

CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

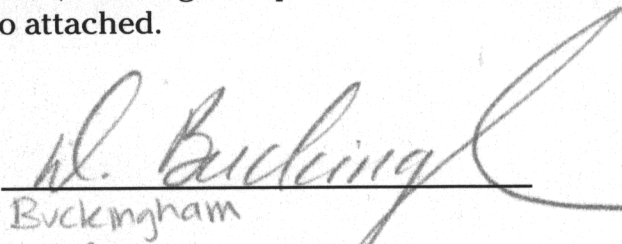
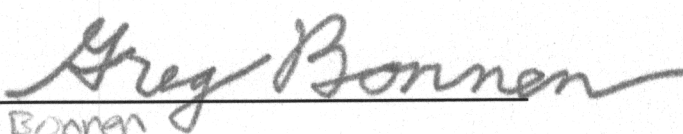
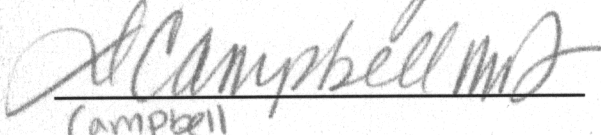
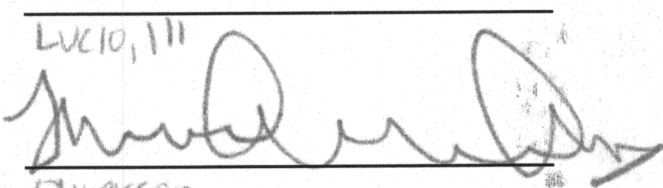
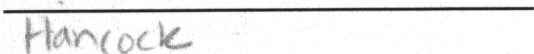
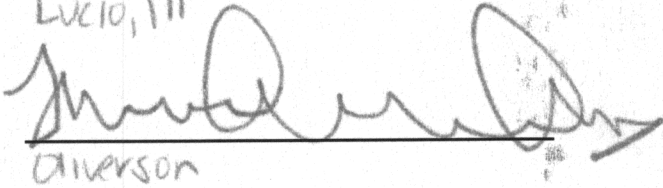
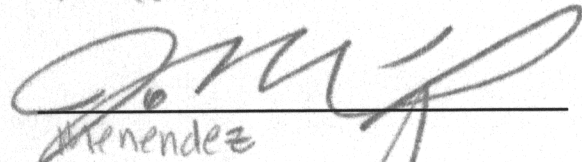
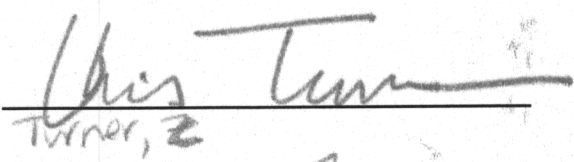
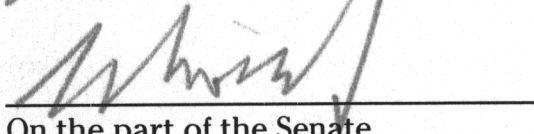
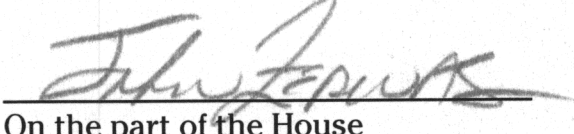
5/25/19  
Date

Honorable Dan Patrick  
President of the Senate

Honorable Dennis Bonnen  
Speaker of the House of Representatives

Sirs:

We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on HB 2327 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

 Buckingham	 Bonnen
 Campbell	 Lucio, III
 Hancock	 Diverson
 Hernandez	 Turner, C
 Schwerdtner	 Zerwas
On the part of the Senate	On the part of the House

Note to Conference Committee Clerk:

Please type the names of the members of the Conference Committee under the lines provided for signature. Those members desiring to sign the report should sign each of the six copies. Attach a copy of the Conference Committee Report and a Section by Section side by side comparison to each of the six reporting forms. The original and two copies are filed in house of origin of the bill, and three copies in the other house.

