BILL ANALYSIS

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C.S.H.B. 4290
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State Affairs
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Texas consumers with managed care health plans regulated by the Texas Department of Insurance (TDI), such as health maintenance organizations and preferred provider plans, currently are entitled to an independent review of their carriers' decisions to deny a pre-authorization of treatment based on a carrier's decision that the treatment is not medically necessary, but current law does not require an independent review of a carrier's conclusion that a treatment should be denied because it is experimental or investigational. In addition, current law does not provide for an independent review of a carrier's conclusion after the fact that a treatment was not medically necessary.

Health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review of the denial. However, such decisions are entitled to independent review both prospectively and retroactively through a process coordinated by TDI. A study by a national association of health plans found that a majority of states currently have independent review programs that cover either all adverse decisions or all adverse decisions involving medical necessity or services deemed to be experimental. Texas is the only state with limitations on retrospective reviews of denials based on medical necessity and the only state with an independent review law that does not extend to retrospective reviews of at least emergency and urgent care.

TDI has received numerous complaints regarding these issues, but there is little TDI can do to address them. Carriers have varying standards for what is considered experimental and investigational and, in regard to retrospective reviews, TDI's data regarding workers' compensation claim denials show that carriers incorrectly issue retrospective denials more often than prospective denials, with retrospective medical necessity decisions, including experimental and investigational denials, overturned 68 percent of the time after an independent review is conducted, while prospective medical necessity decisions are overturned approximately 30 percent of the time.

C.S.H.B. 4290 amends current law relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Sections 1305.004(a)(1), (10), and (23), Insurance Code, to redefine "adverse determination," "independent review," and "screening criteria."

SECTION 2. Amends Section 1305.053, Insurance Code, as follows:

> Sec. 1305.053. CONTENTS OF APPLICATION. Requires that each certificate application include certain information including a description of programs and procedures to be utilized that includes certain information including the utilization review program described in Subchapter H (Utilization Review; Retrospective Review), rather than the utilization review and retrospective review programs described in Subchapter H.

SECTION 3. Amends Section 1305.154(c), Insurance Code, to create Subdivision (9)(D) from existing text and delete Subdivision (9)(E).

SECTION 4. Amends the heading to Subchapter H, Chapter 1305, Insurance Code, to read as follows:

SUBCHAPTER H. UTILIZATION REVIEW

SECTION 5. Amends Section 1305.351, Insurance Code, as follows:

Sec. 1305.351. New heading: UTILIZATION REVIEW IN NETWORK. (a) Makes no changes to this subsection.

(b) Requires that any screening criteria used for utilization review, rather than utilization review or retrospective review, related to a workers' compensation health care network be consistent with the network's treatment guidelines.

(c) Makes no changes to this subsection.

(d) Makes a conforming change.

SECTION 6. Amends Section 1305.353(a), Insurance Code, to make conforming changes.

SECTION 7. Amends Sections 4201.002(1) and (13), Insurance Code, to redefine "adverse determination" and "utilization review."

SECTION 8. Amends Section 4201.051, Insurance Code, as follows:

Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF COVERAGE OR BENEFITS. Provides that this chapter does not apply to a person who provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan and does not determine whether a particular health care service provided or to be provided to an enrollee is medically necessary or appropriate or experimental or investigational.

SECTION 9. Amends Section 4201.206, Insurance Code, as follows:

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Requires that a utilization review agent, subject to the notice requirements of Subchapter G (Notice of Determinations), before an adverse determination is issued by an agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of health care service, provide the healthcare provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination.

SECTION 10. Amends Subchapter G, Chapter 4201, Insurance Code, by adding Section 4201.305, as follows:

Sec. 4201.305. NOTICE OF ADVERSE DETERMINATION FOR RETROSPECTIVE UTILIZATION REVIEW. (a) Requires the utilization review agent, notwithstanding Sections 4201.302 (General Time for Notice) and 4201.304 (Time for Notice of Adverse Determination), if a retrospective utilization review is conducted, to provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received.

(b) Authorizes the period under Subsection (a) to be extended once by the utilization review agent for a period not to exceed 15 days, if the utilization review agent determines that an extension is necessary due to matters beyond the

utilization review agent's control and notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the utilization review agent expects to make a determination.

(c) Requires that the notice of extension, if the extension under Subsection (b) is required because of the failure of the provider of record or the patient to submit information necessary to reach a determination on the request, specifically describe the required information necessary to complete the request and give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.

(d) Provides that if the period for making the determination under this section is extended because of the failure of the provider of record or the patient to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the utilization review agent sends the notification of the extension to the provider of record or the patient until the earlier of the date on which the provider of record or the patient responds to the request for additional information or the date by which the specified information was to have been submitted.

(e) Provides that if the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapter J (Payment of Claims to Physicians and Providers), Chapter 843 (Health Maintenance Organizations), the time limits established under Subchapter J, Chapter 843, control.

(f) Provides that if the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapters C (Prompt Payment of Claims) and C-1 (Other Provisions Relating to Payment of Claims), Chapter 1301 (Preferred Provider Benefit Plans), the time limits established under Subchapters C and C-1, Chapter 1301, control.

(g) Provides that if the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Section 408.027 (Payment of Health Care Provider), Labor Code, the time limits established under Section 408.027, Labor Code, control.

SECTION 11. Amends Section 4201.401, Insurance Code, by adding Subsection (c) to require that the utilization review agent comply with the independent review organization's determination regarding the experimental or investigational nature of health care items and services for an enrollee.

SECTION 12. Amends Section 4201.456, Insurance Code, to make conforming changes.

SECTION 13. Amends Section 401.011(38-a), Labor Code to redefine "retrospective review."

SECTION 14. Amends Section 408.0043(a), Labor Code, to provide that this section applies to a person, other than a chiropractor or a dentist, who performs health care services under this title as a doctor performing peer review; a doctor performing a utilization review of a health care service provided to an injured employee, rather than a utilization review of a health care service provided to an injured employee, including a retrospective review; a doctor performing an independent review of a health care service provided to an injured employee, rather than an independent review of a health care service provided to an injured employee, including a retrospective review; a designated doctor; a doctor performing a required medical examination; or a doctor serving as a member of the medical quality review panel.

SECTION 15. Amends Section 408.0044(a), Labor Code, to make conforming changes.

SECTION 16. Amends Section 408.0045(a), Labor Code, to make conforming changes.

SECTION 17. Amends Section 408.023(h), Labor Code, to provide that notwithstanding Section 4201.152, Insurance Code, a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle, including utilization review, rather than utilization review and retrospective review, may only use doctors licensed to practice in this state.

SECTION 18. Amends Section 413.031(e-3), Labor Code, to make conforming changes.

SECTION 19. Repealers: Section 1305.004(a)(21) (relating to the definition of "retrospective review"), Insurance Code; Section 1305.352 (General Standards for Retrospective Review), Insurance Code; and Subchapter K (Claims Review of Medical Necessity), Chapter 4201 (Utilization Review Agents), Insurance Code.

SECTION 20. Makes application of this Act prospective to January 1, 2010.

SECTION 21. Effective date: September 1, 2009.