Louisiana

Louisiana - HB 479

Sponsor: Representative Larry Frieman

Actions: 03/03/2022 Prefiled; Referred to the House Committee on Health and Welfare

Summary: Summary for 3/3/2022 Version

This measure requires the provision of medication requested by an individual with medical power of attorney within 24 hours.

This measure applies to physicians. This measure requires anyone with medical power of attorney who requests a hospital staff member to administer any particular medication to be granted emergency privilege and access to a physician within 24 hours of the request. Physicians may only be requested for the sole purpose of administering a requested medication. Hospitals are not liable for any harm caused by such administration of medication.

This measure takes effect on August 1, 2022.

Bill Links 3/3/2022 Version

Louisiana - HB 611

Sponsor: Representative Larry Selders (D)

Actions: 03/04/2022 Prefiled; Referred to House Committee on Health and Welfare

Summary: Summary for 3/04/2022 Version

This measure prohibits a healthcare provider from submitting a certificate of need unless directed by the House or Senate Committee on Health and Welfare.

This measure allows the Department of Health to uphold any certificate of need requirement.

This measure takes effect on August 1, 2022.

Bill Links 3/4/2022 Version

Louisiana - SB 112

Sponsor: Carla Roberts

Actions: 03/02/2022 Prefiled; referred to the Senate Committee on Insurance

Summary: Summary for 3/2/2022 Version

This measure establishes a process for certain providers to bypass the prior authorization process for certain procedures and establishes rules governing the process for determining whether a provider qualifies and how a provider may appeal a decision made by an insuerer.

This measure applies to health insurers and utilization review organizations.

This measure directs insurers to process prior authorization claims in a timely manner without delay. Once performed by the provider, covered services must be paid for by the insurer. Insurers are prohibited from requiring any information to be submitted with a request for prior authorization of a claim unless the same information is required for submission of a claim for covered healthcare services.

This measure provides that once an insurer has issued a prior authorization for a particular covered healthcare service or once a particular covered healthcare service has been deemed prior authorized, the insurer may not deny any claim subsequently submitted for healthcare services included in the prior authorization unless:

1. The insurer's policy has a benefit limitation, including annual maximums or a frequency limit, that was exhausted between the time of the granting of the prior authorization and the date on which the service was performed by the provider.
2. The documentation for the claim provided by the provider fails to support the claim that was the subject of the prior authorized claim request.
3. The covered service is provided to the patient when their condition has changed to the degree that the prior authorized medical procedure treatment is no longer considered medically necessary.
4. If the medical procedure is provided to a patient and the patient's condition has changed to the degree that if the prior authorization of a claim sought on the date of the procedure or treatment was performed, it would have been denied under the patient's health benefit plan in effect at the time of the granting of prior authorization.
5. Another payer is primarily responsible for payment under the terms and conditions of the coverage under the patient's health insurance plan under which prior authorization is sought.
6. The provider has already paid for the covered service identified on the claim.
7. The claim was submitted fraudulently or the prior authorization of a claim was based in whole or in part on erroneous information provided to the insurer by the provider, patient, or other people.
8. The patient receiving the procedure or treatment was not eligible to receive the procedure or service on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known that the patient was ineligible under the health benefit plan.

Insurers are prohibited from requiring prior authorized health care providers to request prior authorization for certain services. Prior authorized health care providers are providers who have obtained prior authorization of claims for at least 80% of all prior authorization requests submitted for a particular covered healthcare service to the health insurer in the prior twelve-month period. This measure permits insurers to evaluate whether a provider continues to qualify for exemptions under this measure to be exempt from obtaining prior authorization for a particular covered service, evaluations may only be made annually. Providers are not required to request an exemption from

the prior authorization process in order to qualify as a prior authorized healthcare provider, the designation is granted solely based on whether or not the provider meets the criteria.

