

By: Bonnen of Galveston

H.B. No. 2387

A BILL TO BE ENTITLED

1 AN ACT

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

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

8 SECTION 1. Section 533.005, Government Code, is amended by
9 adding Subsection (e) to read as follows:

10 (e) In addition to the requirements under Subsection (a), a
11 contract described by that subsection must require the managed care
12 organization to comply with Section 4201.156, Insurance Code.

13 SECTION 2. Section 843.348(b), Insurance Code, is amended
14 to read as follows:

15 (b) A health maintenance organization that uses a
16 preauthorization process for health care services shall provide
17 each participating physician or provider, not later than the fifth
18 [~~10th~~] business day after the date a request is made, a list of
19 health care services that [~~do not~~] require preauthorization and
20 information concerning the preauthorization process.

21 SECTION 3. Subchapter J, Chapter 843, Insurance Code, is
22 amended by adding Sections 843.3481, 843.3482, 843.3483, and
23 843.3484 to read as follows:

24 Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

1 (a) A health maintenance organization that uses a preauthorization
2 process for health care services shall make the requirements and
3 information about the preauthorization process readily accessible
4 to enrollees, physicians, providers, and the general public by
5 posting the requirements and information on the health maintenance
6 organization's Internet website.

7 (b) The preauthorization requirements and information
8 described by Subsection (a) must:

9 (1) be posted:

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

13 (B) in a format that is easily searchable and
14 accessible;

15 (2) be written in plain language that is easily
16 understandable by enrollees, physicians, providers, and the
17 general public;

18 (3) include a detailed description of the
19 preauthorization process and procedure; and

20 (4) include an accurate and current list of the health
21 care services for which the health maintenance organization
22 requires preauthorization that includes the following information
23 specific to each service:

24 (A) the effective date of the preauthorization
25 requirement;

26 (B) a list or description of any supporting
27 documentation that the health maintenance organization requires

1 from the physician or provider ordering or requesting the service
2 to approve a request for that service;

3 (C) the applicable screening criteria using
4 Current Procedural Terminology codes and International
5 Classification of Diseases codes; and

6 (D) statistics regarding preauthorization
7 approval and denial rates for the service in the preceding year and
8 for each previous year the preauthorization requirement was in
9 effect, including statistics in the following categories:

10 (i) physician or provider type and
11 specialty, if any;

12 (ii) indication offered;

13 (iii) reasons for request denial;

14 (iv) denials overturned on internal appeal;

15 (v) denials overturned on external appeal;

16 and

17 (vi) total annual preauthorization
18 requests, approvals, and denials for the service.

19 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

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

1 (b) For a change in a preauthorization requirement or
2 process that removes a service from the list of health care services
3 requiring preauthorization or amends a preauthorization
4 requirement in a way that is less burdensome to enrollees or
5 participating physicians or providers, a health maintenance
6 organization shall provide each participating physician or
7 provider written notice of the change in the preauthorization
8 requirement and disclose the change in the health maintenance
9 organization's newsletter or network bulletin, if any, not later
10 than the fifth day before the date the change takes effect.

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

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

1 organization.

2 Sec. 843.3484. EFFECT OF PREAUTHORIZATION WAIVER. A waiver
3 of preauthorization requirements under Section 843.3483 may not be
4 construed to:

5 (1) authorize a physician or provider to provide
6 health care services outside of the physician's or provider's
7 applicable scope of practice as defined by state law; or

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

11 SECTION 4. Section 1301.135(a), Insurance Code, is amended
12 to read as follows:

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

19 SECTION 5. Subchapter C-1, Chapter 1301, Insurance Code, is
20 amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and
21 1301.1354 to read as follows:

22 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

23 (a) An insurer that uses a preauthorization process for medical
24 care or health care services shall make the requirements and
25 information about the preauthorization process readily accessible
26 to insureds, physicians, health care providers, and the general
27 public by posting the requirements and information on the insurer's

1 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 insureds, physicians, health care providers, and
12 the 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 medical
16 care and health care services for which the insurer requires
17 preauthorization that includes the following information specific
18 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 insurer requires from the physician or
23 health care provider ordering or requesting the service to approve
24 a request for the 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 the insurer's
2 preauthorization approval and denial rates for the medical care or
3 health care service in the preceding year and for each previous year
4 the preauthorization requirement was in effect, including
5 statistics in the following categories:

