

By: Bonnen of Galveston, Guillen

H.B. No. 2327

A BILL TO BE ENTITLED

1 AN ACT

2 relating to preauthorization of certain medical care and health
3 care services by certain health benefit plan issuers and to the
4 regulation of utilization review, independent review, and peer
5 review for health benefit plan and workers' compensation coverage.

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

7 ARTICLE 1. PREAUTHORIZATION

8 SECTION 1.01. Section 843.348(b), Insurance Code, is
9 amended to read as follows:

10 (b) A health maintenance organization that uses a
11 preauthorization process for health care services shall provide
12 each participating physician or provider, not later than the fifth
13 [~~10th~~] business day after the date a request is made, a list of
14 health care services that [~~do not~~] require preauthorization and
15 information concerning the preauthorization process.

16 SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is
17 amended by adding Sections 843.3481, 843.3482, 843.3483, and
18 843.3484 to read as follows:

19 Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

20 (a) A health maintenance organization that uses a preauthorization
21 process for health care services shall make the requirements and
22 information about the preauthorization process readily accessible
23 to enrollees, physicians, providers, and the general public by
24 posting the requirements and information on the health maintenance

1 organization's Internet website.

2 (b) The preauthorization requirements and information
3 described by Subsection (a) must:

4 (1) be posted:

5 (A) conspicuously in a location on the Internet
6 website that does not require the use of a log-in or other input of
7 personal information to view the information; and

8 (B) in a format that is easily searchable and
9 accessible;

10 (2) be written in plain language that is easily
11 understandable by enrollees, physicians, providers, and the
12 general public;

13 (3) include a detailed description of the
14 preauthorization process and procedure; and

15 (4) include an accurate and current list of the health
16 care services for which the health maintenance organization
17 requires preauthorization that includes the following information
18 specific to each service:

19 (A) the effective date of the preauthorization
20 requirement;

21 (B) a list or description of any supporting
22 documentation that the health maintenance organization requires
23 from the physician or provider ordering or requesting the service
24 to approve a request for that service;

25 (C) the applicable screening criteria using
26 Current Procedural Terminology codes and International
27 Classification of Diseases codes; and

1 (D) statistics regarding preauthorization
2 approval and denial rates for the service in the preceding year and
3 for each previous year the preauthorization requirement was in
4 effect, including statistics in the following categories:

5 (i) physician or provider type and
6 specialty, if any;

7 (ii) indication offered;

8 (iii) reasons for request denial;

9 (iv) denials overturned on internal appeal;

10 (v) denials overturned on external appeal;

11 and

12 (vi) total annual preauthorization
13 requests, approvals, and denials for the service.

14 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

15 (a) Except as provided by Subsection (b), not later than the 60th
16 day before the date a new or amended preauthorization requirement
17 takes effect, a health maintenance organization that uses a
18 preauthorization process for health care services shall provide
19 each participating physician or provider written notice of the new
20 or amended preauthorization requirement and disclose the new or
21 amended requirement in the health maintenance organization's
22 newsletter or network bulletin, if any.

23 (b) For a change in a preauthorization requirement or
24 process that removes a service from the list of health care services
25 requiring preauthorization or amends a preauthorization
26 requirement in a way that is less burdensome to enrollees or
27 participating physicians or providers, a health maintenance

1 organization shall provide each participating physician or
2 provider written notice of the change in the preauthorization
3 requirement and disclose the change in the health maintenance
4 organization's newsletter or network bulletin, if any, not later
5 than the fifth day before the date the change takes effect.

6 (c) Not later than the fifth day before the date a new or
7 amended preauthorization requirement takes effect, a health
8 maintenance organization shall update its Internet website to
9 disclose the change to the health maintenance organization's
10 preauthorization requirements or process and the date and time the
11 change is effective.

12 Sec. 843.3483. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER.
13 In addition to any other penalty or remedy provided by law, a health
14 maintenance organization that uses a preauthorization process for
15 health care services that violates this subchapter with respect to
16 a required publication, notice, or response regarding its
17 preauthorization requirements, including by failing to comply with
18 any applicable deadline for the publication, notice, or response,
19 waives the health maintenance organization's preauthorization
20 requirements with respect to any health care service affected by
21 the violation, and any health care service affected by the
22 violation is considered preauthorized by the health maintenance
23 organization.