Prior Auth



# CONFERENCE COMMITTEE REPORT

3<sup>rd</sup> Printing

H.B. No. 2327

A BILL TO BE ENTITLED

AN ACT

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

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

## ARTICLE 1. PREAUTHORIZATION

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

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

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

### Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

(a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by 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 ~~fourth~~ 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, or a denial of another service if the  
2 requesting health care provider includes a written statement with  
3 supporting documentation that the service is necessary to treat a  
4 life-threatening condition or prevent serious harm to the patient.

5 That procedure must include a review by a health care provider who:

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

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

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

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

15 (B) ordered, requested, provided, or to be  
16 provided by a physician, is licensed to practice medicine in this  
17 state.

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

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

26 (2) is of the same or a similar specialty as the health  
27 care provider who would typically manage the medical or dental

1 condition, procedure, or treatment under review in the appeal; and

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

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

7 (B) ordered, requested, provided, or to be  
8 provided by a physician, is licensed to practice medicine in this  
9 state.

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

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

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

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

27 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty

1 utilization review agent's utilization review plan, including  
2 reconsideration and appeal requirements, must be:

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

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

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

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

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

24           (b) Personnel who obtain oral or written information  
25 directly from a physician or other health care provider must be a  
26 nurse, physician assistant, or other health care provider of the  
27 same specialty as the agent and who are licensed or otherwise

1 authorized to provide the specialty health care service in this ~~by~~  
2 ~~a] state [licensing agency in the United States].~~

3 SECTION 2.12. Sections 4201.456 and 4201.457, Insurance  
4 Code, are amended to read as follows:

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

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

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

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

27 SECTION 2.13. Section 4202.002, Insurance Code, is amended

1 by adding Subsection (b-1) to read as follows:

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

3 (1) ensure that personnel conducting independent  
4 review for a health care service are licensed or otherwise  
5 authorized to provide the same or a similar health care service in  
6 this state; and

7 (2) be consistent with the licensing laws of this  
8 state.

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

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

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

19 Sec. 151.057. APPLICATION TO UTILIZATION REVIEW. (a) In  
20 this section:

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

26 (2) "Payor" has the meaning assigned by Section  
27 4201.002, Insurance Code.



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

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

6                   (B) prescription drug benefits under Section  
7 1369.056, Insurance Code.

8           (4) "Utilization review agent" means:

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

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

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

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

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

20                   (1) makes on behalf of a utilization review agent or  
21 directs a utilization review agent to make an adverse  
22 determination, including:

23                   (A) an adverse determination made on  
24 reconsideration of a previous adverse determination;

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

27                   (C) a refusal to provide benefits for a

1 prescription drug under Section 1369.056, Insurance Code; or

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

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

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

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

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

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

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

19 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization  
20 review agent or an insurance carrier that uses doctors to perform  
21 reviews of health care services provided under this chapter,  
22 including utilization review, or peer reviews under Section  
23 408.0231(g), Labor Code, may only use doctors licensed to practice  
24 in this state.

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

27 (d) The department shall assign the review request to an

1 independent review organization. An [~~Notwithstanding Section~~  
2 ~~4202.002, an~~] independent review organization that uses doctors to  
3 perform reviews of health care services under this chapter may only  
4 use doctors licensed to practice in this state.

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

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

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

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

18 ARTICLE 3. TRANSITIONS; EFFECTIVE DATE

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

1 law is continued in effect for that purpose.

2       SECTION 3.02. The changes in law made by Article 2 of this  
3 Act apply only to utilization, independent, or peer review  
4 requested on or after September 1, 2020. Utilization, independent,  
5 or peer review requested before September 1, 2020, is governed by  
6 the law as it existed immediately before the effective date of this  
7 Act, and that law is continued in effect for that purpose.

