BILL ANALYSIS

C.S.H.B. 2645
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Independent review organizations are businesses regulated by the Texas Department of Insurance (TDI) that perform administrative reviews of adverse determinations regarding the medical necessity and appropriateness or the experimental or investigational nature of health care services. Interested parties assert that, after January 1, 2014, such organizations may be unable to continue performing workers' compensation and health care case reviews, which could subject portions of the state's independent review organization processes to federal takeover. The parties further assert a need to strengthen TDI's ability to review independent review organization certification, renewal applications, and processes in order to bring federal health care standards designed to protect patient information into state law regulating such organizations.

C.S.H.B. 2645 seeks to modernize the regulations under which the state's independent review organizations operate and facilitate collaboration between all of the groups involved in the independent review organization process, including TDI, doctors, patients, insurance companies, and utilization review agents, so that they better understand and work with one another.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 1 and 5 of this bill.

ANALYSIS

C.S.H.B. 2645 amends the Insurance Code to remove a provision requiring the commissioner of insurance to adopt standards and rules that prohibit an attorney who is, or has in the past served as, the registered agent for an independent review organization from representing the independent review organization in legal proceedings, and instead requires the commissioner to adopt standards and rules that prohibit an individual who serves as an officer, director, manager, executive, or supervisor of an independent review organization from serving as an officer, director, manager, executive, supervisor, employee, agent, or independent contractor of another independent review organization. The bill, in provisions prescribing the standards and rules that the commissioner is required to adopt regarding the disclosure of patient information by an independent review organization, clarifies that the commissioner is required to adopt standards and rules prohibiting the organization from publicly disclosing patient information protected by the federal Health Insurance Portability and Accountability Act of 1996 or from transmitting the information to a subcontractor involved in the independent review process that has not signed an agreement similar to the business associate agreement required by regulations adopted under that federal act.

C.S.H.B. 2645 requires the commissioner to adopt standards and rules requiring an independent review organization to maintain a physical address and a mailing address in Texas, be incorporated in Texas, and be in good standing with the comptroller of public accounts, in addition to current requirements for the organization to be based and certified in Texas and to

locate the organization's primary offices in Texas. The bill requires the commissioner to adopt standards and rules requiring an independent review organization to surrender its certification as part of an agreed order, rather than requiring the organization to surrender its certification voluntarily while the organization is under investigation or as part of an agreed order.

C.S.H.B. 2645 removes provisions requiring the commissioner to adopt standards and rules requiring an independent review organization to apply for and receive a new certification after it is sold to a new owner, and instead requires the commissioner to adopt standards and rules to require the organization to do the following: notify the Texas Department of Insurance (TDI) of an agreement to sell the organization or shares in the organization; submit, not later than the 60th day before the date of the sale, the name of the purchaser and a complete and legible set of fingerprints for each of the purchaser's officers, owners, or shareholders or, if the purchaser if publicly held, each shareholder or owner of more than five percent of any of the applicant's stock or options, and any additional information necessary to comply with applicable provisions of the bill relating to certification as an independent review organization; and complete the transfer of ownership after TDI has sent written confirmation that the certification requirements under the bill's provisions have been satisfied. The bill requires TDI to send the written confirmation of compliance not later than the expiration of the fourth week after the date TDI determines the requirements are satisfied.

C.S.H.B. 2645 requires standards ensuring the confidentiality of medical records transmitted to an independent review organization to require organizations and utilization review agents to transmit and store records in compliance with the federal Health Insurance Portability and Accountability Act of 1996 and the regulations and standards adopted under that act. The bill requires the commissioner to adopt standards requiring the following: that an officer of the organization attest, on application for certification, that the office is located at a physical address; that the office be equipped with a computer system capable of processing requests for independent review and capable of accessing all electronic records related to the review and the independent review process; that all records be maintained electronically and made available to TDI on request; and that, in the case of an office located in a residence, the working office be located in a room set aside for independent review business purposes and in a manner to ensure the confidentiality of those transmitted medical records.

C.S.H.B. 2645 requires the standards adopted by the commissioner for independent review organizations to require each independent review organization to make the organization's determination for a life-threatening condition not later than the earlier of the third day, rather than the fifth day, after the date the organization receives the information necessary to make the determination or, with respect to a review of a health care service provided to a person eligible for workers' compensation medical benefits, the eighth day after the date the organization receives the request that the determination be made or, with respect to a review of a health care service other than a service provided to a person eligible for workers' compensation medical benefits, the third day after the date the organization receives the request that the determination be made.