24 Sec. 843.3484. EFFECT OF PREAUTHORIZATION WAIVER. A waiver
25 of preauthorization requirements under Section 843.3483 may not be
26 construed to:

27 (1) authorize a physician or provider to provide

1 health care services outside of the physician's or provider's
2 applicable scope of practice as defined by state law; or

3 (2) require the health maintenance organization to pay
4 for a health care service provided outside of the physician's or
5 provider's applicable scope of practice as defined by state law.

6 SECTION 1.03. Section 1301.135(a), Insurance Code, is
7 amended to read as follows:

8 (a) An insurer that uses a preauthorization process for
9 medical care or ~~and~~ health care services shall provide to each
10 preferred provider, not later than the fifth ~~10th~~ business day
11 after the date a request is made, a list of medical care and health
12 care services that require preauthorization and information
13 concerning the preauthorization process.

14 SECTION 1.04. Subchapter C-1, Chapter 1301, Insurance Code,
15 is amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and
16 1301.1354 to read as follows:

17 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

18 (a) An insurer that uses a preauthorization process for medical
19 care or health care services shall make the requirements and
20 information about the preauthorization process readily accessible
21 to insureds, physicians, health care providers, and the general
22 public by posting the requirements and information on the insurer's
23 Internet website.

24 (b) The preauthorization requirements and information
25 described by Subsection (a) must:

26 (1) be posted:

27 (A) conspicuously in a location on the Internet

1 website that does not require the use of a log-in or other input of
2 personal information to view the information; and

3 (B) in a format that is easily searchable and
4 accessible;

5 (2) be written in plain language that is easily
6 understandable by insureds, physicians, health care providers, and
7 the general public;

8 (3) include a detailed description of the
9 preauthorization process and procedure; and

10 (4) include an accurate and current list of medical
11 care and health care services for which the insurer requires
12 preauthorization that includes the following information specific
13 to each service:

14 (A) the effective date of the preauthorization
15 requirement;

16 (B) a list or description of any supporting
17 documentation that the insurer requires from the physician or
18 health care provider ordering or requesting the service to approve
19 a request for the service;

20 (C) the applicable screening criteria using
21 Current Procedural Terminology codes and International
22 Classification of Diseases codes; and

23 (D) statistics regarding the insurer's
24 preauthorization approval and denial rates for the medical care or
25 health care service in the preceding year and for each previous year
26 the preauthorization requirement was in effect, including
27 statistics in the following categories:

- 1 (i) physician or health care provider type
- 2 and specialty, if any;
- 3 (ii) indication offered;
- 4 (iii) reasons for request denial;
- 5 (iv) denials overturned on internal appeal;
- 6 (v) denials overturned on external appeal;
- 7 and
- 8 (vi) total annual preauthorization
- 9 requests, approvals, and denials for the service.

10 (c) The provisions of this section may not be waived,
11 voided, or nullified by contract.

12 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

13 (a) Except as provided by Subsection (b), not later than the 60th
14 day before the date a new or amended preauthorization requirement
15 takes effect, an insurer that uses a preauthorization process for
16 medical care or health care services shall provide to each
17 preferred provider written notice of the new or amended
18 preauthorization requirement and disclose the new or amended
19 requirement in the insurer's newsletter or network bulletin, if
20 any.

21 (b) For a change in a preauthorization requirement or
22 process that removes a service from the list of medical care or
23 health care services requiring preauthorization or amends a
24 preauthorization requirement in a way that is less burdensome to
25 insureds, physicians, or health care providers, an insurer shall
26 provide each preferred provider written notice of the change in the
27 preauthorization requirement and disclose the change in the

1 insurer's newsletter or network bulletin, if any, not later than
2 the fifth day before the date the change takes effect.

3 (c) Not later than the fifth day before the date a new or
4 amended preauthorization requirement takes effect, an insurer
5 shall update its Internet website to disclose the change to the
6 insurer's preauthorization requirements or process and the date and
7 time the change is effective.

8 (d) The provisions of this section may not be waived,
9 voided, or nullified by contract.

10 Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE; AUTOMATIC
11 WAIVER. (a) In addition to any other penalty or remedy provided by
12 law, an insurer that uses a preauthorization process for medical
13 care or health care services that violates this subchapter with
14 respect to a required publication, notice, or response regarding
15 its preauthorization requirements, including by failing to comply
16 with any applicable deadline for the publication, notice, or
17 response, waives the insurer's preauthorization requirements with
18 respect to any medical care or health care service affected by the
19 violation, and any medical care or health care service affected by
20 the violation is considered preauthorized by the insurer.

