

**SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE
PROVIDED UNDER A HEALTH BENEFIT PLAN OR
HEALTH INSURANCE POLICY**
28 TAC §§19.1701 – 19.1719

**SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED
UNDER WORKERS' COMPENSATION INSURANCE COVERAGE**
28 TAC §§19.2001 – 19.2017

1. INTRODUCTION. The Texas Department of Insurance proposes new Title 28 Texas Administrative Code, Subchapter R, §§19.1701 – 19.1719, concerning utilization reviews for health care provided under a health benefit plan or health insurance policy, and new Subchapter U, 28 TAC §§19.2001 – 19.2017, concerning utilization reviews for health care provided under workers' compensation insurance coverage. These new sections are necessary to: (i) implement House Bill 4290, 81st Legislature, Regular Session, effective September 1, 2009, which revises the definitions of "adverse determination" and "utilization review" in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service; and (ii) make other changes necessary, as determined by TDI with the advice of the Utilization Review Advisory Committee, for clarity and effective implementation and enforcement of Insurance Code Chapter 4201.

The commissioner of insurance and the commissioner of workers' compensation, in their joint statement to the members of the URA advisory committee dated February 10, 2010, stressed that although Subchapters R and U address a function that is provided in both the health and workers' compensation systems, the rules derive from a common statute, Insurance Code Chapter 4201. Insurance Code §4201.054(a) states,

“Except as provided by this section, [Chapter 4201] 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.” Under Insurance Code §4201.054(c), Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. Under Insurance Code §1305.351, Insurance Code Chapter 1305 prevails in the event of a conflict between Insurance Code Chapters 4201 and 1305. Insurance Code Chapter 4201, to the extent it is not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers’ compensation utilization review.

The expertise of both TDI and TDI-DWC staff was utilized throughout the rulemaking process, and workers’ compensation stakeholder feedback was considered and incorporated throughout the open meetings of the URA advisory committee and the informal draft process. TDI and TDI-DWC have determined that Subchapter R and Subchapter U rules should be consistent whenever possible for the benefit of both regulated entities and consumers. Because there are statutes that specifically govern utilization review for workers’ compensation coverage, there are differences between Subchapter R and Subchapter U rules as needed to implement and maintain consistency with the relevant statutes. However, because there are utilization review agents that might be subject to both subchapters, TDI and TDI-DWC recognize the importance of consistency for ease of interpretation and compliance. Uniform standards

offer a more consistent and efficient utilization review process for enrollees and injured employees, who are equally entitled to the highest quality of utilization review.

In conjunction with this proposal, TDI is proposing the repeal of existing Subchapter R, §19.1701, concerning general provisions; §19.1702, concerning limitations on applicability; §19.1703, concerning definitions; §19.1704, concerning certification of utilization review agents; §19.1705, concerning general standards of utilization review; §19.1706, concerning personnel; §19.1707, concerning prohibitions of certain activities of utilization review agents; §19.1708, concerning utilization review agent contact with and receipt of information from health care providers; §19.1709, concerning on-site review by the utilization review agent; §19.1710, concerning notice of determinations made by utilization review agents; §19.1711, concerning requirements prior to adverse determination; §19.1712, concerning appeal of adverse determination of utilization review agents; §19.1713, concerning utilization review agent's telephone access; §19.1714, concerning confidentiality; §19.1715, concerning retrospective review of medical necessity; §19.1716, concerning complaints and information; §19.1717, concerning administrative violations; §19.1718, concerning criminal penalties; §19.1719, concerning responsibility of HMOs and insurers performing utilization review under the Insurance Code, Article 21.58A, §14(g) and (h); §19.1720, concerning specialty utilization review agent; §19.1721, concerning independent review of adverse determinations; §19.1722, concerning utilization review advisory committee; §19.1723, concerning preauthorization; and §19.1724, concerning verification.

In addition, TDI is proposing the repeal of existing Subchapter U, §19.2001, concerning general provisions; §19.2002, concerning limitations on applicability; §19.2003, concerning definitions; §19.2004, concerning certification of utilization review agents; §19.2005, concerning general standards of utilization review; §19.2006, concerning personnel; §19.2007, concerning prohibitions of certain activities of utilization review agents; §19.2008, concerning utilization review agent contact with and receipt of information from health care providers; §19.2009, concerning on-site review by the utilization review agent; §19.2010, concerning notice of determinations made by utilization review agents, excluding retrospective review; §19.2011, concerning requirements prior to adverse determination; §19.2012, concerning appeal of adverse determination of utilization review agents; §19.2013, concerning utilization review agent's telephone access; §19.2014, concerning confidentiality; §19.2015, concerning retrospective review of medical necessity; §19.2016, concerning complaints and reporting requirements; §19.2017, concerning administrative violations; §19.2018, concerning criminal penalties; §19.2019, concerning responsibility of insurance companies performing utilization review under the Insurance Code, Article 21.58A, §14(h); §19.2020, concerning specialty utilization review agent; and §19.2021, concerning independent review organizations non-involvement.

House Bill 4290

House Bill 4290 amends the definition of "utilization review" to specifically include retrospective review of the medical necessity and appropriateness of health care services. House Bill 4290 further amends the term to include a system for prospective,

concurrent, or retrospective review to determine the experimental or investigational nature of health care services.

The Senate Committee on State Affairs' Bill Analysis for HB 4290 specifies the legislative intent of HB 4290:

...[C]urrent law does not require an independent review of a carrier's conclusion that treatment should be denied because it is experimental or investigational.

In addition, current law does not provide for an independent review of a carrier's conclusion after the fact that a treatment was not medically necessary. Health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review both prospectively and retroactively through a process coordinated by TDI. ... Texas is the only state with limitations on retrospective reviews of denials based on medical necessity and the only state with an independent review law that does not extend to retrospective reviews of at least emergency and urgent care.

TDI has received numerous complaints regarding these issues, but there is little TDI can do to address them. Carriers have varying standards for what is considered experimental and investigational and, in regard to retrospective reviews, TDI's data regarding workers' compensation claim denials show that carriers incorrectly issue retrospective denials more often than prospective denials, with retrospective medical necessity decisions, including experimental and investigational denials, overturned 68% of the time after an independent review is conducted, while prospective medical necessity decisions are overturned approximately 30% of the time. C.S.H.B. 4290 amends current law relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service."

TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Substituted), C.S.H.B. 4290, 81st Leg., R.S. (May 12, 2009).

For a more detailed comparison of the existing requirements to the proposed new requirements, Figure: 28 TAC Chapter 19 – Preamble shows existing requirements that are retained in, or replaced by, proposed new Subchapter R and U rules or retained in Insurance Code.

FIGURE: 28 TAC Chapter 19 – Preamble

Existing Requirements in 28 TAC:	Retained in or replaced with:
§19.1702(b)	28 TAC §19.1704(a)
§19.1702(c)	28 TAC §19.1702(a)(2)
§19.1703(1) – (3)	N/A
§19.1703(4) – (8)	28 TAC §19.1703(1) – (5)
§19.1703(9)	28 TAC §19.1703(7)
§19.1703(10)	28 TAC §19.1703(33)
§19.1703(11) and (12)	N/A
§19.1703(13) – (17)	TIC §4201.002(2) – (6)
§19.1703(18)	N/A
§19.1703(19)	TIC §4201.002(7)
§19.1703(20) – (22)	28 TAC §19.1703(21) – (23)
§19.1703(23)	TIC §4201.002(8)
§19.1703(24)	N/A
§19.1703(25) and (26)	TIC §4201.002(9) – (10)
§19.1703(27)	28 TAC §19.1703(24)
§19.1703(28)	TIC §4201.002(11)
§19.1703(29) – (31)	28 TAC §19.1703(25) – (27)
§19.1703(32)	28 TAC §19.1703(30)
§19.1703(33) and (34)	28 TAC §19.1703(31) – (32)
§19.1703(35)	N/A
§19.1703(36) – (38)	TIC §4201.002(13) – (15)
§19.1703(39)	28 TAC §19.1703(35)
§19.1703(40)	TIC §4201.002(16)
§19.1704(a) and (b)	28 TAC §19.1704(d)
§19.1704(c)	28 TAC §19.1704(b)
§19.1704(d)	28 TAC §19.1704(b)(1); TIC §4201.107
§19.1704(e)	28 TAC §19.1704(e) and (f)
§19.1704(f)	28 TAC §19.1704(h)
§19.1704(g)	28 TAC §19.1704(i)
§19.1704(h)(1)	28 TAC §19.1706(a)
§19.1704(h)(2)	28 TAC §19.1704(b)
§19.1704(h)(3)	28 TAC §19.1713
§19.1704(h)(4)	28 TAC §19.1712(a)
§19.1704(i)	28 TAC §19.1704(i)
§19.1705 introductory paragraph	28 TAC §19.1705(a)
§19.1705(1) – (3)	28 TAC §19.1705(b) – (f)
§19.1705(4)	28 TAC §19.1705(e)
§19.1706(a)	28 TAC §19.1706(a)
§19.1706(b)	N/A
§19.1706(c)	28 TAC §19.1706(c) and (d)

Existing Requirements in 28 TAC:	Retained in or replaced with:
§19.1706(d)	TIC §4201.152
§19.1706(e)	28 TAC §19.1716(d)
§19.1707(a) and (b)	N/A
§19.1708(a)	N/A
§19.1708(b) and (c)	28 TAC §19.1707(a) – (b)
§19.1708(d)	N/A
§19.1708(e)	28 TAC §19.1707(c)
§19.1709(a)	TIC §4201.202
§19.1709(b)	28 TAC §19.1708(a) and (b)
§19.1710(a)	28 TAC §19.1709(a)
§19.1710(b)	28 TAC §19.1709(d)(1)
§19.1710(c)(1) – (5)	28 TAC §19.1709(b)(1) – (3), (5), (8)
§19.1710(d)(1) – (3)	28 TAC §19.1709(d)(3) and (e)(1)
§19.1710(e)	28 TAC §19.1717
§19.1711	28 TAC §19.1710
§19.1712(a)	TIC §4201.352
§19.1712(b)(1)	28 TAC §19.1711(a)(2); TIC §4201.354
§19.1712(b)(2)	28 TAC §19.1711(a)(3)(A)
§19.1712(b)(3) – (5)	28 TAC §19.1711(a)(6) – (8)
§19.1712(c)	28 TAC §19.1711(a)(10)
§19.1713(a)	28 TAC §19.1712(a)
§19.1713(b)	TIC §4201.004(a)(2)
§19.1713(c)	TIC §4201.004(b)
§19.1714(a)	TIC §4201.551
§19.1714(b)	TIC §4201.552
§19.1714(c)	TIC §4201.553
§19.1714(d)	TIC §4201.555
§19.1714(e)	28 TAC §19.1713(a)(4)
§19.1714(f)	TIC §4201.556
§19.1714(g)	TIC §4201.558
§19.1714(h)	TIC §4201.551; TIC §4201.557
§19.1714(i)	28 TAC §19.1713(a)
§19.1714(j)	28 TAC §19.1713(a)(1)
§19.1714(k)	28 TAC §19.1713(b)
§19.1714(l) and (m)	28 TAC §19.1713(a)(2) and (3)
§19.1714(n)	N/A
§19.1715(b)	28 TAC §19.1711(b); TIC §4201.354

Existing Requirements in 28 TAC:	Retained in or replaced with:
§19.1715(c)	28 TAC §19.1709(e)(2)
§19.1716(a)	28 TAC §19.1705(f)
§19.1716(b)	28 TAC §19.1714(a)
§19.1716(b)(1) – (3)	28 TAC §19.1714(b)(1) – (3)
§19.1716(b)(4)	N/A
§19.1716(b)(5) and (6)	28 TAC §19.1714(b)(4) – (5)
§19.1716(b)(6)(A) – (C)	28 TAC §19.1714(c)(1) – (3)
§19.1716(c)(1) – (5)	28 TAC §19.1714(d)
§19.1716(d)	N/A
§19.1716(e)	28 TAC §19.1714(e)
§19.1716(f)	N/A
§19.1716(g)	28 TAC §19.1714(f)
§19.1717(a) – (c)	N/A
§19.1717(d) – (f)	28 TAC §19.1715
§19.1718	N/A
§19.1719(a)(1)	N/A
§19.1719(a)(2)	TIC §4201.057
§19.1719(a)(3)	28 TAC §19.1704(a)(2)
§19.1719(a)(4)	TIC §4201.053 and §4201.057
§19.1719(a)(5)	TIC Chapter 258
§19.1719(b)	TIC §4201.058
§19.1720(a)	TIC §4201.452
§19.1720(b)	28 TAC §19.1716(c)
§19.1720(c)	28 TAC §19.1716(d)
§19.1720(d) and (e)	28 TAC §19.1704
§19.1720(f)	28 TAC §19.1716(e)
§19.1720(g)	28 TAC §19.1716(b)
§19.1720(h) – (i)	28 TAC §19.1716(f) – (g)
§19.1721(a), (b), and (c)	28 TAC §19.1717(a) and (b)
§19.1721(d) – (f)	28 TAC §19.1717(c)
§19.1721(g)	28 TAC §19.1717(c)(1)
§19.1721(h)	TIC §4201.402
§19.1721(i)	28 TAC §19.1717(c)(2), TIC §4201.401
§19.1721(j)	28 TAC §19.1717(c)(3), TIC §4201.403
§19.1722	N/A
§19.2002 introductory paragraph	28 TAC §19.2002(a)
§19.2002(2) and (3)	N/A

Existing Requirements in 28 TAC:	Retained in or replaced with:
§19.2003(1) – (3)	N/A
§19.2003(4) – (9)	28 TAC §19.2003(1) – (6)
§19.2003(10)	28 TAC §19.2003(34)
§19.2003(11)	N/A
§19.2003(12)	28 TAC §19.2003(9)
§19.2003(13) and (14)	28 TAC §19.2003(14) and (15)
§19.2003(15)	TIC §4201.002(5)
§19.2003(16) and (17)	N/A
§19.2003(18) and (19)	28 TAC §19.2003(16)
§19.2003(20)	TIC §4201.002(7)
§19.2003(21)	28 TAC §19.2003(22)
§19.2003(22)	28 TAC §19.2003(21)
§19.2003(23)	TIC §4201.002(8)
§19.2003(24)	N/A
§19.2003(25)	28 TAC §19.2003(27)
§19.2003(26)	TIC §4201.002(11)
§19.2003(27)	28 TAC §19.2003(28)
§19.2003(28) and (29)	28 TAC §19.2003(32) and (33)
§19.2003(30) and (31)	28 TAC §19.2003(36) and (37)
§19.2003(32)	28 TAC §19.2003(35)
§19.2003(33) – (36)	TIC §4201.002(13) – (16)
§19.2003(37)	28 TAC §19.2003(41)
§19.2003(38)	28 TAC §19.2003(7)
§19.2004(a) and (b)	28 TAC §19.2004(d)
§19.2004(c)	28 TAC §19.2004(b)
§19.2004(d)	28 TAC §19.2004(b)(1), TIC §4201.107
§19.2004(e)	28 TAC §19.2004(e) and (f)
§19.2004(f)(1)	28 TAC §19.2006(a)
§19.2004(f)(2)	28 TAC §19.2004(b)
§19.2004(f)(3)	28 TAC §19.2013
§19.2004(f)(4)	28 TAC §19.2012(a)
§19.2004(g)	28 TAC §19.2004(h)
§19.2004(h)	28 TAC §19.2004(i)
§19.2004(i)	28 TAC §19.2004(j)
§19.2005 introductory paragraph	28 TAC §19.2005(a)
§19.2005(1) – (4)	28 TAC §19.2005(b) – (f)
§19.2006(a)	28 TAC §19.2006(a)

Existing Requirements in 28 TAC:	Retained in or replaced with:
§19.2006(b)	N/A
§19.2006(c)	28 TAC §19.2006(c) and (d)
§19.2006(d)	28 TAC §19.2006(e)
§19.2006(e)	N/A
§19.2007	N/A
§19.2008(a)	N/A
§19.2008(b) and (c)	28 TAC §19.2007(a) and (b)
§19.2008(d)	N/A
§19.2008(e) and (f)	28 TAC §19.2007(c) and (d)
§19.2009(a)	TIC §4201.202
§19.2009(b)	28 TAC §19.2008(a) and (b)
§19.2010(a) and (b)	28 TAC §19.2009(a)
§19.2010(c)	28 TAC §19.2009(b)
§19.2011	28 TAC §19.2010
§19.2012	28 TAC §19.2011
§19.2013(a)	28 TAC §19.2012(a)
§19.2013(b)	TIC §4201.004(a)(2)
§19.2014(a)	TIC §4201.551
§19.2014(b)	TIC §4201.552
§19.2014(c)	TIC §4201.553
§19.2014(d)	TIC §4201.555
§19.2014(e)	28 TAC §19.2013(a)(4)
§19.2014(f)	TIC §4201.556
§19.2014(g)	TIC §4201.558
§19.2014(h)	TIC §4201.551; TIC §4201.557
§19.2014(i)	28 TAC §19.2013(a)
§19.2014(j)	28 TAC §19.2013(a)(1)
§19.2014(k)	28 TAC §19.2013(b)
§19.2014(l) and (m)	28 TAC §19.2013(a)(2) and (3)
§19.2014(n)	N/A
§19.2015(a)	28 TAC §19.2005(c)
§19.2015(b)	28 TAC §19.2009(b)
§19.2016(a)	28 TAC §19.2005(f)
§19.2016(b)	28 TAC §19.2014(a)
§19.2016(c)	28 TAC §19.2014(b)
§19.2016(d)	28 TAC §19.2014(d)
§19.2016(e)	N/A

Existing Requirements in 28 TAC:	Retained in or replaced with:
§19.2016(f)	28 TAC §19.2014(e) and (f)
§19.2016(g)	N/A
§19.2016(h)	28 TAC §19.2014(g)
§19.2017(a) – (c)	N/A
§19.2017(d) – (f)	28 TAC §19.2014(a) - (c)
§19.2018	N/A
§19.2019(a)(1)	N/A
§19.2019(b) and (c)	28 TAC §19.2004(a)
§19.2020(a)	TIC §4201.452
§19.2020(b)	28 TAC §19.2016(c)
§19.2020(c)	28 TAC §19.2016(d)
§19.2020(d) and (e)	28 TAC §19.2004
§19.2020(f)	28 TAC §19.2016(e)
§19.2020(g)	28 TAC §19.2016(b)
§19.2020(h)	28 TAC §19.2016(g)
§19.2020(i)	28 TAC §19.2016(h)
§19.2021	28 TAC §19.2017

The following paragraphs include a description of all of the proposed new requirements necessary to implement HB 4290 and to make the other changes that TDI, with the advice of the URA advisory committee, determined are necessary for effective compliance with and effective implementation of Insurance Code Chapter 4201.

