AN ACT

relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.

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

SECTION 1. Sections 1305.004(a)(1), (10), and (23), Insurance Code, are amended to read as follows:

(1) "Adverse determination" has the meaning assigned by Chapter 4201 [~~means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are not medically necessary or appropriate~~].

(10) "Independent review" means a system for final administrative review by an independent review organization of the medical necessity and appropriateness, or the experimental or investigational nature, of health care services being provided, proposed to be provided, or that have been provided to an employee.

(23) "Screening criteria" means the written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review [~~or retrospective review~~].

SECTION 2. 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;

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

(C) the utilization review program [~~and retrospective review programs~~] 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 3. 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;

(C) utilization review;

[~~(D) retrospective review;~~] and

(D) [~~(E)~~] 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;

(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

(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 4. The heading to Subchapter H, Chapter 1305, Insurance Code, is amended to read as follows:

SUBCHAPTER H. UTILIZATION REVIEW[~~, RETROSPECTIVE REVIEW~~]

SECTION 5. Section 1305.351, Insurance Code, is amended to read as follows:

Sec. 1305.351. UTILIZATION REVIEW [~~AND RETROSPECTIVE REVIEW~~] IN NETWORK. (a) The requirements of Chapter 4201 apply to utilization review conducted in relation to claims in a workers' compensation health care network. In the event of a conflict between Chapter 4201 and this chapter, this chapter controls.

(b) Any screening criteria used for utilization review [~~or retrospective review~~] related to a workers' compensation health care network must be consistent with the network's treatment guidelines.

(c) The preauthorization requirements of Section 413.014, Labor Code, and commissioner of workers' compensation rules adopted under that section, do not apply to health care provided through a workers' compensation network. If a network or carrier uses a preauthorization process within a network, the requirements of this

subchapter and commissioner rules apply. A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency.

(d) Notwithstanding Section 4201.152, a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review [~~and retrospective review~~], or peer reviews under Section 408.0231(g), Labor Code, may only use doctors licensed to practice in this state.

SECTION 6. Section 1305.353(a), Insurance Code, is amended to read as follows:

(a) The entity performing utilization review [~~or retrospective review~~] shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review [~~or retrospective review~~].

SECTION 7. Sections 4201.002(1) and (13), Insurance Code, are amended to read as follows:

(1) "Adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

(13) "Utilization review" includes [~~means~~] a system for prospective, [~~or~~] concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care

services [~~being provided or proposed to be provided to an individual in this state~~]. The term does not include a review in response to an elective request for clarification of coverage.

SECTION 8. Section 4201.051, Insurance Code, is amended to read as follows:

Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF COVERAGE OR BENEFITS. This chapter does not apply to a person who:

(1) provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and

(2) does not determine whether a particular health care service provided or to be provided to an enrollee is:

(A) medically necessary or appropriate; or

(B) experimental or investigational.

SECTION 9. Section 4201.206, Insurance Code, is amended to read as follows:

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service [~~issues an adverse determination~~], the agent shall provide the health care 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. Subchapter G, Chapter 4201, Insurance Code, is

amended by adding Section 4201.305 to read as follows:

Sec. 4201.305. NOTICE OF ADVERSE DETERMINATION FOR RETROSPECTIVE UTILIZATION REVIEW. (a) Notwithstanding Sections 4201.302 and 4201.304, if a retrospective utilization review is conducted, the utilization review agent shall 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) The period under Subsection (a) may be extended once by the utilization review agent for a period not to exceed 15 days, if the utilization review agent:

(1) determines that an extension is necessary due to matters beyond the utilization review agent's control; and

(2) 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) 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, the notice of extension must:

(1) specifically describe the required information necessary to complete the request; and

(2) 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) 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:

(1) the date on which the provider of record or the patient responds to the request for additional information; or

(2) the date by which the specified information was to have been submitted.

(e) 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, Chapter 843, the time limits established under Subchapter J, Chapter 843, control.

(f) 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 and C-1, Chapter 1301, the time limits established under Subchapters C and C-1, Chapter 1301, control.

(g) 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, Labor Code, the time limits established under Section 408.027, Labor Code, control.

SECTION 11. Section 4201.401, Insurance Code, is amended by

adding Subsection (c) to read as follows:

(c) The utilization review agent shall 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. Section 4201.456, Insurance Code, is amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service [~~issues an adverse determination~~], the agent shall provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the agent.

SECTION 13. Section 401.011(38-a), Labor Code, is amended to read as follows:

(38-a) "Retrospective review" means the utilization review process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee [~~has the meaning assigned by Chapter 1305, Insurance Code~~].

SECTION 14. 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[~~, including a retrospective review~~];

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

(4) a designated doctor;

(5) a doctor performing a required medical examination; or

(6) a doctor serving as a member of the medical quality review panel.

SECTION 15. 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;

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

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

(4) a doctor performing a required dental examination.

SECTION 16. 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[~~, including a retrospective review~~];

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

(4) a designated doctor providing chiropractic services;

(5) a doctor performing a required medical examination; or

(6) a chiropractor serving as a member of the medical quality review panel.

SECTION 17. Section 408.023(h), Labor Code, is amended to read as follows:

(h) 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 [~~and retrospective review~~], may only use doctors licensed to practice in this state.

SECTION 18. Section 413.031(e-3), Labor Code, is amended to

read as follows:

(e-3) Notwithstanding Subsections (d) and (e) of this section or Chapters 4201 and 4202, Insurance Code, a doctor, other than a dentist or a chiropractor, who performs a utilization review or an independent review[~~, including a retrospective review,~~] of a health care service provided to an injured employee is subject to Section 408.0043. A dentist who performs a utilization review or an independent review[~~, including a retrospective review,~~] of a dental service provided to an injured employee is subject to Section 408.0044. A chiropractor who performs a utilization review or an independent review[~~, including a retrospective review,~~] of a chiropractic service provided to an injured employee is subject to Section 408.0045.

SECTION 19. The following laws are repealed:

(1) Section 1305.004(a)(21), Insurance Code;

(2) Section 1305.352, Insurance Code; and

(3) Subchapter K, Chapter 4201, Insurance Code.

SECTION 20. This Act applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2010, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 21. This Act takes effect September 1, 2009.

President of the Senate

Speaker of the House

I certify that H.B. No. 4290 was passed by the House on April 30, 2009, by the following vote: Yeas 144, Nays 0, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 4290 on May 29, 2009, by the following vote: Yeas 144, Nays 0, 1 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 4290 was passed by the Senate, with amendments, on May 26, 2009, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

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Governor