HLS 26RS-1002 **ORIGINAL**

2026 Regular Session

HOUSE BILL NO. 915

BY REPRESENTATIVE DICKERSON

MEDICAID: Provides with respect to utilization management practices

AN ACT

To amend and reenact R.S. 46:460.74; relative to the state medical assistance program; to provide a utilization management process; to provide established time frames for managed care organizations to make determinations; to provide guidelines for a managed care organization's failure to make a determination; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:460.74 is hereby amended and reenacted to read as follows:

§460.74. ~~Prior authorization~~ Utilization management; time periods; criteria; notice to providers

A. A managed care organization 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.

~~A.~~ B. The prior authorization requirements of the department and each managed care organization, including prior authorization requirements applicable in the Medicaid pharmacy program, shall either be furnished to the healthcare provider within twenty-four hours of a request for the requirements or posted in an easily searchable format on the website of the respective managed care organization or the

department. Information posted in accordance with the requirements of this Section shall include the date of last review.

~~B.~~ C. If the department or a managed care organization denies a prior authorization request, then the department or managed care organization shall provide written notice of the denial to the provider requesting the prior authorization within ~~three~~ two 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.

D.(1) A managed care organization shall make all standard service authorization determinations within five business days of obtaining appropriate clinical documentation that may be required regarding a proposed procedure or service requiring a review determination with the following exceptions:

(a) A managed care organization shall make all inpatient hospital service authorizations within two calendar days of obtaining appropriate clinical documentation.

(b) A managed care organization shall make all concurrent review determinations within one calendar day of obtaining the appropriate clinical documentation.

(c) A managed care organization shall make all Community Psychiatric Support and Treatment services and Psychosocial Rehabilitation Services authorizations within five calendar days of obtaining appropriate clinical documentation.

(d) A managed care organization shall make all determinations for any behavioral health crisis services that require prior authorization as expeditiously as

the enrollee's condition requires, but no later than one calendar day after obtaining appropriate clinical documentation.

(2) The standard service authorization determination may be extended up to an additional five calendar days if either of the following conditions are met:

(a) The enrollee or the health care provider requests an extension.

(b) The managed care organization obtains approval for an extension from the Louisiana Department of Health that is based upon a need for additional clinical information and the extension is in the enrollee's best interest.

E.(1) In the event a healthcare provider indicates or the managed care organization determines that following the standard service authorization timeframe could seriously jeopardize the enrollee's life; health; or ability to attain, maintain, or regain maximum function, the managed care organization shall make an expedited authorization determination and provide notice as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours after receipt of the request for service.

(2) The expedited authorization determination may be extended up to an additional five calendar days if either of the following conditions are met:

(a) The enrollee or the health care provider requests an extension.

(b) The managed care organization obtains approval for an extension from the Louisiana Department of Health that is based upon a need for additional clinical documentation and the extension is in the enrollee's best interest.

F. The managed care organization shall make retrospective review determinations within thirty calendar days of obtaining the results of any appropriate clinical documentation that may be required.

G. The managed care organization shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the enrollee's health condition made by the provider.

H. If a managed care organization fails to make a determination within the time frames set forth in this Section the managed care organization shall be prohibited from denying the claim based upon a lack of prior authorization.

I. (1) For purposes of this Section, "appropriate clinical documentation" 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 participating provider or facility does not include all the necessary information required by the health insurance issuer then the health insurance issuer shall have one calendar day to inform the provider or facility what additional information is necessary to make the determination and shall allow a provider or facility no less than 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.

(2) When conducting a utilization review determination, a managed care organization shall:

(a) Accept any evidence-based information from a provider or facility that will assist in the authorization process.

(b) Collect only the information necessary to authorize the service and maintain a process for the provider or facility to submit such records.

(c) 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; to include admission or extension of stay and frequency or duration of service.

(d) Base utilization review determinations on the medical information in the enrollee's records and obtained by the managed care organization up to the time of the review determination.

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)]

HB 915 Original 2026 Regular Session Dickerson

**Abstract:** Provides for utilization management practices instead of prior authorization and the appropriate guidelines for utilization management.

Present law provides for prior authorization, its criteria, and notice to providers.

Proposed law changes prior authorization to utilization management and specifies that managed care organizations shall maintain written procedures for making utilization review determinations; the managed care organization utilization review determination shall be completed as expeditiously as the enrollee's health condition requires.

Proposed law allows for retrospective review determinations within thirty calendar days of obtaining the results of any appropriate clinical documentation that may be required.

Proposed law prohibits managed care organizations from denying claims based upon the lack of prior authorization because the managed care organization failed to make a determination in a timely manner.

(Amends R.S. 46:460.74)