relevant evaluation period.

12           B.(1) A final determination of a rescission may be made only by an  
13 individual licensed to practice medicine in Louisiana.

14           (2) If the provider is a physician, the determination shall be made by an  
15 individual licensed to practice medicine in Louisiana who has the same or  
16 similar specialty as the physician whose exemption is being rescinded.

17           (3) The health insurance issuer shall provide written notice to the prior  
18 authorized healthcare provider not less than twenty-five days before the  
19 proposed rescission is to take effect. This notice shall include all of the  
20 following:

21           (a) The sample information used to make the determination.

22           (b) A plain language explanation of how the provider may appeal and  
23 seek an independent review of the determination.

24           C. A health insurance issuer may deny an exemption from prior  
25 authorized healthcare provider only if one of the following conditions are met:

26           (1) The provider does not have the exemption at the time of the relevant  
27 evaluation period.

28           (2) The health insurance issuer provides the provider with actual  
29 statistics and data for the relevant prior authorization request evaluation period

1 and detailed information sufficient to demonstrate that the provider does not  
2 satisfy the criteria for an exemption from prior authorization requirements for  
3 the particular covered healthcare service.

4 §1020.67. Independent review of exemption determination

5 A. A provider shall have a right to review an adverse determination  
6 regarding a prior authorization exemption to be conducted by an independent  
7 review organization as defined in R.S. 22:2392. A health insurance issuer shall  
8 not require a provider to engage in an internal appeal process before requesting  
9 a review by an independent review organization under this Section.

10 B. A health insurance issuer shall pay for the following:

11 (1) The costs of any appeal or independent review of an adverse  
12 determination regarding a prior authorization exemption requested under this  
13 Section.

14 (2) The applicable fees established in R.S. 40:1165.1 for copies of medical  
15 records or other documents requested from a provider during an exemption  
16 rescission review requested under this Section.

17 C. An independent review organization shall complete an expedited  
18 review of an adverse determination regarding a prior authorization exemption  
19 not later than the thirtieth day after the date that a provider files the request for  
20 a review under this Section.

21 D. A provider may request that the independent review organization  
22 consider another random sample of not less than five and no more than twenty  
23 claims submitted to the health insurance issuer by the provider during the  
24 relevant evaluation period for the relevant covered healthcare service as part  
25 of its review. If the provider makes a request for review under this Subsection,  
26 the independent review organization shall base its determination on the medical  
27 necessity of claims reviewed by the health insurance issuer under R.S.  
28 22:1020.66 and reviewed under this Subsection.

29 §1020.68. Effect of appeal or independent review determination



1           A. A health insurance issuer is bound by an appeal or independent  
2 review determination that does not affirm the determination made by the health  
3 insurance issuer to rescind a prior authorization exemption.

4           B. A health insurance issuer shall not retroactively deny a covered  
5 healthcare service on the basis of a rescission of an exemption, nor if the health  
6 insurance issuer's determination to rescind the prior authorization exemption  
7 is affirmed by an independent review organization.

8           C. If a determination of a prior authorization exemption made by the  
9 health insurance issuer is overturned on review by an independent review  
10 organization, the health insurance issuer shall not attempt to rescind the  
11 exemption before the end of the next evaluation period that occurs and may  
12 rescind only the exemption after the health insurance issuer complies with R.S.  
13 22:1020.66 and 1020.67.

14 §1020.69. Eligibility for exemption following rescission or denial

15           After a final determination or review affirming the rescission or denial  
16 of an exemption for a specific covered healthcare service, a provider is eligible  
17 for consideration of an exemption for the same healthcare service after the  
18 evaluation period that follows the evaluation period which formed the basis of  
19 the rescission or denial of an exemption.

20 §1020.70. Eligibility for exemption following rescission or denial

21           After a final determination or review affirming the rescission or denial  
22 of an exemption for a specific covered healthcare service, a provider is eligible  
23 for reconsideration of an exemption for the same covered healthcare service  
24 after the evaluation period that follows the evaluation period which formed the  
25 basis of the rescission or denial of an exemption.

26 §1020.71. Effect of prior authorization exemption

27           A. A health insurance issuer shall not deny or reduce payment to a prior  
28 authorized healthcare provider for a covered healthcare service for which the  
29 physician or provider has qualified for an exemption from prior authorization

1 requirements under R.S. 22:1020.64 based on medical necessity or  
2 appropriateness of care unless the physician or provider did either of the  
3 following:

4 (1) Knowingly and materially misrepresented the healthcare service in  
5 a request for payment submitted to the health insurance issuer with the specific  
6 intent to deceive and obtain an unlawful payment from the health insurance  
7 issuer.

8 (2) Failed to substantially perform the covered healthcare service.

9 B. A health insurance issuer shall not conduct a retrospective review of  
10 a covered healthcare service subject to an exemption except for the following:

11 (1) To determine if the physician or provider qualifies for an exemption  
12 under this Subpart.

13 (2) If the health insurance issuer has a reasonable cause to suspect a basis  
14 for denial under Subsection A.

15 C. Not later than five days after qualifying for an exemption from prior  
16 authorization requirements, a health insurance issuer shall provide to a  
17 provider a notice that includes:

18 (1) A statement that the physician or provider qualifies for an exemption  
19 from prior authorization requirements pursuant to this Subpart.

20 (2) A list of the covered healthcare services and health benefit plans to  
21 which the exemption applies.

22 (3) A statement of the duration of the exemption, provided the exemption  
23 is not granted for less than one year.

24 D. If a provider submits a prior authorization request for a covered  
25 healthcare service for which the physician or provider qualifies for an  
26 exemption, the health insurance issuer shall promptly provide notice to the  
27 provider that includes the information described by Subsection C of this Section  
28 and a notification of the health maintenance organization's or insurer's  
29 payment requirements.



Proposed law creates an exemption for a certain healthcare provider who is designated as prior authorized health care provider. Proposed law defines a "prior authorized healthcare provider" as a healthcare provider that is no longer required to seek prior authorization for a particular procedure or treatment if the health insurance issuer has approved not less than 80% of the prior authorization requests submitted by the provider for the particular health care treatment to that health insurance issuer.

Proposed law provides for the duration of an exemption for a prior authorized healthcare provider and sets forth requirements that must be satisfied in order for the health insurance issuer to deny or rescind an exemption.

Proposed law provides for a time period and content requirements for the mandatory notice that must be given by the health insurance issuer in order to rescind the exemption granted to the prior authorized healthcare provider.

Proposed law allows a healthcare provider to seek a review of a denial or rescission of a prior authorization exemption conducted by an independent review organization as defined by present law.

Proposed law further provides that the health insurance issuer shall pay any fees associated with the independent review of the adverse determination and for the copies of any applicable records associated with the rescission of the exemption.

Proposed law prohibits a health insurance issuer from conducting a retrospective review of a healthcare service subject to an exemption except to determine if the prior authorized healthcare provider still qualifies for an exemption or if the health insurance issuer has a reasonable cause to suspect a basis for denial exists under the provisions of proposed law.

Proposed law provides for timelines and content of the notice that must be given to any provider qualifying for an exemption under the provisions of proposed law.

Proposed law provides that violations of proposed law are considered to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance and subject to the penalties under present law.

Proposed law provides that the Dept. of Insurance is to promulgate any rules that are necessary to implement and enforce the provisions of proposed law.

Effective August 1, 2022.

(Adds R.S. 22:1020.61 - 1020.73 and R.S. 22:1964(31))