to file complaints regarding provider demands for amounts owed by health insurance issuers. The procedures shall include all actions that will be taken by the health insurance issuer to address non-compliant providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions: R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6015. Limitations on Claim Filing and Audits

A. Health insurance issuers that limit the period of time that a claim may be filed for payment of benefits shall have the same limited period of time following payment of such claims to perform any review or audit for purposes of reconsidering the validity of such claims. For example, where a health insurance issuer limits the period for filing a claim for benefits to 12 months, then the health insurance issuer shall be limited to 12 months from the date of payment to perform any review or audit of the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6017. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2009 (September 2000).

Chapter 62. Regulation 103—Utilization Review Organizations and Independent Review Organizations

§6201. Purpose

A. The purpose of this regulation is:

1. to establish the standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services;

2. to provide the standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for the appropriate resolution of internal and external appeals; and

3. to provide uniform standards for the establishment and maintenance of an internal claims and appeals process and external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2173 (October 2015).

§6203. Applicability and Scope

A. This regulation applies to all utilization review organizations, independent review organizations, health insurance issuers and health maintenance organizations that are doing business and acting as a utilization review organization or independent review organization in the state of Louisiana or who are seeking to do business as a utilization review organization or independent review organization in the state of Louisiana, as well as to health insurance issuers when they are a party to an external review request.

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2173 (October 2015).

§6205. Authorization or Licensure as a URO

A. No health insurance issuer or entity acting on behalf of or as an agent of a health insurance issuer shall act as a utilization review organization unless licensed to do so by the commissioner. The license shall become effective upon approval by the commissioner and shall remain in effect, unless suspended or revoked by an action of the commissioner.

B. Entities who are not health insurance issuers but who are seeking to become licensed as a URO must complete and submit an application packet to the commissioner. The packet must include the application on the form approved and provided by the commissioner, payment of the initial fee per R.S. 22:821(B)(36) and all supporting documentation. Failure to submit all required documentation may result in processing delays or disapproval of the application. To obtain a copy of the URO application, visit www.ldi.la.gov/industry/company-licensing/application-forms.

C. Entities who are health insurance issuers and hold a valid certificate of authority in this state are not required to complete an application. However, the following documentation must be submitted to the commissioner:

1. a general description of the operation of the URO, including a statement that the URO does not engage in the practice of medicine nor acts to impinge or encumber the independent medical judgment of treating physicians or providers;

2. a copy of the URO's program description or procedures manual;

3. a sample copy of any contract, absent fees charged, for making utilization review determinations that is entered into with another health insurance issuer.

AUTHORITY NOTE:Promulgated in accordance with R.S.

22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2173 (October 2015).

§6207. Approval of Independent Review Organizations (IRO)

A. The commissioner must approve eligible IROs prior to their conducting external reviews or acting in the capacity of an IRO. However, no organization shall be approved as an IRO or added to the list of approved IROs until it has submitted for approval a completed application packet and proof of accreditation by a nationally recognized private accrediting body that maintains accreditation standards equivalent to or higher than the minimum qualifications set forth in R.S. 22:2441. If the commissioner does not approve an IRO, the IRO will be notified of the disapproval in writing.

B. The application packet must include the application completed on the form approved and provided by the commissioner, payment of the initial fee per R.S. 22:821(B)(37) and all supporting documentation as outlined in the application. Failure to submit all required documentation may result in processing delays or disapproval of the application. To obtain a copy of the IRO application, visit www.ldi.la.gov/industry/company-licensing/application-forms.

C. IRO approvals are effective for two years from the date of approval. A request for re-approval must be submitted on the application form that has been approved by the commissioner and shall be accompanied by the applicable fee. Re-approval applications must be submitted not less than 60 days prior to the expiration of the most current approval.

D. If an approved IRO's specialty changes at any point during the two-year period, the IRO must inform the LDI of this change in writing within seven business days of such change.

E. The commissioner will maintain and update the list of approved IROs. However, the commissioner may also revoke approval prior to the expiration of the two-year term, should it be determined that the IRO has lost its accreditation or no longer meets the minimum requirements under R.S. 22:2441. In such case, the IRO will be removed from the list of IROs and must cease conducting reviews. Any reviews that are pending for review by an IRO that has been removed from the list may be reassigned by the commissioner to another IRO.

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2173 (October 2015).

§6209. Requesting an External Review

A. All requests for external review must be made by the health insurance issuer through the IRO review request module, which can be accessed via the industry access link on the LDI's website: www.ldi.la.gov. When a covered person or his authorized representative requests an external review, the health insurance issuer shall notify the LDI by entering this request via the link. The request must be entered even if the health insurance issuer determines the request is ineligible for review.