C.S.H.B. 2645 adds to the information required on an application for certification as an independent review organization a description of any relationship the applicant has with a health benefit plan, health maintenance organization, insurer, utilization review agent, nonprofit health corporation, payor, health care provider, a group representing any of those entities, or any other independent review organization in Texas, as well as a description of any relationship the named individual has with any other independent review organization in Texas. The bill also adds to the information required on such an application a description of the procedures used by the applicant to verify physician and provider credentials; a description of the software used by the credentialing manager for managing computer processes, electronic databases, and records; and a description of the applicant's use of communications, records, and computer processes to manage the independent review process.

C.S.H.B. 2645 requires the commissioner to establish certifications for independent review of health care services provided to persons eligible for workers' compensation medical benefits and other health care services after considering accreditation, if any, by a nationally recognized accrediting organization that imposes requirements for accreditation that are the same as, substantially similar to, or more stringent than TDI requirements for accreditation. The bill requires TDI to make available to applicants applications for certification to review health care services provided to persons eligible for workers' compensation medical benefits and other health care services.

C.S.H.B. 2645 requires the commissioner to require each of the applicant's officers, owners, or shareholders or, if the purchaser is publicly held, each shareholder or owner of more than five percent of any of the applicant's stock or options to submit a complete and legible set of fingerprints to TDI for the purpose of obtaining criminal history record information from the Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI). The bill requires TDI to conduct a criminal history check of each applicant using information provided with an application for certification as an independent review organization and using information made available to TDI by DPS, the FBI, and any other criminal justice agency under Government Code provisions regulating DPS. The bill requires an application for certification for review of health care services to require an organization that is accredited by a nationally recognized accrediting organization imposing accreditation requirements that are the same as, substantially similar to, or more stringent than TDI accreditation requirements to provide evidence to TDI of the accreditation. The bill requires the commissioner to consider the evidence if the accrediting organization published and made available to the commissioner the organization's requirements for and methods used in the accreditation process. The bill authorizes an independent review organization that is accredited by such a nationally recognized accrediting organization to request that TDI expedite the application process. The bill authorizes a certified independent review organization that becomes accredited by such an organization to provide evidence of that accreditation to TDI that is required to be maintained in the TDI file related to the independent review organization's certification. The bill requires biennial renewal of certification.

C.S.H.B. 2645 reduces the frequency with which an independent review organization is required to submit the information required in an application for certification as an independent review organization from an annual basis to a biennial basis and requires the commissioner to designate biennially, rather than annually, each organization that meets the standards for an independent review organization. The bill requires information regarding a material change to be submitted on the form adopted by the commissioner not later than the 30th day after the date the material change occurs and, if the material change is a relocation of the organization, requires the organization to inform TDI that the location is available for TDI inspection before the date of the relocation and requires an officer to attend the inspection on TDI request.

C.S.H.B. 2645 requires the commissioner to establish a group to advise TDI and make recommendations related to the efficiency of independent review. The bill requires the commissioner to appoint as a member of the group a TDI employee to report group recommendations and policies to the commissioner. The bill requires the commissioner to appoint as members of the group individuals who have applied for membership and specifies the types of individuals that must be included in the membership. The bill establishes that a recommendation of the advisory group does not bind the commissioner. The bill provides for members' terms, filling vacancies, and the appointment of a presiding member of the group and requires the advisory group to meet annually and otherwise at the request of the presiding member or the commissioner and to make recommendations to the commissioner at least annually. The bill prohibits a member of the group from receiving compensation for service as a group member. The bill requires the commissioner by rule to require referral by random assignment of adverse determinations to independent review organizations and requires the commissioner, on referral of a determination, to notify the utilization review agent, the payor, the independent review organization, the patient or the patient's representative, and the provider of