6 (i) physician or health care provider type
7 and specialty, if any;

8 (ii) indication offered;

9 (iii) reasons for request denial;

10 (iv) denials overturned on internal appeal;

11 (v) denials overturned on external appeal;

12 and

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

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

17 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

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

26 (b) For a change in a preauthorization requirement or
27 process that removes a service from the list of medical care or

1 health care services requiring preauthorization or amends a
2 preauthorization requirement in a way that is less burdensome to
3 insureds, physicians, or health care providers, an insurer shall
4 provide each preferred provider written notice of the change in the
5 preauthorization requirement and disclose the change in the
6 insurer's newsletter or network bulletin, if any, not later than
7 the fifth day before the date the change takes effect.

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

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

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

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

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

4 (1) authorize a physician or health care provider to
5 provide medical care or health care services outside of the
6 physician's or health care provider's applicable scope of practice
7 as defined by state law; or

8 (2) require the insurer to pay for a medical care or
9 health care service provided outside of the physician's or health
10 care provider's applicable scope of practice as defined by state
11 law.

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

14 SECTION 6. Section 4201.002(12), Insurance Code, is amended
15 to read as follows:

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

24 SECTION 7. Sections 4201.151 and 4201.152, Insurance Code,
25 are amended to read as follows:

26 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization
27 review agent's utilization review plan, including reconsideration

1 and appeal requirements, must be reviewed by a physician licensed
2 to practice medicine in this state and conducted in accordance with
3 standards developed with input from appropriate health care
4 providers and approved by a physician licensed to practice medicine
5 in this state.

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

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

13 Sec. 4201.1525. UTILIZATION REVIEW BY PHYSICIAN. (a) A
14 utilization review agent that uses a physician to conduct
15 utilization review may only use a physician licensed to practice
16 medicine in this state.

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

20 SECTION 9. Section 4201.153(d), Insurance Code, is amended
21 to read as follows:

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

27 (1) an appropriate physician, dentist, or other health

1 care provider; or

2 (2) if the treatment is requested, ordered, provided,
3 or to be provided by a physician, a physician licensed to practice
4 medicine in this state who is of the same or a similar specialty as
5 that physician [~~to determine medical necessity~~].

6 SECTION 10. Sections 4201.155, 4201.206, and 4201.251,
7 Insurance Code, are amended to read as follows:

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

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

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

27 (b) If the health care service described by Subsection (a)

1 was ordered, requested, or provided, or is to be provided by a
2 physician, the opportunity described by that subsection must be
3 with a physician licensed to practice medicine in this state who is
4 of the same or a similar specialty as that physician.

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

13 SECTION 11. Subchapter D, Chapter 4201, Insurance Code, is
14 amended by adding Section 4201.156 to read as follows:

15 Sec. 4201.156. REVIEW PROCEDURES FOR EMERGENCY CARE CLAIMS.

16 (a) Utilization review of an emergency care claim must be made by a
17 utilization review agent who is a physician licensed under Subtitle
18 B, Title 3, Occupations Code.

19 (b) With respect to an enrollee's emergency medical
20 condition that is the basis for an emergency care claim, a
21 utilization review agent:

22 (1) may not make an adverse determination for the
23 emergency care claim predominantly based on the condition's
24 classification under a Current Procedural Terminology or
25 International Classification of Diseases code; and

26 (2) must review the enrollee's medical records.

27 SECTION 12. Sections 4201.252(a) and (b), Insurance Code,

1 are amended to read as follows:

2 (a) Personnel employed by or under contract with a
3 utilization review agent to perform utilization review must be
4 appropriately trained and qualified and meet the requirements of
5 this chapter and other applicable law, including licensing
6 requirements.

7 (b) Personnel, other than a physician licensed to practice
8 medicine in this state, who obtain oral or written information
9 directly from a patient's physician or other health care provider
10 regarding the patient's specific medical condition, diagnosis, or
11 treatment options or protocols must be a nurse, physician
12 assistant, or other health care provider qualified and licensed or
13 otherwise authorized by law and the appropriate licensing agency in
14 this state to provide the requested service.

15 SECTION 13. Section 4201.356, Insurance Code, is amended to
16 read as follows:

17 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY
18 REVIEW. (a) The procedures for appealing an adverse determination
19 must provide that a physician licensed to practice medicine in this
20 state makes the decision on the appeal, except as provided by
21 Subsection (b) or (c).