21 (b) The provisions of this section may not be waived,
22 voided, or nullified by contract.

23 Sec. 1301.1354. EFFECT OF PREAUTHORIZATION WAIVER. (a) A
24 waiver of preauthorization requirements under Section 1301.1353
25 may not be construed to:

26 (1) authorize a physician or health care provider to
27 provide medical care or health care services outside of the

1 physician's or health care provider's applicable scope of practice
2 as defined by state law; or

3 (2) require the insurer to pay for a medical care or
4 health care service provided outside of the physician's or health
5 care provider's applicable scope of practice as defined by state
6 law.

7 (b) The provisions of this section may not be waived,
8 voided, or nullified by contract.

9 ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

10 SECTION 2.01. Section 4201.002(12), Insurance Code, is
11 amended to read as follows:

12 (12) "Provider of record" means the physician or other
13 health care provider with primary responsibility for the health
14 care~~[, treatment, and]~~ services provided to or requested on behalf
15 of an enrollee or the physician or other health care provider that
16 has provided or has been requested to provide the health care
17 services to the enrollee. The term includes a health care facility
18 where the health care services are ~~[if treatment is]~~ provided on an
19 inpatient or outpatient basis.

20 SECTION 2.02. Sections 4201.151 and 4201.152, Insurance
21 Code, are amended to read as follows:

22 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization
23 review agent's utilization review plan, including reconsideration
24 and appeal requirements, must be reviewed by a physician licensed
25 to practice medicine in this state and conducted in accordance with
26 standards developed with input from appropriate health care
27 providers and approved by a physician licensed to practice medicine

1 in this state.

2 Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~
3 PHYSICIAN. A utilization review agent shall conduct utilization
4 review under the supervision and direction of a physician licensed
5 to practice medicine in this [~~by a~~] state [~~licensing agency in the~~
6 ~~United States~~].

7 SECTION 2.03. Subchapter D, Chapter 4201, Insurance Code,
8 is amended by adding Section 4201.1525 to read as follows:

9 Sec. 4201.1525. UTILIZATION REVIEW BY PHYSICIAN. (a) A
10 utilization review agent that uses a physician to conduct
11 utilization review may only use a physician licensed to practice
12 medicine in this state.

13 (b) A payor that conducts utilization review on the payor's
14 own behalf is subject to Subsection (a) as if the payor were a
15 utilization review agent.

16 SECTION 2.04. Section 4201.153(d), Insurance Code, is
17 amended to read as follows:

18 (d) Screening criteria must be used to determine only
19 whether to approve the requested treatment. Before issuing an
20 adverse determination, a utilization review agent must obtain a
21 determination of medical necessity by referring a proposed [A]
22 denial of requested treatment [~~must be referred~~] to:

23 (1) an appropriate physician, dentist, or other health
24 care provider; or

25 (2) if the treatment is requested, ordered, provided,
26 or to be provided by a physician, a physician licensed to practice
27 medicine in this state who is of the same or a similar specialty as

1 that physician [~~to determine medical necessity~~].

2 SECTION 2.05. Sections 4201.155, 4201.206, and 4201.251,
3 Insurance Code, are amended to read as follows:

4 Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW
5 PROCEDURES. (a) A utilization review agent may not establish or
6 impose a notice requirement or other review procedure that is
7 contrary to the requirements of the health insurance policy or
8 health benefit plan.

9 (b) This section may not be construed to release a health
10 insurance policy or health benefit plan from full compliance with
11 this chapter or other applicable law.

12 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
13 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the
14 notice requirements of Subchapter G, before an adverse
15 determination is issued by a utilization review agent who questions
16 the medical necessity, the [~~or~~] appropriateness, or the
17 experimental or investigational nature[~~r~~] of a health care service,
18 the agent shall provide the health care provider who ordered,
19 requested, provided, or is to provide the service a reasonable
20 opportunity to discuss with a physician licensed to practice
21 medicine in this state the patient's treatment plan and the
22 clinical basis for the agent's determination.

23 (b) If the health care service described by Subsection (a)
24 was ordered, requested, or provided, or is to be provided by a
25 physician, the opportunity described by that subsection must be
26 with a physician licensed to practice medicine in this state who is
27 of the same or a similar specialty as that physician.