Subchapters R and U new sections.

Section 19.1701 and §19.2001 address **General Provisions**. Section 19.1701(a) and §19.2001(a) change the existing provisions relating to the statutory basis for the rules in Subchapter R and Subchapter U, respectively, to reflect that the new subchapters incorporate the most recent amendments to Insurance Code Chapter

4201. Additionally, §19.2001(a) incorporates the most recent amendments to Insurance Code Chapter 1305 and to Labor Code Title 5. Section 19.1701(b) and §19.2001(b) amend the existing severability clause language to conform to current agency style. Section 19.1701(c) and §19.2001(c) track Insurance Code §4201.001, with the addition of the word “medical” as a clarifying change in §19.1701(c)(4) and §19.2001(c)(4).

Section 19.1702 and §19.2002 address **Applicability**. Section 19.1702(a) provides that 28 TAC Chapter 19, Subchapter R applies to utilization review performed under a health benefit plan or a health insurance policy and does not apply to utilization review performed under workers' compensation insurance coverage. Section 19.2002(a) specifies that Subchapter U applies to utilization review performed under workers' compensation insurance coverage, as set forth in Insurance Code Chapters 1305 and 4201 and Labor Code Title 5, and does not affect the authority of TDI-DWC to exercise the powers granted to it under Labor Code Title 5 and Insurance Code Chapter 4201. These subsections are necessary to state the applicability of Subchapters R and U.

Section 19.1702(a)(1) and §19.2002(a)(1), relating to the non-applicability of Subchapters R and U, respectively, track Insurance Code §4201.051. Section 19.1702(a)(2) and §19.2002(a)(1) clarify that a person performing administrative tasks for a URA, that does not determine medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, is not subject to the requirements under Subchapter R or U, respectively. Insurance Code §4201.101 provides that a URA may not conduct utilization review unless the commissioner issues

a certificate of registration to the agent under Subchapter C, Chapter 4201. Utilization review is defined in Insurance Code §4201.002(13), which provides that 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.

Section 19.1702(b) explains that provisions of Insurance Code Chapter 843, concerning Health Maintenance Organizations; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; and Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to new Subchapter R. Insurance Code §4201.053 provides that Chapter 4201 does not apply to the state Medicaid program. However, Subchapter R does apply to the Texas Children's Health Insurance Program.

Section 19.2002(b)(1) provides that health care providers performing peer reviews or required medical examinations under Labor Code §408.004 regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. The subsection requires health care providers to comply with Subchapter U; Labor Code Title 5; and rules adopted under the Texas Workers' Compensation Act,

including monitoring and enforcement provisions. This new provision clarifies that some peer reviews and required medical examinations are utilization review.

Section 19.2002(b)(2) provides that insurance carriers must process medical bills as required by Labor Code Title 5 and rules adopted under the Texas Workers' Compensation Act including Chapter 133, Subchapter A of this title (relating to General Rules for Medical Billing and Processing). This provision clarifies that these proposed rules do not exempt insurance carriers from the TDI-DWC's medical billing rules or otherwise modify insurance carrier's duties under those rules.

To implement Insurance Code §4201.054(c), §19.2002(b)(3) provides that if there is a conflict between Subchapter U and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail. These required amendments are consistent with Insurance Code §4201.054(a), which provides that except as provided by §4201.054, Chapter 4201 applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5. Additionally, Insurance Code §4201.054(c) provides that Labor Code Title 5 prevails in the event of a conflict between Chapter 4201 and Labor Code Title 5.

Section 19.2002(b)(4) provides that if there is a conflict between the URA rules and the certified health care network rules adopted by TDI, the rules adopted for networks in 28 TAC Chapter 10 prevail. The rules for workers' compensation health care networks in 28 TAC Chapter 10 implement Insurance Code Chapter 1305.

Insurance Code §1305.351(a) provides that in the event of a conflict between Chapter 4201 and Chapter 1305, Chapter 1305 prevails.

Section 19.1703 and §19.2003 address **Definitions**. Section 19.1703(a) and §19.2003(a) provide that the terms defined in Insurance Code Chapter 4201 have the same meaning as used in proposed new Subchapter R and Subchapter U rules, respectively.

The definition of “adverse determination” in §19.1703(b)(1) and §19.2003(b)(1) add the phrase “made on behalf of any payor” to the definition of “adverse determination” in existing Insurance Code §4201.002(1) to clarify TDI’s position that the definition includes determinations made on behalf of all payors, including payors that conduct utilization review in-house.

Further, the definitions of “adverse determination” in Subchapters R and U specifically implement HB 4290. Insurance Code §4201.002(1) defined “adverse determination,” prior to the enactment of HB 4290, to mean a URA’s determination that health care services provided or proposed to be provided to a patient are not medically necessary or appropriate, but the provision was not interpreted to include retrospective review of medical necessity. This interpretation was based on the definition of “utilization review” in Insurance Code §4201.002(13) as a system for “prospective or concurrent” review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual in this state. After the enactment of HB 4290, the definitions of “adverse determination” and “utilization review”

were revised in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service.

Additionally, §19.1703(b)(1) and §19.2003(b)(1) add the provision that the term “adverse determination” does not include a denial of health care services due to the lack of prospective or concurrent utilization review. This change is necessary to clarify that a denial of health care services for which the enrollee or injured employee, respectively, should have sought prospective or concurrent utilization review is not within the scope of the term.

The definition in §19.2003(b)(1) also clarifies that, for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. Although this clarification is inconsistent with the statutory definition of “adverse determination” under Insurance Code §4201.002(1), it is consistent with Labor Code §408.021 and §413.014. Insurance Code §4201.054 provides that, in the event of a conflict, Labor Code Title 5 prevails. It is TDI’s and TDI-DWC’s position that based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services.

Labor Code §408.021 entitles an injured employee, under both network coverage and non-network coverage, to all medically necessary health care services. Although injured employees under non-network coverage are entitled to experimental and investigational services, those services must be preauthorized under Labor Code

§413.014, relating to preauthorization requirements, concurrent review, and certification of health care.

Despite this difference in the definition of the term “adverse determination” under Insurance Code Chapter 4201 and Labor Code Chapter 408, it is necessary that Subchapter U contain provisions relating to the experimental or investigational nature of care in the context of utilization review. Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of “utilization review.”

The definition of “appeal” in §19.1703(b)(2) and §19.2003(b)(2) updates the existing definition and clarifies that the term refers to the URA’s formal process in which an enrollee, or an injured employee, respectively, their representative, or provider of record may request reconsideration of an adverse determination. Section 19.2003(b)(2) also provides that the term includes reconsideration processes prescribed by Labor Code Title 5 and applicable rules for workers’ compensation.

The definition of the term “certificate” in §19.1703(b)(3) and §19.2003(b)(3) is more detailed and accurate than the existing definition to reflect that an insurance carrier or HMO may be certified or registered, but that a “certificate” is not issued to an insurance carrier or HMO that is registered as a URA under §19.1704 or §19.2004, respectively.

The §19.1703(b)(4) and §19.2003(b)(4) definition of “commissioner” is defined in Insurance Code §31.001, which provides that “In this code and other insurance laws: (1) “Commissioner” means the commissioner of insurance.”

In §19.2003(b)(5), the term “compensable injury” is as defined in Labor Code §401.011, which provides that “Compensable injury means an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle.”

Section 19.1703(b)(5) and §19.2003(b)(6) define “complaint” as an oral or written expression of dissatisfaction with a URA concerning the URA’s process in conducting a utilization review. The term “complaint” does not include: (A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351, or (B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party. This definition is necessary to track statutory language in Insurance Code §4201.351 and clarify that a misunderstanding promptly resolved, to the complaining parties’ satisfaction, does not constitute disagreement with an adverse determination or an appeal.

Section 19.1703(b)(6) and §19.2003(b)(7) define “concurrent utilization review” as a form of utilization review that is subject to these rules.

Section 19.1703(b)(7) defines “declination” and tracks existing §19.1703(9) with changes to replace the word “carrier” with “benefit plan” for clarity. The definition is necessary to clarify the term as used in §19.1719.

Section 19.1703(b)(8) and §19.2003(b)(8) define the term “disqualifying association” to ensure a consistent application in identifying situations in which conflicts of interest may exist for health care providers performing utilization review. The definition of “disqualifying association” includes any association that may reasonably be perceived as having the potential to influence the conduct or decision of a reviewing physician or doctor. This reasonableness standard can be used to evaluate whether a personal or family relationship may be considered a disqualifying association and is more flexible than a detailed list of specific family relationships that are always considered to be disqualifying associations. The prohibition against disqualifying associations is necessary to prevent a reviewing physician or doctor from directly or indirectly exercising bias, prejudice, or preferential treatment of determinations made by health care providers performing utilization review.

Section 19.1703(b)(9) and §19.2003(b)(9) define the term “doctor.” This definition mirrors the definition of doctor in existing 28 TAC §19.2003(12) and tracks the statutory language in Labor Code §401.011(17).

Section 19.1703(b)(10) and §19.2003(b)(10) define the term “experimental or investigational.” This definition is consistent with Labor Code §413.014(a), 28 TAC §134.600, and 28 TAC §12.5(12). This proposed definition is necessary to ensure a uniform application of the term. To the extent a health plan defines the term “experimental or investigational” differently than the rules, the definition set forth in the rules will control. TDI and TDI-DWC determined that a common definition ensures that enrollees or injured employees, regardless of the plan under which they receive

coverage, are treated similarly with respect to determinations on the experimental or investigational nature of care. TDI defined this new term based on its general rulemaking authority under Insurance Code §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.1703(b)(11) and §19.2003(b)(11) define the term “Form No. LHL005 URA application” to clarify that the form is to be used to apply for certification or registration as a URA in Texas, for renewal of a certification or registration, and also to report a material change to a certification or registration form previously submitted to TDI. Insurance Code §4201.104 authorizes the commissioner to promulgate forms to be filed under Insurance Code Chapter 4201, Subchapter C, for initial certification. Additionally, this definition clarifies the use of the form and implements Insurance Code §4201.107, which provides that a URA shall report any material change to the information disclosed in a form filed under Subchapter C of Chapter 4201 not later than the 30th day after the date the change takes effect.

Section 19.1703(b)(12) and §19.2003(b)(12) define the term “Form No. LHL009 request for a review by an IRO” as a request for a review by an independent review organization. This form is completed by the requesting party and submitted to the URA. This definition is consistent with Insurance Code §4201.303(a)(4), which requires a URA to include a notice to the enrollee of their right to appeal an adverse determination to an IRO and of the procedures to obtain that review. The definition is also consistent with Insurance Code 4201.359(a)(3), which requires the appealing party’s right to notice of the procedures for obtaining review of a denial by an IRO.

Section 19.1703(b)(13) and §19.2003(b)(13) define the term “Form No. 11 biographical affidavit” as the attachment to the application form. The application form requires the name, biographical affidavit, and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under 28 TAC §1.503 (relating to Application of Fingerprint Requirement) and 28 TAC §1.504 (relating to Fingerprint Requirement). The biographical form is necessary because, under 28 TAC §1.502(c) and (e), TDI developed guidelines relating to the matters that TDI will consider in determining whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction. These matters include criminal background checks for each director, officer, and executive of the applicant.

Section 19.2003(b)(14) defines the term “health care” and changes the existing definition in §19.2003(13) to include “a medical or surgical supply, appliance, brace, artificial member, or prosthetic or orthotic device, including the fitting of, change or repair to, or training in the use of the appliance, brace, member, or device,” for consistency with the definition in Labor Code §401.011.

Section 19.1703(b)(14) and §19.2003(b)(15) define the term “health care facility.” This definition is consistent with Labor Code §401.011(20).

Section 19.1703(b)(15) defines the term “health coverage” to provide a uniform understanding and application of what constitutes “health coverage” under the Subchapter R rules.

Section 19.1703(b)(16) defines the term “health maintenance organization or HMO” and references the statutory definition in Insurance Code §843.002.

Section 19.1703(b)(17) and §19.2003(b)(16) define the term “insurance carrier or insurer.” The definitions are not identical, because the §19.2003(16) definition references workers’ compensation insurance, which is not applicable under §19.1703(16).

Section 19.1703(b)(18) and §19.2003(b)(17) define the term “independent review organization or IRO” and references the definition in 28 TAC §12.5.

Section 19.1703(b)(19) and §19.2003(b)(18) define the term “legal holiday” in accord with the definition of a “national holiday” in Government Code §662.003(a).

Section 19.2003(b)(19) defines the term “medical benefit” and references the statutory definition in Labor Code §401.011.

Section 19.2003(b)(20) defines the term “medical emergency” and tracks the definition in Insurance Code §1305.004(13), with a clarifying change from the use of the term “patient” to the term “injured employee.” The definition in §19.2003(20) also mirrors the definition of the term “medical emergency” in 28 TAC Chapter 133 (relating to General Medical Provisions), §133.2(a)(4)(A), adopted to be effective July 1, 2012.

The §19.1703(b)(20) and §19.2003(b)(21) definition of “medical records” is based on the definition of “medical records” in Insurance Code §1305.004(14), which defines the term for purposes of the Workers’ Compensation Health Care Network Act. In §19.1703(19), the term “enrollee” is used instead of “injured employee.” The definition of the term “medical records” from Insurance Code §1305.004(14) was also changed in new §19.1703(19) and §19.2003(21) to include the phrase “mental health records as allowed by law.” The addition of the phrase “mental health records as allowed by law”

was recommended by the URA advisory committee and is necessary to ensure the availability of mental health records as allowed. This amendment is proposed under the commissioner's authority to adopt rules to implement Chapter 4201 under Insurance Code §4201.003(a).

Section 19.1703(b)(21) and §19.2003(b)(22) define the term "mental health medical record summary." The URA advisory committee recommended adding this definition to the Subchapter U rules for uniform application and consistency with the Subchapter R rules.

Section 19.1703(b)(22) and §19.2003(b)(23) define the term "mental health therapist." This definition incorporates the URA advisory committee recommendation to add the qualifier "as appropriate" to indicate that not all of the individuals licensed under subparagraphs (A) – (H) are authorized to diagnose, evaluate, and treat any mental or emotional condition or disorder.

Section 19.1703(b)(23) and §19.2003(b)(24) define the term "mental or emotional condition or disorder." The definition of the term "mental or emotional condition or disorder" in existing §19.1703(22) was amended for new Subchapter R and Subchapter U to delete the phrase "revision of the" to clarify that the most current Diagnostic and Statistical Manual of Mental Disorders must be used, rather than just the new "revision" because both new "editions" and new "revisions" of the manual are published.

Section 19.2003(b)(25) defines the term "payor." For purposes of Subchapter R, the statutory definition under Insurance Code §4201.002(10) is used. For purposes of Subchapter U, in proposed new §19.2003(25), TDI and TDI-DWC tailored the definition

of “payor” to include a person or entity that provides, offers to provide, or administers workers’ compensation benefits, in recognition that the definition of “payor” under Subchapters R and U should not be identical. The clarifying change under Insurance Code §4201.002(10) is not in conflict with Insurance Code Chapter 1305 or Labor Code Title 5. The references to “payor” are also necessary because the rules specifically distinguish between insurance carriers for which it is or is not the payor. The term “payor” is also necessary for consistency with the IRO rules under 28 TAC §12.1 et. seq., which contemplate an IRO’s interaction with URAs and payors.

Proposed new §19.2003(b)(26) defines the term “peer review.” This definition was recommended by the URA advisory committee. TDI and TDI-DWC clarify that the proposed requirements contained in Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care. For example, the proposed requirements in Subchapter U do not apply to compensability or an injured employee's ability to return to work. Section 19.2002(b)(1) specifies, in part, that:

Health care providers performing peer reviews or required medical examinations under Labor Code §408.004 regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. Peer reviewers must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers’ Compensation Act including, but not limited to, Chapter 180 of this title, relating to Monitoring and Enforcement.

This provision describes requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care and does not apply to peer reviews performed for other issues, for example, extent of injury issues.

Section 19.1703(b)(24) and §19.2003(b)(27) define the term “person” for uniform application of Subchapter R and Subchapter U rules.

Section 19.1703(b)(25) and §19.2003(b)(28) define the term “preauthorization.” The definition in existing §19.1703(29) is changed in proposed new §19.1703(b)(25) and §19.2003(b)(28) to add the descriptor “form of prospective utilization review by a payor or its URA of. . .” to incorporate by reference reviews of medical necessity and appropriateness, which are included in the definition of “utilization review” in Insurance Code §4201.002(14). A separate reference to reviews of medical necessity and appropriateness in the definition of “preauthorization” is unnecessary.

Section 19.1703(b)(26) defines the term “preferred provider” and changes the existing definition in §19.1703(30) to use the term “carrier” instead of “benefit plan” for clarity and uniform implementation.

