INSURANCE CODE

TITLE 14. UTILIZATION REVIEW AND INDEPENDENT REVIEW

CHAPTER 4201. UTILIZATION REVIEW AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4201.001. PURPOSE. The purpose of this chapter is to:

(1) promote the delivery of quality health care in a cost-effective manner;

(2) ensure that a utilization review agent adheres to reasonable standards for conducting utilization review;

(3) foster greater coordination and cooperation between a health care provider and utilization review agent;

(4) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and

(5) ensure that a utilization review agent maintains the confidentiality of medical records in accordance with applicable law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.002. DEFINITIONS. In this chapter:

(1) "Adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

(2) "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

(A) place the individual's health in serious jeopardy;

(B) result in serious impairment to bodily functions;

(C) result in serious dysfunction of a bodily organ or part;

(D) result in serious disfigurement; or

(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.

(3) "Enrollee" means an individual covered by a health insurance policy or health benefit plan. The term includes an individual who is covered as an eligible dependent of another individual.

(4) "Health benefit plan" means a plan of benefits, other than a health insurance policy, that:

(A) defines the coverage provisions for health care for enrollees; and

(B) is offered or provided by a public or private organization.

(5) "Health care provider" means a person, corporation, facility, or institution that is:

(A) licensed by a state to provide or is otherwise lawfully providing health care services; and

(B) eligible for independent reimbursement for those health care services.

(6) "Health insurance policy" means an insurance policy, including a policy written by a corporation subject to Chapter 842, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

(7) "Life-threatening" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(8) "Nurse" means a professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse.

(9) "Patient" means the enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance policy.

(10) "Payor" means:

(A) an insurer that writes health insurance policies;

(B) a preferred provider organization, health

maintenance organization, or self-insurance plan; or

(C) any other person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider in this state under a policy, plan, or contract.

(11) "Physician" means a licensed doctor of medicine or a doctor of osteopathy.

(12) "Provider of record" means the physician or other health care provider with primary responsibility for the health care services provided to or requested on behalf of an enrollee or the physician or other health care provider that has provided or has been requested to provide the health care services to the enrollee. The term includes a health care facility where the health care services are provided on an inpatient or outpatient basis.

(13) "Utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

(14) "Utilization review agent" means an entity that conducts utilization review for:

(A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy;

(B) a payor; or

(C) an administrator holding a certificate of authority under Chapter 4151.

(15) "Utilization review plan" means the screening criteria and utilization review procedures of a utilization review agent.

(16) "Working day" means a weekday that is not a legal holiday.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 7, eff.

September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.01, eff. September 1, 2019.

Sec. 4201.003. RULES. (a) The commissioner may adopt rules to implement this chapter.

(b) A rule adopted under this chapter relates only to a person or entity subject to this chapter.

(c) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(11), eff. September 1, 2011.

(d) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(11), eff. September 1, 2011.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.008(11), eff. September 1, 2011.

Sec. 4201.004. TELEPHONE ACCESS. (a) A utilization review agent shall:

(1) have appropriate personnel reasonably available, by toll-free telephone at least 40 hours per week during normal business hours in this state, to discuss patients' care and allow response to telephone review requests;

(2) have a telephone system capable, during hours other than normal business hours, of accepting or recording incoming telephone calls or of providing instructions to a caller; and

(3) respond to a call made during hours other than normal business hours not later than the second working day after the later of:

(A) the date the call was received; or

(B) the date the details necessary to respond have been received from the caller.

(b) A utilization review agent must provide to the commissioner a written description of the procedures to be used when responding with respect to poststabilization care subsequent

to emergency treatment as requested by a treating physician or other health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER B. APPLICABILITY OF CHAPTER

Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF COVERAGE OR BENEFITS. This chapter does not apply to a person who:

(1) provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and

(2) does not determine whether a particular health care service provided or to be provided to an enrollee is:

(A) medically necessary or appropriate; or

(B) experimental or investigational.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 8, eff. September 1, 2009.