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

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
ARTICLE 1. PREAUTHORIZATION	ARTICLE 1. Same as House version except as follows:	ARTICLE 1. Same as House version.
SECTION 1.01. Section 843.348(b), Insurance Code, is amended.	SECTION 1.01. Same as House version.	SECTION 1.01. Same as House version.
SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484 to read as follows:  <u>(b) The preauthorization requirements and information described by Subsection (a) must:</u> <u>(1) be posted:</u> <u>(A) conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and</u>  <u>(B) in a format that is easily searchable and accessible;</u> <u>(2) be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;</u>  <u>(3) include a detailed description of the preauthorization process and procedure; and</u> <u>(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:</u> <u>(A) the effective date of the preauthorization requirement;</u> <u>(B) a list or description of any supporting documentation that the health maintenance organization requires from the</u>	SECTION 1.02. Same as House version except as follows:  <u>(b) The preauthorization requirements and information described by Subsection (a) must:</u> <u>(1) be posted:</u> <u>(A) <i>except as provided by Subsection (c) or (d)</i>, conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and</u> <u>(B) in a format that is easily searchable and accessible;</u> <u>(2) <i>except for the screening criteria under Paragraph (4)(C)</i>, be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;</u> <u>(3) include a detailed description of the preauthorization process and procedure; and</u> <u>(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:</u> <u>(A) the effective date of the preauthorization requirement;</u> <u>(B) a list or description of any supporting documentation that the health maintenance organization requires from the</u>	SECTION 1.02. Same as House version.

House Bill 2327  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

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

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

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

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

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on *internal* appeal;

*(v) denials overturned on external appeal; and*

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

SENATE VERSION (IE)

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

(C) the applicable screening criteria, *which may include* Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding *calendar* year, including statistics in the following categories: [FA1(1)]

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

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on appeal; and

(v) total annual preauthorization requests, approvals, and denials for the service.

*(c) This section may not be construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. A health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's medical necessity or appropriateness determinations.* [FA1(2)]

*(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health*

CONFERENCE

House Bill 2327  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

SENATE VERSION (IE)

CONFERENCE

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide *each participating physician or provider written* notice of the new or amended preauthorization requirement *and disclose the new or amended requirement* in the health maintenance organization's newsletter or network bulletin, if any.

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

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE: *AUTOMATIC WAIVER*. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health

*maintenance organization has contracted, the health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.*

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide notice of the new or amended preauthorization requirement in the health maintenance organization's newsletter or network bulletin, if any, *and on the health maintenance organization's Internet website.*

(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide notice of the change in the preauthorization requirement in the health maintenance organization's newsletter or network bulletin, if any, *and on the health maintenance organization's Internet website* not later than the fifth day before the date the change takes effect.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, *waives the health maintenance organization's preauthorization requirements with respect to any health care service affected by the violation, and any health care service affected by the violation is considered preauthorized by the health maintenance organization.*

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

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

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

SECTION 1.03. Section 1301.135(a), Insurance Code, is amended.

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

**Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about**

SENATE VERSION (IE)

with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, *must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation.*

SECTION 1.03. Same as House version.

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

**Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about**

CONFERENCE

SECTION 1.03. Same as House version.

SECTION 1.04. Same as House version.



**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

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

(1) be posted:

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

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

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

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

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

(A) the effective date of the preauthorization requirement;

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

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

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care

SENATE VERSION (IE)

the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

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

(1) be posted:

(A) *except as provided by Subsection (c) or (d)*, conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

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

(2) *except for the screening criteria under Paragraph (4)(C)*, be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

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

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

(A) the effective date of the preauthorization requirement;

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

(C) the applicable screening criteria, *which may include* Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care

CONFERENCE

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

service in the preceding year ***and for each previous year the preauthorization requirement was in effect***, including statistics in the following categories:

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

SENATE VERSION (IE)

service in the preceding *calendar* year, including statistics in the following categories: [FA1(3)]

- (i) physician or health care provider type and specialty, if any;
- (ii) indication offered;
- (iii) reasons for request denial;
- (iv) denials overturned on appeal; and
- (v) total annual preauthorization requests, approvals, and denials for the service.

