

By: Duncan

S.B. No. 2200

A BILL TO BE ENTITLED

AN ACT

1
2 relating to retrospective utilization review and utilization
3 review to determine the experimental or investigational nature of a
4 health care service.

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

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

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

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

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

22 SECTION 2. Section 1305.053, Insurance Code, is amended to
23 read as follows:

24 Sec. 1305.053. CONTENTS OF APPLICATION. Each certificate

1 application must include:

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

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

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

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

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

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

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

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

25 (B) an income statement;

26 (C) a cash flow statement; and

27 (D) the sources and uses of all funds;

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

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

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

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

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

14 (C) the utilization review program [~~and~~
15 ~~retrospective review programs~~] described in Subchapter H;

16 (9) a list of all contracted network providers that
17 demonstrates the adequacy of the network to provide comprehensive
18 health care services sufficient to serve the population of injured
19 employees within the service area and maps that demonstrate that
20 the access and availability standards under Subchapter G are met;
21 and

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

24 SECTION 3. Section 1305.154(c), Insurance Code, is amended
25 to read as follows:

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

27 (1) a description of the functions that the carrier

1 delegates to the network, consistent with the requirements of
2 Subsection (b), and the reporting requirements for each function;

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

9 (3) a provision that the contract:

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

12 (B) must be terminated immediately if cause
13 exists;

14 (4) a hold-harmless provision stating that the
15 network, a management contractor, a third party to which the
16 network delegates a function, and the network's contracted
17 providers are prohibited from billing or attempting to collect any
18 amounts from employees for health care services under any
19 circumstances, including the insolvency of the carrier or the
20 network, except as provided by Section 1305.451(b)(6);

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

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

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

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

17 (9) a contingency plan under which the carrier would,
18 in the event of termination of the contract or a failure to perform,
19 reassume one or more functions of the network under the contract,
20 including functions related to:

21 (A) payments to providers and notification to
22 employees;

23 (B) quality of care;

24 (C) utilization review;

25 [~~(D) retrospective review,~~] and

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

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

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

12 (12) an acknowledgment that:

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

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

25 (13) a requirement that the network and any management
26 contractor or third party to which the network delegates a function
27 provide all necessary information to allow the carrier to provide

1 information to employees as required by Section 1305.451; and

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

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

11 SUBCHAPTER H. UTILIZATION REVIEW [~~AND RETROSPECTIVE REVIEW~~]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (A) medically necessary or appropriate; or

14 (B) experimental or investigational.

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

17 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
18 ADVERSE DETERMINATION. Subject to the notice requirements of
19 Subchapter G, before an adverse determination is issued by a
20 utilization review agent who questions the medical necessity or
21 appropriateness, or the experimental or investigational nature, of
22 a health care service [~~issues an adverse determination~~], the agent
23 shall provide the health care provider who ordered the service a
24 reasonable opportunity to discuss with a physician the patient's
25 treatment plan and the clinical basis for the agent's
26 determination.

27 SECTION 10. Section 4201.401, Insurance Code, is amended by

1 adding Subsection (c) to read as follows:

2 (c) The utilization review agent shall comply with the
3 independent review organization's determination regarding the
4 experimental or investigational nature of health care items and
5 services for an enrollee.

6 SECTION 11. Section 4201.456, Insurance Code, is amended
7 to read as follows:

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

19 SECTION 12. Section 401.011(38-a), Labor Code, is amended
20 to read as follows:

21 (38-a) "Retrospective review" means the utilization
22 review process of reviewing the medical necessity and
23 reasonableness of health care that has been provided to an injured
24 employee [~~has the meaning assigned by Chapter 1305, Insurance~~
25 ~~Code~~].

26 SECTION 13. Section 408.0043(a), Labor Code, is amended to
27 read as follows:

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

4 (1) a doctor performing peer review;

5 (2) a doctor performing a utilization review of a
6 health care service provided to an injured employee[, ~~including a~~
7 ~~retrospective review~~];

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

11 (4) a designated doctor;

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

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

16 SECTION 14. Section 408.0044(a), Labor Code, is amended to
17 read as follows:

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

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

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

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

1 (4) a doctor performing a required dental examination.

2 SECTION 15. Section 408.0045(a), Labor Code, is amended to
3 read as follows:

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

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

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

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

14 (4) a designated doctor providing chiropractic
15 services;

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

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

20 SECTION 16. Section 408.023(h), Labor Code, is amended to
21 read as follows:

22 (h) Notwithstanding Section 4201.152, Insurance Code, a
23 utilization review agent or an insurance carrier that uses doctors
24 to perform reviews of health care services provided under this
25 subtitle, including utilization review [~~and retrospective review~~],
26 may only use doctors licensed to practice in this state.

27 SECTION 17. Section 413.031(e-3), Labor Code, is amended to

1 read as follows:

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

14 SECTION 18. The following laws are repealed:

- 15 (1) Section 1305.004(a)(21), Insurance Code;
16 (2) Section 1305.352, Insurance Code; and
17 (3) Subchapter K, Chapter 4201, Insurance Code.

18 SECTION 19. This Act applies only to a health benefit plan
19 delivered, issued for delivery, or renewed on or after January 1,
20 2010. A health benefit plan delivered, issued for delivery, or
21 renewed before January 1, 2010, is governed by the law as it existed
22 immediately before the effective date of this Act, and that law is
23 continued in effect for that purpose.

24 SECTION 20. The change in law made by this Act applies only
25 to a claim for workers' compensation benefits based on a
26 compensable injury that occurs on or after the effective date of
27 this Act. A claim based on a compensable injury that occurs before

1 that date is governed by the law in effect on the date the
2 compensable injury occurred, and the former law is continued in
3 effect for that purpose.

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