Sec. 4201.052. CERTAIN CONTRACTS WITH FEDERAL GOVERNMENT. This chapter does not apply to a contract with the federal government to provide utilization review with respect to a patient who is eligible for services under Title XVIII or XIX of the Social Security Act (42 U.S.C. Section 1395 et seq. or Section 1396 et seq.).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.053. MEDICAID AND OTHER STATE HEALTH OR MENTAL HEALTH PROGRAMS. (a) Except as provided by Section 4201.057, this chapter does not apply to:

(1) the state Medicaid program;

(2) the services program for children with special health care needs under Chapter 35, Health and Safety Code;

(3) a program administered under Title 2, Human Resources Code;

(4) a program of the Department of State Health Services relating to mental health services;

(5) a program of the Department of Aging and Disability Services relating to intellectual disability services; or

(6) a program of the Texas Department of Criminal Justice.

Text of subsection effective until April 01, 2025

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

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

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551;

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579;

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601; and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 533, Government Code.

Text of subsection effective on April 01, 2025

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

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

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551;

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579;

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601; and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 1, eff. September 1, 2015.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.139, eff. April 1, 2025.

Sec. 4201.054. WORKERS' COMPENSATION BENEFITS. (a) Except as provided by this section, this chapter applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code.

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to utilization review of a health care service provided to a person eligible for workers' compensation benefits under Title 5, Labor Code.

(c) Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code.

(d) The commissioner of workers' compensation may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 7(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 7(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec.

3B.075(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.075(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.075(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.075(b), eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 2, eff. September 1, 2015.

Sec. 4201.055. HEALTH CARE SERVICE PROVIDED UNDER AUTOMOBILE INSURANCE POLICY. This chapter does not apply to utilization review of a health care service provided under an automobile insurance policy or contract that is authorized under Chapter 2301 or Article 5.13-2 or that is issued under Chapter 981. Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.056. EMPLOYEE WELFARE BENEFIT PLANS. This chapter does not apply to the terms or benefits of an employee welfare benefit plan defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)). Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.057. HEALTH MAINTENANCE ORGANIZATIONS. (a) In this section, "health maintenance organization" includes a health maintenance organization that contracts with the Health and Human Services Commission or with an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code.

(b) This chapter applies to a health maintenance organization except as expressly provided by this section.

(c) As a condition of holding a certificate of authority to engage in the business of a health maintenance organization, a health maintenance organization that performs utilization review

must:

(1) comply with this chapter, except Subchapter C; and

(2) submit to assessment of a maintenance tax under Chapter 258 to cover the costs of administering compliance with this subsection.

(d) The commissioner shall adopt rules for appropriate verification and enforcement of compliance with Subsection (c).

(e) Notwithstanding Subsection (c)(1), a health maintenance organization that performs utilization review for a person or entity subject to this chapter, other than a person or entity for which the health maintenance organization is the payor, must obtain a certificate of registration under Subchapter C and shall comply with all of the provisions of this chapter.

(f) This chapter does not prohibit or limit the distribution of a portion of the savings from the reduction or elimination of unnecessary medical services, treatment, supplies, confinements, or days of confinement in a health care facility through profit sharing, bonus, or withholding arrangements to a participating physician or participating health care provider for providing health care services to an enrollee.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.058. INSURERS. (a) This chapter applies to an insurer subject to this code that delivers or issues for delivery a health insurance policy in this state except as expressly provided by this section. As a condition of holding a certificate of authority to engage in the business of insurance, an insurer that performs utilization review shall comply with this chapter, except Subchapter C. The insurer is subject to assessment of a maintenance tax under Chapter 257 to cover the costs of administering compliance with this subsection.

(b) The commissioner shall adopt rules for appropriate verification and enforcement of compliance with Subsection (a).