1 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A
2 utilization review agent may delegate utilization review to
3 qualified personnel in the hospital or other health care facility
4 in which the health care services to be reviewed were or are to be
5 provided. The delegation does not release the agent from the full
6 responsibility for compliance with this chapter or other applicable
7 law, including the conduct of those to whom utilization review has
8 been delegated.

9 SECTION 2.06. Sections 4201.252(a) and (b), Insurance Code,
10 are amended to read as follows:

11 (a) Personnel employed by or under contract with a
12 utilization review agent to perform utilization review must be
13 appropriately trained and qualified and meet the requirements of
14 this chapter and other applicable law, including licensing
15 requirements.

16 (b) Personnel, other than a physician licensed to practice
17 medicine in this state, who obtain oral or written information
18 directly from a patient's physician or other health care provider
19 regarding the patient's specific medical condition, diagnosis, or
20 treatment options or protocols must be a nurse, physician
21 assistant, or other health care provider qualified and licensed or
22 otherwise authorized by law and the appropriate licensing agency in
23 this state to provide the requested service.

24 SECTION 2.07. Section 4201.356, Insurance Code, is amended
25 to read as follows:

26 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY
27 REVIEW. (a) The procedures for appealing an adverse determination

1 must provide that a physician licensed to practice medicine in this
2 state makes the decision on the appeal, except as provided by
3 Subsection (b) or (c).

4 (b) For a health care service ordered, requested, provided,
5 or to be provided by a physician, the procedures for appealing an
6 adverse determination must provide that a physician licensed to
7 practice medicine in this state who is of the same or a similar
8 specialty as that physician makes the decision on appeal, except as
9 provided by Subsection (c).

10 (c) If not later than the 10th working day after the date an
11 appeal is denied the enrollee's health care provider states in
12 writing good cause for having a particular type of specialty
13 provider review the case, a health care provider who is of the same
14 or a similar specialty as the health care provider who would
15 typically manage the medical or dental condition, procedure, or
16 treatment under consideration for review and who is licensed or
17 otherwise authorized by the appropriate licensing agency in this
18 state to manage the medical or dental condition, procedure, or
19 treatment shall review the decision denying the appeal. The
20 specialty review must be completed within 15 working days of the
21 date the health care provider's request for specialty review is
22 received.

23 SECTION 2.08. Sections [4201.357](#)(a), (a-1), and (a-2),
24 Insurance Code, are amended to read as follows:

25 (a) The procedures for appealing an adverse determination
26 must include, in addition to the written appeal, a procedure for an
27 expedited appeal of a denial of emergency care or a denial of

1 continued hospitalization. That procedure must include a review by
2 a health care provider who:

3 (1) has not previously reviewed the case; [~~and~~]

4 (2) is of the same or a similar specialty as the health
5 care provider who would typically manage the medical or dental
6 condition, procedure, or treatment under review in the appeal; and

7 (3) for a review of a health care service:

8 (A) ordered, requested, provided, or to be
9 provided by a health care provider who is not a physician, is
10 licensed or otherwise authorized by the appropriate licensing
11 agency in this state to provide the service in this state; or

12 (B) ordered, requested, provided, or to be
13 provided by a physician, is licensed to practice medicine in this
14 state.

15 (a-1) The procedures for appealing an adverse determination
16 must include, in addition to the written appeal and the appeal
17 described by Subsection (a), a procedure for an expedited appeal of
18 a denial of prescription drugs or intravenous infusions for which
19 the patient is receiving benefits under the health insurance
20 policy. That procedure must include a review by a health care
21 provider who:

22 (1) has not previously reviewed the case; [~~and~~]

23 (2) is of the same or a similar specialty as the health
24 care provider who would typically manage the medical or dental
25 condition, procedure, or treatment under review in the appeal; and

26 (3) for a review of a health care service:

27 (A) ordered, requested, provided, or to be

1 provided by a health care provider who is not a physician, is
2 licensed or otherwise authorized by the appropriate licensing
3 agency in this state to provide the service in this state; or

4 (B) ordered, requested, provided, or to be
5 provided by a physician, is licensed to practice medicine in this
6 state.

7 (a-2) An adverse determination under Section 1369.0546 is
8 entitled to an expedited appeal. The physician or, if appropriate,
9 other health care provider deciding the appeal must consider
10 atypical diagnoses and the needs of atypical patient populations.
11 The physician must be licensed to practice medicine in this state
12 and the health care provider must be licensed or otherwise
13 authorized by the appropriate licensing agency in this state.

