RS 22:1821

PART II. HEALTH AND ACCIDENT INSURANCE CLAIMS PAYMENTS
SUBPART A. HEALTH AND ACCIDENT INSURANCE CLAIMS PAYMENTS – GENERAL PROVISIONS

NOTE: §1821 (Section heading) eff. until Jan. 1, 2024. See Acts 2023, No. 322.

§1821. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers; prohibitions

NOTE: §1821 (Section heading) eff. Jan. 1, 2024. See Acts 2023, No. 322.

§1821. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telehealth reimbursement by insurers; prohibitions

A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B of this Section, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney fees to be determined by the court. Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, shall have jurisdiction to try such cases.

B. All claims for accidental death arising under the terms of health and accident contracts where such contracts insure against accidental death shall be settled by the insurer within sixty days of receipt of due proof of death and should the insurer fail to do so without just cause, then the amount due shall bear interest at the rate of six percent per annum from date of receipt of due proof of death by the insurer until paid.

C. Any person, partnership, corporation or other organization, or the State of Louisiana which provides or contracts to provide health and accident benefit coverage as a self-insurer for his or its employees, stockholders, or any other persons, shall be subject to the provisions of this Section, including the provisions relating to penalties and attorney fees, without regard to whether the person or organization is a commercial insurer; however, this Section shall not apply to collectively bargained union welfare plans other than health and accident plans.

D.(1) In any event where the contract between an insurer or self-insurer and the insured is issued or delivered in this state and contains a provision that in non-emergency cases the insured is required to be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care, or medical services which are prescribed or ordered by a duly licensed health care provider who possesses admitting and clinical staff privileges at an acute care health care facility or ambulatory surgical care facility, the insurer, self-insurer, third-party administrator, or independent contractor shall be held liable in damages to the insured only for damages incurred or resulting from unreasonable delay, reduction, or denial of the proposed medically necessary services or care according to the information received from the health care provider at the time of the request for a prospective evaluation or review by the duly licensed health care provider, as provided in the contract; such damages shall be limited solely to the physical injuries which are the direct and proximate cause of the unreasonable delay, reduction, or denial as further defined in this Subsection together with reasonable attorney fees and court costs.

(2)(a) Any insurer, health maintenance organization, preferred provider organization, or other managed care organization requirement that the insured be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure shall be inapplicable to an emergency medical condition.

(b) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization which includes emergency medical services as part of its policy or contract, shall provide coverage and shall subsequently pay providers for emergency medical services provided to an insured,

enrollee, or patient who presents himself with an emergency medical condition. This Subparagraph shall not be construed to require coverage for illnesses, conditions, diseases, equipment, supplies, or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract. The provisions of this Subparagraph shall not apply to hospital indemnity, disability, or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

(c) An insurer, health maintenance organization, preferred provider organization, or other managed care organization shall not retrospectively deny or reduce payments to providers for emergency medical services of an insured, enrollee, or patient even if it is determined that the emergency medical condition, initially presented is later identified through screening not to be an actual emergency, except in the following cases:

(i) Material misrepresentation, fraud, omission, or clerical error.

(ii) Any payment reductions due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured.

(iii) Cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

(d) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization shall inform its insureds, enrollees, patients, and affiliated providers about all applicable policies related to emergency care access, coverage, payment, and grievance procedures. It is the ultimate responsibility of the insurer, health maintenance organization, or preferred provider organization to inform any contracted third party administrator, independent contractor, or primary care provider about the emergency care provisions contained in this Paragraph.

(e) Failure to comply with the provisions of Subparagraphs (a), (b), and (c) of this Paragraph shall subject the insurer, health maintenance organization, preferred provider organization, or other managed care organization to penalties as provided for in Subsection A of this Section and to penalties for violations as provided in R.S. 22:1969.

(f) The provisions of this Paragraph shall not apply to medical benefit plans that are established under and regulated by the Employment Retirement Income Security Act of 1974.

(g) As used in this Paragraph, the following definitions shall apply:

(i) "Emergency medical condition" is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

(aa) Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(bb) Serious impairment to bodily function.

(cc) Serious dysfunction of any bodily organ or part.

(ii) "Emergency medical services" are those medical services necessary to screen, evaluate, and stabilize an emergency medical condition.

(iii) "Managed care organization" means a licensed insurance company, hospital or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care organization may include but is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.

(iv) "Managed care plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

(3)(a) For the purposes of this Subsection, a period of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator, or independent

contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services, shall not be considered unreasonable.

(b) For the purposes of this Subsection, a period in excess of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator, or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services may be considered unreasonable depending on the circumstances of each individual case.

(c) For the purposes of this Subsection, the term "unreasonable reduction" shall mean the decreasing or limiting of either of the following:

(i) Previously certified or approved health care or medical services as contracted for between the insurer and insured.

(ii) Continued hospitalization and medical services without providing a procedure or method for certifying an extension of hospitalization and medical services by the insurer's or self-insurer's review or screening procedure in the event of continued hospitalization or medical attention, or both, as deemed medically necessary according to current established medical criteria.

(d) For the purposes of this Subsection, an "unreasonable denial" shall mean the failure to do any of the following:

(i) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure.