(c) Notwithstanding Subsection (a), an insurer subject to this code that performs utilization review for a person or entity subject to this chapter, other than a person or entity for which the

insurer is the payor, must obtain a certificate of registration under Subchapter C and shall comply with all of the provisions of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER C. CERTIFICATION

Sec. 4201.101. CERTIFICATE OF REGISTRATION REQUIRED. A utilization review agent may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.102. REQUIREMENTS FOR CERTIFICATION. (a) The commissioner may issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all applicable rules adopted by the commissioner.

(b) As a condition of holding a certificate of registration or renewal of a certificate, a utilization review agent must maintain compliance with Subchapters D, E, and F.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.103. CERTIFICATE RENEWAL. Certification may be renewed biennially by filing, not later than March 1, a renewal form with the commissioner accompanied by a fee in an amount set by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.104. CERTIFICATION AND RENEWAL FORMS. (a) The commissioner shall promulgate forms to be filed under this subchapter for initial certification and for a renewal certificate of registration. The form for initial certification must require:

(1) the utilization review agent's name, address,

telephone number, and normal business hours;

(2) the name and address of an agent for service of process in this state;

(3) a summary of the utilization review plan;

(4) information concerning the categories of personnel who will perform utilization review for the agent;

(5) a copy of the procedures established under Subchapter H for the appeal of an adverse determination;

(6) a certification that the agent will comply with this chapter; and

(7) a copy of the procedures for resolving oral or written complaints initiated by enrollees, patients, or health care providers as required by Section 4201.204.

(b) The commissioner may not require that the summary of the utilization review plan include proprietary details.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.105. FEES. The commissioner shall establish, administer, and enforce the fees for initial certification and certification renewal in amounts that do not exceed the amounts necessary to cover the cost of administering this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.106. CERTIFICATE NOT TRANSFERABLE. A certificate of registration is not transferable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.107. REPORTING MATERIAL CHANGES. A utilization review agent shall report any material change to the information disclosed in a form filed under this subchapter not later than the 30th day after the date the change takes effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.108. LIST OF UTILIZATION REVIEW AGENTS. (a) The commissioner shall maintain and update monthly a list of each utilization review agent to whom a certificate of registration has been issued and the renewal date of the certificate.

(b) The commissioner shall provide the list at cost to each individual or organization requesting the list.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER D. UTILIZATION REVIEW: GENERAL STANDARDS

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.02, eff. September 1, 2019.

Sec. 4201.152. UTILIZATION REVIEW UNDER PHYSICIAN. A utilization review agent shall conduct utilization review under the direction of a physician licensed to practice medicine in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.02, eff. September 1, 2019.

Sec. 4201.153. SCREENING CRITERIA AND REVIEW PROCEDURES. (a) A utilization review agent shall use written medically acceptable screening criteria and review procedures that are

established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers.

(b) A utilization review determination shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria.

(c) Screening criteria must be:

(1) objective;

(2) clinically valid;

(3) compatible with established principles of health care; and

(4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

(d) Screening criteria must be used to determine only whether to approve the requested treatment. A denial of requested treatment must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.154. REVIEW AND INSPECTION OF SCREENING CRITERIA AND REVIEW PROCEDURES. (a) A utilization review agent's written screening criteria and review procedures shall be made available for:

(1) review and inspection to determine appropriateness and compliance as considered necessary by the commissioner; and

(2) copying as necessary for the commissioner to accomplish the commissioner's duties under this code.

(b) Any information obtained or acquired under the authority of this section, Section 4201.153, and this chapter is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena except to the extent necessary for the commissioner to enforce this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff.

April 1, 2007.

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.03, eff. September 1, 2019.