***(c) This section may not be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. An insurer may, instead of making that information publicly available on the insurer's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or other health care provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the insurer's medical necessity or appropriateness determinations.*** [FA1(4)]

***(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the insurer has received from a third party with which the insurer has contracted, the insurer may, instead of making that information publicly available on the insurer's Internet website, provide the material to a physician or health care provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.***

CONFERENCE

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

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

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide *to each preferred provider written* notice of the new or amended preauthorization requirement *and disclose the new or amended requirement* in the insurer's newsletter or network bulletin, if any.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide *each preferred provider written* notice of the change in the preauthorization requirement *and disclose the change* in the insurer's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

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

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

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE: AUTOMATIC WAIVER. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a

SENATE VERSION (IE)

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

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide notice of the new or amended preauthorization requirement in the insurer's newsletter or network bulletin, if any, *and on the insurer's Internet website.*

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide notice of the change in the preauthorization requirement in the insurer's newsletter or network bulletin, if any, *and on the insurer's Internet website* not later than the fifth day before the date the change takes effect.

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

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

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical

CONFERENCE

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, ***waives the insurer's preauthorization requirements with respect to*** any medical care or health care service affected by the violation, ***and any medical care or health care service affected by the violation is considered preauthorized by the insurer.***

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

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

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

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

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

ARTICLE 2. UTILIZATION, INDEPENDENT, AND  
PEER REVIEW

SENATE VERSION (IE)

care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, ***must provide an expedited appeal under Section 4201.357 for*** any medical care or health care service affected by the violation.

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

ARTICLE 2. Same as House version except as follows.

CONFERENCE

ARTICLE 2. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

SECTION 2.01. Section 4201.002(12), Insurance Code, is amended.

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

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

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

Sec. 4201.1525. UTILIZATION REVIEW BY PHYSICIAN. (a) A utilization review agent that uses a physician to conduct utilization review may only use a physician licensed to practice medicine in this state.  
(b) A payor that conducts utilization review on the payor's own behalf is subject to Subsection (a) as if the payor were a utilization review agent.

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

(d) Screening criteria must be used to determine only whether to approve the requested treatment. Before issuing an adverse determination, a utilization review agent must obtain a determination of medical necessity by referring a

SENATE VERSION (IE)

SECTION 2.01. Same as House version.

SECTION 2.02. Same as House version except as follows:

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

*No equivalent provision.*

SECTION 2.03. Section 4201.153(d), Insurance Code, is amended to read as follows:

(d) Screening criteria must be used to determine only whether to approve the requested treatment. Before issuing an adverse determination, a utilization review agent must obtain a determination of medical necessity and

CONFERENCE

SECTION 2.01. Same as House version.

SECTION 2.02. Same as House version.

SECTION 2.03. Same as House version.

SECTION 2.04. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

proposed [A] denial of requested treatment [~~must be referred~~] to:

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

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

SECTION 2.05.

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 [~~or~~] 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 who is of the same or a similar specialty as that physician.

SENATE VERSION (IE)

appropriateness by referring a proposed [A] denial of requested treatment [~~must be referred~~] to an appropriate physician, dentist, or other health care provider [~~to determine medical necessity~~]. [FA1(5)]

SECTION 2.04. Same as House version except 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 [~~or~~] 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 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 . [FA1(6)]

CONFERENCE

SECTION 2.05. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

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

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

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

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

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

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

SENATE VERSION (IE)

SECTION 2.05. Sections 4201.252(a) and (b), Insurance Code, are amended to read as follows:

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

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

SECTION 2.06. Section 4201.356, Insurance Code, is amended to read as follows:

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

CONFERENCE

SECTION 2.06. Same as House version.

SECTION 2.07. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

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

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

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

- (1) has not previously reviewed the case; ~~and~~
- (2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

SENATE VERSION (IE)

(b) If not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests ~~*states in writing good cause for having*~~ a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review and who is licensed or otherwise authorized by the appropriate licensing agency in the United States to manage the medical or dental condition, procedure, or treatment shall review the denial or the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.

