AN ACT

relating to preauthorization requirements for certain health care services and utilization review for certain health benefit plans.

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

SECTION 1. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Section 1551.2181 to read as follows:

Sec. 1551.2181. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health benefit plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

SECTION 2. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Section 1575.1701 to read as follows:

Sec. 1575.1701. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health benefit plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

SECTION 3. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Section 1579.1061 to read as follows:

Sec. 1579.1061. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING

CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health coverage plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

SECTION 4. Section 4201.206, Insurance Code, is amended to read as follows:

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

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

SECTION 5. Chapter 4201, Insurance Code, is amended by adding Subchapter N to read as follows:

SUBCHAPTER N. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES

Sec. 4201.651. DEFINITIONS. (a) In this subchapter,

"preauthorization" means a determination by a health maintenance organization, insurer, or person contracting with a health maintenance organization or insurer that health care services proposed to be provided to a patient are medically necessary and appropriate.

(b) In this subchapter, terms defined by Section 843.002, including "health care services," "physician," and "provider," have the meanings assigned by that section.

Sec. 4201.652. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843, except that this subchapter does not apply to:

(A) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(B) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(2) a preferred provider benefit plan or exclusive provider benefit plan offered by an insurer under Chapter 1301; and

(3) a person who contracts with a health maintenance organization or insurer to issue preauthorization determinations or perform the functions described in this subchapter for a health benefit plan to which this subchapter applies.

Sec. 4201.653. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH

CARE SERVICES. (a) A health maintenance organization or an insurer that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service if, in the most recent six-month evaluation period, as described by Subsection (b), the health maintenance organization or insurer has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service.

(b) Except as provided by Subsection (c), a health maintenance organization or insurer shall evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) once every six months.

(c) A health maintenance organization or insurer may continue an exemption under Subsection (a) without evaluating whether the physician or provider qualifies for the exemption under Subsection (a) for a particular evaluation period.

(d) A physician or provider is not required to request an exemption under Subsection (a) to qualify for the exemption.

Sec. 4201.654. DURATION OF PREAUTHORIZATION EXEMPTION. (a) A physician's or provider's exemption from preauthorization requirements under Section 4201.653 remains in effect until:

(1) the 30th day after the date the health maintenance organization or insurer notifies the physician or provider of the health maintenance organization's or insurer's determination to rescind the exemption under Section 4201.655, if the physician or

provider does not appeal the health maintenance organization's or insurer's determination; or

(2) if the physician or provider appeals the determination, the fifth day after the date the independent review organization affirms the health maintenance organization's or insurer's determination to rescind the exemption.

(b) If a health maintenance organization or insurer does not finalize a rescission determination as specified in Subsection (a), then the physician or provider is considered to have met the criteria under Section 4201.653 to continue to qualify for the exemption.

Sec. 4201.655. DENIAL OR RESCISSION OF PREAUTHORIZATION EXEMPTION. (a) A health maintenance organization or insurer may rescind an exemption from preauthorization requirements under Section 4201.653 only:

(1) during January or June of each year;

(2) if the health maintenance organization or insurer makes a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted by the physician or provider during the most recent evaluation period described by Section 4201.653(b), that less than 90 percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health maintenance organization or insurer when conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(3) if the health maintenance organization or insurer

complies with other applicable requirements specified in this section, including:

(A) notifying the physician or provider not less than 25 days before the proposed rescission is to take effect; and

(B) providing with the notice under Paragraph (A):

(i) the sample information used to make the determination under Subdivision (2); and

(ii) a plain language explanation of how the physician or provider may appeal and seek an independent review of the determination.

(b) A determination made under Subsection (a)(2) must be made by an individual licensed to practice medicine in this state. For a determination made under Subsection (a)(2) with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

(c) A health maintenance organization or insurer may deny an exemption from preauthorization requirements under Section 4201.653 only if:

(1) the physician or provider does not have the exemption at the time of the relevant evaluation period; and

(2) the health maintenance organization or insurer provides the physician or provider with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider does not meet the criteria for an exemption from

preauthorization requirements for the particular health care service under Section 4201.653.

Sec. 4201.656. INDEPENDENT REVIEW OF EXEMPTION DETERMINATION. (a) A physician or provider has a right to a review of an adverse determination regarding a preauthorization exemption be conducted by an independent review organization. A health maintenance organization or insurer may not require a physician or provider to engage in an internal appeal process before requesting a review by an independent review organization under this section.

(b) A health maintenance organization or insurer shall pay:

(1) for any appeal or independent review of an adverse determination regarding a preauthorization exemption requested under this section; and

(2) a reasonable fee determined by the Texas Medical Board for any copies of medical records or other documents requested from a physician or provider during an exemption rescission review requested under this section.

(c) An independent review organization must complete an expedited review of an adverse determination regarding a preauthorization exemption not later than the 30th day after the date a physician or provider files the request for a review under this section.