14 SECTION 2.09. Section 4201.359, Insurance Code, is amended
15 by adding Subsection (c) to read as follows:

16 (c) A physician described by Subsection (b)(2) must comply
17 with this chapter and other applicable laws and be licensed to
18 practice medicine in this state. A health care provider described
19 by Subsection (b)(2) must comply with this chapter and other
20 applicable laws and be licensed or otherwise authorized by the
21 appropriate licensing agency in this state.

22 SECTION 2.10. Sections 4201.453 and 4201.454, Insurance
23 Code, are amended to read as follows:

24 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
25 utilization review agent's utilization review plan, including
26 reconsideration and appeal requirements, must be:

27 (1) reviewed by a health care provider of the

1 appropriate specialty who is licensed or otherwise authorized to
2 provide the specialty health care service in this state; and

3 (2) conducted in accordance with standards developed
4 with input from a health care provider of the appropriate specialty
5 who is licensed or otherwise authorized to provide the specialty
6 health care service in this state.

7 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF
8 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent
9 shall conduct utilization review under the direction of a health
10 care provider who is of the same specialty as the agent and who is
11 licensed or otherwise authorized to provide the specialty health
12 care service in this [~~by a~~] state [~~licensing agency in the United~~
13 ~~States~~].

14 SECTION 2.11. Sections 4201.455(a) and (b), Insurance Code,
15 are amended to read as follows:

16 (a) Personnel who are employed by or under contract with a
17 specialty utilization review agent to perform utilization review
18 must be appropriately trained and qualified and meet the
19 requirements of this chapter and other applicable law of this
20 state, including licensing laws.

21 (b) Personnel who obtain oral or written information
22 directly from a physician or other health care provider must be a
23 nurse, physician assistant, or other health care provider of the
24 same specialty as the agent and who are licensed or otherwise
25 authorized to provide the specialty health care service in this [~~by~~
26 ~~a~~] state [~~licensing agency in the United States~~].

27 SECTION 2.12. Sections 4201.456 and 4201.457, Insurance

1 Code, are amended to read as follows:

2 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
3 ADVERSE DETERMINATION. Subject to the notice requirements of
4 Subchapter G, before an adverse determination is issued by a
5 specialty utilization review agent who questions the medical
6 necessity, the [~~or~~] appropriateness, or the experimental or
7 investigational nature[~~r~~] of a health care service, the agent shall
8 provide the health care provider who ordered, requested, provided,
9 or is to provide the service a reasonable opportunity to discuss the
10 patient's treatment plan and the clinical basis for the agent's
11 determination with a health care provider who is:

- 12 (1) of the same specialty as the agent; and
13 (2) licensed or otherwise authorized to provide the
14 specialty health care service in this state.

15 Sec. 4201.457. APPEAL DECISIONS. A specialty utilization
16 review agent shall comply with the requirement that a physician or
17 other health care provider who makes the decision in an appeal of an
18 adverse determination must be:

- 19 (1) of the same or a similar specialty as the health
20 care provider who would typically manage the specialty condition,
21 procedure, or treatment under review in the appeal; and
22 (2) licensed or otherwise authorized to provide the
23 health care service in this state.

24 SECTION 2.13. Section 4202.002, Insurance Code, is amended
25 by adding Subsection (b-1) to read as follows:

- 26 (b-1) The standards adopted under Subsection (b)(3) must:
27 (1) ensure that personnel conducting independent

1 review for a health care service are licensed or otherwise
2 authorized to provide the same or a similar health care service in
3 this state; and

4 (2) be consistent with the licensing laws of this
5 state.

6 SECTION 2.14. Section 408.0043, Labor Code, is amended by
7 adding Subsection (c) to read as follows:

8 (c) Notwithstanding Subsection (b), if a health care
9 service is requested, ordered, provided, or to be provided by a
10 physician, a person described by Subsection (a)(1), (2), or (3) who
11 reviews the service with respect to a specific workers'
12 compensation case must be of the same or a similar specialty as that
13 physician.

14 SECTION 2.15. Subchapter B, Chapter 151, Occupations Code,
15 is amended by adding Section 151.057 to read as follows:

16 Sec. 151.057. APPLICATION TO UTILIZATION REVIEW. (a) In
17 this section:

18 (1) "Adverse determination" means a determination
19 that health care services provided or proposed to be provided to an
20 individual in this state by a physician or at the request or order
21 of a physician are not medically necessary or are experimental or
22 investigational.

23 (2) "Payor" has the meaning assigned by Section
24 4201.002, Insurance Code.