SECTION 2.07. Sections 4201.357(a), (a-1), and (a-2), Insurance Code, are amended to read as follows:

(a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, ~~or~~ a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. That procedure must include a review by a health care provider who:

- (1) has not previously reviewed the case; ~~and~~
- (2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

CONFERENCE

SECTION 2.08. Same as Senate version except as follows:

(a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, [or] a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. That procedure must include a review by a health care provider who:

- (1) has not previously reviewed the case; ~~and~~
- (2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and



House Bill 2327  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

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

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

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

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

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

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

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

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

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

(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations. The physician must be licensed to practice medicine in ***this state*** and the health care provider

SENATE VERSION (IE)

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

(A) ordered, requested, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by ***an*** appropriate licensing agency in ***the United States***; or

(B) ordered, requested, or to be provided by a physician, is licensed to practice medicine in ***the United States***.

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

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

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

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

(A) ordered, requested, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by the appropriate licensing agency in ***the United States***; or [FA1(7)]

(B) ordered, requested, or to be provided by a physician, is licensed to practice medicine in ***the United States***. [FA1(8)]

(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations. The physician must be licensed to practice medicine in ***the United States*** and the health care

CONFERENCE

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

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

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

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

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

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

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

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

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

(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations. The physician must be licensed to practice medicine in ***this state*** and the health care provider

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

must be licensed or otherwise authorized by *the* appropriate licensing agency in *this state*.

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

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

SECTION 2.10. Sections 4201.453 and 4201.454, Insurance Code, are amended.

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

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

(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care

SENATE VERSION (IE)

provider must be licensed or otherwise authorized by *an* appropriate licensing agency in *the United States*.

SECTION 2.08. Section 4201.359, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) A physician described by Subsection (b)(2) must comply with this chapter and other applicable laws and be licensed to practice medicine. A health care provider described by Subsection (b)(2) must comply with this chapter and other applicable laws and be licensed or otherwise authorized by *an* appropriate licensing agency in *the United States*.

SECTION 2.09. Same as House version.

SECTION 2.10. Sections 4201.455(a) and (b), Insurance Code, are amended to read as follows:

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

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

CONFERENCE

must be licensed or otherwise authorized by the appropriate licensing agency in *this state*.

SECTION 2.09. Same as House version.

SECTION 2.10. Same as House version.

SECTION 2.11. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

SENATE VERSION (IE)

CONFERENCE

service in this [by a] state [licensing agency in the United States].

SECTION 2.12. Sections 4201.456 and 4201.457, Insurance Code, are amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION.

Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the [or] 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 the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is:

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

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

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

SECTION 2.11. Sections 4201.456 and 4201.457, Insurance Code, are amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION.

Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the [or] appropriateness, or the experimental or investigational nature[;] of a health care service, the agent shall provide the health care provider who ordered, requested, or is to provide the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is:

- (1) of the same specialty as the agent; and
- (2) licensed or otherwise authorized to provide the specialty health care service by a licensing agency in the United States.

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

- (1) of the same or a similar specialty as the health care provider who would typically manage the specialty condition, procedure, or treatment under review in the appeal; and
- (2) licensed or otherwise authorized to provide the health care service by a licensing agency in the United States.

SECTION 2.12. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

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

(b-1) The standards adopted under Subsection (b)(3) must:  
(1) ensure that personnel conducting independent review for a health care service are licensed or otherwise authorized to provide the same or a similar health care service in this state;  
and  
(2) be consistent with the licensing laws of this state.

SECTION 2.14. Section 408.0043, Labor Code, is amended.

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

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

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

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

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

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

SENATE VERSION (IE)

*No equivalent provision.*

SECTION 2.12. Same as House version.

*No equivalent provision.*

CONFERENCE

SECTION 2.13. Same as House version.

SECTION 2.14. Same as House version.

SECTION 2.15. Same as House version.