Section 19.1703(b)(27) and §19.2003(b)(29) define the term “provider of record” to closely track Insurance Code §4201.002(12). Changes are made to clarify that a doctor is included among the persons that do not necessarily have to render care, treatment, or services to be considered the provider of record. Section 19.1703(26) and §19.2003(29) also replace the terminology “care, treatment, and services” from Insurance Code §4201.002(12) with “health care services” for consistency with other uses of this phrase throughout the text. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers’ compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter

4201. There is no direct conflict with the use of “provider of record” and Labor Code Title 5, and TDI has the rulemaking authority to define and utilize the term “provider of record” throughout the Subchapter U rules.

Section 19.1703(b)(28) and §19.2003(b)(30) define the term “reasonable opportunity” as “at least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination: (A) no less than one working day prior to issuing a prospective utilization review adverse determination; (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or (C) prior to issuing a concurrent or post-stabilization review adverse determination.”

The definition of the term “reasonable opportunity” in new §19.1703(28) and §19.2003(30) recognizes the incompatibility of timeframes for concurrent utilization review and post-stabilization review. Under Insurance Code §843.348 and §1301.135, an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical or health care services for concurrent hospitalization care within 24 hours of receipt of the request. Additionally, an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical care or health care services involving post-stabilization treatment within one hour from receipt of the request.

The required timeframes for notification of the adverse determination for workers' compensation non-network coverage must be provided within the timeframes specified by 28 TAC §134.600. Section 134.600(i) requires a decision for preauthorization requests within three working days and a decision for certain requests for concurrent review within one working day of receipt of the request.

The required timeframes for notification of the adverse determination for workers' compensation network coverage must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102. Under Insurance Code §1305.353(d), the URA must generally issue a determination on a preauthorization request not later than the third working day after the receipt of the request. However, under Insurance Code §1305.353(e), if the proposed services are for concurrent hospitalization care, the URA must transmit a determination within 24 hours of receipt of the request. Under Insurance Code §1305.353(f), if the proposed health care services involve post-stabilization treatment or a life-threatening condition, the URA must transmit a determination within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. Title 28 TAC §10.102 reiterates these statutory requirements.

Based on these timeframes, the URA must issue a determination for requests for prospective review no later than the third working day. This three-working-day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination. However, for concurrent review, TDI recognizes that requiring one working day for the peer-to-peer discussion

may prevent the URA from providing the determination within the required 24-hour timeframe. Additionally, for post-stabilization treatment requests, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required one-hour timeframe.

Under Insurance Code §4201.305, the URA must provide notice of a retrospective review adverse determination within a reasonable time period, but not later than 30 days after the date on which the claim is received. Under Insurance Code §4201.305(b), this period may be extended once for a period not to exceed 15 days, if the URA takes certain additional steps. Because of the longer time period granted to URAs to issue determinations when conducting retrospective utilization review, TDI and TDI-DWC determined that five working days is a reasonable time to afford the provider of record to discuss the determination. These new sections are implementing the required peer-to-peer discussion statutory requirements under Insurance Code §4201.206. These new sections are also proposed under TDI's general rulemaking authority under both Insurance Code §36.001 and §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.1703(b)(29) and §19.2003(b)(31) define the term "registration." Insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but instead must register. The new definition clarifies that the registration process only applies to an insurer that performs utilization review solely for its own insureds or injured employees.

Section 19.1703(b)(30) and §19.2003(b)(32) define the term “retrospective utilization review.” These sections change the definition in existing §19.1703(32) and §19.2003(28) and incorporate the term “utilization review” into the definition. Because reviews of “medical necessity and appropriateness” are included in the scope of “utilization review,” separate internal reference to reviews of “medical necessity and appropriateness” is deleted. The addition of the sentence “Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted” clarifies that health care services that require preauthorization are not subject to retrospective review.

Section 19.1703(b)(31) defines the term “routine vision services” and tracks existing §19.1703(33).

Section 19.1703(b)(32) and §19.2003(b)(33) define the term “screening criteria.” The new definition tracks existing §19.1703(34) and deletes the reference to “(e.g., appropriateness evaluation protocol (AEP) and intensity of service; severity of illness; discharge; and appropriateness screens (ISD-A))” because screening criteria must meet the requirements of Insurance Code §4201.153 and the examples provided in the definition are redundant.

Section 19.1703(b)(33) and §19.2003(b)(34) define the term “TDI” as the Texas Department of Insurance.

Section 19.2003(b)(35) defines the term “TDI-DWC” as the Texas Department of Insurance, Division of Workers’ Compensation.

Section 19.2003(b)(36) defines the term "Texas Workers' Compensation Act" as Labor Code, Title 5, Subtitle A.

Section 19.2003(b)(37) defines the term "treating doctor" to track the definition in Labor Code §401.011.

Section 19.1703(b)(34) and §19.2003(b)(38) define the term "URA."

Section 19.1703(35) defines the term "verification" and replaces the term "carrier" in existing §19.1703(39) with the term "benefit plan" for clarity and consistency.

Section 19.2003(b)(39) defines the term "workers' compensation health care network." This definition is consistent with Insurance Code §1305.004(16).

Section 19.2003(b)(40) defines the term "workers' compensation health plan" to reference the applicability of a political subdivision contracting directly with health care providers or through a health benefits pool under Labor Code §504.053 to Subchapter U.

Section 19.2003(b)(41) defines the term "workers' compensation insurance coverage" to track the definition in Labor Code §401.011.

Section 19.2003(b)(42) defines the term "workers' compensation network coverage" and §19.2003(43) defines the term "workers' compensation non-network coverage."

Section 19.1704 and §19.2004 address **Certification or Registration of URAs**. The change to the title of existing §19.2004 reflects the application of the section to persons holding a "registration" as a URA. Section 19.1704(a) and §19.2004(a), added to implement Insurance Code §4201.101, provide that a person acting as or holding

itself out as a URA must be certified or registered under Insurance Code Chapter 4201; 28 TAC Chapter 19, Subchapter R; or 28 TAC Chapter 19, Subchapter U, respectively. Section 4201.101 provides that a URA may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under Chapter 4201, Subchapter C.

Section 19.1704(a)(1) and (2) and §19.2004(a)(1) and (2) are necessary to address certification and registration requirements for HMOs and insurers. Section 19.1704(a)(1) and §19.2004(a)(1) provide that if an HMO or insurer performs utilization review for an individual or entity subject to the subchapter for which it is not the payor, the HMO or insurer must have a valid certificate as required by Insurance Code §4201.101. This provision is consistent with Insurance Code §4201.057(e) and §4201.058(c).

Section 19.1704(a)(2) and §19.2004(a)(2) provide that if an HMO or insurer performs utilization review only for coverage for which it is the payor, the HMO or insurer must have a valid registration.

Section 19.1704(b) and §19.2004(b) specify the URA application filing requirements for both certification and registration. Section 19.1704(b) and §19.2004(b) adopt by reference Form No. LHL005 URA application, which is to be used for initial certification or registration, renewal of a certification or registration as a URA in this state, or to report a material change. This new form is proposed under the commissioner's authority to both promulgate forms under Insurance Code §4201.104 and to adopt rules to implement Chapter 4201 under §4201.003.

Subsections (b) and (c) distinguish between the form and fee filing requirements for these two types of application. Subsection (b)(1) provides that a Form No. LHL005 URA application must be used to apply for URA certification or registration. Subsection (b)(2) provides that the application form requires the biographical affidavit be submitted as an attachment to the application. Section 19.1704(c) and §19.2004(c) provide that an application for certification must be accompanied by the original application fee in the amount specified by §19.802, and that this fee requirement does not apply to an applicant for registration.

Section 19.1704(d) and §19.2004(d) provide information on where to obtain and file the application form.

Section 19.1704(e) and §19.2004(e) address the original application requirements and process, and are proposed under TDI's general rulemaking authority in Insurance Code §4201.003(a). Section 19.1704(e) and §19.2004(e) also clarify that TDI will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

Section 19.1704(f) and §19.2004(f) change the requirements in existing §19.1704(e)(2) and §19.2004(e)(2) by lessening the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days from the date of TDI's latest notice of the omissions or deficiencies. This reduction in time is necessary to streamline the application process, providing TDI with information more quickly. This increased efficiency will make URAs more quickly available to the Texas consumer. Section 19.1704(f) and §19.2004(f) also provide that

the applicant may request in writing additional time to correct the omissions or deficiencies in the application, and that the request for the additional time must be approved by TDI in writing for the requested extension to be effective.

Section 19.1704(g) and §19.2004(g) provide that each active certification or registration expires two years after the date of issuance.

Section 19.1704(h) and §19.2004(h) clarify that the two-year renewal requirements apply to both certification and registrations, the process of submitting a Form No. LHL005 URA application to TDI, and the fees for renewal of a certification. Insurance Code §4201.103 provides that certification may be renewed biennially by filing with the commissioner, not later than March 1, a renewal form accompanied by a fee in an amount set by the commissioner. Insurance Code §4201.104(a) authorizes the commissioner to promulgate forms to be filed for a renewal certificate of registration.

Section 19.1704(h)(1) and §19.2004(h)(1), relating to continued operation during TDI review, provides that a URA may continue to operate under its certification or registration until the renewal application is denied or issued by TDI if a URA meets two requirements. The URA must have sent to TDI, on or before the expiration of its certification or registration, the information specified in subsection (h); and the URA must have submitted the fee required for certification renewal, if applicable.

Section 19.1704(h)(2) and §19.2004(h)(2) specify the requirements for renewal if the certification or registration has been expired for 90 days or less. Under §19.1704(h)(2) and §19.2004(h)(2), the URA may renew the certification or registration by filing a completed renewal application, the fee as applicable for certification renewal,

and the required information described in subsection (h). Section 19.1704(h)(3) and §19.2004(h)(3) prohibit the URA from operating from the time the certification or registration has expired until the time TDI granted the URA a renewal certification or registration.

Section 19.1704(h)(3) and §19.2004(h)(3) specify the requirements if the certification or registration has been expired for longer than 90 days. The URA may not renew the certification or registration, but must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable for certification in accord with §19.1704 or §19.2004.

Section 19.1704(i) and §19.2004(i), regarding contesting a denial of an application or renewal, track existing §19.1704(g) and §19.2004(h) with nonsubstantive clarifications.

Section 19.1704(j) and §19.2004(j) describe an existing URA's obligation to update its application within 90 calendar days after the effective date of the rule. However, the submission of an updated application does not change the URA's existing renewal date, and subsection (h) of this section still governs the URA's renewal process.

Section 19.1705 and §19.2005 address **General Standards of Utilization Review**. The components listed in existing §19.1705(1) – (3) and §19.2005(1) – (3) to be included in the utilization review plan are not included in the proposed new sections because TDI proposes updated required components in subsections (b) – (f) of

§19.1705 and §19.2005 or the components are otherwise incorporated into other sections, and the retention of the provisions would be repetitive.

Section 19.1705(a) and §19.2005(a) require that the utilization review plan be approved by a physician; periodically updated; and include input from both primary and specialty physicians, doctors, or other health care providers, in accord with Insurance Code §4201.151.

Section 19.1705(b) and §19.2005(b) add a statutorily required general standard of utilization review relating to special circumstances. It requires the utilization review determination to take into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. This requirement is consistent with Insurance Code §4201.153.

Section 19.2005(b) also provides that for purposes of new §19.2005, disability must not be construed to mean an injured employee who is off work or receiving income benefits. This provision is included to further clarify the scope of special circumstances. In establishing general standards for utilization review, the language in §19.2005(b) distinguishes the term "disability" as it is used in general medical environments from how the term is used in the Texas workers' compensation system. The term "disability" as used in this section should not be confused with the Texas Workers' Compensation Act's definition of "disability." Labor Code §401.011(16) defines "disability" as "the

inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage.”

Section 19.1705(c) and §19.2005(c) add screening criteria provisions. The sections describe the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome-focused, and compliant with Insurance Code §4201.153. Insurance Code §4201.153(a) – (c) requires that a URA use written medically acceptable screening criteria and review procedures that are established, periodically evaluated, and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. It further requires that a utilization review determination be made in accord 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. The screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, §19.1705(c) and §19.2005(c) require screening criteria to recognize that the URA must use generally accepted standards of medical practice recognized in the medical community if evidence-based medicine is not available for a particular health care service provided. This provision is necessary because evidence-based medicine is not always available. This provision also harmonizes the Subchapter R screening criteria requirements with Subchapter U screening criteria requirements. Section 19.2005(d) also incorporates requirements of Labor Code §401.011(22-a) and

is necessary because evidence-based medicine is not always available. Insurance Code §4201.054(c) states that Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. TDI determined this conforming change is necessary in the Subchapter R rules to implement the existing requirements for screening criteria in accord with §4201.153 while maintaining screening criteria standards that are consistent with the screening criteria standards under Subchapter U. This requirement is adopted under the commissioner's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.1705(d) and §19.2005(d) require that adverse determinations be referred to and determined by an appropriate physician, doctor, or other health care provider. This requirement implements the expanded scope of adverse determinations under HB 4290. The requirement in §19.1705(d) and §19.2005(d) is consistent with Insurance Code §4201.153(d) and existing §19.1705(a)(3). Existing §19.1705(a)(3) already allowed a health care provider to make adverse determination decisions. New §19.2005(d) also requires that physicians and doctors performing utilization review comply with Labor Code §§408.0043 – 408.0045. References to these Labor Code provisions are necessary to ensure that physicians and doctors meet these professional certification requirements for conducting utilization review.

Section 19.1705(e) and §19.2005(e) permit a URA to delegate utilization review to qualified personnel in a hospital utilization review program or a qualified health care

provider. These sections are consistent with Insurance Code §4201.251, regarding delegation of utilization review.

Section 19.1705(f) and §19.2005(f) require the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with Insurance Code §4201.204. Additionally, the sections add a new requirement that the written response include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI. This information is necessary to inform the consumer of the right to file a complaint and the means by which the consumer may contact TDI.

Section 19.2005(g) requires utilization review plan written policies to evidence compliance with Labor Code §504.055. This proposed new subsection corresponds with the requirements of Labor Code §504.055(c), which states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection (b)." Labor Code §504.055(b) provides, in part, that, "This section applies only to a first responder who sustains a serious bodily injury, as defined by Section 1.07, Penal Code, in the course and scope of employment."

Section 19.1706 and §19.2006 address **Requirements and Prohibitions Relating to Personnel**. Section 19.1706(a) and §19.2006(a) require all health care providers employed or contracted with the URA to perform utilization review to be appropriately trained, qualified, and currently licensed. This requirement is more

stringent than the requirement in existing §19.1704(h)(1) and §19.2004(f)(1), which only requires that the URA have available the qualified medical personnel to provide the services requested. However, this more stringent requirement incorporates the existing requirement under §19.1706 and §19.2006 that personnel employed or contracted with the URA to perform utilization review be appropriately trained, qualified, and, if applicable, currently licensed. The additional criteria will ensure that utilization review is conducted by appropriate individuals and should ensure a higher quality of utilization review.

Section 19.1706(a) and §19.2006(a) also require personnel conducting utilization review to hold an unrestricted license, administrative license, or to be otherwise authorized to provide health care by a licensing agency in the United States, or in Texas, respectively. These new sections were unanimously recommended by the URA advisory committee and are consistent with Insurance Code §4201.252(a), which requires personnel employed or contracted with a URA to perform utilization review to be appropriately trained and qualified.

Section 19.1706(b) and §19.2006(b) prohibit a physician, doctor, or other health care provider who conducts utilization review from having any disqualifying associations with the physician, doctor, or other health care provider who issued the initial adverse determination. Section 19.1706(b) and §19.2006(b) also prohibit a physician, doctor, or other health care provider who conducts utilization review from having any disqualifying associations with the enrollee or health care provider who is requesting the utilization review or an appeal, or the injured employee, respectively. The subsections also clarify

that being employed or contracted with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association; however, another disqualifying association may apply.

Section 19.1706(c) and §19.2006(c) require that the URA provide to TDI information and qualifications of the personnel employed or contracted to perform the utilization review on filing an original or renewal application. This information is important because it allows TDI to monitor the credentials of staff performing utilization review. To avoid unnecessary administrative burdens, TDI clarifies that URAs do not have to provide information on any administrative staff that is not conducting utilization review.

Section 19.2006(c) also requires all personnel performing utilization review of workers' compensation services to be licensed in Texas or be otherwise authorized to provide health care services in Texas, which is consistent with the objectives of Labor Code §408.023(h) and House Bill 1006, 80th Legislature, Regular Session, effective September 1, 2007, and is necessary to ensure that appropriate health care providers, in accord with Insurance Code §4201.153(d), are used to determine medical necessity.

Section 19.1706(d) and §19.2006(d) require URAs to develop and implement written procedures to determine if physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

Section 19.2006(e) requires utilization review conducted by a URA to be under the direction of a physician currently licensed without restriction to practice medicine.

This section implements Insurance Code §1305.351 and Labor Code §408.023(h), which provide that only doctors licensed to practice in this state may perform utilization review.

Section 19.1706(e) requires the URA to provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment related to acquired brain injury treatment, consistent with Insurance Code §1352.004. Section 1352.004 provides that "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider. Under §1352.004, the commissioner must adopt rules to require that a health benefit plan issuer provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

The purpose of the training is to prevent denial of coverage in violation of §1352.003 and to avoid confusion of medical benefits with mental health benefits. The commissioner must prescribe by rule the basic requirements for the training, in consultation with the Texas Traumatic Brain Injury Advisory Council. Although Insurance Code §1352.004 specifies that a health benefit plan issuer must provide this training and is silent concerning a URA, new §19.1706(f) will ensure that URA personnel will receive adequate training, consistent with the plain language of §1352.004 requiring training for personnel responsible for utilization review under the

plan. The requirement that URA personnel receive the training is adopted under the commissioner's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201 and under Insurance Code §1352.004(b).

