By: Patterson H.B. No. 4385

A BILL TO BE ENTITLED

AN ACT

relating to medical benefits under the workers' compensation system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 1305.053, Insurance Code, is amended to read as follows:

Sec. 1305.053. CONTENTS OF APPLICATION. Each certificate application must include:

(1) a description or a copy of the applicant's basic organizational structure documents and other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(2) biographical information regarding each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other person having control of the applicant;

(3) a copy of the form of any contract between the applicant and any provider or group of providers, and with any third party performing services on behalf of the applicant under Subchapter D;

(4) a copy of the form of each contract with an insurance carrier, as described by Section 1305.154;

(5) a financial statement, current as of the date of the application, that is prepared using generally accepted accounting practices and includes:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(6) a statement acknowledging that lawful process in a legal action or proceeding against the network on a cause of action arising in this state is valid if served in the manner provided by Chapter 804 for a domestic company;

(7) a description and a map of the applicant's service area or areas, with key and scale, that identifies each county or part of a county to be served;

(8) a description of programs and procedures to be utilized, including:

(A) a complaint system, as required under Subchapter I; and

(B) a quality improvement program, as required under Subchapter G; [~~and~~

[~~(C) the utilization review program described in Subchapter H;~~]

(9) a list of all contracted network providers that demonstrates the adequacy of the network to provide comprehensive

health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate that the access and availability standards under Subchapter G are met; and

(10) any other information that the commissioner requires by rule to implement this chapter.

SECTION 2. Section 1305.154(c), Insurance Code, is amended to read as follows:

(c) A network's contract with a carrier must include:

(1) a description of the functions that the carrier delegates to the network, consistent with the requirements of Subsection (b), and the reporting requirements for each function;

(2) a statement that the network and any management contractor or third party to which the network delegates a function will perform all delegated functions in full compliance with all requirements of this chapter, the Texas Workers' Compensation Act, and rules of the commissioner or the commissioner of workers' compensation;

(3) a provision that the contract:

(A) may not be terminated without cause by either party without 90 days' prior written notice; and

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's contracted providers are prohibited from billing or attempting to collect any

amounts from employees for health care services under any circumstances, including the insolvency of the carrier or the network, except as provided by Section 1305.451(b)(6);

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services described under Subsection (b) as well as any other services or functions delegated by the carrier, including functions delegated to a management contractor, subject to the carrier's oversight and monitoring of the network's performance;

(7) a requirement that the network provide the carrier, at least monthly and in a form usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the division of workers' compensation with respect to any services provided under the contract, as determined by commissioner rules;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with the data reporting requirements of the Texas Workers' Compensation Act and rules of the commissioner of workers' compensation;

(9) a contingency plan under which the carrier would,

in the event of termination of the contract or a failure to perform, reassume one or more functions of the network under the contract, including functions related to:

(A) payments to providers and notification to employees;

(B) quality of care; and

(C) [~~utilization review; and~~

[~~(D)~~] continuity of care, including a plan for identifying and transitioning employees to new providers;

(10) a provision that requires that any agreement by which the network delegates any function to a management contractor or any third party be in writing, and that such an agreement require the delegated third party or management contractor to be subject to all the requirements of this subchapter;

(11) [~~a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party who performs a function that requires a license as a utilization review agent under Chapter 4201 or any other license under this code or another insurance law of this state;~~

[~~(12)~~] an acknowledgment that:

(A) any management contractor or third party to whom the network delegates a function must perform in compliance with this chapter and other applicable statutes and rules, and that the management contractor or third party is subject to the carrier's and the network's oversight and monitoring of its performance; and

(B) if the management contractor or the third party fails to meet monitoring standards established to ensure that functions delegated to the management contractor or the third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or the network may cancel the delegation of one or more delegated functions;

(12) [~~(13)~~] a requirement that the network and any management contractor or third party to which the network delegates a function provide all necessary information to allow the carrier to provide information to employees as required by Section 1305.451; and

(13) [~~(14)~~] a provision that requires the network, in contracting with a third party directly or through another third party, to require the third party to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

SECTION 3. Section 1305.451(b), Insurance Code, is amended to read as follows:

(b) The written description required under Subsection (a) must be in English, Spanish, and any additional language common to an employer's employees, must be in plain language and in a readable and understandable format, and must include, in a clear, complete, and accurate format:

(1) a statement that the entity providing health care to employees is a workers' compensation health care network;