SUBCHAPTER E. UTILIZATION REVIEW: RELATIONS WITH PATIENTS AND HEALTH CARE PROVIDERS

Sec. 4201.201. REPETITIVE CONTACTS WITH HEALTH CARE PROVIDER OR PATIENT; FREQUENCY OF REVIEWS. A utilization review agent:

(1) may not engage in unnecessary or unreasonable repetitive contacts with a health care provider or patient; and

(2) shall base the frequency of contacts or reviews on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.202. OBSERVING OR PARTICIPATING IN PATIENT'S CARE. (a) Unless approved for an individual patient by the provider of record or modified by contract, a utilization review agent shall be prohibited from observing, participating in, or otherwise being present during a patient's examination, treatment, procedure, or therapy.

(b) This subchapter, Subchapters D and F, and Section

4201.102(b) may not be construed to otherwise limit or deny contact with a patient for purposes of conducting utilization review unless otherwise specifically prohibited by law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.203. MENTAL HEALTH THERAPY. (a) A utilization review agent may not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes.

(b) Notwithstanding this section, a utilization review agent may require submission of a patient's medical record summary.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.204. COMPLAINT SYSTEM. (a) A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review.

(b) The complaint procedure must include a requirement that the utilization review agent provide a written response to the complainant within 30 days.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42 , Sec. 3.01(7), eff. September 1, 2015.

(d) A utilization review agent shall maintain a record of each complaint until the third anniversary of the date the complainant filed the complaint.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(7), eff. September 1, 2015.

Sec. 4201.205. DESIGNATED INITIAL CONTACT. (a) A health care provider may designate one or more individuals as the initial

contact or contacts for a utilization review agent seeking routine information or data.

(b) A designation made under this section may not preclude a utilization review agent or medical advisor from contacting a health care provider or the provider's employees who are not designated under this section under circumstances in which:

(1) a review might otherwise be unreasonably delayed; or

(2) the designated individual is unable to provide the necessary data or information that the agent requests.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

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.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 9, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.03, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 4, eff.

September 1, 2021.

Sec. 4201.207. CHARGES BY HEALTH CARE PROVIDER FOR PROVIDING MEDICAL INFORMATION. (a) Unless precluded or modified by contract, a utilization review agent shall reimburse a health care provider for the reasonable costs of providing medical information in writing, including the costs of copying and transmitting requested patient records or other documents.

(b) A health care provider's charges for providing medical information to a utilization review agent may not:

(1) exceed the cost of copying records regarding a workers' compensation claim as set by rules adopted by the commissioner of workers' compensation; or

(2) include any costs otherwise recouped as part of the charges for health care.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 8(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.076(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.076(a), eff. September 1, 2007.

SUBCHAPTER F. UTILIZATION REVIEW: PERSONNEL

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.03, eff. September 1, 2019.

Sec. 4201.252. PERSONNEL. (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 to provide the requested service.

(c) This section may not be interpreted to require personnel who perform clerical or administrative tasks to have the qualifications prescribed by this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.04, eff. September 1, 2019.

Sec. 4201.253. PROHIBITED BASES FOR EMPLOYMENT, COMPENSATION, EVALUATIONS, OR PERFORMANCE STANDARDS. A utilization review agent may not permit or provide compensation or another thing of value to an employee or agent of the utilization review agent, condition employment of the agent's employees or agent evaluations, or set employee or agent performance standards, based on the amount of volume of adverse determinations, reductions of or limitations on lengths of stay, benefits, services, or charges, or the number or frequency of telephone calls or other contacts with health care providers or patients, that are inconsistent with this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER G. NOTICE OF DETERMINATIONS

Sec. 4201.301. GENERAL DUTY TO NOTIFY. A utilization review agent shall provide notice of a determination made in a utilization review to:

(1) the enrollee's provider of record; and

(2) the enrollee or a person acting on the enrollee's behalf.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.302. GENERAL TIME FOR NOTICE. A utilization review agent must mail or otherwise transmit the notice required by this subchapter not later than the second working day after the date of the request for utilization review and the agent receives all information necessary to complete the review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.303. ADVERSE DETERMINATION: CONTENTS OF NOTICE. (a) Notice of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and

(4) a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

(b) For an enrollee who has a life-threatening condition, the notice required by Subsection (a)(4) must include a description of the enrollee's right to an immediate review by an independent review organization and of the procedures to obtain that review.