Section 19.1707 and §19.2007 address **URA Contact With and Receipt of Information from Health Care Providers.**

Section 19.1707(a) and §19.2007(a) clarify existing §19.1708(b) and §19.2008(b) requirements affecting the health care provider's charge for providing medical information by providing a specific citation to 28 TAC §134.120 (relating to Reimbursement for Medical Documentation). This clarification is necessary for purposes of readability and ease of compliance. Also, because there are no existing relevant TDI-DWC rules or guidelines specifying costs that may not be reimbursed separately, new §19.2007(a) also deletes the existing prohibition against inclusion of costs that may not be reimbursed separately in a health care provider's charge for providing medical information. Section 19.2007(a) also provides that a health care provider must submit required documentation to the URA when submitting a medical bill under 28 TAC Chapter 133. Under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

The reimbursement requirement in §19.2007(a) for workers' compensation utilization review mirrors the reimbursement requirement for URAs in §19.1707(a) of these rules, and applies to requests for medical information related to all types of utilization review, including concurrent and retrospective review. This alignment is

necessary to ensure consistent regulation of URAs and to prevent confusion for URAs that are certified for both health and workers' compensation.

In terms of prospective and concurrent utilization review, existing rules in Chapter 10 (for network care) and Chapter 134 (for non-network care) clarify that a health care provider submitting a request for health care services must include information to substantiate the medical necessity of the services requested. In terms of retrospective utilization review, existing rules in Chapter 133, which apply to both network and non-network care, clarify when medical information must be submitted and the types of information that must be submitted along with a medical bill for health care services that have already been rendered. Thus, the health care provider is bearing some of the cost.

An insurance carrier may already have provided written medical information that is later being requested by the URA. In that case, it is the insurance carrier's obligation to supply the URA with whatever medical information it may already have to avoid unnecessary requests for information from the health care provider. However, if the insurance carrier is not able to provide this information to the URA or does not have this information and the URA has determined that the information is necessary to conduct utilization review, then the URA, with whatever financial arrangements the URA has with the insurance carrier, is expected to reimburse the health care provider for the requested written medical information. It is in the requesting provider's interest to provide the relevant information to avoid a denial based on lack of the necessary documentation.

Proposed new §19.1707(b) and §19.2007(b) require the URA conducting utilization review to request “all relevant and updated medical records” to complete the review. This ensures that the URA uses the most recent and complete information possible to review the treatment of the enrollee or injured employee, respectively. Although treatment may vary on a case-by-case basis, TDI determined that this requirement will enable the most effective review. Existing text under §19.1708(c) stated, “These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility.” Thus, existing regulations already required that requested items be relevant to the utilization review.

Section 19.1707(b)(1) and §19.2007(b)(1) permit the URA to request identifying information about the claim and about the treating physician, doctor, or other health care provider. This information clarifies the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records needed to complete the review. Information about the doctor is included as part of the medical record.

Section 19.1707(b)(2) and §19.2007(b)(2) prohibit URAs from routinely requesting copies of all medical records. These sections are designed to allow the URA to seek the information necessary for the review on a case-by-case without routinely requesting an entire medical record. These sections mirror existing requirements in §19.1708(b)(2) and §19.2008(c)(2). The intent of the new sections is to require the URA to evaluate what records are needed. Section 19.1708(b) and §19.2008(b) do not

require an overly broad request that would result in the transmission of unnecessary information. A balance in the amount of information requested will result in more efficient review, both because of the relevance of the provided documents and the reduced cost. Even though the requesting party must submit information to support the request, the URA should request missing information, if known, as a matter of due diligence.

Section 19.1707(c) and §19.2007(c) mirror the requirements in existing §19.1708(e) and §19.2008(e).

Section 19.1707(d) and §19.2007(d) add the modifying phrase “that relate to the mental health therapist's treatment of an injured employee's mental or emotional condition or disorder” to the prohibition in existing §19.1708(f) and §19.2008(f), and further describe the process or progress notes that are contemplated. The sections also provide that the prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes.

Section 19.1707(d)(1) and §19.2007(d)(1) provide that this prohibition does not preclude the URA from requiring submission of an injured employee's mental health medical record summary. Section 19.1707(d)(2) and §19.2007(d)(2) provide that the prohibition does not preclude the URA from requiring submission of medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder. The consistency between the Subchapter R and Subchapter U proposed new rules is necessary because the rules are based on the same underlying statute. Insurance Code §4201.203(a) prohibits a URA from requiring

the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes, as a condition of treatment approval or for any other reason. Section 4201.203(b) clarifies that a URA may nonetheless require submission of a patient's medical record summary.

Section 19.1708 and §19.2008 address **On-Site Review by the URA**. Section 19.1708(a) and §19.2008(a) require URA staff members to identify themselves by name, organization, photo identification, and the URA identification card with TDI's assigned certificate number. This requirement applies at all times while the members are engaged in utilization review, and not just during "on-site reviews." This requirement is intended to ensure that all parties involved are aware that the URA is conducting the utilization review and are able to confirm the identity of the URA staff members who are engaged in utilization review.

Section 19.1708(b) and §19.2008(b), relating to on-site review at a health care facility, change the references in existing §19.1709(b) and §19.2009(b), from hospital to a "health care facility." The broader term "health care facility" includes a hospital, emergency clinic, outpatient clinic, or other facility providing health care and is necessary for clarification and accuracy.

Section 19.1709 and §19.2009 address **Notice of Determinations Made in Utilization Review**. Section 19.2009(a) addresses requirements for both favorable and adverse determination notices. Section 19.1709(a) and §19.2009(a)(1) track the requirements in Insurance Code §4201.301.

To clarify distinctions between requirements within the sections that apply to prospective and concurrent review, versus retrospective review, the sections are formatted so that §19.2009(a)(2) and §19.1709(d) apply to prospective and concurrent review, and §19.2009(a)(3) and §19.1709(e) apply to retrospective review. Section 19.2009(a)(2) and §19.1709(d)(3) specify required timeframes for notification of an adverse determination for consistency with Insurance Code §4201.304. Section 19.1709(d)(3) also adds clarifying language that the denial of post-stabilization care subsequent to emergency treatment must be followed by a written notification within three working days of the telephone or electronic transmission. These rules do not repeat the rest of the requirements under Insurance Code §4201.304 because no other clarifying changes were made. Section 19.1709(d)(1) tracks the requirements in Insurance Code §4201.302.

Section 19.2009(a)(2)(A) and §19.2009(a)(2)(B) specify required timeframes for notification of a prospective or concurrent utilization review adverse determination and adopt timeframe requirements to be consistent with 28 TAC §134.600 for workers' compensation non-network coverage, or with Insurance Code §1305.353 and 28 TAC §10.102 for workers' compensation network coverage, respectively.

Section 19.2009(a)(3)(A) and (B) require the notice of a retrospective adverse determination to be provided within the timeframes specified by TDI-DWC rules in 28 TAC Chapter 133 for workers' compensation non-network coverage, and TDI rules in 28 TAC Chapter 10 (relating to Workers' Compensation Health Care Networks) and TDI-DWC rules in 28 TAC Chapter 133 (relating to General Medical Provisions) for workers'

compensation network coverage, respectively. These provisions are consistent with Insurance Code §4201.305.

Section 19.1709(b) and §19.2009(b) clarify that that the subsections regulate the information that must be included in notices of prospective, concurrent, or retrospective utilization review adverse determinations. With the exception of §19.1709(b)(4) and §19.2009(b)(4), all of the information that must be included in all notices of adverse determinations in §19.1709(a) and §19.2009(b) are required by Insurance Code §4201.303(a). TDI added one notice element to the list in §4201.303(a). Insurance Code §1305.353(b) states, "Notification of an adverse determination *must* include" certain elements and §4201.303(a) states, "Notice of an adverse determination *must* include" certain elements. These lead-in sentences indicate that TDI does not have authority to exclude one of these statutory requirements, but these statutes do not limit the elements in the notice to only those elements. This proposal includes all of the statutory elements and adds to the notice requirements under Insurance Code §4201.003, which grants rulemaking authority to implement Insurance Code Chapter 4201.

Section 19.1709(b)(4) and §19.2009(b)(4) require notice of the professional specialty of the physician, doctor, or other health care provider who made the adverse determination. Section 19.2009(b)(4) also requires notice of the Texas license number of the physician, doctor, or other health care provider that made the adverse determination.

TDI determined that the additional notice element in §19.1709(b)(4) and §19.2009(b)(4) is necessary to provide important consumer information to the enrollee, or injured employee, respectively, and the provider of record should the adverse determination be appealed. Specifically, this information is necessary for the consumer's understanding of the professional background and training of that physician, doctor, or other health care provider. The information that would be provided under the proposed new notice element may also assist the provider of record in assessing whether the enrollee or injured employee, respectively, might benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician, doctor, or other health care provider that made the adverse determination if an appeal of the adverse determination is filed.

Section 19.1709(b)(5) – (9) and §19.2009(b)(3), (5), (6), and (9) are consistent with Insurance Code §4201.303(a)(4) and §4201.303(b). The requirement in §19.1709(b) and §19.2009(b), regarding the provision of information on the URA appeal process and notice of the independent review process, along with a copy of Form No. LHL009 request for a review by an IRO, will inform the enrollee, or injured employee, respectively, of available options following an adverse determination. The information will also inform the provider of record of what information is necessary for the appeal of an adverse determination. The release of information to an IRO must also comply with Insurance Code §4201.552, which prohibits a URA from disclosing 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. Section 4201.552 also requires that 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 be dated and contain the patient's signature.

Section 19.1709(c) specifies the requirements relating to a notice of determination concerning an acquired brain injury. A URA must comply with the notice requirements relating to notification of favorable determinations and relating to notice of adverse determinations. Additionally, in regard to a determination concerning an acquired brain injury as defined by 28 TAC §21.3102, not later than three business days after the date on which an individual requests utilization review or an extension of coverage that is based on medical necessity or appropriateness, the URA must notify the requestor of the determination through a direct telephone contact. Section 19.1709(c) also provides that the subsection does not apply to a determination made for coverage under a small employer health benefit plan, consistent with Insurance Code §1352.006.

Section 19.2009(c) clarifies that the notice of adverse determination may constitute a peer review report required by 28 TAC §180.28 (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also complies with the required elements of that section. This clarification allows the URA to consolidate the notice of an adverse determination and the peer review report into one document if the document contains all the notice elements required under both §19.2009(c) and 28 TAC §180.28.

Section 19.1709(d)(2) and §19.2009(a)(4) require a URA to ensure that the preauthorization numbers it assigns comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 C.F.R. §162.1102. These standards apply under federal law to health insurers and HMOs, and already apply to health insurers and HMOs conducting utilization review. For consistency among all URAs, TDI determined it is necessary to require preauthorization numbers issued by all URAs to comply with the federal data and format requirements. This requirement will prevent different numbering systems based on whether the URA is subject to the federal regulations.

Section 19.1709(e)(1) requires the notice of a retrospective adverse determination to be provided within the timeframes specified by Insurance Code §4201.305 and §19.1709(e). Section 19.1709(e)(2) tracks Insurance Code §4201.203.

Section 19.1710 and §19.2010 address **Requirements Prior to Issuing Adverse Determination**. Section 19.1710 and §19.2010 address requirements regarding any instance in which the URA is questioning health care services on the basis of medical necessity or appropriateness or on the basis of the experimental or investigational nature of the services prior to issuing a prospective or concurrent utilization review adverse determination. The URA must afford the provider of record a reasonable opportunity, as defined in §19.1703(b)(28) and §19.2003(30), to discuss the plan of treatment with a physician. The inclusion of dentists in the existing rule is not included in these proposed rules because dentists provide specialty health services that

are subject to the peer-to-peer discussion requirements under §19.1716 and §19.2016, relating to specialty URAs.

Section 19.1710 and §19.2010 require that the discussion include, *at a minimum*, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record, that, on appeal, might lead to a different utilization review decision, in addition to the discussion of the plan of treatment for the enrollee. By specifying minimum elements, the proposed rules clarify that the required discussion may also include other matters as deemed necessary by the URA or provider of record.

Section 19.1710(1) and §19.2010(1) specify that when the URA provides the reasonable opportunity required under §19.1710 or §19.2010, respectively, the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination.

Section 19.1710(2) and §19.2010(2) require the URA to maintain documentation detailing the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination; the date and time that the discussion, if any, took place; and the outcome. Section 19.1710(2) and §19.2010(2) also require that the URA submit this required documentation to TDI on request. These requirements are necessary to enable TDI to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist TDI in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the

provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

These requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements resulting from the expanded definition of “utilization review” under HB 4290 to specifically incorporate “retrospective review.” Insurance Code §4201.206 provides that, subject to the notice requirements of Chapter 4201, Subchapter G, and before an adverse determination is issued by a URA, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Because in pertinent part Insurance Code §4201.002 defines a “utilization review agent” as “an entity that conducts utilization review” and the term “utilization review” includes “retrospective review” under Insurance Code §4201.002(13), the §4201.206 requirement for a reasonable opportunity discussion applies to URAs conducting retrospective review.

Section 19.1711 and §19.2011 address **Written Procedures for Appeal of Adverse Determinations**. Section 19.1711(a) and §19.2011(a) govern appeal of prospective or concurrent adverse determinations. The sections require each URA to comply with its written procedures for appeals and require a URA's written procedures for appeals to comply with insurance Code Chapter 4201, Subchapter H.

Section 19.1711(a)(1) requires these procedures to include a statement specifying the timeframes for filing the written or oral appeal, which may not be less

than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the enrollee adequate time to appeal an adverse determination and specifies a uniform minimum time period for all enrollees to submit an appeal.

Section 19.2011(a)(1) addresses the timeframes for filing the appeal for workers' compensation network coverage. It requires the URA's written procedures for appeals to include a statement specifying the timeframes for filing the oral or written appeal in accord with Insurance Code §1305.354, which may not be less than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the injured employee adequate time to appeal the adverse determination and is consistent with 28 TAC §10.103 (relating to Reconsideration of Adverse Determination).

Under §19.1711(a)(1) and §19.2011(a)(1), all enrollees, or injured employees, respectively, will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review. These provisions are also consistent with Insurance Code §4201.353, which provides that the procedures for appealing an adverse determination must be reasonable.

Section 19.2011(a)(2) addresses the timeframes for filing the appeal for workers' compensation non-network coverage. It requires the URA's written procedures for appeals to include a statement specifying that the timeframes for filing the oral or written appeal must comply with 28 TAC §134.600 (relating to preauthorization, concurrent review, and voluntary certification of health care) and 28 TAC Chapter 133, Subchapter D (relating to dispute of medical bills).

Section 19.1711(a)(2) and §19.2011(a)(3) require the URA's written procedures for appeals to include a provision that an enrollee, or injured employee, respectively, their representative, or the provider of record may appeal the adverse determination by making an oral or written request. This requirement is consistent with Insurance Code §4201.354.

Section 19.1711(a)(3)(A) – (D) maintains the existing requirements relating to an appeal acknowledgement letter to be sent by the URA to the appealing party.

Section 19.1711(a)(4) requires the written procedures for appeals to include a provision that an appeal decision must be made by a physician who has not previously reviewed the case. This provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b), relating to specialty provider reviews.

Section 19.2011(a)(4) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician, dentist, or chiropractor who has not previously reviewed the case. This provision is consistent with Insurance Code §4201.356(a), Insurance Code §1305.354, 28 TAC Chapter 180, and 28 TAC §10.103. This requirement provides consistency of utilization reviews for all injured employees.

Section 19.2011(a)(5) requires that in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, the URA must afford the provider of record a reasonable opportunity, as defined in

§19.2003(30), to discuss the plan of treatment for the injured employee with a physician before issuing an adverse determination. The discussion must include, at a minimum, the clinical basis for the URA's decision. Denial of an appeal is an adverse determination, which would require the URA to afford the provider of record a reasonable opportunity to discuss the plan of treatment before issuing an adverse determination. This provision is consistent with Insurance Code §4201.206.

Section 19.1711(a)(5) further requires the written procedures to include a provision that in any instance in which the URA is questioning the medical necessity, appropriateness, or the experimental, or investigational nature of the health care services, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician before issuing an adverse determination. The provision must require the discussion to include, at a minimum, the clinical basis for the URA's decision.

Section 19.1711(a)(6) mirrors the requirement under Insurance Code §4201.356(b), which provides a process for requesting a particular type of specialty provider to review a case and requires the specialty review to be completed within 15 working days. Insurance Code §4201.457 governs the appeal decisions for specialty URAs.

Section 19.2011(a)(6) requires the URA's written procedures for appeals to include a provision that, after the URA has sought review of the appeal, the URA must issue a response letter explaining the resolution to the appeal to certain individuals specified on the basis of the underlying workers' compensation coverage.

Section 19.1711(a)(7) tracks the requirements in Insurance Code §4201.357.

Section 19.1711(a)(7)(C) requires the written procedures for appeal to include a provision that an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification. The requirement for the follow-up letter is necessary to ensure that the appealing party receives prompt written documentation of the expedited appeal determination.

Section 19.2011(a)(7)(A) – (G) specify the elements of information that must be included in the response letter for both workers' compensation network and non-network coverage. Subparagraph (A) requires a statement of the specific medical or dental reasons for the resolution. Subparagraph (B) requires the clinical basis for the decision, including screening criteria. Subparagraph (C) requires the professional specialty and Texas license number of the physician who made the determination. Subparagraph (D) requires notice of the appealing party's right to seek review of the denied appeal by an IRO, the procedure for obtaining that review, and procedures for obtaining a copy of Form No. LHL009 request for a review by an IRO. Subparagraph (E) states procedures for filing a complaint in accord with Insurance Code §4201.204. Subparagraph (F) requires a description of the screening criteria that were used in making the determination for workers' compensation network coverage, as well as a description of the network adopted treatment guidelines. Subparagraph (G) requires the URA conducting utilization review for workers' compensation non-network coverage to include a description of guidelines used in accord with 28 TAC Chapter 137 in making

a determination. These requirements provide the injured employee with important information concerning the basis for the determination.