An exemption from requirements of prior authorization of a claim must remain in effect and may not be rescinded until one of the following takes place: Thirty days after the date the insurer notifies the provider that their exemption was rescinded. If the provider appeals the determination, then five days after the independent review organization confirms in writing the insurer's determination to rescind the exemption or designation, and written notice is given to the provider. Insurers must finalize a rescission determination, if a rescission determination is not finalized, the provider is still considered to have satisfied the criteria and qualifies for the exemption. Recessions may only occur in January of each year. Determinations of recission may only be made on the basis of a retrospective review of a random sample of no fewer than five and no more than twenty claims submitted by the provider during the most recent annual evaluation period. Final determinations may only be made by individuals licensed to practice medicine in Louisiana. If the provider is a physician, the determination may be made by an individual licensed to practice medicine in Louisiana who has the same or similar specialty as the physician whose exemption is being rescinded. Insurers must provide a written notice to the prior authorized provider no less than twenty-five days before the proposed rescission is to take effect. The notice must include the sample information used to make the determination and a plain language explanation of how the provider may appeal the determination.

This measure provides that an insurer may deny an exemption if one of the following conditions is met: the provider does not have the exemption at the time of the relevant evaluation period, or the insurer provides the provider with actual statistics and data for the relevant prior authorization request evaluation period and detailed information sufficient to demonstrate that the provider does not satisfy the criteria for an exemption from prior authorization requirements for the particular covered service.

Providers have the right to review adverse determinations and for the review to be conducted by an independent review organization. Insurers may not require a provider to engage in an internal appeal process before requesting a review by an independent review organization. Insurers must pay for the costs of all appeals or independent reviews and the applicable fees for copies of medical records or other documents. Independent review organizations must complete an expedited review within 30 days of receiving the request. Providers may request that the independent review organization consider another random sample of no less than five and no more than twenty claims submitted to the insurer by the provider during the relevant evaluation period for the relevant covered healthcare services as part of its review.

This measure prohibits insurers from denying or reducing payment to a prior authorized provider for a covered service for which the physician or provider has qualified for an exemption from prior authorization requirements based on medical necessity or appropriateness of care unless the physician or provider knowingly and materially misrepresented the service in a request for payment submitted to the insurer with the specific intent to deceive and obtain an unlawful payment from the insurer or failed to substantially perform the covered service. This measure prohibits insurers from conducting retrospective reviews of covered healthcare services to an exemption except to determine if a physician qualifies for an exemption or if an insurer has a reasonable cause to suspect a basis for denial.

Any violation of this measure is considered to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

This measure defines "covered healthcare services" as healthcare procedures or treatments that are covered and payable under the terms of the health benefit plan issued by the health insurance

issuer. "Covered healthcare services" shall not mean a treatment or procedure which is performed that is either not payable or not covered under the health benefit plan.

This measure defines "exemption" as an exception granted to a prior authorized healthcare provider related to a particular covered healthcare service for which a prior authorized healthcare provider is not required to obtain permission in advance to perform the covered healthcare service on a covered person in order to be paid under the terms of the health benefit plan.

This measure defines "prior authorization" as a determination by a health insurance issuer, or person contracting with a health insurance issuer, that covered healthcare services proposed to be provided to a covered person are medically necessary and appropriate.

This measure defines "prior authorized healthcare provider" as a healthcare provider who has obtained the prior authorization of claims for not less than eighty percent of all prior authorization requests submitted for a particular covered healthcare service to the health insurance issuer in the prior twelve month period so that the provider need not submit a claim for prior authorization to receive payment under the health benefit plan for that particular covered healthcare service performed on the covered person.

This measure will take effect on August 1, 2022.

Bill Links 3/2/2022 Version

Louisiana - SB 30

Sponsor: Senator Fred Mills (R)

Actions: 02/11/2022 Prefiled

Summary: Summary of 2/11/2022 Version

This measure requires certain healthcare providers to be subject to a facility need review before they can be licensed and/or Medicaid certified.

This measure requires certain healthcare providers to be subject to facility need review and provides for the creation and composition of a facility need review committee, the review process used by the committee, and the rights of the applicant subject to review. This measure provides that facility need review must be satisfied before a provider can proceed with licensure and Medicaid provider certification.

The following providers are subject to a certificate of need review: home and community-based services, adult day healthcare providers, hospice providers, pediatric day healthcare facilities, behavioral health service providers, opioid treatment programs, intermediate care facilities, and adult residential care providers.

This measure requires the Louisiana Department of Health to develop and implement policies and procedures to require intermediate care facilities for people with developmental disabilities (ICF/DD)

providers to notify new residents and their families and guardians of sex offenders living in their facilities upon admission.

This measure places a moratorium on nursing facilities, additional beds for nursing facilities, and provides exemptions to the rule.

This measure takes effect August 1, 2022.

Bill Links 2/11/2022 Version