Prior Authorization Update | LSMS Requested Legislation Enacted

The LSMS requested 2 key pieces of legislation related to Prior Authorization/Utilization Management in the 2023 legislative session. Both bills were successfully passed and have now been signed by Gov. John Bel Edwards. Their effective dates are Jan. 1, 2024. Below is general information to help physicians understand the legislation.

**ACT 312**

Rep. Thomas Pressly * Utilization Management Standards

ACT 312 (HB 468) creates an infrastructure and minimum standards for health insurance issuers requiring a utilization review process for healthcare services and pharmaceuticals.

- **Requires** health insurance issuers to
  - Maintain documented PA programs utilizing evidenced based clinical review criteria
  - Acknowledge receipt of and maintain information submitted by providers throughout the appeals process
  - Provide specific clinical review criteria within 72 hours
  - Allow providers to submit requests for utilization review outside normal business hours

- **Establishes** timeframes shown in chart below

<table>
<thead>
<tr>
<th>Expedited</th>
<th>Standard</th>
<th>Concurrent Review</th>
<th>Retrospective Review</th>
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</thead>
<tbody>
<tr>
<td>Urgent but not</td>
<td>Knee Surgery</td>
<td>Inpatient</td>
<td>Service already</td>
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<tr>
<td>emergent</td>
<td>Colonoscopy</td>
<td>hospital</td>
<td>performed</td>
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<tr>
<td>* Medications</td>
<td>* Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 business</td>
<td>5 business</td>
<td>24 hours</td>
<td>30 days</td>
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<td>days</td>
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- **Prohibits** claim denial based solely on failure to obtain PA when PA request is not determined timely
- **Limits** the reasons for the claim denial when the PA for the service was approved (guarantee of payment)
- **Requires** a PA to be valid for a minimum of 3 months
- **Prohibits** additional utilization review requirements during the perioperative period when a PA was not required or had already been approved
- **Establishes** a process for adverse determinations
- **Establishes** a “truer” peer-to-peer review

**ACT 333**


ACT 333 (SB 188) closely tracks transparency requirements being proposed by the Centers for Medicare and Medicaid Services relative to Medicare Advantage organizations expected to go into effect January 1, 2026.

- **Requires** health plans to annually report certain prior authorization metrics to the Department of Insurance including:
  - A list of all items and services requiring PA
  - Percentages of expedited and standard PA requests approved, denied, approved after appeal, approved after the review timeframe was extended and the average and median timeframes between submission and a decision

- **Requires** health plans to annually publish to their website (and timely update) items and services requiring PA

- **Requires** health plans to provide a list of all items and services that require PA and their policies and procedures used to make PA decisions to health care providers seeking to participate with the health plans.

To Also Know...

Last year’s Act 432 (SB 112) required each health insurer to develop and post its own version of prior authorization relief for providers. The original bill had mirrored Texas’ “gold card” legislation but was heavily amended in Senate Insurance Committee.

The required plans are to be submitted to the Louisiana Department of Insurance by July 1. The Department has shared its intentions to host these plans for public review on its website: www.ldi.la.gov.