Section 19.1711(a)(8)(A) – (H) specify the elements of information that must be included in the response letter. Subparagraph (A) requires a statement of the specific medical, dental, or contractual reasons for the resolution, as required in existing §19.1712(b)(5)(A). Subparagraph (B) requires the clinical basis for the decision. Subparagraph (C) requires a description of or the source of the screening criteria that were used in making the determination. Subparagraph (D) requires the professional specialty of the physician who made the determination. Subparagraph (E) requires notice of the appealing party's right to seek review of the denied appeal by an IRO. Subparagraph (F) requires notice of the IRO process and the procedures for obtaining that review. Subparagraph (G) requires a copy of Form No. LHL009 request for a review by an IRO in addition to the existing rule requirement for a notice of the appealing party's right to seek review of the denied appeal by an IRO and the procedures for obtaining that review. Subparagraph (H) requires procedures for filing a complaint in accord with Insurance Code §4201.204 and as described in §19.1705(f).

Section 19.2011(8) specifies the timeframes for written notifications of the appeal determination as a required component of the response letter under the URA's procedures. These appeals must be resolved in accord with 28 TAC §10.103 for workers' compensation network coverage and 28 TAC §134.600 for workers' compensation non-network coverage.

Section 19.1711(a)(9) requires the URA's written appeal procedures to include a provision that the appeal must be resolved as soon as practical, but in accord with Insurance Code §4201.359, in no case later than 30 days after the date the URA receives the written appeal or the one-page appeal form from the appealing party referenced in §19.1711(a)(3).

Section 19.1711(a)(10) and §19.2011(a)(9) provide that an enrollee or injured employee, respectively, may request and is entitled to an immediate review by an IRO of an adverse determination in a circumstance involving a life-threatening condition. This provision is consistent with Insurance Code §4201.360. Section 19.2011(a)(9) also provides that in a circumstance involving a request for a medical interlocutory order under 28 TAC §134.550, the injured employee is entitled to an immediate review by an IRO of the adverse determination.

These rules implement statutory provisions of Insurance Code Chapter 4201. Insurance Code §4201.303(b) provides that for an enrollee who has a life-threatening condition, the notice of an adverse determination must include a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review. Insurance Code §4201.360 provides that notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of the URA's adverse determination.

The terms "life-threatening" and "medical emergency" overlap but are not synonymous. The term "life-threatening," under Insurance Code §4201.002(7), is a

disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. There is no requirement that the likelihood of death is imminent or the condition is acute. The terms "emergency care," under Insurance Code §4201.002(2), and "medical emergency," under Insurance Code §1305.004(13), both require the condition to be of recent or sudden onset, respectively, and require immediate medical care or attention, in part, to avoid placing the individual's health in serious jeopardy. Section 19.2003(20) also contains a separate definition of "medical emergency" that tracks the definition in Insurance Code §1305.004(13) with a clarifying change from the use of the term "patient" to the term "injured employee."

The concept of "life-threatening" conditions may also be found in the workers' compensation system in the IRO regulations under 28 TAC §12.5, which defines "life-threatening condition," and §12.205 and §12.206, which contain requirements specific to instances of life-threatening conditions. TDI is not introducing a new concept in these rules. Title 28 TAC §133.305 also defines "life-threatening," and 28 TAC §133.308(i) provides that in a preauthorization or concurrent review dispute request, an employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to comply with procedures for a reconsideration.

Additionally, Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI's intent to apply the requirements regarding life-threatening conditions to emergency treatment.

Section 19.1711(b) and §19.2011(b) govern appeals of retrospective adverse determinations and require the URA to maintain and make available a written description of these appeal procedures. Section 19.2011(b) requires that these appeals comply with §19.2009.

Section 19.1711(b)(1) requires the appeal procedures to comply with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims), if applicable, because not all entities subject to Subchapter R may be subject to 28 TAC Chapter 21, Subchapter T. Section 19.1711(b)(2) requires that these appeals comply with §19.1709.

Section 19.2011(b)(1) requires workers' compensation network coverage appeal procedures to comply with the requirements in Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133. This subsection clarifies that for claims under network coverage these requirements are to be applied in tandem with TDI's rules concerning workers' compensation health care networks and also with TDI-DWC's rules concerning general medical procedures.

Section 19.2011(b)(2) requires a URA's workers' compensation non-network coverage appeal procedure to comply with the requirements of 28 TAC Chapter 133. This provision clarifies that these proposed rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify their duties under those rules.

Section 19.1711(c) addresses appeals of adverse determinations concerning acquired brain injuries. A URA must make a determination concerning an acquired brain injury no later than three business days after the date an individual requests

utilization review or an extension of coverage based on medical necessity or appropriateness. The URA must provide notification of the determination through a direct telephone contact to the requestor. This provision is consistent with Insurance Code §1352.006.

Section 19.1712 and §19.2012 address **URA's Telephone Access**. Section 19.1712(a) and §19.2012(a) track Insurance Code §4201.004, and clarify that a URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central time and Mountain time. The clarifying phrase "Central time and Mountain time" is necessary because Texas includes both time zones and the location of the URA should not pose a barrier to care.

Section 19.1712(b) clarifies that the section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1718 or §19.1719. This exemption is necessary because §19.1718 and §19.1719 specify detailed telephone access requirements for HMOs or preferred provider benefit plans, respectively.

Section 19.2012(b) requires a URA to have and implement procedures when responding to two types of requests. The procedures must address requests for drugs that require preauthorization if the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency. They also must address requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by a treating physician or provider of record.

The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or pharmacy the ability to obtain a medical interlocutory order in certain instances in which preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). Subchapter R rules do not have an equivalent requirement because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy. The purpose of new §19.2012(b) is to require the URA to have specific procedures for high-risk situations.

Section 19.1713 and §19.2013 address **Confidentiality**. Section 19.1713(a) and §19.2013(a) require a URA to provide its certification number, name, and professional qualifications when contacting a physician's, doctor's, or other health care provider's office. Section 19.1713(a)(1) and §19.2013(a)(1) require the URA to present written documentation that the URA is acting as an agent of the payor or insurance carrier, respectively, for the relevant enrollee or injured employee, respectively. These requirements are consistent with Insurance Code §4201.551(a).

Section 19.1713(a)(2) and §19.2013(a)(2) clarify that the duty to retain the information rests with the URA, and is consistent with Insurance Code §4201.557, which states, "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.”

Section 19.1713(a)(3) and §19.2013(a)(3) make the requirement that information be retained for “at least two years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened” in existing §19.1714(m) and §19.2014(m), respectively, obsolete. Section 19.1713(a)(3) and §19.2013(a)(2) require the information to be retained for at least *four* years and broadens the scope of information that the URA must retain to include all information generated and obtained by a URA in the course of utilization review, and not just that information relating to cases for which an adverse decision was made or information relating to a case that may be reopened.

TDI determined that an increased timeframe for retaining all information generated and obtained by a URA in the course of utilization review is necessary to address any potential issues that might arise in an appeal, including judicial review of an approval or adverse determination. The information retained may be necessary for the appeal process, which could take longer than two years. In addition, the four year retention requirement is consistent with confidentiality requirements for IROs under 28 TAC §12.208(h).

The longer retention period allows sufficient time for TDI to examine the information. TDI generally conducts URA examinations triennially, but does not always examine each URA exactly every three years. The requirement that the URA maintain

information for four years will ensure that TDI has the opportunity to review the information.

Section 19.1713(a)(4) and §19.2013(a)(4) track the limitation on a URA's charges for providing a copy of recorded personal information to individuals in existing §19.1713(e) and §19.2013(e).

Section 19.1713(b) and §19.2013(b) clarify that the confidentiality requirements pertain to both: (1) the information received by the URA from the enrollee or injured employee, respectively; their representative; or the physician, doctor, or other health care provider; and (2) the information exchanged between the URA and third parties. Section 19.1713(b) and §19.2013(b) address a URA's procedures for specific information exchanged for conducting reviews. Section 19.1713(b) and §19.2013(b) incorporate the requirements in existing §19.1714(k) and §19.2014(k) and restructure the requirements for ease of readability.

Section 19.1714 and §19.2014 address **Regulatory Requirements Subsequent to Certification or Registration**. TDI determined that the requirements in existing §19.1716(a) and §19.2016(a) are not necessary because they repeat the requirements in Insurance Code §4201.204.

Section 19.1714(a) and §19.2014(a) require that information related to complaints be included in the summary report submitted to TDI by March 1 of each year, which tracks existing §19.1716(b) and §19.2016(b). Section 19.1714(a) and §19.2014(a) also broaden the types of information that the URA must provide in the summary report to include information related to adverse determinations and appeals of

adverse determinations. These sections are authorized under Insurance Code §4201.204(c) and Insurance Code §38.001.

Section 19.1714(b) and §19.2014(b) track the requirement in the last sentence in existing §19.1716(b) and §19.2016(c). Section 19.1714(b)(1) and §19.2014(b)(1) mirror the requirements in existing §19.1716(b)(1) and §19.2016(c)(1). Section 19.1714(b)(2) and §19.2014(b)(2) mirror the requirements in existing §19.1716(b)(2) and §19.2016(c)(2), and clarify that “successor codes and modifiers” are applicable as part of the requirement to include a listing of appeals of adverse determinations by the medical condition that is the source of the dispute in the summary report submitted to TDI. The requirements in existing §19.1716(b)(4) are not included in the proposed new rules because appeals of adverse determinations are not classified by the categories of “benefit denial,” “timely determinations,” or “screening criteria.” TDI does not collect that information and the requirements are unnecessary.

Section 19.1714(b)(3) and §19.2014(b)(3) track the requirements in existing §19.1716(b)(2) and §19.2016(b)(2), respectively. Section 19.1714(b)(4) and §19.2014(b)(4) track the requirements in existing §19.1716(b)(5), with a clarifying change from the phrase “at each level of the notification and appeal process” to the phrase “at each level within the internal utilization review process.” This change clarifies that the summary does not need to include the outcomes for an IRO, contested case hearing, or judicial review. Section 19.1714(b)(5) and §19.2014(b)(5) track the requirements in existing §19.1716(b)(6).

Section 19.1714(c)(1) – (3) and §19.2014(c)(1) – (3) track the requirements in existing §19.1716(b)(6)(A) – (C) and existing §19.2016(b)(1) – (3).

TDI determined that the more detailed complaint procedure requirements in existing §19.1716(c)(1) – (5) and existing §19.2016(d)(1) – (5) are not necessary because they are too restrictive and inconsistent with procedures that TDI follows for investigating and resolving other types of complaints. Those requirements are not included in the new rules; nor are supporting requirements in existing §19.1716(d) and existing §19.2016(e).

Section 19.1714(d) and §19.2014(d) provide that TDI must process complaints received against a URA under TDI's established procedures for investigation and resolution of complaints. These sections are authorized under Insurance Code §4201.003(a) and Insurance Code §36.001.

Section 19.1714(e) and §19.2014(d) reiterate TDI's authority in Insurance Code §38.001 to address inquiries to a URA, related to any matter connected with the URA transactions, that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA must respond in writing to an inquiry not later than the 10th day after receipt of the inquiry.

Section 19.2014(f) clarifies that Subchapter U does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed or contracted with URAs to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules. This provision is

necessary to clarify that the investigative authority of the commissioner of workers' compensation or TDI-DWC is not limited to the authority stated in Subchapter U.

Section 19.1714(f) and §19.2014(g) contain the same requirements that are in existing §19.1716(g) and §19.2016(h), and clarify that an on-site review by TDI may be scheduled or unscheduled. Under §19.1714(f) and §19.2014(g), an on-site review will only take place during working days and normal business hours. Section 19.1714(f) and §19.2014(g) incorporate the existing provisions in §19.1716(g)(3) and §19.2016(h)(3) that the URA must make available all records relating to its operation during any on-site review. Section 19.1714(f)(2) and §19.2014(g)(2) provide that, at a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

Existing §19.1716(f) and §19.2016(g), relating to lists of URAs, are not included in the proposed new rules because TDI now maintains a list of certified URAs on its website that is available to individuals or organizations interested in learning about a URA's certification status. This list is updated in real time. Further, TDI determined that existing §19.1716(g)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is no longer necessary. Insurance Code §4201.601 authorizes TDI to take certain steps if a person or entity conducting utilization review is believed to be in violation of Chapter 4201 or applicable rules. These steps include the authority to compel the production of necessary information if it is believed that the URA is in violation of the Insurance Code or rules relating to reasonable accessibility.

Section 19.1715 and §19.2015 address **Administrative Violations**. Section 19.1715 and §19.2015(a) provide that the commission of fraudulent or deceptive acts in obtaining or using a URA registration is a violation of Insurance Code Chapter 4201. Section 19.1715 and §19.2015(a) contain the same requirements that are in existing §19.1717(f) and §19.2017(e). Insurance Code §4201.601 authorizes TDI to take certain steps if a person or entity conducting utilization review is believed to be in violation of Chapter 4201 or applicable rules.

Section 19.1715 and §19.2015(b) clarify that the commissioner's authority under Subchapters R and U, respectively, is in addition to remedies provided under Insurance Code Chapter 4201, Subchapter M, concerning enforcement.

Section 19.2015(c) clarifies that the provisions in §19.2015 do not limit the joint enforcement actions of TDI and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

These provisions are consistent with Insurance Code Chapter 4201, Subchapter M. Insurance Code §4201.601 permits the commissioner to compel production of information necessary to determine whether a violation has occurred. Additionally, under Insurance Code §4201.603, the commissioner may impose a sanction under Insurance Code Chapter 82, issue a cease and desist order under Insurance Code Chapter 83, or assess an administrative penalty under Insurance Code Chapter 84 if the commissioner determines a person or entity conducting utilization review has violated Insurance Code Chapter 4201.

Section 19.1716 and §19.2016 address **Specialty URA** requirements. Section 19.1716(a) and §19.2016(a) require a specialty URA to submit to TDI the application, information, and fee required in §19.1704 or §19.2004, respectively, to be certified or registered as a specialty URA. This provision implements Insurance Code §4201.101.

Section 19.1716(b) and §19.2016(b) require a specialty URA to 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 by a state licensing agency in the U.S. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery. This provision tracks the requirements in Insurance Code §4201.454 and is consistent with Insurance Code §1305.351(d) and Labor Code §408.023(h).

Additionally, under Insurance Code §4201.456, the specialty URA must provide the health care provider, who ordered 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 specialty URA. A specialty URA must meet the requirements of Insurance Code §4201.002(5), regarding the definition of the term "health care provider," to qualify as a specialty URA.

Section 19.1716(c) and §19.2016(c) provide that a specialty URA is subject to the requirements of Subchapter R or Subchapter U, respectively, except for those rules implementing those statutory requirements from which a specialty URA is exempt. The

rules that are not applicable to specialty URAs, as outlined in §19.1716(c)(1) – (4) and §19.2016(c)(1) – (4), are consistent with Insurance Code §4201.452, which provides that a specialty URA is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Section 19.1716(c)(1) and §19.2016(c)(1) provide that specialty URAs are not subject to the requirements of §19.1705(a) and §19.2005(a), respectively, because the requirements regarding review and approval of the utilization review plan are based on Insurance Code §4201.151, from which specialty URAs are exempt. Specialty URAs are required, under §19.1716(d) and §19.2016(d), to use only a health care provider of the appropriate specialty. Under Insurance Code §4201.453, a specialty URA must have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accord with standards developed with input from a health care provider of the appropriate specialty.

Section 19.1716(c)(2) and §19.2016(c)(2) provide that specialty URAs are not subject to the requirements of §19.1706(a), (c), and (d) and §19.2006(a) and (c) – (e), respectively, because they implement Insurance Code §4201.252 from which specialty URAs are exempt. Specialty URA requirements relating to employed or contracted physicians, doctors, other health care providers, and personnel are set forth in §19.1716(e) and §19.2016(e).

Section 19.1716(c)(3) and §19.2016(c)(3) provide that specialty URAs are not subject to the requirements of §19.1710 and §19.2010, respectively, because those sections implement Insurance Code §4201.206, from which specialty URAs are exempt.

Instead, these respective regulatory concerns are specifically addressed for specialty URAs in §19.1716(f) and §19.2016(g) based on the peer-to-peer discussion requirements that specifically apply to specialty URAs under Insurance Code §4201.456.

Section 19.1716(c)(4) and §19.2016(c)(4) provide that specialty URAs are not subject to the requirements of §19.1711(a)(4) – (6) and §19.2011(a)(4) – (5) because those sections implement Insurance Code §4201.206 and §4201.356, from which specialty URAs are exempt.

Section 19.1716(d) and §19.2016(d) require a specialty URA to have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accord with standards developed with input from a health care provider of the appropriate specialty. This provision implements Insurance Code §4201.453.

Section 19.1716(e) and §19.2016(e) address requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Section 19.1716(e) and §19.2016(e) incorporate the requirements of existing §19.1720(f) and §19.2020(f), respectively. Section 19.1716(e)(1) and §19.2016(e)(1) require physicians, doctors, other health care providers, and personnel employed by or contracted with a specialty URA to perform utilization review to be appropriately trained, qualified, and currently licensed. Section 19.2016(e)(1) further requires personnel listed in subsection (e) to be appropriately trained, qualified, and currently licensed in accord with 28 TAC Chapter 180 (relating to Monitoring and Enforcement).

Section 19.1716(e)(2) and §19.2016(e)(2) require personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by a state licensing board or the Texas Medical Board, respectively, or to be otherwise authorized to provide health care services in the U.S. or Texas, respectively. This requirement is based on an URA advisory committee recommendation and is necessary to ensure that all personnel are appropriately trained and qualified to conduct specialty utilization review.