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

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

14 SECTION 14. Sections 4201.357(a), (a-1), and (a-2),
15 Insurance Code, are amended to read as follows:

16 (a) The procedures for appealing an adverse determination
17 must include, in addition to the written appeal, a procedure for an
18 expedited appeal of a denial of emergency care or a denial of
19 continued hospitalization. That procedure must include a review by
20 a health care provider who:

21 (1) has not previously reviewed the case; ~~and~~

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

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

26 (A) ordered, requested, provided, or to be
27 provided by a health care provider who is not a physician, is

1 licensed or otherwise authorized by the appropriate licensing
2 agency in this state to provide the service in this state; or

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

6 (a-1) The procedures for appealing an adverse determination
7 must include, in addition to the written appeal and the appeal
8 described by Subsection (a), a procedure for an expedited appeal of
9 a denial of prescription drugs or intravenous infusions for which
10 the patient is receiving benefits under the health insurance
11 policy. That procedure must include a review by a health care
12 provider who:

13 (1) has not previously reviewed the case; ~~and~~

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

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

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

22 (B) ordered, requested, provided, or to be
23 provided by a physician, is licensed to practice medicine in this
24 state.

25 (a-2) An adverse determination under Section 1369.0546 is
26 entitled to an expedited appeal. The physician or, if appropriate,
27 other health care provider deciding the appeal must consider

1 atypical diagnoses and the needs of atypical patient populations.
2 The physician must be licensed to practice medicine in this state
3 and the health care provider must be licensed or otherwise
4 authorized by the appropriate licensing agency in this state.

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

7 (c) A physician described by Subsection (b)(2) must comply
8 with this chapter and other applicable laws and be licensed to
9 practice medicine in this state. A health care provider described
10 by Subsection (b)(2) must comply with this chapter and other
11 applicable laws and be licensed or otherwise authorized by the
12 appropriate licensing agency in this state.

13 SECTION 16. Sections 4201.453 and 4201.454, Insurance Code,
14 are amended to read as follows:

15 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
16 utilization review agent's utilization review plan, including
17 reconsideration and appeal requirements, must be:

18 (1) reviewed by a health care provider of the
19 appropriate specialty who is licensed or otherwise authorized to
20 provide the specialty health care service in this state; and

21 (2) conducted in accordance with standards developed
22 with input from a health care provider of the appropriate specialty
23 who is licensed or otherwise authorized to provide the specialty
24 health care service in this state.

25 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF
26 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent
27 shall conduct utilization review under the direction of a health

1 care provider who is of the same specialty as the agent and who is
2 licensed or otherwise authorized to provide the specialty health
3 care service in this [~~by a~~] state [~~licensing agency in the United~~
4 ~~States~~].

5 SECTION 17. Sections 4201.455(a) and (b), Insurance Code,
6 are amended to read as follows:

7 (a) Personnel who are employed by or under contract with a
8 specialty utilization review agent to perform utilization review
9 must be appropriately trained and qualified and meet the
10 requirements of this chapter and other applicable law of this
11 state, including licensing laws.

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

18 SECTION 18. Sections 4201.456 and 4201.457, Insurance Code,
19 are amended to read as follows:

20 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
21 ADVERSE DETERMINATION. Subject to the notice requirements of
22 Subchapter G, before an adverse determination is issued by a
23 specialty utilization review agent who questions the medical
24 necessity, the [~~or~~] appropriateness, or the experimental or
25 investigational nature[~~r~~] of a health care service, the agent shall
26 provide the health care provider who ordered, requested, provided,
27 or is to provide the service a reasonable opportunity to discuss the

1 patient's treatment plan and the clinical basis for the agent's
2 determination with a health care provider who is:

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

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

- 10 (1) of the same or a similar specialty as the health
11 care provider who would typically manage the specialty condition,
12 procedure, or treatment under review in the appeal; and

- 13 (2) licensed or otherwise authorized to provide the
14 health care service in this state.

15 SECTION 19. Section 4202.002, Insurance Code, is amended by
16 adding Subsection (b-1) to read as follows:

17 (b-1) The standards adopted under Subsection (b)(3) must:

- 18 (1) ensure that personnel conducting independent
19 review for a health care service are licensed or otherwise
20 authorized to provide the same or a similar health care service in
21 this state; and

- 22 (2) be consistent with the licensing laws of this
23 state.