(2) the network's toll-free number and address for obtaining additional information about the network, including information about network providers;

(3) a statement that in the event of an injury, the employee must select a treating doctor:

(A) from a list of all the network's treating doctors who have contracts with the network in that service area; or

(B) as described by Section 1305.105;

(4) a statement that, except for emergency services, the employee shall obtain all health care and specialist referrals through the employee's treating doctor;

(5) an explanation that network providers have agreed to look only to the network or insurance carrier and not to employees for payment of providing health care, except as provided by Subdivision (6);

(6) a statement that if the employee obtains health care from non-network providers without network approval, except as provided by Section 1305.006, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(7) information about how to obtain emergency care services, including emergency care outside the service area, and after-hours care;

(8) [~~a list of the health care services for which the insurance carrier or network requires preauthorization or concurrent review;~~

[~~(9)~~] an explanation regarding continuity of

treatment in the event of the termination from the network of a treating doctor;

(9) [~~(10)~~] a description of the network's complaint system, including a statement that the network is prohibited from retaliating against:

(A) an employee if the employee files a complaint against the network or appeals a decision of the network; or

(B) a provider if the provider, on behalf of an employee, reasonably files a complaint against the network or appeals a decision of the network;

(10) [~~(11)~~] a summary of the insurance carrier's or network's procedures relating to adverse determinations and the availability of the independent review process;

(11) [~~(12)~~] a list of network providers updated at least quarterly, including:

(A) the names and addresses of the providers;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure of which providers are accepting new patients; and

(12) [~~(13)~~] a description of the network's service area.

SECTION 4. Section 4201.054(a), Insurance Code, is amended to read as follows:

(a) This [~~Except as provided by this section, this~~] chapter does not apply [~~applies~~] to [~~utilization review of~~] a health care service provided to a person eligible for workers' compensation

medical benefits under Title 5, Labor Code. [~~The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code.~~]

SECTION 5. Section 408.0043(a), Labor Code, is amended to read as follows:

(a) This section applies to a person, other than a chiropractor or a dentist, who performs health care services under this title as:

(1) a doctor performing peer review;

(2) [~~a doctor performing a utilization review of a health care service provided to an injured employee;~~

[~~(3)~~] a doctor performing an independent review of a health care service provided to an injured employee;

[~~(4) a designated doctor;~~

[~~(5) a doctor performing a required medical examination;~~] or

(3) [~~(6)~~] a doctor serving as a member of the medical quality review panel.

SECTION 6. Section 408.0044(a), Labor Code, is amended to read as follows:

(a) This section applies to a dentist who performs dental services under this title as:

(1) a doctor performing peer review of dental services; or

(2) [~~a doctor performing a utilization review of a dental service provided to an injured employee;~~

[~~(3)~~] a doctor performing an independent review of a dental service provided to an injured employee[~~; or~~

[~~(4) a doctor performing a required dental examination~~].

SECTION 7. Section 408.0045(a), Labor Code, is amended to read as follows:

(a) This section applies to a chiropractor who performs chiropractic services under this title as:

(1) a doctor performing peer review of chiropractic services;

(2) [~~a doctor performing a utilization review of a chiropractic service provided to an injured employee;~~

[~~(3)~~] a doctor performing an independent review of a chiropractic service provided to an injured employee;

[~~(4) a designated doctor providing chiropractic services;~~

[~~(5) a doctor performing a required medical examination;~~] or

(3) [~~(6)~~] a chiropractor serving as a member of the medical quality review panel.

SECTION 8. Section 408.021(a), Labor Code, is amended to read as follows:

(a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed as determined by the employee's treating doctor. The employee is specifically entitled to health care that:

(1) cures or relieves the effects naturally resulting

from the compensable injury;

(2) promotes recovery; or

(3) enhances the ability of the employee to return to or retain employment.

SECTION 9. Sections 408.0231(b), (c), (e), and (f), Labor Code, are amended to read as follows:

(b) The commissioner by rule shall establish criteria for:

(1) deleting or suspending a doctor from the list of approved doctors; and

(2) imposing sanctions on a doctor or an insurance carrier as provided by this section[~~:~~

[~~(3) monitoring of utilization review agents, as provided by a memorandum of understanding between the division and the Texas Department of Insurance; and~~

[~~(4) authorizing increased or reduced utilization review and preauthorization controls on a doctor~~].