**House Bill 2327**  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

SENATE VERSION (IE)

CONFERENCE

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

(4) "Utilization review agent" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

House Bill 2327  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION	SENATE VERSION (IE)	CONFERENCE
<u>(5) discusses a patient's treatment plan and the clinical basis for an adverse determination before the adverse determination is issued, as provided by Section 4201.206, Insurance Code.</u> <u>(c) For purposes of Subsection (b), a denial of health care services based on the failure to request prospective or concurrent review is not considered an adverse determination.</u>		
SECTION 2.16. Section 1305.351(d), Insurance Code, is amended.	SECTION 2.13. Same as House version.	SECTION 2.16. Same as House version.
SECTION 2.17. Section 1305.355(d), Insurance Code, is amended.	SECTION 2.14. Same as House version.	SECTION 2.17. Same as House version.
SECTION 2.18. Section 408.023(h), Labor Code, is amended.	SECTION 2.15. Same as House version.	SECTION 2.18. Same as House version.
SECTION 2.19. Section 413.031(e-2), Labor Code, is amended.	SECTION 2.16. Same as House version.	SECTION 2.19. Same as House version.
<i>No equivalent provision.</i>	ARTICLE 3. JOINT INTERIM STUDY	Same as House version.
ARTICLE 3. TRANSITIONS; EFFECTIVE DATE	ARTICLE 4. Same as House version.	ARTICLE 3. Same as House version.

House Bill 2327  
Conference Committee Report  
Section-by-Section Analysis

HOUSE VERSION

SENATE VERSION (IE)

CONFERENCE

SECTION 3.01. Article 1 transition provision.

SECTION 4.01. Same as House version.

SECTION 3.01. Same as House version.

SECTION 3.02. The changes in law made by Article 2 of this Act apply only to utilization, independent, or peer review requested on or after *the effective date of this Act*. Utilization, independent, or peer 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 4.02. Same as House version.

SECTION 3.02. Same as House version except the date that a utilization, independent, or peer review is requested to which Article 2 applies is changed to on or after *September 1, 2020*.

*[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]*

SECTION 3.03. Effective date.

SECTION 4.03. Same as House version.

SECTION 3.03. Same as House version.

**LEGISLATIVE BUDGET BOARD**  
**Austin, Texas**

**FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION**

**May 25, 2019**

**TO:** Honorable Dan Patrick, Lieutenant Governor, Senate  
Honorable Dennis Bonnen, Speaker of the House, House of Representatives

**FROM:** John McGeady, Assistant Director    Sarah Keyton, Assistant Director  
Legislative Budget Board

**IN RE: HB2327** by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **Conference Committee Report**

<b>No significant fiscal implication to the State is anticipated.</b>
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This bill would amend the Insurance Code and Labor Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, State Office of Risk Management, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review that was requested on or after January 1, 2020. The bill would take effect on September 1, 2019.



## **Local Government Impact**

No fiscal implication to units of local government is anticipated.

**Source Agencies:** 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 529 Health and Human Services Commission

**LBB Staff:** WP, CLo, CP

**Certification of Compliance with  
Rule 13, Section 6(b), House Rules of Procedure**

Rule 13, Section 6(b), House Rules of Procedure, requires a copy of a conference committee report signed by a majority of each committee of the conference to be furnished to each member of the committee in person or, if unable to deliver in person, by placing a copy in the member's newspaper mailbox at least one hour before the report is furnished to each member of the house under House Rule 13, Section 10(a). The paper copies of the report submitted to the chief clerk under Rule 13, Section 10(b), must contain a certificate that the requirement of Rule 13, Section 6(b), has been satisfied, and that certificate must be attached to the copy of the report furnished to each member under Rule 13, Section 10(d). Failure to comply with this requirement is not subject to a point of order under Rule 13.

I certify that a copy of the conference committee report on HB 2327 was furnished to each member of the conference committee in compliance with Rule 13, Section 6(b), House Rules of Procedure, before submission of the paper copies of the report to the chief clerk under Rule 13, Section 10(b), House Rules of Procedure.

Greg Boman  
(name)

May 25, 2019  
(date)