Under §19.2016(f) the utilization review by a specialty URA must be conducted under the direction of a physician, doctor, or other health care provider of the same specialty, and the physician, doctor, or other health care provider must be currently licensed to provide the specialty health care service in Texas. This is consistent with Insurance Code §1305.351 and Labor Code §408.023(h).

Section 19.1716(f) and §19.2016(g) mirror existing §19.1716(h) and §19.2020(h). Section 19.1716(f)(1) and §19.2016(g)(1) provide that when the specialty URA provides the reasonable opportunity required under this subsection, the specialty URA must include its phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. This requirement is necessary to provide the provider of record with the necessary information should the provider of record require further discussion with the specialty URA.

Section 19.1716(f)(2) and §19.2016(g)(2) require the specialty URA to maintain documentation detailing the discussion opportunity provided, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the

time any discussion took place, and the outcome. The specialty URA must submit this documentation to TDI or TDI-DWC, respectively, if requested. These requirements enable TDI to monitor whether reasonable opportunities for discussion are offered and to collect information on peer-to-peer discussion results. This information will assist TDI in ensuring compliance with these requirements and in determining the effectiveness of peer-to-peer discussions.

Section 19.1716(g) and §19.2016(h) clarify that an appeal decision must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination. These provisions are consistent with Insurance Code §4201.457, which governs the appeal decisions for specialty URAs.

Section 19.1717 and §19.2017 address **Independent Review of Adverse Determinations**. Section 19.1717(a) and §19.2017(a) address notification for life-threatening conditions and track the requirements in existing §19.1721(a). The notification of adverse determination subject to the timeframes discussed in the subparagraphs relate to notices of determination made in *prospective and concurrent* utilization review. These provisions implement Insurance Code §4201.304.

Section 19.2017(a)(1)(A) and (B) specify the timeframes for notification of an adverse determination based on the status of the coverage. For workers' compensation non-network coverage, the adverse determination notice must be provided within the timeframes specified by 28 TAC §134.600. For workers' compensation network

coverage, the adverse determination notice must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102.

Section 19.1717(a)(1) and §19.2017(a)(1)(C) add a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process. Section 19.1717(a)(1) requires the URA to provide a copy of Form No. LHL009 request for a review by an IRO to the enrollee, an individual acting on behalf of the enrollee, and the provider of record, at the time they are notified of the adverse determination. This requirement will inform the enrollee of additional options following an adverse determination and enable the enrollee to quickly and efficiently request independent review. Section 19.2017(a)(1)(C) requires the URA to notify the persons listed in subparagraph (C) of the procedure for obtaining a copy of Form No. LHL009 request for a review by an IRO. This requirement is necessary to inform the enrollee or injured employee, respectively, of the process for independent review in the event of life-threatening conditions.

Section 19.1717(a)(2) and §19.2017(a)(2) require that the enrollee, or injured employee, respectively, their representative, or their provider of record determine the existence of a life-threatening condition on the basis of the prudent layperson standard. This standard requires that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is life-threatening. This new requirement is necessary to clarify that a health care provider does not have to make the determination that the condition is life-threatening, which

provides more flexibility to the enrollee or injured employee as long as the prudent layperson test is met.

Insurance Code §4201.002(7) defines “life-threatening” as a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The statute does not specify who must make the determination that the disease or condition is life-threatening. TDI interprets this provision broadly to allow determination of the existence of a life-threatening condition based on a prudent layperson standard, rather than more narrowly allowing only medical personnel to make the determination. Under this interpretation, an enrollee or injured employee who cannot obtain a medical opinion that his or her condition is life-threatening may still be entitled to a faster notice of adverse determination and immediate access to independent review. This requirement is proposed under TDI’s rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Section 19.1717(b) and §19.2017(a)(3) clarify that a party who receives an adverse determination or is denied an appeal involving a life-threatening condition is entitled to review by an IRO. This provision implements Insurance Code §4201.360.

Section 19.1717(c) and §19.2017(b) govern independent review involving life-threatening and nonlife-threatening conditions. Section 19.1717(c) and §19.2017(b) require the URA to notify TDI within one working day from the date the request for an independent review is received. A “working day” is defined by Insurance Code §4201.002(16). The requirement that the URA notify TDI within one working day from the date the request for an independent review is received is necessary because

prompt action is needed to initiate the process of independent review to ensure proper and timely medical treatment for enrollees and injured employees. TDI determined that the “working day” requirement will avoid impractical deadlines in situations when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Section 19.1717(c) and §19.2017(b) also require the URA to submit to TDI through TDI's Internet website Form No. LHL009 request for a review by an IRO, which is submitted to the URA by the party requesting independent review. This requirement should result in greater efficiency and less required time for the URA and in a quicker response time for the injured employee or enrollee who is requesting the independent review.

Under §19.1717(c)(1) and §19.2017(b)(1), TDI, within one working day of receipt of the complete request for independent review, will randomly assign an IRO to conduct the independent review. TDI will notify the URA, payor, IRO, enrollee, or injured employee, respectively, their representative, provider of record, and any other providers listed by the URA as having records relevant to the review of the assignment of the IRO. This prompt assignment is necessary for both life-threatening and non life-threatening conditions because assigning IROs is a primary function of TDI.

The requirements in existing §19.1721(h) are not included in the proposed new rules because the requirements are found in Insurance Code §4201.402 and inclusion of the requirements would be repetitive.

Section 19.2017(b)(2) references additional requirements for an independent review of an adverse determination for a workers' compensation non-network coverage review under the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to 28 TAC Chapter 133, Subchapter D. This provision clarifies that these proposed rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify their duties under those rules.

Section 19.2017(b)(3) references additional requirements for an independent review of an adverse determination for a workers' compensation network coverage review under Insurance Code Chapter 1305, TDI and TDI-DWC rules, including but not limited to, 28 TAC Chapter 10, Subchapter F and Chapter 133, Subchapter D. This subsection clarifies that for claims under network coverage these proposed sections are to be applied in tandem with TDI's rules concerning workers' compensation health care networks and with TDI-DWC's rules concerning general medical procedures.

Section 19.1717(c)(2) specifies that *the payor*, in addition to the URA, must comply with the IRO's determination. This amendment is necessary to clarify that payors must also comply with the IRO's determination, because sometimes the URA and the payor are different parties. This provision implements Insurance Code §4201.401.

Section 19.1717(c)(3) retains the requirements in existing §19.1721(j) and (k) and implements Insurance Code §4201.403.

Section 19.1718 addresses **Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans** and implements Insurance

Code §§843.348, 1301.135, and 4201.304. Section 19.1718(a) clarifies that the words and terms used in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in §19.1718. Section 19.1718(b) retains the requirements in existing §19.1723(a), which track the requirements in Insurance Code §843.348. Section 19.1718(c) and §19.1718(f)(2) do not use the term “business day,” as used in existing §19.1723(b) and (f)(2), but instead use the term “working day” for consistency with the other rule provisions that contain the “working day” requirement. The requirements in existing §19.1723(c) are not included in the proposed new rules because the requirements are found in Insurance Code §843.348(e) and inclusion of the requirements would be repetitive. Section 19.1718(d) – (i) retain the requirements in existing §19.1723(d) – (i).

Section 19.1718(d)(2) adds a requirement that the initial determination by an HMO or preferred provider benefit plan indicating whether proposed services are preauthorized within 24 hours of receipt of the request must be followed, within three working days, by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. This requirement is necessary to ensure that prompt written documentation of the adverse determination is provided to the relevant parties.

Section 19.1719 addresses **Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans** and implements Insurance Code §§843.347, 1301.133, and 4201.304. Section 19.1719(a) clarifies that the words and terms used in Insurance Code Chapter 1301 and Chapter 843 have the same

meaning when used in §19.1719. Section 19.1719(a) – (c) retain the requirements in existing §19.1724(a) – (c). The requirements in existing §19.1724(d) are not included in the proposed new rules because the requirements are in Insurance Code §843.347(h) and (i), and inclusion of the requirements would be repetitive. Section 19.1719(d) – (i) retain the requirements in existing §19.1724(e) – (k). The requirements in existing §19.1724(l) and (m) are not included in the proposed new rules because the requirements are in Insurance Code §1301.133(g) and (h), and inclusion of the requirements would be repetitive.

2. FISCAL NOTE. Debra Diaz-Lara, director, Managed Care Quality Assurance Office, has determined that for each year of the first five years the proposed new sections will be in effect, there will be no fiscal impact to state and local governments because of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy because of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Diaz-Lara also has determined that for each year of the first five years the proposed new sections are in effect, there are several public benefits anticipated because of the enforcement and administration of the proposal, as well as potential costs for persons required to comply with the proposal. TDI drafted the proposed rules to maximize public benefits consistent with the intent of the authorizing statutes while mitigating costs.

ANTICIPATED PUBLIC BENEFITS

The anticipated public benefits in general are (i) the updating of existing rules regulating URAs to comply with legislation enacted by the 81st Legislature; (ii) clarification of existing rules to facilitate compliance, implementation, and enforcement of these rules; and (iii) an improved regulatory framework for URAs.

Compliance with legislation. The anticipated public benefits of the proposed new rules related to compliance with legislation include the establishment of a regulatory framework that supports the operation of a URA. The new rules are in compliance with the requirements of HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, which effectively revises the definition of “adverse determination” in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service. These new rules will assist health care consumers by providing for a review of claims that could otherwise be denied without recourse.

Clarification of existing rules. Additionally, the anticipated public benefits of the proposed new rules related to clarification of existing rules are: (i) consistency of terminology throughout the text for readability and ease of understanding; (ii) increased clarity concerning the evidence-based or generally accepted standards on which a URA must base its screening criteria, which will result in valid and sound decisions because credible and scientific guidelines are used and will also result in increased confidence in the URA’s decisions; (iii) updated references and citations for readability and ease of understanding; (iv) increased clarity in existing rules to assist persons applying for or renewing a certificate of registration; (v) increased clarity concerning confidentiality

requirements to better protect the enrollee's or injured employee's health care information; (vi) enhanced oversight of URAs that will result in better and more efficient compliance with requirements; and (vii) improved telephone access to URAs that will provide health care consumers with easier and more efficient access to URAs.

Other anticipated public benefits of the proposed new rules related to clarification of existing rules are: (i) establishment of standards for the review of the medical necessity or appropriateness of health care services by health care providers of the appropriate specialty, which will result in utilization review by the appropriate personnel; (ii) the establishment of a standardized complaint process for consumers for easier and more efficient resolution of their oral or written complaints concerning the utilization review; (iii) greater transparency concerning the documentation or evidence, if any, that can be submitted by the provider of record that on appeal might lead to a different utilization review decision; (iv) standards for the determination of a life-threatening condition to be made by the prudent layperson standard, permitting consumers to have determinations made in a timely manner when life-threatening conditions exist; (v) expanding the preauthorization decision regarding facility-based surgeries to include necessary pain medication, which reduces the risk that an injured employee would be unable to obtain necessary pain medications after surgery through their approved preauthorization request; (vi) increased coordination and cooperation between health care providers and URAs which will result in the sharing of enrollee or injured employee information necessary for the utilization review; and (vii) improved communications and knowledge of medical benefits among all parties concerned before expenses are

incurred, which may result in enrollees and injured employees avoiding expenses for uncovered medical treatment.

Improved regulatory framework. The anticipated public benefits of the proposed new rules relating to the improved regulatory framework for URAs are: (i) additional required notice elements in Form No. LHL005 URA application that will result in the provision of additional information to TDI necessary to certify or register a URA; (ii) disclosure of screening criteria to be filed with TDI to ensure that URAs adhere to reasonable standards for conducting utilization reviews, which will provide consistent use of criteria that are evidence-based, scientifically valid, or outcome focused, or if evidence-based medicine is not available for a particular health care service provided, criteria based on generally accepted standards of medical practice recognized in the medical community, for health consumers; (iii) allowing the auditing of URAs through the mandatory filing requirements to promote the delivery of quality health care in a cost-effective manner, including protection of enrollee or injured employee safety; (iv) ensuring that URAs maintain the confidentiality of medical records in accord with applicable law; and (v) inclusion of written procedures to be filed with TDI for greater transparency concerning preauthorization of services; appeals of adverse determinations; and the licensure, qualifications, and training of health care providers used by the URA, which will result in enhanced oversight by TDI and TDI-DWC and a more efficient utilization review process for health consumers.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL

TDI anticipates that there will be probable costs to persons required to comply with several of the proposed new sections during each year of the first five years that the rules will be in effect.

TDI identified two sections in Subchapters R and two parallel sections in Subchapter U that require peer-to-peer discussions before a URA issues a retrospective review adverse determination. These requirements are the result of the HB 4290 amendments of the statutory definitions of the terms “adverse determination” and “utilization review.” These two requirements are in §19.1710 and §19.2010 and §19.1716(f) and §19.2016(g).

Because the costs relating to the requirements for offering peer-to-peer discussions prior to issuance of retrospective review adverse determinations is a result of the enactment of HB 4290 and existing statutory requirements, any costs of complying with the requirements in §19.1710 and §19.2010 and §19.1716(f) and §19.2016(g), which implement statutory provisions, are not the result of the proposed rules.

TDI identified 15 requirements of the proposal that may result in compliance costs for entities subject to Subchapter R or Subchapter U including: (i) §19.1704(b) and §19.2004(b); (ii) §19.1704(f) and §19.2004(f); (iii) §19.1705(c) and §19.2005(c); (iv) §19.1705(f) and §19.2005(f); (v) §§19.1703(8), 19.1706(b), 19.2003(8) and 19.2006(b); (vi) §19.1706(c) and §19.2006(c); (vii) §19.1709(d)(2) and §19.2009(a)(4); (viii) §19.1709(b) and §19.2009(b); (ix) §19.1710 and §19.2010; (x) §19.1711(a) and §19.2011(a); (xi) §19.1711(b) and §19.2011(b); (xii) §19.1713(a)(3) and

§19.2013(a)(3); (xiii) §19.1717(a) and §19.2017(a); (xiv) §19.1716(d) and §19.2016(d); and (xv) §19.1716(f) and §19.2016(g). TDI identified two requirements that may result in compliance costs for entities subject only to Subchapter U including §19.2012(b) and §19.2016(b)(3). Any other costs to comply with §19.1701 – §19.1719 and §19.2001 – §19.2017 result from the enactment of HB 4290 or are statutory requirements under Insurance Code Chapter 4201 and are not a result of the adoption, enforcement, or administration of the proposal.

A. Repetitive Cost Note Information.

There are cost components and analyses that are used throughout this cost note numerous times. For purposes of readability and brevity, TDI included under this part of the cost note the detail for these repetitive cost components and analyses. The cost note has been prepared in accord with the requirements in Government Code §2001.024(a)(5), relating to the content of a rule notice, and Government Code Chapter 2006, relating to agency actions affecting small businesses.

(i) *URA staff wages in an insurance-related industry.* The number of hours that will be required to comply with a particular proposed requirement will vary, and as a result, any total cost, as well as other possible relevant factors, is addressed in the cost note discussion for the individual proposed requirement. TDI's analysis of the cost for URA staff wages to perform required compliance tasks is based on the following factors.

(l) A general operations manager working in an insurance-related industry earns a median hourly wage of approximately \$64, according to the Texas Workforce Commission, Labor Market and Career Information Department, Occupation and

Employment Statistics Estimate Delivery System, available at:

<http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5242&occcode=11-1021&compare=2>.

(II) An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of approximately \$21, according to the Texas Workforce Commission OES Report available at:

<http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5242&occcode=43-6011&compare=2>.

(III) Computer programmers working in Texas earn a median hourly wage of \$35, according to the Texas Workforce Commission OES Report available at:

<http://www.texasindustryprofiles.com/apps/win/eds.php?occgroupp=15&occcode=15-1131>.

(ii) *Printing costs.* TDI's analysis of standard printing and paper costs in this cost note is based on the following factors. TDI estimates that the cost of printing could range from approximately six to eight cents per page for printing and paper. TDI anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including the number of pages that will need to be printed, and whether in-house printing costs or out-of-house printing costs will be incurred. The printing costs may vary or be slightly higher if in-house printing is not used, or both.

(iii) *Mailing costs.* TDI's analysis of standard mailing costs in this cost note is based on the following factors. According to the U. S. Postal Service business price

calculator, available at: <http://dbcalc.usps.gov/>, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP code in the United States is 27 cents. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the 27-cent cost; this estimate is based on six pages of standard 20 lb printing paper, which weighs one ounce. TDI determined that the cost of a standard business envelope is two cents. Accordingly, for each additional mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than 29 cents. TDI anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including the number of mailings and the number of pages to be mailed.

I. Estimated Costs for Entities Subject to Subchapter R and/or Subchapter U.

The following proposed provisions may result in compliance costs for URAs, including HMO and insurer URAs and specialty URAs, to comply with either Subchapter R or Subchapter U:

A. Estimated Costs to URAs, Including HMO and Insurer URAs; and Specialty URAs.

Section 19.1704(b) and §19.2004(b): URA Application Form No. LHL005.

Although some of the information is required by Insurance Code §§4201.004, 4201.102, and 4201.104; 28 TAC §1.503 (relating to Application of Fingerprint Requirement); and 28 TAC §1.504 (relating to Fingerprint Requirement), the following information is required as a result of both §19.1704(b) and §19.2004(b): (i) policies relating to

availability of personnel and telephone messaging systems; (ii) utilization review plan written policies that evidence compliance with various enumerated sections of Subchapter R or Subchapter U, as applicable; (iii) copies of template letters for notification of determinations made in utilization review that comply with §19.1709 or §19.1711, or with §19.2009 or §19.2011, as applicable; (iv) written evidence that the applicant is doing business in Texas in accord with the Texas Business Organizations Code; and (v) a letter of good standing from the Texas Comptroller of Public Accounts. Additionally, the following information is required from URAs conducting utilization review for health care provided under workers' compensation coverage and subject to §19.2004(b): utilization review plan written policies which attest that peer reviews comply with the Texas Workers' Compensation Act and rules adopted pursuant to the Texas Workers' Compensation Act.