B. If the covered person or his authorized representative requests an external review, but the health insurance issuer determines that the request is not complete, the health insurance issuer shall notify the LDI through the IRO review request module described in §6209.A by completing the field indicating that the covered person's or his authorized representative's request is incomplete and stating with specificity the information or materials needed to make the request complete. Such notice shall be provided to the LDI within five business days following the date of receipt of the external review request from the covered person or his authorized representative pursuant to R.S. 22:2436.

C. If the covered person or his authorized representative requests an external review, but the health insurance issuer denies the request as being ineligible pursuant to R.S. 22:2436(B), the covered person or his authorized representative may appeal in writing to the commissioner. The health insurance issuer and the covered person or his authorized representative both may submit additional documentation, such as the policy to verify coverage limitations as well as dates of coverage, documentation of service dates, etc., to help establish why the denial should be upheld or reversed. However, no medical or protected health information should be submitted to the commissioner for this review, unless such information is determinative of the issue in the appeal.

D. Upon receipt of an appeal of a health insurance issuer's eligibility determination, the LDI may contact the health insurance issuer's designated contact to request additional information, if necessary. Therefore, all health insurance issuers should ensure that the designated contact's information is regularly updated in the industry access portal, as all electronic communications, including assignment of a case to an IRO, reporting of an IRO's external review results, reporting of the commissioner's decision on eligibility for an external review, etc., will be sent automatically to the designated contact of record that is on file with the LDI.

E. To facilitate notice of the right to appeal a determination of ineligibility to the commissioner, the health insurance issuer shall include the reason for ineligibility, as well as the following language (or language that is substantially similar), in its notice to the covered person.

> "[Name of health insurance issuer] has determined that your request for an independent external review of your adverse determination does not meet the eligibility requirements for independent external reviews because [reason]. However, [name of health insurance issuer]'s determination that you are ineligible for an external review may be appealed to the Commissioner of Insurance, who has the authority to reverse [name of health insurance issuer]'s decision and order an independent external review of your adverse determination. If you wish to appeal this decision, you should go to the following website: https://ldi.la.gov/OnlineServices/IROConsumerAppeals.

Once you access the website, enter your last name and case number where instructed. Following verification of your name and case number, you will be able to enter the reasons you believe your adverse determination should be eligible for an independent external review. If you have questions or if you or your authorized representative is unable to access the website, you may contact the Louisiana Department of Insurance by email at ConsumerAppeals@ldi.la.gov or by telephone at (225) 342-1355. Your case number is _____."

1. Health insurance issuers must also upload a copy of the adverse determination letter when reporting external review requests that have been deemed ineligible.

F. If the covered person or his authorized representative requests an external review and the health insurance issuer does not deny the request as being ineligible or if the commissioner reverses a request that the health insurance issuer had deemed ineligible for external review, the health insurance issuer must submit the request to the LDI for assignment of an external review by using the IRO review request form which can be located on the LDI website, www.ldi.la.gov via the industry access portal.

G. When completing the IRO review request form, the health insurance issuer must enter the following information:

1. covered person's name;

2. covered person's contact information (address, telephone, email address, fax);

3. name of covered person's authorized representative (if applicable);

4. authorized representative's contact information (if applicable);

5. policy/contract number;

6. name of primary care doctor or specialist;

7. type of specialty;

8. type of appeal requested: medical, rescission or experimental;

9. type of appeal requested: standard or expedited;

10. result of request: eligible or ineligible.

H. Once the case has been assigned, neither the covered person nor the health insurance issuer may request the case be reassigned to another IRO, as all IRO assignments are final, unless reassignment is necessary pursuant to §6211.E.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2436 and R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2174 (October 2015), amended LR 49:899 (May 2023).

§6211. Assignment of Cases to IRO for External Review

A. When an external review is requested and deemed eligible for review, the commissioner will randomly assign that case to an approved IRO for an external review.

B. IROs will be notified of a case assignment via email, which will also include the external review case number specific to the case. To access the case via the industry access portal, click on the link that will be provided in the notice of assignment email.

C. To open and access the case file, click on the "View" button next to the case number. From there, the IRO will have access to the insured's contact information, or the insured's authorized representative's contact information, and supporting documentation for review. The IRO will also enter on this screen its final decision to either uphold or reverse the adverse determination. When the IRO submits its decision in the case, it will receive a confirmation message that the decision was successfully submitted.

D. Notification of the case assignment will also be given to the covered person and the health insurance issuer, and will include the name and contact information of the IRO to whom the case has been assigned.

E. Reassignment of an external review may occur only when:

1. there exists a conflict of interest pursuant to R.S. 22:2441(D). If a conflict exists, the LDI must be informed of such conflict via the industry access link;

2. the IRO is not qualified to perform the type of review requested;

3. the IRO loses its accreditation; or

4. the IRO fails to meet the minimum requirements as set forth in R.S. 22:2441.

F. Should an IRO reassignment be necessary, the commissioner will immediately and randomly reassign another IRO to conduct the review.

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2174 (October 2015).