(d) A physician or provider may request that the independent review organization consider another random sample of not less than five and no more than 20 claims submitted to the health maintenance organization or insurer by the physician or provider during the relevant evaluation period for the relevant health care service as

part of its review. If the physician or provider makes a request under this subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the health maintenance organization or insurer under Section 4201.655 and reviewed under this subsection.

Sec. 4201.657. EFFECT OF APPEAL OR INDEPENDENT REVIEW DETERMINATION. (a) A health maintenance organization or insurer is bound by an appeal or independent review determination that does not affirm the determination made by the health maintenance organization or insurer to rescind a preauthorization exemption.

(b) A health maintenance organization or insurer may not retroactively deny a health care service on the basis of a rescission of an exemption, even if the health maintenance organization's or insurer's determination to rescind the preauthorization exemption is affirmed by an independent review organization.

(c) If a determination of a preauthorization exemption made by the health maintenance organization or insurer is overturned on review by an independent review organization, the health maintenance organization or insurer:

(1) may not attempt to rescind the exemption before the end of the next evaluation period that occurs; and

(2) may only rescind the exemption after if the health maintenance organization or insurer complies with Sections 4201.655 and 4201.656.

Sec. 4201.658. ELIGIBILITY FOR PREAUTHORIZATION EXEMPTION FOLLOWING FINALIZED EXEMPTION RESCISSION OR DENIAL. After a final

determination or review affirming the rescission or denial of an exemption for a specific health care service under Section 4201.653, a physician or provider is eligible for consideration of an exemption for the same health care service after the six-month evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

Sec. 4201.659. EFFECT OF PREAUTHORIZATION EXEMPTION. (a) A health maintenance organization or insurer may not deny or reduce payment to a physician or provider for a health care service for which the physician or provider has qualified for an exemption from preauthorization requirements under Section 4201.653 based on medical necessity or appropriateness of care unless the physician or provider:

(1) knowingly and materially misrepresented the health care service in a request for payment submitted to the health maintenance organization or insurer with the specific intent to deceive and obtain an unlawful payment from the health maintenance organization or insurer; or

(2) failed to substantially perform the health care service.

(b) A health maintenance organization or an insurer may not conduct a retrospective review of a health care service subject to an exemption except:

(1) to determine if the physician or provider still qualifies for an exemption under this subchapter; or

(2) if the health maintenance organization or insurer has a reasonable cause to suspect a basis for denial exists under

Subsection (a).

(c) For a retrospective review described by Subsection (b)(2), nothing in this subchapter may be construed to modify or otherwise affect:

(1) the requirements under or application of Section 4201.305, including any timeframes specified by that section; or

(2) any other applicable law, except to prescribe the only circumstances under which:

(A) a retrospective utilization review may occur as specified by Subsection (b)(2); or

(B) payment may be denied or reduced as specified by Subsection (a).

(d) Not later than five days after qualifying for an exemption from preauthorization requirements under Section 4201.653, a health maintenance organization or insurer must provide to a physician or provider a notice that includes:

(1) a statement that the physician or provider qualifies for an exemption from preauthorization requirements under Section 4201.653;

(2) a list of the health care services and health benefit plans to which the exemption applies; and

(3) a statement of the duration of the exemption.

(e) If a physician or provider submits a preauthorization request for a health care service for which the physician or provider qualifies for an exemption from preauthorization requirements under Section 4201.653, the health maintenance organization or insurer must promptly provide a notice to the

physician or provider that includes:

(1) the information described by Subsection (d); and

(2) a notification of the health maintenance organization's or insurer's payment requirements.

(f) Nothing in this subchapter may be construed to:

(1) authorize a physician or provider to provide a health care service outside the scope of the provider's applicable license issued under Title 3, Occupations Code; or

(2) require a health maintenance organization or insurer to pay for a health care service described by Subdivision (1) that is performed in violation of the laws of this state.

SECTION 6. Subchapter N, Chapter 4201, Insurance Code, as added by this Act, applies only to a request for preauthorization of health care services made on or after January 1, 2022. A request for preauthorization of health care services made before January 1, 2022, 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. Section 4201.206, Insurance Code, as amended by this Act, applies only to a utilization review requested on or after the effective date of this Act. A utilization review requested before the effective date of this Act 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 8. This Act takes effect September 1, 2021.

President of the Senate

Speaker of the House

I certify that H.B. No. 3459 was passed by the House on May 7, 2021, by the following vote: Yeas 127, Nays 16, 1 present, not voting; that the House concurred in Senate amendments to H.B. No. 3459 on May 28, 2021, by the following vote: Yeas 140, Nays 4, 2 present, not voting; and that the House adopted H.C.R. No. 112 authorizing certain corrections in H.B. No. 3459 on May 29, 2021, by the following vote: Yeas 139, Nays 1, 1 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 3459 was passed by the Senate, with amendments, on May 22, 2021, by the following vote: Yeas 29, Nays 1; and that the Senate adopted H.C.R. No. 112 authorizing certain corrections in H.B. No. 3459 on May 30, 2021, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

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Governor