

# SENATE AMENDMENTS

2<sup>nd</sup> Printing

By: Smithee

H.B. No. 4290

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 [~~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. This Act takes effect September 1, 2009.

# ADOPTED

MAY 26 2009

*Henry S. Paul*  
Secretary of the Senate

By: Duncan

H.B. No. 4290

Substitute the following for H.B. No. 4290:

By: D

C.S. H.B. No. 4290

## 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 [~~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 a  
26 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. Subchapter G, Chapter 4201, Insurance Code, is

1 amended by adding Section 4201.305 to read as follows:

2 Sec. 4201.305. NOTICE OF ADVERSE DETERMINATION FOR  
3 RETROSPECTIVE UTILIZATION REVIEW. (a) Notwithstanding Sections  
4 4201.302 and 4201.304, if a retrospective utilization review is  
5 conducted, the utilization review agent shall provide notice of an  
6 adverse determination under the retrospective utilization review  
7 in writing to the provider of record and the patient within a  
8 reasonable period, but not later than 30 days after the date on  
9 which the claim is received.

10 (b) The period under Subsection (a) may be extended once by  
11 the utilization review agent for a period not to exceed 15 days, if  
12 the utilization review agent:

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

15 (2) notifies the provider of record and the patient  
16 before the expiration of the initial 30-day period of the  
17 circumstances requiring the extension and the date by which the  
18 utilization review agent expects to make a determination.

19 (c) If the extension under Subsection (b) is required  
20 because of the failure of the provider of record or the patient to  
21 submit information necessary to reach a determination on the  
22 request, the notice of extension must:

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

25 (2) give the provider of record and the patient at  
26 least 45 days from the date of receipt of the notice of extension to  
27 provide the specified information.

1        (d) If the period for making the determination under this  
2 section is extended because of the failure of the provider of record  
3 or the patient to submit the information necessary to make the  
4 determination, the period for making the determination is tolled  
5 from the date on which the utilization review agent sends the  
6 notification of the extension to the provider of record or the  
7 patient until the earlier of:

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

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

12        (e) If the periods for retrospective utilization review  
13 provided by this section conflict with the time limits concerning  
14 or related to payment of claims established under Subchapter J,  
15 Chapter 843, the time limits established under Subchapter J,  
16 Chapter 843, control.

17        (f) If the periods for retrospective utilization review  
18 provided by this section conflict with the time limits concerning  
19 or related to payment of claims established under Subchapters C and  
20 C-1, Chapter 1301, the time limits established under Subchapters C  
21 and C-1, Chapter 1301, control.

22        (g) If the periods for retrospective utilization review  
23 provided by this section conflict with the time limits concerning  
24 or related to payment of claims established under Section 408.027,  
25 Labor Code, the time limits established under Section 408.027,  
26 Labor Code, control.

27        SECTION 11. 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 12. Section 4201.456, Insurance Code, is amended to  
7 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 13. 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 14. 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 15. 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 16. 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 medical  
17 examination; or

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

20 SECTION 17. 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 18. 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 an  
8 independent review[~~, including a retrospective review,~~] of a dental  
9 service provided to an injured employee is subject to Section  
10 408.0044. A chiropractor who performs a utilization review or an  
11 independent review[~~, including a retrospective review,~~] of a  
12 chiropractic service provided to an injured employee is subject to  
13 Section 408.0045.

14 SECTION 19. 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 20. 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 21. This Act takes effect September 1, 2009.

**LEGISLATIVE BUDGET BOARD**  
**Austin, Texas**

**FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION**

**May 27, 2009**

**TO:** Honorable Joe Straus, Speaker of the House, House of Representatives

**FROM:** John S. O'Brien, Director, Legislative Budget Board

**IN RE: HB4290** by Smithee (Relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.), **As Passed 2nd House**

**No significant fiscal implication to the State is anticipated.**

The bill would amend the Labor Code regarding the use of retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service for workers compensation claims. The bill would also result in the Texas Department of Insurance amending rules to implement the provisions of the bill. Any additional workload from the passage of the bill could be handled with existing agency resources.

**Local Government Impact**

No fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JOB, SD, KJG, CH



**LEGISLATIVE BUDGET BOARD**  
Austin, Texas

**FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION**

**May 12, 2009**

**TO:** Honorable Robert Duncan, Chair, Senate Committee on State Affairs

**FROM:** John S. O'Brien, Director, Legislative Budget Board

**IN RE:** **HB4290** by Smithee (Relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.), **Committee Report 2nd House, Substituted**

**No significant fiscal implication to the State is anticipated.**

The bill would amend the Labor Code regarding the use of retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service for workers compensation claims. The bill would also result in the Texas Department of Insurance amending rules to implement the provisions of the bill. Any additional workload from the passage of the bill could be handled with existing agency resources.

**Local Government Impact**

No fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JOB, KJG, CH





**LEGISLATIVE BUDGET BOARD**  
**Austin, Texas**

**FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION**

**May 8, 2009**

**TO:** Honorable Robert Duncan, Chair, Senate Committee on State Affairs

**FROM:** John S. O'Brien, Director, Legislative Budget Board

**IN RE: HB4290** by Smithee (Relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.), **As Engrossed**

**No significant fiscal implication to the State is anticipated.**

The bill would amend the Labor Code regarding the use of retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service for workers compensation claims. The bill would also result in the Texas Department of Insurance amending rules to implement the provisions of the bill. Any additional workload from the passage of the bill could be handled with existing agency resources.

**Local Government Impact**

No fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JOB, KJG, CH



**LEGISLATIVE BUDGET BOARD**

**Austin, Texas**

**FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION**

**April 2, 2009**

**TO:** Honorable John T. Smithee, Chair, House Committee on Insurance

**FROM:** John S. O'Brien, Director, Legislative Budget Board

**IN RE: HB4290** by Smithee (Relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.), **Committee Report 1st House, As Amended**

**No significant fiscal implication to the State is anticipated.**

The bill would amend the Labor Code regarding the use of retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service for workers compensation claims. The change from the bill would only apply to workers compensation claims for a compensable injury that occurs on or after the effective date of the bill which would be September 1, 2009. The bill would also result in the Texas Department of Insurance amending rules to implement the provisions of the bill. Any additional workload from the passage of the bill could be handled with existing agency resources.

**Local Government Impact**

No fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JOB, KJG, CH



**LEGISLATIVE BUDGET BOARD**  
**Austin, Texas**

**FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION**

**March 30, 2009**

**TO:** Honorable John T. Smithee, Chair, House Committee on Insurance

**FROM:** John S. O'Brien, Director, Legislative Budget Board

**IN RE: HB4290** by Smithee (Relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service.), **As Introduced**

**No significant fiscal implication to the State is anticipated.**

The bill would amend the Labor Code regarding the use of retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service for workers compensation claims. The change from the bill would only apply to workers compensation claims for a compensable injury that occurs on or after the effective date of the bill which would be September 1, 2009. The bill would also result in the Texas Department of Insurance amending rules to implement the provisions of the bill. Any additional workload from the passage of the bill could be handled with existing agency resources.

**Local Government Impact**

No fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JOB, KJG, CH