record.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2645 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 4202.002, Insurance Code, is amended by amending Subsection (c) and adding Subsections (d) and (e) to read as follows:	SECTION 1. Section 4202.002, Insurance Code, is amended by amending Subsection (c) and adding Subsections (d), (e), and (f) to read as follows:
(c) In addition to the standards described by Subsection (b), the commissioner shall adopt standards and rules that:	(c) In addition to the standards described by Subsection (b), the commissioner shall adopt standards and rules that:
(1) prohibit:	(1) prohibit:
(A) more than one independent review organization from operating out of the same office or other facility;	(A) more than one independent review organization from operating out of the same office or other facility;
(B) an individual or entity from owning more than one independent review organization;	(B) an individual or entity from owning more than one independent review organization;
(C) an individual from owning stock in or serving on the board of more than one independent review organization;	(C) an individual from owning stock in or serving on the board of more than one independent review organization;
(D) an individual who has served on the board of an independent review organization whose certification was revoked for cause from serving on the board of another independent review organization before the fifth anniversary of the date on which the revocation occurred; and	(D) an individual who has served on the board of an independent review organization whose certification was revoked for cause from serving on the board of another independent review organization before the fifth anniversary of the date on which the revocation occurred;
(E)	(E) an individual who serves as an officer, director, manager, executive, or supervisor of an independent review organization from serving as an officer, director, manager, executive, supervisor, employee, agent, or independent contractor of another independent review organization
[~~an attorney who is, or has in the past served as, the registered agent for an independent review organization from representing the independent review organization in legal proceedings; and~~	[~~an attorney who is, or has in the past served as, the registered agent for an independent review organization from representing the independent review organization in legal proceedings~~]; and
[~~(F)~~] an independent review organization from:	(F) an independent review organization from:
(i) publicly disclosing [~~confidential~~] patient information protected by the Health Insurance Portability and Accountability	(i) publicly disclosing [~~confidential~~] patient information protected by the Health Insurance Portability and Accountability

Act of 1996 (42 U.S.C. Section 1320d et seq.); or

(ii) transmitting the information to a subcontractor involved in the independent review process that has not signed an agreement similar to the business associate agreement required by regulations adopted under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) [~~, except to a provider who is under contract to perform the review~~]; and

(2) require:

(A) an independent review organization to:

(i) maintain a physical address and a mailing address in this state;

(ii) be incorporated in this state;

(iii) be in good standing with the comptroller; and

(iv) be certified under this chapter [~~be based and certified in this state and to locate the organization's primary offices in this state~~];

(B) an independent review organization to [~~voluntarily~~] surrender the organization's certification [~~while the organization is under investigation or~~] as part of an agreed order; and

(C) an independent review organization to:

(i) notify the department of an agreement to sell the organization or shares in the organization;

(ii) not less than the 45th day before the date of the sale, submit the name of the purchaser and a complete and legible set of fingerprints for each officer of the purchaser and for each owner or shareholder of the purchaser or, if the purchaser is publicly held, each owner or shareholder described by Section 4202.004(a)(1), and any additional information necessary to comply with Section 4202.004(f); and

(iii) complete the transfer of ownership after the department has sent written confirmation that the requirements of Section 4202.004(f) have been satisfied [~~apply for and receive a new certification after the organization is sold to a new owner~~].

Act of 1996 (42 U.S.C. Section 1320d et seq.); or

(ii) transmitting the information to a subcontractor involved in the independent review process that has not signed an agreement similar to the business associate agreement required by regulations adopted under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) [~~, except to a provider who is under contract to perform the review~~]; and

(2) require:

(A) an independent review organization to:

(i) maintain a physical address and a mailing address in this state;

(ii) be incorporated in this state;

(iii) be in good standing with the comptroller; and

(iv) be based and certified in this state and to locate the organization's primary offices in this state;

(B) an independent review organization to [~~voluntarily~~] surrender the organization's certification [~~while the organization is under investigation or~~] as part of an agreed order; and

(C) an independent review organization to:

(i) notify the department of an agreement to sell the organization or shares in the organization;

(ii) not later than the 60th day before the date of the sale, submit the name of the purchaser and a complete and legible set of fingerprints for each officer of the purchaser and for each owner or shareholder of the purchaser or, if the purchaser is publicly held, each owner or shareholder described by Section 4202.004(a)(1), and any additional information necessary to comply with Section 4202.004(d); and

(iii) complete the transfer of ownership after the department has sent written confirmation in accordance with Subsection (d) that the requirements of this chapter have been satisfied [~~apply for and receive a new certification after the organization is sold to a new owner~~].

(d) The department shall send the written confirmation required by Subsection (c)(2)(C)(iii) not later than the expiration of the fourth week after the date the department determines the requirements are satisfied.

(d) Standards to ensure the confidentiality of medical records transmitted to an independent review organization under Subsection (b)(2) must require organizations and utilization review agents to transmit and store records in compliance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) and the regulations and standards adopted under that Act.