(c) For an enrollee who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, the notice required by Subsection (a)(4) must include a description of the enrollee's right to an immediate review by an independent review organization and of the procedures to obtain that review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 3, eff. September 1, 2015.

Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. (a) Subject to Subsection (b), a utilization review agent shall provide notice of an adverse determination required by this subchapter as follows:

(1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;

(2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or

(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

(b) A utilization review agent shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the health insurance policy not later than the 30th day before the date on which the provision of

prescription drugs or intravenous infusions will be discontinued. Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 4, eff. September 1, 2015.

Sec. 4201.305. NOTICE OF ADVERSE DETERMINATION FOR RETROSPECTIVE UTILIZATION REVIEW. (a) Notwithstanding Sections 4201.302 and 4201.304, if a retrospective utilization review is conducted, the utilization review agent shall provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received.

(b) The period under Subsection (a) may be extended once by the utilization review agent for a period not to exceed 15 days, if the utilization review agent:

(1) determines that an extension is necessary due to matters beyond the utilization review agent's control; and

(2) notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the utilization review agent expects to make a determination.

(c) If the extension under Subsection (b) is required because of the failure of the provider of record or the patient to submit information necessary to reach a determination on the request, the notice of extension must:

(1) specifically describe the required information necessary to complete the request; and

(2) give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.

(d) If the period for making the determination under this section is extended because of the failure of the provider of record or the patient to submit the information necessary to make the determination, the period for making the determination is tolled

from the date on which the utilization review agent sends the notification of the extension to the provider of record or the patient until the earlier of:

(1) the date on which the provider of record or the patient responds to the request for additional information; or

(2) the date by which the specified information was to have been submitted.

(e) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapter J, Chapter 843, the time limits established under Subchapter J, Chapter 843, control.

(f) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapters C and C-1, Chapter 1301, the time limits established under Subchapters C and C-1, Chapter 1301, control.

(g) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Section 408.027, Labor Code, the time limits established under Section 408.027, Labor Code, control.

Added by Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 10, eff. September 1, 2009.

SUBCHAPTER H. APPEAL OF ADVERSE DETERMINATION

Sec. 4201.351. COMPLAINT AS APPEAL. For purposes of this subchapter, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.352. WRITTEN DESCRIPTION OF APPEAL PROCEDURES. A utilization review agent shall maintain and make available a written description of the procedures for appealing an adverse

determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.353. APPEAL PROCEDURES MUST BE REASONABLE. The procedures for appealing an adverse determination must be reasonable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.354. PERSONS OR ENTITIES WHO MAY APPEAL. The procedures for appealing an adverse determination must provide that the adverse determination may be appealed orally or in writing by:

(1) an enrollee;

(2) a person acting on the enrollee's behalf; or

(3) the enrollee's physician or other health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.355. ACKNOWLEDGMENT OF APPEAL. (a) The procedures for appealing an adverse determination must provide that, within five working days from the date the utilization review agent receives the appeal, the agent shall send to the appealing party a letter acknowledging the date of receipt.

(b) The letter must also include a list of:

(1) the procedures required by this subchapter; and

(2) the documents that the appealing party must submit for review.

(c) When a utilization review agent receives an oral appeal of an adverse determination, the agent shall send a one-page appeal form to the appealing party.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

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).

(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 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 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.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.05, eff. September 1, 2019.

Sec. 4201.357. EXPEDITED APPEAL FOR DENIAL OF EMERGENCY CARE, CONTINUED HOSPITALIZATION, PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS. (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, 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.

(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.

(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.

(b) The time for resolution of an expedited appeal under this section shall be based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 5, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 6, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 103 (S.B. 680), Sec. 3, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.06, eff. September 1, 2019.