(c) Rules adopted under Subsection (b) are in addition to, and do not affect, the rules adopted under Section 415.023(b). The criteria for deleting a doctor from the list or for recommending or imposing sanctions may include anything the commissioner considers relevant, including:

(1) a sanction of the doctor by the commissioner for a violation of Chapter 413 or Chapter 415;

(2) a sanction by the Medicare or Medicaid program for:

(A) substandard medical care;

(B) overcharging;

(C) overutilization of medical services; or

(D) any other substantive noncompliance with requirements of those programs regarding professional practice or billing;

(3) evidence from the division's medical records that [~~the applicable insurance carrier's utilization review practices or~~] the doctor's charges, fees, diagnoses, treatments, evaluations, or impairment ratings are substantially different from those the commissioner finds to be fair and reasonable based on either a single determination or a pattern of practice;

(4) a suspension or other relevant practice restriction of the doctor's license by an appropriate licensing authority;

(5) professional failure to practice medicine or provide health care, including chiropractic care, in an acceptable manner consistent with the public health, safety, and welfare;

(6) findings of fact and conclusions of law made by a court, an administrative law judge of the State Office of Administrative Hearings, or a licensing or regulatory authority; or

(7) a criminal conviction.

(e) The commissioner shall act on a recommendation by the medical advisor selected under Section 413.0511 and, after notice and the opportunity for a hearing, may impose sanctions under this section on a doctor or an insurance carrier [~~or may recommend action regarding a utilization review agent~~]. The commissioner and the commissioner of insurance shall enter into a memorandum of understanding to coordinate the regulation of insurance carriers

[~~and utilization review agents~~] as necessary to ensure[~~:~~

[~~(1)~~] compliance with applicable regulations[~~; and~~

[~~(2) that appropriate health care decisions are reached under this subtitle and under Chapter 4201, Insurance Code~~].

(f) The sanctions the commissioner may recommend or impose under this section include:

(1) reduction of allowable reimbursement;

(2) mandatory preauthorization of all or certain health care services;

(3) required peer review monitoring, reporting, and audit;

(4) deletion or suspension from the approved doctor list [~~and the designated doctor list~~];

(5) restrictions on appointment under this chapter;

(6) conditions or restrictions on an insurance carrier regarding actions by insurance carriers under this subtitle in accordance with the memorandum of understanding adopted under Subsection (e); and

(7) mandatory participation in training classes or other courses as established or certified by the division.

SECTION 10. Section 408.122, Labor Code, is amended to read as follows:

Sec. 408.122. ELIGIBILITY FOR IMPAIRMENT INCOME BENEFITS. A claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists. A [~~If the~~] finding of impairment made by the

claimant's treating doctor is presumed to be accurate [~~is made by a doctor chosen by the claimant and the finding is contested, a designated doctor or a doctor selected by the insurance carrier must be able to confirm the objective clinical or laboratory finding on which the finding of impairment is based~~].

SECTION 11. Section 409.0091(e), Labor Code, is amended to read as follows:

(e) It is not a defense to a subclaim by a health care insurer that:

(1) the subclaimant has not sought reimbursement from a health care provider or the subclaimant's insured; or

(2) [~~the subclaimant or the health care provider did not request preauthorization under Section 413.014 or rules adopted under that section; or~~

[~~(3)~~] the health care provider did not bill the workers' compensation insurance carrier, as provided by Section 408.027, before the 95th day after the date the health care for which the subclaimant paid was provided.

SECTION 12. Section 410.307(b), Labor Code, is amended to read as follows:

(b) If substantial change of condition is disputed, the court shall require the employee's treating [~~designated~~] doctor in the case to verify the substantial change of condition, if any. The findings of the treating [~~designated~~] doctor shall be presumed to be correct, and the court shall base its finding on the medical evidence presented by the treating [~~designated~~] doctor in regard to substantial change of condition unless the preponderance of the

other medical evidence is to the contrary.

SECTION 13. Section 413.002(b), Labor Code, is amended to read as follows:

(b) In monitoring [~~health care providers who serve as designated doctors under Chapter 408 and~~] independent review organizations who provide services described by this chapter, the division shall evaluate:

(1) compliance with this subtitle and with rules adopted by the commissioner relating to medical policies, fee guidelines, treatment guidelines, return-to-work guidelines, and impairment ratings; and

(2) the quality and timeliness of decisions made under Section [~~408.0041, 408.122, 408.151, or~~] 413.031.