TDI anticipates that URAs may incur costs associated with drafting new policies and procedures, obtaining additional documentation, and submitting additional information. These estimated costs will likely be initial costs on initial application and initial drafting of requisite policies and procedures and subsequent costs every two years on renewal and policy and procedure updating. TDI determined that the total estimated cost for a URA to comply with §19.1704(b) or §19.2004(b), as applicable, could vary based on the following cost components: (i) cost of general operations manager wages; (ii) cost of administrative assistant wages; and (iii) cost to mail and print new policies, procedures, and additional paperwork.

(i) Cost of general operations manager wages. TDI anticipates that, because the proposed required provisions will likely require development of new policies and procedures, a URA's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures. Drafting of the new policies and procedures will likely require, on average, approximately four hours of a general operations manager's time. Additionally, the procedures and policies required under §19.1704(b) or §19.2004(b), as applicable, must be submitted on renewal of the URA's certification or registration every two years, and the URA's policies and procedures may require review and/or amendments biennially. TDI anticipates that the review and amendments will also require a general operations manager's time.

(ii) Cost of administrative assistant wages. TDI anticipates that a URA's administrative assistant will make copies of template letters for notification of determinations made in utilization review, obtain written evidence that the applicant is doing business in Texas in accord with the Texas Business Organizations Code, and obtain a letter of good standing from the Texas Comptroller of Public Accounts. TDI anticipates that these required tasks will take approximately two hours. This documentation also must be submitted on renewal of the URA's certification or registration every two years and the URA may incur similar costs biennially.

(iii) Cost to mail and print new policies, procedures, and additional paperwork. TDI anticipates that a URA could incur a cost for mailing and printing new policies and procedures, copies of template letters for notification of determinations made in utilization review, and written evidence that the applicant is doing business in Texas in

accord with the Texas Business Organizations Code as specified in §19.1704(b) or §19.2004(b), as applicable. This documentation must be submitted on renewal of the URA's certification or registration every two years and the URA may incur similar costs biennially.

Section 19.1704(f) and §19.2004(f): Correction of Omissions or Deficiencies and Submission of a Request for a Waiver. Section 19.1704(f) and §19.2004(f) require an applicant to correct omissions or deficiencies in the URA application within 15 working days of the date of TDI's latest notice of omissions or deficiencies. Under existing rules, an applicant has 30 days to correct omissions or deficiencies. Section 19.1704(f) and §19.2004(f) also allow the applicant to request in writing additional time to correct the omissions or deficiencies. TDI determined that the total estimated cost for a URA to comply with §19.1704(e) or §19.2004(d), as applicable, could vary based on cost of administrative assistant wages.

Cost of administrative assistant wages. TDI anticipates that a URA's administrative assistant will correct omissions or deficiencies in the URA application. The shorter time period of 15 days for correction may require some reassignment of job responsibilities and that one-time cost will vary based on the salaries of staff. However, TDI does not anticipate that the shorter time period will require any new staff. Alternatively, if an extension of time is requested in writing, TDI anticipates that a URA's administrative assistant will write and submit the request. TDI anticipates that writing and submitting the request could take approximately an hour, and a URA could incur an average one-time cost of administrative staff wages for submitting a written request for

additional time. TDI does not anticipate that there will be any additional compliance costs for actually making or submitting the corrections as a result of §19.1704(f) or §19.2004(f), as applicable, because the costs are required under existing rules.

Section 19.1705(c) and §19.2005(c): Development of Screening Criteria.

Section 19.1705(c) and §19.2005(c) require URAs to utilize written screening criteria. Currently, certified URAs conducting utilization review for health coverage under workers' compensation coverage may already have acceptable screening criteria in place because of existing statutory requirements. TDI-DWC's adopted treatment guidelines under 28 TAC §137.100 are evidence-based and presumed to prescribe medically reasonable care under the Texas Workers' Compensation Act. These statutory requirements and adopted treatment guidelines should, in some cases, mitigate the costs required to comply with §19.2005(c).

Although the proposed rules do not prescribe the specific review criteria and procedures to be used by the URA, TDI determined that the total estimated cost for a URA to comply with §19.1705(c) or §19.2005(c), as applicable, could vary based on the following cost components: (i) cost to acquire some additional review criteria to comply with the requirement to utilize written screening criteria that are evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153; and (ii) cost to utilize generally accepted standards of medical practice recognized in the medical community if evidence-based medicine is not available. TDI, however, cannot realistically estimate costs imposed by these

variables and can only state that the cost will likely be determined by the types and number of criteria and standards already used by a particular URA.

Section 19.1705(f) and §19.2005(f): Complaint System. Under Insurance Code §4201.204, the complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. Additionally, as a result of §19.1705(f) and §19.2005(f), the written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI. TDI anticipates that URAs may incur nominal costs associated with including TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI in the written response. TDI determined that the total estimated cost for a URA to comply with §19.1705(f) or §19.2005(f) could vary based on the cost of an administrative assistant wages.

Though TDI identified one factor attributable to the costs of compliance with §19.1705(f) or §19.2005(f), as applicable, it is not possible for TDI to estimate the total amount of cost attributable to compliance with these provisions. There are numerous factors affecting the total cost that are not suitable to reliable quantification by TDI, including the number of complainant responses that will be required for each URA, or which are minimal.

Cost of administrative assistant wages. TDI anticipates that inclusion of the additional required information in each written response to complainants as specified in §19.1705(f) and §19.2005(f) may require a one-time cost of approximately two hours of

administrative staff time. TDI anticipates that the additional required information will be drafted, on a one-time basis, for inclusion in existing templates of the written responses to complainants. TDI estimates that a URA could incur a one-time cost for administrative staff wages.

Section 19.1703(8), §19.1706(b), §19.2003(8), and §19.2006(b): Requirements and Prohibitions Relating to Personnel. Any URA subject to §19.1703(8) and §19.1706(b) or §19.2003(8) and §19.2006(b), as applicable, may incur some cost to comply with the proposed requirements. For purposes of determining which physician to use for reviewing the appeal of a specific case, the URA will need to determine whether a disqualifying association exists. Additionally, if all of the URA's existing employed or contracted physicians have a disqualifying association, the URA may incur costs to employ or contract with a qualified physician.

TDI determined that the total estimated cost for a URA to comply with §19.1703(8) and §19.1706(b) or §19.2003(8) and §19.2006(b), as applicable, could vary based on the following cost components: (i) cost of general operations manager wages to determine whether a disqualifying association exists; and (ii) cost of finding a physician.

Cost of general operations manager wages. TDI anticipates that a URA's general operations manager will determine whether a disqualifying association exists, and this determination will likely require on average less than an hour.

Cost of finding a physician. Because being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination

does not in itself constitute a disqualifying association, it is not anticipated that the URA will need to contract with any additional physicians or doctors. However, in the event that all of the URA's employed or contracted physicians have disqualifying associations, the URA may incur costs to obtain a physician. These costs will vary depending on the URA's method of locating a physician and the number of physicians available.

Section 19.1706(c) and §19.2006(c): Documentation of Information on Physicians, Doctors, and other Health Care Providers. Section 19.1706(c) and §19.2006(c) require the URA to provide the name, number, type, license number and state of licensure, and qualifications of the personnel either employed by or under contract to perform the utilization review to TDI on filing an original application or renewal application. Section 19.2006(c) also requires the URA to provide the Texas license number of their personnel. While some of this information is required under existing rules, the following information is required as a result of both §19.1706(c) and §19.2006(c): (i) name of personnel; and (ii) license number and state of licensure of personnel or Texas license number, respectively.

TDI anticipates that URAs may incur minimal costs associated with submitting the information review required by §19.1706(c) or §19.2006(c) to TDI. These estimated costs will vary depending on how often the URA employs or contracts with personnel to perform utilization review, which will be a primary factor in determining the total cost for a particular URA. TDI determined that the total estimated cost for a URA to comply with §19.1706(c) or §19.2006(c) could vary based on the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to

mail new documentation. Section 19.1706(c) and §19.2006(c) are not applicable to specialty URAs.

(i) *Cost of administrative assistant wages.* TDI anticipates that a URA will utilize an administrative assistant on a recurring basis for submitting the requisite information to TDI. TDI anticipates that a URA's administrative assistant will take approximately one hour to obtain the information, prepare it for mailing, and transmit it in accord with the URA's mailing processes. TDI estimates that a URA could incur a cost of administrative staff wages per submission of an individual's information.

(ii) *Cost to print and mail the information.* A URA could incur a cost for printing the name, license number, and state of licensure for submission, and TDI anticipates that the additional information will require less than one additional page to print. TDI estimates that the required documentation will not exceed one page and will result in a mailing cost of approximately \$0.29 per submission.

Section 19.1709(d)(2) and §19.2009(a)(4): Preauthorization Numbers. Any URA subject to §19.1709(d)(2) and §19.2009(a)(4), as applicable, that has not already modified its automated system to align with the formats required under the standards adopted by the U.S. Department of Health and Human Services in 45 CFR §162.1102, will incur some cost to modify its system to comply with the proposed requirements. While the format for the preauthorization number in professional, institutional, and dental electronic transactions is alphanumeric, the format for pharmacy transactions is numeric. Accordingly, URAs that currently assign only alphanumeric preauthorization numbers will need to modify their automated systems to assign numeric

preauthorization numbers for drugs. With the adoption of the federal electronic transaction standards, it is likely that the majority of URAs have already addressed this data issue. It is estimated, however, that approximately 35 percent of URAs will need to implement the associated format change. TDI determined that the total estimated cost for a URA to comply with §19.1709(d)(2) or §19.2009(a)(4), as applicable, could vary based on the cost of programming to modify the URA's automated system.

Cost of programming to modify the automated system. The URAs that will have to modify their automated systems to comply with these proposed requirements will need to initiate an automation project to design the changes, evaluate their automation systems for other corollary impacts, modify the assignment logic for preauthorization numbers, and test the changes prior to implementation. TDI anticipates that a URA could incur a one-time cost for programming necessary for this type of automation project. TDI estimates that an in-house programmer could require approximately 90 hours to complete this automation project with a one-time cost for a computer programmer.

Section 19.1709(b) and §19.2009(b): Notice of Adverse Determinations made in Prospective, Concurrent, or Retrospective Utilization Review. Although some of the information in §19.1709(b) and §19.2009(b) is required as a result of existing rules and Insurance Code §4201.303, the following information is required as a result of both §19.1709(b) and §19.2009(b): (i) the professional specialty and state(s) of licensure of the physician or doctor that made the determination; (ii) a description of the URA's appeal process; and (iii) notice of the independent review process and a

copy of Form No. LHL009 request for a review by an IRO. Additionally, subject to §19.2009(b)(8), for workers' compensation non-network coverage, a URA must include a description of guidelines utilized in accord with Chapter 137 (relating to Disability Management) in the written notice of the adverse determination.

Although TDI does not expect an increase in the number of requests for an IRO based on the required inclusion of a copy of Form No. LHL009 request for a review by an IRO with the written notification of adverse determination, it is possible that the inclusion of the form could increase the number of requests. An increased number of requests could result in an increased number of independent reviews for which a URA must pay under Insurance Code §4201.403. However, it is not possible for TDI to estimate the amount of costs that a URA would incur because there are numerous factors involved that are not suitable to reliable quantification by TDI, including the number of written notifications of adverse determinations that are sent and whether the inclusion of the copy of Form No. LHL009 request for a review by an IRO would actually result in a request for independent review that would not have otherwise been made.

TDI anticipates that a URA may incur costs associated with drafting new templates for written notification of adverse determination and sending the additional information with each written notification of adverse determination as a result of the proposed new rules. TDI determined that the total estimated cost for a URA to comply could vary based on the following cost components for each of the set of requirements:

- (i) cost of general operations manager wages;
- (ii) cost of programming automated

fields in the notice; (iii) cost of administrative assistant wages; and (iv) cost to print and mail additional paperwork and Form No. LHL009 request for a review by an IRO.

(i) *Cost of general operations manager wages.* The proposed requirements will likely require development of a new template for the written notification of adverse determination. TDI anticipates that a URA's general operations manager will do most, if not all, of the drafting and basic review of each of the new templates, and will likely require, on average, approximately one to two hours of a general operations manager's time.

(ii) *Cost of programming automated fields in the notice.* Each notice of adverse determination under §19.1709(b) and §19.2009(b) will not be identical, but there are certain automated fields that may be created to comply more efficiently with the notice requirements. TDI anticipates that a URA could incur a one-time cost for programming necessary to populate certain fields that are required in the notice of adverse determination. TDI estimates that an in-house programmer could require approximately five to 10 hours to format the notice. The total annual amount will depend on the number of hours that a particular URA needs the programmer based on its unique preferences and existing information technology resources. The actual number of hours, types, and cost of personnel will depend on each URA's existing information systems and staffing.

(iii) *Cost of administrative assistant wages.* Because each written notification of adverse determination requires some additional information that is specific to the individual case, TDI anticipates that a URA will incur a recurring cost of administrative

assistant wages to tailor each notification of adverse determination. TDI anticipates that approximately one to two hours will be required for an administrative assistant to tailor each written notification of adverse determination. A URA could have recurring administrative assistant cost per written notification of adverse determination. However, the total cost to the URA for administrative assistant wages will vary depending on the number of written notifications of adverse determination issued.

(iv) Cost to print and mail additional paperwork and the Form No. LHL009 request for a review by an IRO. TDI anticipates that a URA could incur a recurring cost for printing and mailing the additional required notice elements and a copy of Form No. LHL009 request for a review by an IRO. Form No. LHL009 request for a review by an IRO contains four pages, but the additional pages necessary for the required notice elements may vary. TDI is not able to estimate the required number of pages. A URA's total annual cost will also vary based on the number of written notifications of adverse determination issued by each URA.

Section §19.1710 and §19.2010: Documentation of Peer-to-Peer Discussion Requirements Prior to Issuing Adverse Determinations. Section 19.1710 and §19.2010 require the URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome. The URA must also submit the documentation to TDI or TDI-DWC on request. TDI anticipates that a URA may incur ongoing weekly costs associated with recording the date and time the URA offered

the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome and submitting the documentation to TDI on request. Section 19.1710 and §19.2010 are not applicable to specialty URAs.

TDI determined that the total estimated cost for a URA to comply could vary based on the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to TDI on request.

(i) Cost of administrative assistant wages. TDI anticipates that a URA could incur a weekly cost for an administrative assistant of approximately four hours to maintain documentation of peer-to-peer communication and submit records of those communications to TDI on request. This estimate could vary depending on how much time is required based on the particular URA's number of adverse determinations and communications with providers of record. TDI anticipates that each URA has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors of which the URA is aware that will impact the URA's total cost to comply.

TDI also anticipates that a URA will incur a recurring cost of approximately five hours annually of administrative assistant wages to submit the required documentation on request. The total annual cost to the URA will vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of TDI or TDI-DWC requests for the required documentation.

(ii) *Cost to print and mail the required documentation.* TDI anticipates that a URA could incur a cost for printing and mailing the required documentation of the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome to submit to TDI on request. A URA's potential printing costs could vary based on the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

Section 19.1711(a) and §19.2011(a): Written Procedures for Appeals of Prospective or Concurrent Review Adverse Determinations. Although some of the information in §19.1711(a) and §19.2011(a) is required under existing rules or is required by statute, the following new information is required as a result of proposed amendments to §19.1711(a): (i) a statement specifying the timeframes for filing the written or oral appeal; (ii) a provision that appeal decisions must be made by a physician who has not previously reviewed the case; (iii) a provision that states that prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician; and (iv) a provision that states that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that complies with §19.1709(a).

Section 19.2011(a) requires a URA to maintain and make available a written description of appeal procedures involving an adverse determination that is used by the agent and prescribe the information that the written procedures must include. Although

some of the information is required under existing rules or is required by statute, the following new information is required for URAs conducting utilization review for health care provided under workers' compensation insurance coverage: (i) a statement specifying the timeframes for filing the appeal for workers' compensation network coverage, which may not be less than 30 days after the date of issuance of written notification of an adverse determination; (ii) a provision that appeal decisions must be made by a physician who has not previously reviewed the case in accord with 28 TAC Chapter 180 (relating to Monitoring and Enforcement), Insurance Code §1305.354, and 28 TAC §10.103; (iii) a provision that if the health care services in question are dental or chiropractic services, then a dentist or chiropractor, respectively, may make the appeal decision if the services are within the scope of the their license to practice; (iv) a provision that states that prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician; and (v) a provision that states that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that complies with §19.2009(a).

TDI anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with drafting written procedures for appeals and implementing those procedures. TDI determined that the total estimated cost for a URA to comply with §19.1711(a) or §19.2011(a), as applicable, could vary based on the following cost components: (i) cost of general operations manager wages; and (ii) cost of implementation of written procedures, including printing and mailing costs.

TDI anticipates that specialty URAs are likely to incur these same costs to comply with §19.1711(a) or §19.2011(a) with the following exceptions: (i) §19.1711(a)(4) or §19.2011(a)(4) requiring that appeal decisions of prospective or concurrent adverse determinations be made by a physician who has not previously reviewed the case; (ii) §19.1711(a)(5) requiring in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, or §19.2011(a)(5) requiring in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, prior to issuance of a prospective or concurrent adverse determination, the URA to afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee or injured employee with a physician.

(i) Cost of general operations manager wages. TDI anticipates that, because the proposed requirements will likely involve drafting of new procedures, a URA's general operations manager will do most, if not all, of the drafting and basic review of the new written procedures. TDI anticipates that this drafting will likely require on average approximately four to 10 hours of a general operations manager's time for the initial drafting.