Sec. 4201.358. RESPONSE LETTER TO INTERESTED PERSONS. The procedures for appealing an adverse determination must provide that, after the utilization review agent has sought review of the appeal, the agent shall issue a response letter explaining the resolution of the appeal to:

(1) the patient or a person acting on the patient's behalf; and

(2) the patient's physician or other health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.359. NOTICE OF APPEAL. (a) The procedures for appealing an adverse determination must require written notice to the appealing party of the determination of the appeal as soon as practicable, but not later than the 30th calendar day, after the date the utilization review agent receives the appeal.

(b) If the appeal is denied, the notice must include a clear and concise statement of:

(1) the clinical basis for the denial;

(2) the specialty of the physician or other health care provider making the denial; and

(3) the appealing party's right to seek review of the denial by an independent review organization under Subchapter I and the procedures for obtaining that review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.360. IMMEDIATE APPEAL TO INDEPENDENT REVIEW ORGANIZATION IN LIFE-THREATENING CIRCUMSTANCES. Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is:

(1) entitled to an immediate appeal to an independent review organization as provided by Subchapter I; and

(2) not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.3601. IMMEDIATE APPEAL TO INDEPENDENT REVIEW ORGANIZATION FOR DENIAL OF PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS. Notwithstanding any other law, in a circumstance involving the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, the enrollee is:

(1) entitled to an immediate appeal to an independent review organization as provided by Subchapter I; and

(2) not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

Added by Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 7, eff. September 1, 2015.

SUBCHAPTER I. INDEPENDENT REVIEW OF ADVERSE DETERMINATION

Sec. 4201.401. REVIEW BY INDEPENDENT REVIEW ORGANIZATION; COMPLIANCE WITH INDEPENDENT DETERMINATION. (a) A utilization review agent shall allow any party whose appeal of an adverse determination is denied by the agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Chapter 4202.

(b) The utilization review agent shall comply with the independent review organization's determination regarding the medical necessity or appropriateness of health care items and services for an enrollee.

(c) The utilization review agent shall comply with the independent review organization's determination regarding the experimental or investigational nature of health care items and services for an enrollee.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 11, eff. September 1, 2009.

Sec. 4201.402. INFORMATION PROVIDED TO INDEPENDENT REVIEW ORGANIZATION. (a) Not later than the third business day after the date a utilization review agent receives a request for independent review, the agent shall provide to the appropriate independent review organization:

(1) a copy of:

(A) any medical records of the enrollee that are

relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed;

(C) the written notification described by Section 4201.359; and

(D) any documents and other written information submitted to the agent in support of the appeal; and

(2) a list of each physician or other health care provider who:

(A) has provided care to the enrollee; and

(B) may have medical records relevant to the appeal.

(b) A utilization review agent may provide confidential information in the custody of the agent to an independent review organization, subject to rules and standards adopted by the commissioner under Chapter 4202.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.403. PAYMENT FOR INDEPENDENT REVIEW. A utilization review agent shall pay for an independent review conducted under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER J. SPECIALTY UTILIZATION REVIEW AGENTS

Sec. 4201.451. DEFINITION. For purposes of this subchapter, "specialty utilization review agent" means a utilization review agent who conducts utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.452. INAPPLICABILITY OF CERTAIN OTHER LAW. A specialty utilization review agent is not subject to Section

4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

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

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.07, eff. September 1, 2019.

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.07, eff. September 1, 2019.

Sec. 4201.455. PERSONNEL. (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.

(c) This section does not require personnel who perform only clerical or administrative tasks to have the qualifications prescribed by this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.08, eff. September 1, 2019.

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 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 of the same specialty as the agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 12, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.09, eff. September 1, 2019.

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 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.
Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER L. CONFIDENTIALITY OF INFORMATION; ACCESS TO OTHER INFORMATION

Sec. 4201.551. GENERAL CONFIDENTIALITY REQUIREMENT. (a) A utilization review agent shall preserve the confidentiality of individual medical records to the extent required by law.