(e) The commissioner shall adopt standards requiring that:

(1) on application for certification, an officer of the organization attest that the office is located at a physical address;

(2) the office be equipped with a computer system capable of:

(A) processing requests for independent review; and

(B) accessing all electronic records related to the review and the independent review process;

(3) all records only be maintained electronically; and

(4) in the case of an office located in a residence, the working office be located in a room set aside for business purposes.

(e) Standards to ensure the confidentiality of medical records transmitted to an independent review organization under Subsection (b)(2) must require organizations and utilization review agents to transmit and store records in compliance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) and the regulations and standards adopted under that Act.

(f) The commissioner shall adopt standards requiring that:

(1) on application for certification, an officer of the organization attest that the office is located at a physical address;

(2) the office be equipped with a computer system capable of:

(A) processing requests for independent review; and

(B) accessing all electronic records related to the review and the independent review process;

(3) all records be maintained electronically and made available to the department on request; and

(4) in the case of an office located in a residence, the working office be located in a room set aside for independent review business purposes and in a manner to ensure confidentiality in accordance with Subsection (e).

SECTION 2. Section 4202.003, Insurance Code, is amended to read as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of[~~:~~

[~~(A)~~] the fifth day after the date the organization receives the information necessary to make the determination[~~;~~] or, with respect to:

(A) a review of a health care service provided to a person eligible for workers' compensation medical benefits, [~~(B)~~] the eighth day after the date the organization receives the request that the determination be made; or

SECTION 2. Section 4202.003, Insurance Code, is amended to read as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of[~~:~~

[~~(A)~~] the third [~~fifth~~] day after the date the organization receives the information necessary to make the determination[~~;~~] or, with respect to:

(A) a review of a health care service provided to a person eligible for workers' compensation medical benefits, [~~(B)~~] the eighth day after the date the organization receives the request that the determination be made; or

(B) a review of a health care service other than a service described by Paragraph (A), the fourth day after the date the organization receives the request that the determination be made; or [and]

(2) for a condition other than a life-threatening condition, not later than [the earlier of:

[(A) the 15th day after the date the organization receives the information necessary to make the determination; or

[(B)] the 20th day after the date the organization receives all information necessary to make the [request that the] determination [be made].

(B) a review of a health care service other than a service described by Paragraph (A), the third day after the date the organization receives the request that the determination be made; or [and]

(2) for a condition other than a life-threatening condition, not later than the earlier of:

(A) the 15th day after the date the organization receives the information necessary to make the determination; or

(B) the 20th day after the date the organization receives the request that the determination be made.

SECTION 3. Section 4202.004, Insurance Code, is amended to read as follows:

Sec. 4202.004. CERTIFICATION. (a) To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization described by Subdivision (4) that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the applicant or the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G);

(5) the percentage of the applicant's

SECTION 3. Section 4202.004, Insurance Code, is amended to read as follows:

Sec. 4202.004. CERTIFICATION. (a) To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization described by Subdivision (4) that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the applicant or the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; [or]

(H) a group representing any of the entities described by Paragraphs (A) through (G); or

(I) any other independent review organization in the state;

(5) the percentage of the applicant's

revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of:

(A) the areas of expertise of the physicians or other health care providers making review determinations for the applicant;

(B) the procedures used by the applicant to verify physician and provider credentials, including the computer processes, electronic databases, and records, if any, used; and

(C) the software used by the credentialing manager for managing the processes, databases, and records described by Paragraph (B); [~~and~~]

(7) the procedures to be used by the applicant in making independent review determinations under Subchapter I, Chapter 4201; and

(8) a description of the applicant's use of communications, records, and computer processes to manage the independent review process.

(b) The commissioner shall establish and implement separate certifications for independent review of health care services provided to persons eligible for workers' compensation medical benefits and other health care services after considering:

(1) certification processes available in the private sector for members of a national association of independent review organizations with not less than 10 members; and

(2) the advice of the advisory group established under Section 4202.011.

(c) An applicant may apply for certifications for independent review of health care services provided to persons eligible for workers' compensation medical benefits and other health care services.

(d) Notwithstanding any other provision of this chapter, the commissioner by rule may require that a review of health care services provided to persons eligible for workers' compensation medical benefits and other health care services or exclusively other health care services be in compliance with the requirements of the Uniform Health Carrier External Review Act adopted by the National Association of Insurance Commissioners.

revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of:

(A) the areas of expertise of the physicians or other health care providers making review determinations for the applicant;

(B) the procedures used by the applicant to verify physician and provider credentials, including the computer processes, electronic databases, and records, if any, used; and

(C) the software used by the credentialing manager for managing the processes, databases, and records described by Paragraph (B); [~~and~~]

(7) the procedures to be used by the applicant in making independent review determinations under Subchapter I, Chapter 4201; and

(8) a description of the applicant's use of communications, records, and computer processes to manage the independent review process.

