2019 Regular Session

HOUSE BILL NO. 424

BY REPRESENTATIVE STAGNI

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

MEDICAID: Provides relative to denials of provider claims and prior authorization requests by Medicaid managed care organizations

AN ACT

To amend and reenact R.S. 46:460.71(C) and to enact R.S. 46:460.51(15) and 460.74, relative to the medical assistance program of this state known commonly as Medicaid; to provide requirements for Medicaid managed care organizations relative to information on denied claims to be transmitted to healthcare providers; to provide for notices by Medicaid managed care organizations to healthcare providers concerning prior authorization requirements; to require Medicaid managed care organizations and the Louisiana Department of Health to take certain actions pursuant to denial of prior authorizations requests by healthcare providers; to require publication of certain information relative to prior authorization requirements on the websites of Medicaid managed care organizations and the Louisiana Department of Health; to provide for definitions; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:460.71(C) is hereby amended and reenacted and R.S. 46:460.51(15) and 460.74 are hereby enacted to read as follows:

§460.51. Definitions

As used in this Part, the following terms have the meaning ascribed in this Section unless the context clearly indicates otherwise:

* * *

(15) "Prior authorization denial" means any situation in which the department or a managed care organization does not fully approve of services or items being requested by a healthcare provider, including any situation in which a service or item other than the exact service or item requested is approved. Prior authorization denials include, but are not limited to, situations in which a service has been requested for a period of time and is approved for a shorter period of time, fewer hours of a service than requested are approved, or a different item or service from that requested is approved. Prior authorization denials also include, but are not limited to, situations in which previously approved services are being terminated or reduced or when the department or contractor approves the requested item or service, but sets the amount to be reimbursed lower than the amount requested.

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§460.71. Claim payment information

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C.(1) If the claim for payment is denied in whole or in part by the managed care organization or by a fiscal agent or intermediary of the organization, and the denial is remitted in the standard paper format, then the organization shall, in addition to providing all information required by Subsection A of this Section, include a claim denial reason code specific to each CPT code listed that matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program. If the claim is denied by the managed care organization based upon an opinion or interpretation by the managed care organization of a law, regulation, policy, procedure, or medical criteria or guideline, then the managed care organization shall provide with the remittance advice either instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline in the public domain or an actual copy of that law, regulation, policy, procedure, or medical criteria or guideline.

(2) If the claim for payment is denied in whole or in part by the managed care organization or by a fiscal agent or intermediary of the plan, and the denial is

remitted electronically, then the organization shall, in addition to providing all information required by Subsection A of this Section, include an American National Standards Institute compliant reason and remark code and shall make available to the provider of the service a complimentary standard paper format remittance advice that contains a claim denial reason code specific to each CPT code listed that matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program. If the claim is denied by the managed care organization based upon an opinion or interpretation by the managed care organization of a law, regulation, policy, procedure, or medical criteria or guideline, then the managed care organization shall include a copy of that law, regulation, policy, procedure, or medical criteria or guideline in the remittance advice or an equivalent notice of the claim denial.

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§460.74. Prior authorization; criteria; notice to providers

A. The prior authorization requirements of the department and each managed care organization, including prior authorization requirements applicable in the Medicaid pharmacy program, shall be based on publicly available clinical criteria and posted in an easily searchable format on the respective websites of the managed care organizations and the department. Information posted in accordance with the requirements of this Section shall include the date of last review.

B. If the department or a managed care organization denies a prior authorization request, then the department or managed care organization shall provide written notice to the provider requesting the prior authorization of the denial within three business days of making the decision. If the denial of the prior authorization by the department or managed care organization is based upon an interpretation of a law, regulation, policy, procedure, or medical criteria or guideline, then the notice shall contain either instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline in the public domain

or an actual copy of that law, regulation, policy, procedure, or medical criteria or guideline.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

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Abstract: Requires the provision of certain information for the denial of claims and prior authorization requests.

Proposed law defines the term "prior authorization" to mean any situation in which the La. Dept. of Health (LDH) or a managed care organization (MCO) does not fully approve of services or items being requested by a healthcare provider, including any situation in which a service or item other than the exact service or item requested is approved.

Present law provides that when a claim for payment is denied in whole or in part and the denial is remitted in the standard paper format, then the organization shall, in addition to providing all information required, include a claim denial reason code specific to each CPT code listed that matches or is equivalent.

Proposed law provides that when claims are denied by the MCO based upon an opinion or interpretation by the MCO of a law, regulation, policy, procedure, or medical criteria or guideline, then the MCO shall provide with the remittance advice either instructions for accessing such sourse in the public domain or an actual copy.

Present law provides that when a claim for payment is denied in whole or in part and the denial is remitted electronically, then the organization shall, in addition to providing all information required, include an American National Standards Institute compliant reason and remark code and shall make available to the provider of the service a complimentary standard paper format remittance advice that contains a claim denial reason code specific to each CPT code listed that matches or is equivalent.

Proposed law provides that when a claim is denied by the MCO based upon an opinion or interpretation by the MCO of a law, regulation, policy, procedure, or medical criteria or guideline, then the MCO shall include a copy of that source in the remittance advice or an equivalent notice of the claim denial.

Proposed law provides that the prior authorization requirements shall be based on publicly available clinical criteria and posted in an easily searchable format on the respective website of the MCO and LDH and shall include the date of last review.

Proposed law requires that if LDH or an MCO denies a prior authorization request, then LDH or the MCO shall provide written notice to the provider requesting the prior authorization of the denial within three business days of making the decision.

(Amends R.S. 46:460.71(C); Adds 46:460.51(15) and 460.74)