24 SECTION 20. Section 408.0043, Labor Code, is amended by
25 adding Subsection (c) to read as follows:

26 (c) Notwithstanding Subsection (b), if a health care
27 service is requested, ordered, provided, or to be provided by a

1 physician, a person described by Subsection (a)(1), (2), or (3) who
2 reviews the service with respect to a specific workers'
3 compensation case must be of the same or a similar specialty as that
4 physician.

5 SECTION 21. Subchapter B, Chapter 151, Occupations Code, is
6 amended by adding Section 151.057 to read as follows:

7 Sec. 151.057. APPLICATION TO UTILIZATION REVIEW. (a) In
8 this section:

9 (1) "Adverse determination" means a determination
10 that health care services provided or proposed to be provided to an
11 individual in this state by a physician or at the request or order
12 of a physician are not medically necessary or are experimental or
13 investigational.

14 (2) "Payor" has the meaning assigned by Section
15 4201.002, Insurance Code.

16 (3) "Utilization review" has the meaning assigned by
17 Section 4201.002, Insurance Code, and the term includes a review
18 of:

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

21 (B) prescription drug benefits under Section
22 1369.056, Insurance Code.

23 (4) "Utilization review agent" means:

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

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

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

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

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

8 (1) makes on behalf of a utilization review agent or
9 directs a utilization review agent to make an adverse
10 determination, including:

11 (A) an adverse determination made on
12 reconsideration of a previous adverse determination;

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

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

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

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

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

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

25 (5) discusses a patient's treatment plan and the
26 clinical basis for an adverse determination before the adverse
27 determination is issued, as provided by Section 4201.206, Insurance

1 Code.

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

5 SECTION 22. Section 1305.351(d), Insurance Code, is amended
6 to read as follows:

7 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization
8 review agent or an insurance carrier that uses doctors to perform
9 reviews of health care services provided under this chapter,
10 including utilization review, or peer reviews under Section
11 408.0231(g), Labor Code, may only use doctors licensed to practice
12 in this state.

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

15 (d) The department shall assign the review request to an
16 independent review organization. An [~~Notwithstanding Section~~
17 ~~4202.002, an~~] independent review organization that uses doctors to
18 perform reviews of health care services under this chapter may only
19 use doctors licensed to practice in this state.

20 SECTION 24. Section 408.023(h), Labor Code, is amended to
21 read as follows:

22 (h) A [~~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, may only use doctors
26 licensed to practice in this state.

27 SECTION 25. Section 413.031(e-2), Labor Code, is amended to

1 read as follows:

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

6 SECTION 26. The changes in law made by this Act to Chapters
7 843 and 1301, Insurance Code, apply only to a request for
8 preauthorization of medical care or health care services made on or
9 after January 1, 2020, under a health benefit plan delivered,
10 issued for delivery, or renewed on or after that date. A request
11 for preauthorization of medical care or health care services made
12 before January 1, 2020, or on or after January 1, 2020, under a
13 health benefit plan delivered, issued for delivery, or renewed
14 before that date is governed by the law as it existed immediately
15 before the effective date of this Act, and that law is continued in
16 effect for that purpose.

17 SECTION 27. The changes in law made by this Act to Chapters
18 1305, 4201, and 4202, Insurance Code, Chapters 408 and 413, Labor
19 Code, and Chapter 151, Occupations Code, apply only to utilization,
20 independent, or peer review that was requested on or after the
21 effective date of this Act. Utilization, independent, or peer
22 review requested before the effective date of this Act is governed
23 by the law as it existed immediately before the effective date of
24 this Act, and that law is continued in effect for that purpose.

25 SECTION 28. Section 4201.156, Insurance Code, as added by
26 this Act, applies only to a health benefit plan delivered, issued
27 for delivery, or renewed on or after January 1, 2020. A health

1 benefit plan delivered, issued for delivery, or renewed before
2 January 1, 2020, is governed by the law as it existed immediately
3 before the effective date of this Act, and that law is continued in
4 effect for that purpose.

5 SECTION 29. If before implementing any provision of this
6 Act a state agency determines that a waiver or authorization from a
7 federal agency is necessary for implementation of that provision,
8 the agency affected by the provision shall request the waiver or
9 authorization and may delay implementing that provision until the
10 waiver or authorization is granted.

11 SECTION 30. This Act takes effect September 1, 2019.