(ii) Review a request from the insured within the time period as provided for in the contract between the insurer or self-insurer and the insured, which time period shall not exceed two work days as provided for in Subparagraph (a) of this Paragraph.

(iii) Deliver the contracted for health care or medical services previously certified or approved by the insurer's or self-insurer's review or screening procedure for medically necessary treatment or care as mandated by and provided for in the contract between the insurer or self-insurer and the insured.

(iv) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure for an extension of the original certified or approved duration of health care or medical services.

(v) Extend the original certified or approved duration of hospitalization, health care or medical services requested by a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure when treatment or care is deemed medically necessary according to current established medical criteria.

(e) For the purposes of this Subsection, "medically necessary treatment or care" shall mean contemplated hospitalization, inpatient or outpatient health care, or medical services recommended for appropriate treatment or care in accordance with nationally accepted current medical criteria.

(4) Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, has jurisdiction of cases arising under the provisions of Paragraph (1) of this Subsection.

E. No action for the recovery of penalties or attorney fees provided in this Section shall be brought after the expiration of one year after the date proofs of loss are required to be filed.

NOTE: Paragraphs (F)(1) and (2) eff. until Jan. 1, 2024. See Acts 2023, No. 322.

F.(1) Notwithstanding any provision of any policy or contract of insurance or health benefits issued, whenever such policy provides for payment, benefit, or reimbursement for any health care service, including but not limited to diagnostic testing, treatment, referral, or consultation, and such health care service is performed via transmitted electronic imaging or telemedicine, such a payment, benefit, or reimbursement under such policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating health care facility or terminus who is physically present with the individual who is the subject of such electronic imaging transmission and is contemporaneously communicating and

interacting with a licensed physician at the receiving terminus of the transmission. The payment, benefit, or reimbursement to such a licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit.

(2) Any health care service proposed to be performed or performed via transmitted electronic imaging or telemedicine under this Subsection shall be subject to the applicable utilization review criteria and requirements of the insurer. Terminology in a health and accident insurance policy or contract that either discriminates against or prohibits such a method of transmitted electronic imaging or telemedicine shall be void as against public policy of providing the highest quality health care to the citizens of the state.

NOTE: Paragraphs (F)(1) and (2) eff. Jan. 1, 2024. See Acts 2023, No. 322.

F.(1) Notwithstanding any provision of any policy or contract of insurance or health benefits issued, whenever the policy provides for payment, benefit, or reimbursement for any healthcare service, including but not limited to diagnostic testing, treatment, referral, or consultation, and the healthcare service is performed via transmitted electronic imaging or telehealth, the payment, benefit, or reimbursement under the policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating healthcare facility or terminus who is physically present with the individual who is the subject of the electronic imaging transmission and is contemporaneously communicating and interacting with a licensed physician at the receiving terminus of the transmission. The payment, benefit, or reimbursement to the licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement that the licensed physician receives for an intermediate office visit.

(2) Any healthcare service proposed to be performed or performed via transmitted electronic imaging or telehealth pursuant to this Subsection shall be subject to the applicable utilization review criteria and requirements of the insurer. Terminology in a health and accident insurance policy or contract that either discriminates against or prohibits such a method of transmitted electronic imaging or telehealth shall be void as against public policy of providing the highest quality health care to the citizens of the state.

(3) The provisions of this Subsection shall not apply to limited benefit health insurance policies or contracts authorized to be issued in the state.

G.(1) Notwithstanding any provision of law to the contrary, an insurer, managed care company, or other payor shall not set a maximum dollar amount of reimbursement for noninvasive ventilators or ventilation treatments properly ordered and being used in an appropriate care setting.

(2)(a) The Centers for Medicare and Medicaid Services (CMS) classify ventilators as equipment requiring frequent and substantial servicing to avoid risk to patient health. The durable medical equipment (DME) supplier shall be required to provide the patient regular and comprehensive service and preventative maintenance by a certified or registered respiratory therapist. This service shall include but is not limited to masks, tubing, tracheotomy supplies, filters, and other supporting supplies and equipment. Reimbursement shall be at a rate negotiated with the payors to insure that a sustained level of service can be provided to the patient.

(b) Notwithstanding any provision of law to the contrary, an insurer, managed care company, subcontractor, third-party administrator or other payor shall reimburse DME suppliers for home use noninvasive and invasive ventilators on a continuous monthly payment basis for the duration of medical need throughout a patient's valid prescription period.

Acts 1958, No. 125; Acts 1960, No. 287, §1; Acts 1979, No. 240, §1; Acts 1985, No. 429, §1; Acts 1989, No. 773, §1, eff. Jan. 1, 1990; Acts 1990, No. 872, §1, eff. July 25, 1990; Acts 1995, No. 391, §1, eff. June 16, 1995; Acts 1997, No. 846, §1, eff. July 10, 1997; Acts 1997, No. 1313, §1; Acts 1999, No. 1017, §2, eff. July 9, 1999; Redesignated from R.S. 22:657 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2010, No. 919, §1, eff. Jan. 1, 2011; Acts 2012, No. 271, §1; Acts 2021, No. 379, §1; Acts 2023, No. 322, §1, eff. Jan. 1, 2024.

NOTE: See Acts 1997, No. 1313, §3, for definition of health maintenance organization.