(b) The commissioner shall establish certifications for independent review of health care services provided to persons eligible for workers' compensation medical benefits and other health care services after considering accreditation, if any, by a nationally recognized accrediting organization that imposes requirements for accreditation that are the same as, substantially similar to, or more stringent than the department's requirements for accreditation.

No equivalent provision.

No equivalent provision.

(e) The department shall make available to applicants separate applications for certification to review health care services provided to persons eligible for workers' compensation medical benefits and other health care services.

(f) The commissioner shall require that each officer of the applicant and each owner or shareholder of the applicant or, if the purchaser is publicly held, each owner or shareholder described by Subsection (a)(1), submit a complete and legible set of fingerprints to the department for the purpose of obtaining criminal history record information from the Department of Public Safety and the Federal Bureau of Investigation. The department shall conduct a criminal history check of each applicant using information:

(1) provided under this section; and

(2) made available to the department by the Department of Public Safety, the Federal Bureau of Investigation, and any other criminal justice agency under Chapter 411, Government Code.

(g) An application for certification for review of health care services other than health care services provided to persons eligible for workers' compensation medical benefits exclusively must require an organization that is certified by an association described by Subsection (b)(1) to provide the department evidence of the certification and all of the information submitted to the association to obtain the certification.

An independent review organization that is certified by or has applied for certification by an association described by Subsection (b)(1) may request that the department expedite the application process.

(c) The department shall make available to applicants applications for certification to review health care services provided to persons eligible for workers' compensation medical benefits and other health care services.

(d) The commissioner shall require that each officer of the applicant and each owner or shareholder of the applicant or, if the purchaser is publicly held, each owner or shareholder described by Subsection (a)(1) submit a complete and legible set of fingerprints to the department for the purpose of obtaining criminal history record information from the Department of Public Safety and the Federal Bureau of Investigation. The department shall conduct a criminal history check of each applicant using information:

(1) provided under this section; and

(2) made available to the department by the Department of Public Safety, the Federal Bureau of Investigation, and any other criminal justice agency under Chapter 411, Government Code.

(e) An application for certification for review of health care services must require an organization that is accredited by an organization described by Subsection (b) to provide the department evidence of the accreditation.

The commissioner shall consider the evidence if the accrediting organization published and made available to the commissioner the organization's requirements for and methods used in the accreditation process.

An independent review organization that is accredited by an organization described by Subsection (b) may request that the department expedite the application process.

(f) A certified independent review organization that becomes accredited by an organization described by Subsection (b) may provide evidence of that accreditation to the department that shall be maintained in the department's file related to the independent review organization's certification.

(h) Certification must be renewed biennially.

SECTION 4. Section 4202.005, Insurance Code, is amended to read as follows:

Sec. 4202.005. PERIODIC REPORTING OF INFORMATION; BIENNIAL [~~ANNUAL~~] DESIGNATION; UPDATES AND INSPECTION. (a) An independent review organization shall biennially [~~annually~~] submit the information required in an application for certification under Section 4202.004. Anytime there is a material change in the information the organization included in the application, the organization shall submit updated information to the commissioner.

(b) The commissioner shall designate biennially [~~annually~~] each organization that meets the standards for an independent review organization adopted under Section 4202.002.

(c) Information regarding a material change must be submitted on a form adopted by the commissioner not later than the 30th day after the date the material change occurs. If the material change is a relocation of the organization:

(1) the organization must inform the department of a range of dates the location is available for inspection by the department; and

(2) on request of the department, an officer shall attend the inspection.

SECTION 5. Chapter 4202, Insurance Code, is amended by adding Sections 4202.011 and 4202.012 to read as follows:

Sec. 4202.011. ADVISORY GROUP. (a) The commissioner shall establish a group to advise the department and make recommendations approved by a majority vote of the group related to the efficiency of utilization review and independent review generally and the efficiency of the review of health care services.

(b) The commissioner shall appoint as a member of the group a department employee to report to the commissioner group recommendations and policies. The commissioner shall appoint as members of the group individuals who have applied for membership, including:

(g) Certification must be renewed biennially.