§6213. Annual Reporting

A. UROs and/or health insurance issuers acting as UROs must submit an annual report to the commissioner by March 1 of each year, unless otherwise informed by the commissioner. The report must be submitted on the form supplied by the Office of Health Insurance. If a report is not filed on the form provided, the report will not be accepted. A report filing fee shall be due from any URO other than a health insurance issuer, per R.S. 22:821(B)(36).

B. IROs must submit an annual report to the commissioner by March 1 of each year, unless otherwise informed by the commissioner. The report must be submitted on the form supplied by the Office of Health Insurance. If a report is not filed on the form provided, the report will not be accepted. The submission must be accompanied by the annual report filing fee, per R.S. 22:821(B)(37).

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2175 (October 2015).

§6215. Confidentiality

A. All health insurance issuers must annually certify in writing that their utilization review program or the utilization review program of their designated URO complies with all state and federal laws regarding confidentiality and reporting. The certification shall be made on a form supplied by the Office of Health Insurance by March 1 of each year.

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2175 (October 2015).

§6217. Severability

A. If any provision or item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation that can be given effect without the invalid provision, item, or application.

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2175 (October 2015).

§6219. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE:Promulgated in accordance with R.S. 22:2452.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:2175 (October 2015).

Chapter 65. Regulation 18—Non-Profit Funeral Service Associations, Reinstatement of Lapsed Policies

§6501. Policy Directive Number Five to Non-Profit Funeral Service Associations

A. It has come to the attention of the Insurance Department that some non-profit funeral service associations are now reinstating policies which have been lapsed for many years. This is contrary to the insurance laws.

B. A survey of the non-profit association's charters and by-laws, if by-laws are on file with the Secretary of State, reveals that the most favorable reinstatement provisions allow reinstatement of lapsed policies within 90 days from date of lapse, provided all past due assessments are paid. In most cases the by-laws are silent with regard to reinstatement.

C. Lapsed policies may be reinstated only in accordance with the by-laws of the association. A policyholder whose policy has lapsed and who is over the age of 70 and under the age of 90 may reinstate only in the old age group. In the absence of the charter or by-laws pertaining to reinstatement, no lapsed policies may be reinstated.

D. All changes in the charter or by-laws of non-profit funeral service associations must be approved by the Commissioner of Insurance. No amendments to by-laws concerning reinstatement of lapsed policies will be approved, which allows for reinstatement after 90 days from date of lapse.

E. All non-profit funeral service associations must cease reinstating lapsed policies which are issued on the assessment plan except in accordance with their present by-laws. This directive is effective May 1, 1960.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, April 28, 1960.

Chapter 67. Regulation 19—Inclusion of Burial Plots, Vaults, etc., as Part of Funeral Service-Change in Reserve Basis

§6701. Policy Directive Number Six to All Insurance Issuing Funeral Policies

A. The provisions of House Bill 322 will become effective on or about August 1, 1962. This bill amends Section 253 of the Insurance Code by adding Subsection A thereto:

> ALL POLICIES, ENDORSEMENTS OR RIDERS NOW IN YOUR POSSESSION WHICH INCLUDE PAYMENT OR FURNISHING OF BURIAL LOT, TOMBSTONE, MARKER, PLOT, TOMB, VAULT OR COPING ARE NOW DISAPPROVED. SUCH CONTRACTS MUST BE RESUBMITTED TO THE INSURANCE DEPARTMENT FOR APPROVAL IN ACCORDANCE WITH THIS DIRECTIVE.

B. For your information, the new Section 253 of the Insurance Code will read as follows:

> Section 253—Funeral Described: Cost Provision
>
> Every funeral policy shall state, in dollars, the value of the funeral and shall specify therein those things which shall constitute the funeral to be furnished, and shall provide for a stated cash payment which shall not be less than seventy-five per cent of the value of the funeral as stated in the policy in lieu of such funeral in the event it is impossible or impractical to furnish such services as set forth in the policy.
>
> A. Every funeral policy which includes among its benefits the payment for a burial lot, tombstone, marker, plot, tomb, vault or coping shall state in dollars the value of the said benefits and shall specify herein those things which shall constitute the said benefits to be furnished. Such policy shall be valued without the reduction of reserves provided for in R.S. 22:162. In the event such services are not furnished or paid for by the insurer then the amount of insurance shall be paid in cash to the beneficiary by the insurer, at the option of the beneficiary.

C. The effect of this legislation is to require that any funeral policy which includes any burial plot, tombstone, marker, plot, tomb, vault or coping must be reserved on a 100 percent basis, and if the official funeral director is not used, 100 percent of the benefits promised by the insurance contract must be paid in cash to the beneficiary.

D. Therefore, all policies, endorsements or riders now in your possession which include the above enumerated benefits, and which may have been heretofore approved, are now disapproved. No funeral policy which includes any of the above benefits shall be issued until such policy has been