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H.B. No. 3721

A BILL TO BE ENTITLED

AN ACT

relating to an independent review organization to conduct reviews of certain medical necessity determinations under the Medicaid managed care program.

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

SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.039 to read as follows:

Sec. 533.039. INDEPENDENT REVIEW ORGANIZATIONS. (a) In this section, "independent review organization" means an organization certified under Chapter 4202, Insurance Code.

(b) The commission shall contract with an independent review organization to make review determinations with respect to disputes at issue in requests for appeal submitted to the commission challenging a medical necessity determination of a managed care organization that contracts with the commission under this chapter, except as provided by Subsection (b-1) or (g). The executive commissioner by rule shall determine:

(1) the manner in which an independent review organization is to settle the disputes;

(2) when, subject to Subsection (b-1), in the appeals process, an organization may be accessed; and

(3) the recourse available after the organization makes a review determination.

(b-1) With regard to a recipient dispute related to a

1 reduction in or denial of services on the basis of medical
2 necessity, the commission shall ensure that an independent review
3 conducted by an independent review organization under this section
4 occurs after the managed care organization has conducted an
5 internal appeal and before the Medicaid fair hearing is granted. A
6 recipient, or the recipient's parent or legally authorized
7 representative, described by this subsection may opt out of being
8 subject to an independent review determination under this section
9 and instead opt to proceed directly to a Medicaid fair hearing.

10 (c) The commission shall ensure that a contract entered into
11 under Subsection (b):

12 (1) requires an independent review organization to
13 make a review determination in a timely manner as determined by the
14 commission;

15 (2) provides procedures to protect the
16 confidentiality of medical records transmitted to the organization
17 for use in conducting an independent review;

18 (3) sets minimum qualifications for and requires the
19 independence of each physician or other health care provider making
20 a review determination on behalf of the organization;

21 (4) subject to Subsection (c-1), specifies the
22 procedures to be used by the organization in making review
23 determinations;

24 (5) requires the timely notice to a recipient of the
25 results of an independent review, including the clinical basis for
26 the review determination;

27 (6) requires that the organization report the

following aggregate information to the commission in the form and manner and at the times prescribed by the commission:

(A) the number of requests for independent reviews received by the independent review organization;

(B) the number of independent reviews conducted;

(C) the number of review determinations made:

(i) in favor of a managed care organization; and

(ii) in favor of a recipient;

(D) the number of review determinations that resulted in a managed care organization deciding to cover the service at issue;

(E) a summary of the disputes at issue in independent reviews;

(F) a summary of the services that were the subject of independent reviews; and

(G) the average time the organization took to complete an independent review and make a review determination; and

(7) requires that, in addition to the aggregate information required by Subdivision (6), the organization include in the report the information required by that subdivision categorized by managed care organization.

(c-1) The commission shall establish a common procedure for independent reviews conducted under this section. The procedure must provide that a service ordered by a health care provider is presumed medically necessary and the managed care organization bears the burden of proof to show the service is not medically

1 necessary. Medical necessity must be based on publicly available,
2 up-to-date, evidence-based, and peer-reviewed clinical criteria.
3 The commission shall also establish a procedure for expedited
4 reviews that allows the reviewer to identify an appeal that
5 requires an expedited resolution.

6 (d) An independent review organization with which the
7 commission contracts under this section shall:

8 (1) obtain all information relating to the dispute at
9 issue from the managed care organization and the provider in
10 accordance with time frames prescribed by the commission;

11 (2) assign a physician or other health care provider
12 with appropriate expertise as a reviewer to make a review
13 determination;

14 (3) for each review, perform a check to ensure that the
15 organization and the physician or other health care provider
16 assigned to make a review determination do not have a conflict of
17 interest, as defined in the contract entered into between the
18 commission and the organization;

19 (4) communicate procedural rules, approved by the
20 commission, and other information regarding the appeals process to
21 all parties; and

22 (5) render a timely review determination, as
23 determined by the commission.

24 (e) The commission shall ensure that the managed care
25 organization, the provider, and the recipient involved in a dispute
26 do not have a choice in the reviewer who is assigned to perform the
27 review.

1 (e-1) An independent review organization's review
2 determination of medical necessity establishes the minimum level of
3 services a recipient must receive.

4 (f) A managed care organization described by Subsection (b)
5 may not have a financial relationship with or ownership interest in
6 an independent review organization with which the commission
7 contracts. In selecting an independent review organization with
8 which to contract, the commission shall avoid conflicts of interest
9 by considering and monitoring existing relationships between
10 independent review organizations and managed care organizations.
11 An independent review organization with which the commission
12 contracts must:

13 (1) be overseen by a medical director who is a
14 physician licensed in this state; and

15 (2) employ or be able to consult with staff with
16 experience in providing private duty nursing services and long-term
17 services and supports.

18 (g) This section does not apply to, and an independent
19 review organization may not make a review determination with
20 respect to, a dispute involving the commission's office of
21 inspector general or an action taken at the direction of that
22 office, including a dispute relating to:

23 (1) an action taken by a managed care organization at
24 the direction of the office under the lock-in program established
25 in accordance with 42 C.F.R. Part 431.54(e); or

26 (2) the termination or potential termination of a
27 provider's enrollment in a managed care organization's provider

1 network at the direction of the office.

2 (h) The executive commissioner shall adopt rules necessary
3 to implement this section.

4 SECTION 2. If before implementing any provision of this Act
5 a state agency determines that a waiver or authorization from a
6 federal agency is necessary for implementation of that provision,
7 the agency affected by the provision shall request the waiver or
8 authorization and may delay implementing that provision until the
9 waiver or authorization is granted.

10 SECTION 3. This Act takes effect September 1, 2019.