(b) This chapter does not authorize a utilization review agent to take any action that violates a state or federal law or regulation concerning confidentiality of patient records.
Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.552. CONSENT REQUIREMENTS. (a) A utilization review agent may not disclose individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent or except as otherwise required by law.

(b) If the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must:

(1) be dated; and

(2) contain the patient's signature.

(c) The patient's signature for purposes of Subsection (b)(2) must have been obtained one year or less before the date the disclosure is sought or the consent is invalid.
Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.553. PROVIDING INFORMATION TO AFFILIATED ENTITIES. A utilization review agent may provide confidential

information to a third party under contract with or affiliated with the agent solely to perform or assist with utilization review. Information provided to a third party under this section remains confidential.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.554. PROVIDING INFORMATION TO COMMISSIONER. Notwithstanding this subchapter, a utilization review agent shall provide to the commissioner on request individual medical records or other confidential information to enable the commissioner to determine compliance with this chapter. The information is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.555. ACCESS TO RECORDED PERSONAL INFORMATION. (a) If an individual submits a written request to a utilization review agent for access to recorded personal information concerning the individual, the agent shall, within 10 business days from the date the agent receives the request:

(1) inform the requesting individual in writing of the nature and substance of the recorded personal information; and

(2) allow the individual, at the individual's discretion, to:

(A) view and copy, in person, the recorded personal information concerning the individual; or

(B) obtain a copy of the information by mail.

(b) If the information requested under this section is in coded form, the utilization review agent shall provide in writing an accurate translation of the information in plain language.

(c) A utilization review agent's charges for providing a copy of information requested under this section shall be reasonable, as determined by rule adopted by the commissioner. The charges may not include any costs otherwise recouped as part of the

charges for utilization review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.556. PUBLISHING INFORMATION IDENTIFIABLE TO HEALTH CARE PROVIDER. (a) A utilization review agent may not publish data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

(b) The prohibition under this section does not apply to internal systems or reports used by the utilization review agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.557. REQUIREMENT TO MAINTAIN DATA IN CONFIDENTIAL MANNER. A utilization review agent shall maintain all data concerning a patient or physician or other health care provider in a confidential manner that prevents unauthorized disclosure to a third party.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.558. DESTRUCTION OF CERTAIN CONFIDENTIAL DOCUMENTS. When a utilization review agent determines a document in the custody of the agent that contains confidential patient information or confidential physician or other health care provider financial data is no longer needed, the document shall be destroyed by a method that ensures the complete destruction of the information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER M. ENFORCEMENT

Sec. 4201.601. NOTICE OF SUSPECTED VIOLATION; COMPELLING PRODUCTION OF INFORMATION. If the commissioner believes that a

person or entity conducting utilization review is in violation of this chapter or applicable rules, the commissioner:

(1) shall notify the utilization review agent, health maintenance organization, or insurer of the alleged violation; and

(2) may compel the production of documents or other information as necessary to determine whether a violation has occurred.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.602. ENFORCEMENT PROCEEDING. (a) The commissioner may initiate a proceeding under this subchapter.

(b) A proceeding under this chapter is a contested case for purposes of Chapter 2001, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.603. REMEDIES AND PENALTIES FOR VIOLATION. If the commissioner determines that a utilization review agent, health maintenance organization, insurer, or other person or entity conducting utilization review has violated or is violating this chapter, the commissioner may:

(1) impose a sanction under Chapter 82;

(2) issue a cease and desist order under Chapter 83; or

(3) assess an administrative penalty under Chapter 84.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Text of section effective until April 01, 2025

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.140, eff. April 1, 2025.

Text of section effective on April 01, 2025

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 540 or 540A, Government Code, as applicable;

(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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.140, eff. April 1, 2025.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5,

eff. September 1, 2021.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

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.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.