SECTION 14. Section 413.017, Labor Code, is amended to read as follows:

Sec. 413.017. PRESUMPTION OF REASONABLENESS. Medical [~~The following medical~~] services provided by a treating doctor are presumed to be reasonable[~~:~~

[~~(1) medical services consistent with the medical policies and fee guidelines adopted by the commissioner; and~~

[~~(2) medical services that are provided subject to prospective, concurrent, or retrospective review as required by the medical policies of the division and that are authorized by an insurance carrier~~].

SECTION 15. Sections 413.031(a), (e), (e-1), and (h), Labor Code, are amended to read as follows:

(a) A party, including a health care provider, is entitled

to a review of a medical service provided or for which authorization of payment is sought if a health care provider is:

(1) denied payment or paid a reduced amount for the medical service rendered;

(2) [~~denied authorization for the payment for the service requested or performed if authorization is required or allowed by this subtitle or commissioner rules;~~

[~~(3)~~] ordered by the commissioner to refund a payment received; or

(3) [~~(4)~~] ordered to make a payment that was refused or reduced for a medical service rendered.

(e) Except as provided by Subsection [~~Subsections (d),~~] (f), [~~and (m),~~] a review of the medical necessity of a health care service provided under this chapter or Chapter 408 shall be conducted by an independent review organization under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. It is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization.

(e-1) In performing a review of medical necessity under Subsection [~~(d) or~~] (e), the independent review organization shall consider the division's health care reimbursement policies and guidelines adopted under Section 413.011. If the independent review organization's decision is contrary to the division's policies or guidelines adopted under Section 413.011, the independent review organization must indicate in the decision the specific basis for its divergence in the review of medical necessity.

(h) The insurance carrier shall pay the cost of the review if the dispute arises in connection with[~~:~~

[~~(1) a request for health care services that require preauthorization under Section 413.014 or commissioner rules under that section; or~~

[~~(2)~~] a treatment plan under Section 413.011(g) or commissioner rules under that section.

SECTION 16. Section 413.0511(b), Labor Code, is amended to read as follows:

(b) The medical advisor shall make recommendations regarding the adoption of rules and policies to:

(1) develop, maintain, and review guidelines as provided by Section 413.011, including rules regarding impairment ratings;

(2) review compliance with those guidelines;

(3) regulate or perform other acts related to medical benefits as required by the commissioner;

(4) impose sanctions or delete doctors from the division's list of approved doctors under Section 408.023 for:

(A) any reason described by Section 408.0231; or

(B) noncompliance with commissioner rules;

(5) impose conditions or restrictions as authorized by Section 408.0231(f);

(6) receive, and share with the medical quality review panel established under Section 413.0512, confidential information, and other information to which access is otherwise restricted by law, as provided by Sections 413.0512, 413.0513, and

413.0514 from the Texas State Board of Medical Examiners, the Texas Board of Chiropractic Examiners, or other occupational licensing boards regarding a physician, chiropractor, or other type of doctor who applies for registration or is registered with the division on the list of approved doctors;

(7) determine minimal modifications to the reimbursement methodology and model used by the Medicare system as necessary to meet occupational injury requirements; and

(8) monitor the quality and timeliness of decisions made by [~~designated doctors and~~] independent review organizations, and the imposition of sanctions regarding those decisions.

SECTION 17. Sections 413.0512(b) and (c), Labor Code, are amended to read as follows:

(b) The agencies that regulate health professionals who are licensed or otherwise authorized to practice a health profession under Title 3, Occupations Code, and who are involved in the provision of health care as part of the workers' compensation system in this state shall develop lists of health care providers licensed or otherwise regulated by those agencies who have demonstrated experience in workers' compensation [~~or utilization review~~]. The medical advisor shall consider appointing some of the members of the medical quality review panel from the names on those lists and, when appointing members of the medical quality review panel, shall select specialists from various health care specialty fields to serve on the panel to ensure that the membership of the panel has expertise in a wide variety of health care specialty fields. The medical advisor shall also consider nominations for the

panel made by labor, business, and insurance organizations.

(c) The medical quality review panel shall recommend to the medical advisor:

(1) appropriate action regarding doctors, other health care providers, insurance carriers, [~~utilization review agents,~~] and independent review organizations; and

(2) the addition or deletion of doctors from the list of approved doctors under Section 408.023[~~, and~~

[~~(3) the certification, revocation of certification, or denial of renewal of certification of a designated doctor under Section 408.1225~~].

