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(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.

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## 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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HB 915 Reengrossed

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's 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)

### Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Health and Welfare to the original bill:

1. Make a technical change.
2. Change the time period in which a managed care organization shall make all standard service authorization determinations from five business days to seven calendar days.
3. Change the time period in which service authorization determinations may be extended from five business days to seven calendar days.
4. Change that the managed care organization obtains approval for an extension from

the Louisiana Department of Health based upon a need for additional clinical information and the extension is in the enrollee's best interest to the managed care organization justifies to the Louisiana Department of Health, upon request, for additional information and how the extension is in the enrollee's best interest.

The House Floor Amendments to the engrossed bill:

1. Make a technical change.