25 (3) "Utilization review" has the meaning assigned by
26 Section 4201.002, Insurance Code, and the term includes a review
27 of:

1 (A) a step therapy protocol exception request
2 under Section 1369.0546, Insurance Code; and

3 (B) prescription drug benefits under Section
4 1369.056, Insurance Code.

5 (4) "Utilization review agent" means:

6 (A) an entity that conducts utilization review
7 under Chapter 4201, Insurance Code;

8 (B) a payor that conducts utilization review on
9 the payor's own behalf or on behalf of another person or entity;

10 (C) an independent review organization certified
11 under Chapter 4202, Insurance Code; or

12 (D) a workers' compensation health care network
13 certified under Chapter 1305, Insurance Code.

14 (b) A person who does the following is considered to be
15 engaged in the practice of medicine in this state and is subject to
16 appropriate regulation by the board:

17 (1) makes on behalf of a utilization review agent or
18 directs a utilization review agent to make an adverse
19 determination, including:

20 (A) an adverse determination made on
21 reconsideration of a previous adverse determination;

22 (B) an adverse determination in an independent
23 review under Subchapter I, Chapter 4201, Insurance Code;

24 (C) a refusal to provide benefits for a
25 prescription drug under Section 1369.056, Insurance Code; or

26 (D) a denial of a step therapy protocol exception
27 request under Section 1369.0546, Insurance Code;

1 (2) serves as a medical director of an independent
2 review organization certified under Chapter 4202, Insurance Code;

3 (3) reviews or approves a utilization review plan
4 under Section 4201.151, Insurance Code;

5 (4) supervises and directs utilization review under
6 Section 4201.152, Insurance Code; or

7 (5) discusses a patient's treatment plan and the
8 clinical basis for an adverse determination before the adverse
9 determination is issued, as provided by Section 4201.206, Insurance
10 Code.

11 (c) For purposes of Subsection (b), a denial of health care
12 services based on the failure to request prospective or concurrent
13 review is not considered an adverse determination.

14 SECTION 2.16. Section 1305.351(d), Insurance Code, is
15 amended to read as follows:

16 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization
17 review agent or an insurance carrier that uses doctors to perform
18 reviews of health care services provided under this chapter,
19 including utilization review, or peer reviews under Section
20 408.0231(g), Labor Code, may only use doctors licensed to practice
21 in this state.

22 SECTION 2.17. Section 1305.355(d), Insurance Code, is
23 amended to read as follows:

24 (d) The department shall assign the review request to an
25 independent review organization. An [~~Notwithstanding Section~~
26 ~~4202.002, an~~] independent review organization that uses doctors to
27 perform reviews of health care services under this chapter may only

1 use doctors licensed to practice in this state.

2 SECTION 2.18. Section 408.023(h), Labor Code, is amended to
3 read as follows:

4 (h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~
5 utilization review agent or an insurance carrier that uses doctors
6 to perform reviews of health care services provided under this
7 subtitle, including utilization review, may only use doctors
8 licensed to practice in this state.

9 SECTION 2.19. Section 413.031(e-2), Labor Code, is amended
10 to read as follows:

11 (e-2) An [~~Notwithstanding Section 4202.002, Insurance Code,~~
12 ~~an~~] independent review organization that uses doctors to perform
13 reviews of health care services provided under this title may only
14 use doctors licensed to practice in this state.

15 ARTICLE 3. TRANSITIONS; EFFECTIVE DATE

16 SECTION 3.01. The changes in law made by Article 1 of this
17 Act apply only to a request for preauthorization of medical care or
18 health care services made on or after January 1, 2020, under a
19 health benefit plan delivered, issued for delivery, or renewed on
20 or after that date. A request for preauthorization of medical care
21 or health care services made before January 1, 2020, or on or after
22 January 1, 2020, under a health benefit plan delivered, issued for
23 delivery, or renewed before that date is governed by the law as it
24 existed immediately before the effective date of this Act, and that
25 law is continued in effect for that purpose.

26 SECTION 3.02. The changes in law made by Article 2 of this
27 Act apply only to utilization, independent, or peer review

1 requested on or after the effective date of this Act. Utilization,
2 independent, or peer review requested before the effective date of
3 this Act is governed by the law as it existed immediately before the
4 effective date of this Act, and that law is continued in effect for
5 that purpose.

6 SECTION 3.03. This Act takes effect September 1, 2019.