SECTION 4. Section 4202.005, Insurance Code, is amended to read as follows:

Sec. 4202.005. PERIODIC REPORTING OF INFORMATION; BIENNIAL [~~ANNUAL~~] DESIGNATION; UPDATES AND INSPECTION. (a) An independent review organization shall biennially [~~annually~~] submit the information required in an application for certification under Section 4202.004. Anytime there is a material change in the information the organization included in the application, the organization shall submit updated information to the commissioner.

(b) The commissioner shall designate biennially [~~annually~~] each organization that meets the standards for an independent review organization adopted under Section 4202.002.

(c) Information regarding a material change must be submitted on a form adopted by the commissioner not later than the 30th day after the date the material change occurs. If the material change is a relocation of the organization:

(1) the organization must inform the department that the location is available for inspection before the date of the relocation by the department; and

(2) on request of the department, an officer shall attend the inspection.

SECTION 5. Chapter 4202, Insurance Code, is amended by adding Sections 4202.011 and 4202.012 to read as follows:

Sec. 4202.011. ADVISORY GROUP. (a) The commissioner shall establish a group to advise the department and make recommendations related to the efficiency of independent review.

(b) The commissioner shall appoint as a member of the group a department employee to report to the commissioner group recommendations and policies. The commissioner shall appoint as members of the group individuals who have applied for membership, including:

(1) an officer of an independent review organization certified under this chapter;

(2) an officer of a utilization review organization certified under Chapter 4201;

(3) two officers or representatives of associations of independent review organizations:

(A) with not less than 10 members that are certified under this chapter; or

(B) that have been in existence for not less than three years;

(4) an officer or representative of an association of physicians with knowledge of and interest in the independent review process;

(5) an officer or representative of an association of insurance carriers with knowledge of and interest in the independent review process; and

(6) an officer or representative of a patient advocacy association with knowledge of and interest in the independent review process.

(c) A recommendation of the advisory group does not bind the commissioner.

(d) Members of the group serve two-year terms. The commissioner shall appoint a replacement member in the event of a vacancy to serve the remainder of the unexpired term.

(e) The commissioner shall designate one member to serve as presiding member of the group. A member may serve more than one term as presiding member.

(f) The advisory group shall meet annually and otherwise at the request of the presiding member or the commissioner. The group shall make recommendations at least annually to the commissioner.

(g) A member of the group may not receive compensation for service as a group member.

Sec. 4202.012. REFERRAL. The commissioner by rule shall require referral to an independent review organization in appropriate dispute resolution processes involving health care services.

(1) two officers of different independent review organizations certified under this chapter;

(2) an officer of a utilization review organization certified under Chapter 4201;

(3) an officer or representative of an association of physicians with knowledge of and interest in the independent review process;

(4) an officer or representative of an association of insurance carriers with knowledge of and interest in the independent review process; and

(5) two officers or representatives of different patient advocacy associations with knowledge of and interest in the independent review process.

(c) A recommendation of the advisory group does not bind the commissioner.

(d) Members of the group serve two-year terms. The commissioner shall appoint a replacement member in the event of a vacancy to serve the remainder of the unexpired term.

(e) The commissioner shall designate one member to serve as presiding member of the group. A member may serve more than one term as presiding member.

(f) The advisory group shall meet annually and otherwise at the request of the presiding member or the commissioner. The group shall make recommendations at least annually to the commissioner.

(g) A member of the group may not receive compensation for service as a group member.

Sec. 4202.012. REFERRAL. The commissioner by rule shall require referral by random assignment of adverse determinations under Subchapter I, Chapter 4201, to independent review organizations. On referral of a determination, the commissioner shall notify:

(1) the utilization review agent;

(2) the payor;

(3) the independent review organization;

(4) the patient, as defined by Section 4201.002, or the patient's representative; and

	(5) the provider of record as defined by Section 4201.002.
SECTION 6. Chapter 4202, Insurance Code, as amended by this Act, applies only to an independent review organization that applies for an initial certification or renewal certification on or after January 1, 2014. An organization certified before that date is governed by the law as it existed immediately before January 1, 2014, and that law is continued in effect for that purpose.	SECTION 6. Chapter 4202, Insurance Code, as amended by this Act, applies only to an independent review organization that applies for an initial certification or renewal certification on or after January 1, 2014. An organization certified before that date 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 7. This Act takes effect September 1, 2013.	SECTION 7. Same as introduced version.