SECTION 18. Section 413.054(a), Labor Code, is amended to read as follows:

(a) A person who performs services for the division as [~~a designated doctor,~~] an independent medical examiner, a doctor performing a medical case review, or a member of a peer review panel has the same immunity from liability as the commissioner under Section 402.00123.

SECTION 19. Section 415.0035(a), Labor Code, is amended to read as follows:

(a) An insurance carrier or its representative commits an administrative violation if that person:

(1) fails to submit to the division a settlement or agreement of the parties; or

(2) fails to timely notify the division of the termination or reduction of benefits and the reason for that action[~~, or~~

[~~(3) denies preauthorization in a manner that is not in accordance with rules adopted by the commissioner under Section 413.014~~].

SECTION 20. Sections 504.053(c) and (d), Labor Code, are amended to read as follows:

(c) If the political subdivision or pool provides medical benefits in the manner authorized under Subsection (b)(2), the following do not apply:

(1) [~~Sections 408.004 and 408.0041, unless use of a required medical examination or designated doctor is necessary to resolve an issue relating to the entitlement to or amount of income benefits under this title;~~]

[~~(2)~~] Subchapter B, Chapter 408, except for Section 408.021;

(2) [~~(3)~~] Chapter 413, except for Section 413.042; and

(3) [~~(4)~~] Chapter 1305, Insurance Code, except for Sections 1305.501, 1305.502, and 1305.503.

(d) If the political subdivision or pool provides medical benefits in the manner authorized under Subsection (b)(2), the following standards apply:

(1) the political subdivision or pool must ensure that workers' compensation medical benefits are reasonably available to all injured workers of the political subdivision or the injured workers of the members of the pool within a designed service area;

(2) the political subdivision or pool must ensure that all necessary health care services are provided in a manner that will ensure the availability of and accessibility to adequate

health care providers, specialty care, and facilities;

(3) the political subdivision or pool must have an internal review process for resolving complaints relating to the manner of providing medical benefits, including an appeal to the governing body or its designee and appeal to an independent review organization;

(4) the political subdivision or pool must establish reasonable procedures for the transition of injured workers to contract providers and for the continuity of treatment, including notice of impending termination of providers and a current list of contract providers;

(5) the political subdivision or pool shall provide for emergency care if an injured worker cannot reasonably reach a contract provider and the care is for medical screening or other evaluation that is necessary to determine whether a medical emergency condition exists, necessary emergency care services including treatment and stabilization, and services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition;

(6) [~~prospective or concurrent review of the medical necessity and appropriateness of health care services must comply with Article 21.58A, Insurance Code;~~

[~~(7)~~] the political subdivision or pool shall continue to report data to the appropriate agency as required by Title 5 of this code and Chapter 1305, Insurance Code; and

(7) [~~(8)~~] a political subdivision or pool is subject to the requirements under Sections 1305.501, 1305.502, and

1305.503, Insurance Code.

SECTION 21. Section 504.055(b), Labor Code, is amended to read as follows:

(b) This section applies only to a first responder who sustains a [~~serious~~] bodily injury, as defined by Section 1.07, Penal Code, in the course and scope of employment that prevents the first responder from performing the full duties assigned to the first responder at the time of the injury. For purposes of this section, an injury sustained in the course and scope of employment includes an injury sustained by a first responder providing services on a volunteer basis.

SECTION 22. The following provisions are repealed:

(1) Sections 1305.004(a)(19), (27), (28), and (29), Insurance Code;

(2) Section 1305.101(b), Insurance Code;

(3) Section 1305.153(b), Insurance Code;

(4) Subchapter H, Chapter 1305, Insurance Code;

(5) Section 4201.054(b), Insurance Code;

(6) Sections 401.011(22-a), (38-a), (42-a), and (42-b), Labor Code;

(7) Section 408.004, Labor Code;

(8) Section 408.0041, Labor Code;

(9) Section 408.0042, Labor Code;

(10) Section 408.1225, Labor Code;

(11) Section 408.125, Labor Code;

(12) Section 408.151, Labor Code;

(13) Section 409.0091(d), Labor Code;

(14) Section 413.014, Labor Code;

(15) Sections 413.031(d), (g), and (m), Labor Code; and

(16) Section 413.044, Labor Code.

SECTION 23. The change in law made by this Act applies only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before the effective date of this Act is governed by the law in effect on the date the compensable injury occurred, and the former law is continued in effect for that purpose.

SECTION 24. This Act takes effect September 1, 2021.