(ii) Cost of printing and mailing. TDI anticipates that a URA's implementation of the proposed new procedures and requirements will also result in additional costs to the URA. Implementation of these written procedures may require printing and mailing costs for the additional letters or information and will vary based on the number of letters the URA must send.

(iii) Cost factors not quantifiable. It is not possible for TDI to estimate the costs that a URA could incur to implement all of the written procedures because there are numerous factors involved that are not suitable to reliable quantification by TDI. These factors include the extent to which the URA is already implementing the new required procedures and the number of appeals of prospective or concurrent adverse determinations that the URA receives.

Section 19.1711(b) and §19.2011(b): Written Procedures for Appeals of Retrospective Review Adverse Determinations. Section 19.1711(b) or §19.2011(b), as applicable, require a URA to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. TDI anticipates that URAs may incur costs associated with drafting this written description that could vary based on the cost of general operations manager wages necessary for drafting the written description.

Cost of general operations manager wages necessary for drafting the written description. TDI anticipates that, because the proposed requirements will likely require development of a written description of the appeal procedures involving an adverse determination in a retrospective review, a URA's general operations manager will do most, if not all, of the drafting of this written description. TDI anticipates that this drafting will likely require on average approximately four to 10 hours of a general operations manager's time for the initial drafting.

Section 19.1713(a)(3) and §19.2013(a)(3): Retention of Records. Section 19.1713(a)(3) and §19.2013(a)(3) require a URA to retain information generated and

obtained by the URA in the course of utilization review for at least four years, instead of the existing requirement of two years.

TDI anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with storing information generated and obtained by a URA in the course of utilization review for the additional two years. The total estimated cost for a URA to comply could vary based on the cost of storing the required information for an additional two years.

Cost of storing the required information for an additional two years. Although TDI estimates that the cost of storing the required information for an additional two years is nominal, TDI considered the following factors: one thousand pieces of paper will not fill a standard-size file cabinet drawer or a standard-size file box. Electronically, at approximately 26 kilobytes per single page PDF file, 1,000 single-page proof files would amount to approximately 26 megabytes of storage, which is less than one-tenth of one percent of a 40-gigabyte hard drive. Thus, while storing a large number of records may increase a URA's current storage cost, it is unlikely that even the potential maximum volume that could result from compliance with §19.1713(a)(3) and §19.2013(a)(3), as applicable, will result in significant additional costs or in an alteration of a URA's current record storage system.

Section 19.1717(a) and §19.2017(a): Notification of Independent Review of Adverse Determinations Concerning Life-Threatening Conditions. Although some of the information is required under existing rules, each URA will incur a cost to comply with the new requirement to include a copy of Form No. LHL009 request for a review by

an IRO with the notice of the independent review process. The inclusion of a copy of Form No. LHL009 request for a review by an IRO may facilitate the submission of a request for review by an IRO, and increase the overall number of requests for review by an IRO. A URA must pay for an independent review under Insurance Code §4201.403, if the review is conducted under Chapter 4201, Subchapter I, of the Insurance Code. Although TDI does not expect an increase in the number of requests for an IRO based on the required inclusion of a copy of Form No. LHL009 request for a review by an IRO with the written notification of adverse determination, it is possible that the inclusion of the form could increase the number of requests. An increased number of requests could result in an increased number of independent reviews for which a URA must pay under Insurance Code §4201.403.

It is not possible for TDI to estimate the costs that a URA would incur as a result of any increase in the number of requests because the relevant factors are not suitable to reliable quantification. These factors include the number of written notifications of adverse determinations that are sent and whether the copy of Form No. LHL009 request for a review by an IRO would actually cause a request for independent review that would not have otherwise been made.

TDI determined that the total estimated cost for a URA to comply with §19.1717(a) and §19.2017(a), as applicable, could vary based on the following cost components: (i) cost to print and mail the independent review request form; and (ii) the cost of the potential increase in life-threatening cases based on the “prudent layperson” standard.

(i) *Cost to print and mail independent review request form.* TDI anticipates that a URA could incur a cost for printing the four pages of Form No. LHL009 request for a review by an IRO to include with the notice of adverse determination. TDI estimates that any additional mailing cost resulting from this rule proposal would be nominal. A URA's potential printing and mailing costs will also vary depending on the number of notifications of adverse determination that the URA must send.

(ii) *Potential cost of the increase in life-threatening cases based on the "prudent layperson" standard.* Existing rules do not specify who has to make the determination whether a case is life threatening. However, the addition of the "prudent layperson" standard could increase the number of life-threatening cases, and increase the number of requests for independent review for these cases. However, it is not possible for TDI to estimate the amount of costs that a URA would incur due to these increases because the factors involved are not reliably quantifiable. These factors include whether a life-threatening case would not otherwise be considered "life threatening" but for the "prudent layperson" standard and the overall number of life-threatening cases.

B. Estimated Costs to Specialty URAs Only.

Section 19.1716(d) and §19.2016(d): Utilization Review Plan. Section 19.1716(d) and §19.2016(d) require a specialty URA to develop written procedures to ensure that existing §19.1720(c) and §19.2020(c) requirements are implemented. Existing §19.1720(c), relating to utilization review plan for specialty URAs for health care provided under a health benefit plan or health insurance policy, requires a specialty URA to have its utilization review plan, including appeal requirements, reviewed by a

physician, doctor, or other health care provider of the appropriate specialty.

Additionally, the plan must be implemented in accord with standards developed with input from a physician, doctor, or other health care provider of the appropriate specialty.

Existing §19.2020(c), relating to utilization review plan for specialty URAs for health care provided under workers' compensation insurance coverage, mandates the same requirements imposed under existing §19.1720(c).

TDI anticipates that new §19.1716(d) or §19.2016(d) could result in costs to comply for specialty URAs. TDI estimates that the total cost for a specialty URA to comply could vary based on the cost of a general operations manager to develop written procedures.

Cost of a general operations manager wages to develop written procedures. TDI anticipates that, because the proposed provisions will likely require development of new policies and procedures, a URA's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures. TDI anticipates that this development of written procedures will likely require on average approximately eight to 10 hours of a general operations manager's time for the initial drafting.

Section 19.1716(f) and §19.2016(g): Documentation of Peer-to-Peer Discussion Requirements Prior to Issuing Adverse Determinations. Section 19.1716(f) and §19.2016(g) require the specialty URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion

outcome. Further, §19.1716(f)(2) and §19.2016(g)(2) require the specialty URA to submit the documentation to TDI or TDI-DWC on request, as applicable. Under Insurance Code §4201.456, before a specialty URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service issues an adverse determination, the specialty URA must provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the specialty URA's determination with a health care provider who is of the same specialty as the agent.

TDI anticipates that a URA may incur ongoing weekly costs associated with recording the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome and submitting the documentation to TDI on request. TDI determined that the total estimated cost for a URA to comply could vary based on the following components: (i) cost of administrative assistant wages; and (ii) cost to print and mail the documentation to TDI on request.

(i) Cost of administrative assistant wages. TDI anticipates that a URA could incur a weekly cost for an administrative assistant of approximately four hours to maintain documentation of peer-to-peer communication and submit records of those communications to TDI on request. This estimate could vary depending on how much time is required based on the particular URA's number of adverse determinations and communications with providers of record. TDI anticipates that each URA has the information necessary to determine its estimated total monthly and annual costs based

on these factors and any other factors of which the URA is aware that will impact the URA's total cost to comply.

TDI also anticipates that a URA will incur a recurring cost of approximately five hours annually of administrative assistant wages to submit the required documentation on request. The total annual cost to the URA will vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of TDI or TDI-DWC requests for the required documentation.

(ii) *Cost to print and mail the required documentation.* TDI anticipates that a URA could incur a cost for printing and mailing the required documentation of the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome to TDI on request. A URA's potential printing costs could vary based on the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

II. Estimated Costs to URAs, Including HMO and Insurer URAs and Specialty URAs Subject to Additional Subchapter U Requirements that have not been Previously Discussed.

Section 19.2012(b): Requirement for a Written Description of Procedures for Responding to Requests for Drugs, Post-Stabilization Care, and Pain Management Medication under Certain Circumstances. Section 19.2012(b) requires a URA, for health care provided under workers' compensation insurance coverage, to provide a written description to the commissioner setting forth the

procedures that the URA will follow when responding to requests for: (i) drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could pose an unreasonable risk of a medical emergency; and (ii) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by the treating physician or provider of record.

TDI determined that the total estimated one-time cost for a URA to comply with §19.2012(b) could vary based on the following cost components: (i) cost of general operations manager wages; (ii) cost to print and mail the written description of procedures; and (iii) cost to implement the written description of procedures.

(i) Cost of general operations manager wages. TDI anticipates that, because the proposed provision will likely require development of new procedures, a URA's general operations manager will do most, if not all, of the drafting and basic review of these new procedures. TDI anticipates that this drafting will likely require on average approximately 10 hours of a general operations manager's time.

(ii) Cost to print and mail the written description of procedures. TDI anticipates that a URA could incur a cost for printing and mailing the new written description of procedures. A URA's total cost to print and mail the written description of procedures will vary depending on the number of pages and the business practices of the URA.

(iii) Cost to implement the written description of procedures. A URA may incur costs to implement the written procedures. However, it is not possible for TDI to estimate the amount of these costs because the relevant factors are not suitable to

reliable quantification. These factors include: (a) the number of requests for drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could pose an unreasonable risk of a medical emergency; (b) the number of requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by the treating physician or provider of record; and (c) the URA's existing practices.

Section 19.2014(b): Summary Report. Section 19.2014(b) requires additional information to be included in the summary report that the URA must submit to TDI annually. The following additional information that is required in the summary report is not required by statute and is a result of the proposed amendments: (i) the disposition of the appeal of adverse determination (either in favor of the appellant or in favor of the original utilization review determination) at each level within the internal utilization review process; and (ii) the subject matter of any complaint filed with the URA.

TDI anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with submitting the summary report information. TDI determined that the total estimated cost for a URA to comply could vary based on the following cost components: (i) cost of general operations manager wages; and (ii) costs for programming necessary to collect the additional required information.

(i) Cost of general operations manager wages. TDI anticipates that, because the proposed requirements will involve submission of additional information, a URA's general operations manager will do most, if not all, of these submissions. TDI

anticipates that submitting the additional information will likely require on average approximately one to two hours of a general operations manager's time per annual summary report.

(ii) Costs for programming necessary to collect the additional required information. TDI also anticipates that a URA could incur a one-time cost for programming necessary to collect the additional required information. TDI estimates that an in-house programmer could require approximately five to 10 hours to set up a process to automatically collect the information required.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Analysis of Economic Impact

In accord with Government Code §2006.002(c), TDI determined that several sections may have an adverse economic impact on URAs, including HMO URAs, insurer URAs, and specialty URAs, that qualify as small or micro businesses under Government Code §2006.001(1) and (2) and that must comply with the proposed rules. TDI was unable to obtain information relating to the number of URAs that qualify as a small or micro business under Government Code §2006.001(1) and (2). There are a total of 187 certified and 15 registered URAs in the state, including workers' compensation URAs, HMO URAs, insurer URAs, and specialty URAs.

Workers' compensation URAs: Of the 187 certified URAs, 73 are certified for workers' compensation. Of the 15 registered URAs, currently three are registered for workers' compensation.

HMO URAs: There are 18 certified or registered HMO URAs in the state. TDI estimates one to two of these qualify as a small or micro business.

Insurer URAs: There are 17 certified or registered insurer URAs in the state. TDI estimates one to two of these qualify as a small or micro business.

Specialty URAs: There are 24 specialty URAs in the state, all of which are certified. TDI estimates one to two of these qualify as a small or micro business.

Regulatory Flexibility Analysis

The cost of compliance with these rules will not vary between large businesses and small or micro businesses. TDI's cost analysis of these requirements, which can be found in the Public Benefit/Cost Note section of this proposal, applies equally to small or micro business URAs, including HMO URAs, insurer URAs, and specialty URAs.

Under Government Code §2006.002(c), before adopting a rule that may have an adverse economic effect on small or micro businesses, an agency must prepare a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the proposed rule. For each of the proposed new requirements, TDI considered other regulatory methods that accomplish the objectives of the proposal, minimize any adverse economic impact on URAs that qualify as small or micro businesses under Government Code §2006.001(1) and (2), but still protect the health, safety, and environmental and economic welfare of the state.

I. Estimated Costs for Entities Subject to Subchapter R or Subchapter U, or both.

The following provisions may result in compliance costs for URAs, including HMO and insurer URAs and specialty URAs, to comply with either Subchapter R or Subchapter U:

A. Estimated Costs to URAs, Including HMO and Insurer URAs; and Specialty URAs.

Section 19.1704(b) and §19.2004(b): URA Application Form No. LHL005.

TDI considered, as a regulatory alternative, exempting small and micro business URAs from the non-statutory requirements under §19.1704(b) and §19.2004(b). TDI determined, however, that this exemption would not accomplish the objectives of §19.1704(b) and §19.2004(b) and would not be consistent with the health, safety, and environmental and economic welfare of the state, for the following reasons: (i) the exemption is inconsistent with legislative intent; (ii) the exemption could result in some consumers receiving fewer health care services; and (iii) the requirement will have a minimal economic impact.

Additionally, TDI determined that the costs for small and micro businesses to comply with §19.1704(b) and §19.2004(b) are nominal. The adverse impact that would result for Texas consumers of small and micro business URAs exempted from the non-statutory requirements under §19.1704(b) and §19.2004(b) outweighs any economic impact on small and micro business URAs.

(i) Exemption is inconsistent with legislative intent. The Senate Committee on State Affairs Bill Analysis for HB 4290 specifies that the legislative intent of HB 4290 is

to ensure consistent standards for what is considered experimental and investigational.

Exempting small or micro business URAs from the non-statutory requirements of §19.1704(b) and §19.2004(b) would not allow TDI to review the URAs' screening criteria and review procedures, which would not assist in the legislative goal of establishing consistent standards for what is considered experimental and investigational.

(ii) Exemption could result in some consumers receiving less health care services. Requiring all URAs to follow the submission of information requirements under §19.1704(b) and §19.2004(b) for a certification or registration and for renewal of a certification or registration as a URA is necessary to protect the health and economic welfare of consumers. Absent these requirements, TDI's ability to oversee URAs would be diminished. This diminished oversight could lead to inconsistent standards for approval or denial of health care services or inconsistent procedures available for consumers to appeal those standards of review. For example, in Form No. LHL005 URA application, an applicant must submit an adequate summary description of screening criteria and review procedures to be used to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care. An applicant must also submit information regarding the availability of personnel to handle consumer complaints and copies of procedures established for appeal of an adverse determination with an applicant's request for certification or registration as a URA. Exempting small and micro business URAs from these requirements could result in consumers of these small and micro business URAs failing to receive the same health care services because of differing standards for approval or denial of health care

services. Additionally, exempting small and micro business from these requirements could result in consumers of these small and micro business URAs not having available remedies after receiving an adverse determination or in not having the requisite information to pursue remedies after receiving an adverse determination.

Additionally, the uniform submission of policies and procedures to TDI for a certification or registration or for renewal of a certification or registration as a URA under §19.1704(b) and §19.2004(b) promotes confidence in the URA's decisions. For example, in Form No. LHL005 URA application, a URA must certify that its screening criteria and review procedures are established with input from appropriate health care providers and approved by physicians. Those consumers who are involved with URAs that are not required to submit their screening criteria to TDI could be subject to a lesser quality of review. Further, a URA must submit written policies to TDI relating to the availability of personnel and telephone messaging systems for preauthorization and verification for HMO and preferred provider benefit plans. Adopting these types of requirements to apply to all URAs, regardless of size, will result in consistent application of screening criteria and review procedures. This consistent application will, in turn, ensure that all consumers, including those that utilize small and micro business URAs, have the requisite information to obtain necessary services.

Requiring all URAs, regardless of size, to follow the application requirements under §19.1704(b) and §19.2004(b) eliminates the possibility that TDI would have to create a dual tracking system for certifications, registrations, and renewals based on URA business size.

(iii) The requirement will have a minimal economic impact. While compliance with the proposed application requirements in §19.1704(b) and §19.2004(b) may have an adverse economic impact on small or micro business URAs, TDI anticipates that the required compliance will have a minimal adverse economic impact. TDI anticipates that only a minimal amount of additional time and work will be required for completing the new application because the application documents, even with the additional new requirements, will be substantially similar to the existing application that small and micro business URAs must currently submit. This similarity will reduce the time and effort needed to prepare and submit the new application, especially for renewal applications.

Additional costs will be minimal because the URA will already have some of the information available that TDI requires under §19.1704(b) and §19.2004(b). For example, applicants must submit written evidence that the applicant is doing business in Texas in accord with the Business Organizations Code. This evidence may include a letter from the Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state. The applicant URA should already have this required evidence because it would be subject at the time of formation to existing Texas statutory business formation requirements and fees.

Section 19.1704(f) and §19.2004(f): Correction of Omissions or Deficiencies and Submission of a Request for a Waiver. TDI considered the following regulatory alternatives for §19.1704(f) and §19.2004(f) that are not statutory requirements: (i) permitting small and micro business URAs to correct omissions or deficiencies in the URA application within 30 days; (ii) reducing the information small and micro business

URAs must submit to TDI for a waiver; and (iii) permitting small and micro business URAs to apply for a waiver electronically. However, TDI determined that these options would not accomplish the objectives of §19.1704(f) and §19.2004(f) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

(i) Permitting small and micro business URAs to correct omissions or deficiencies in the URA application within 30 days. TDI considered permitting small and micro business URAs 30 days, as existing rules permit, to correct omissions or deficiencies in the URA application. However, the change from 30 days to 15 working days is necessary to streamline the application process, providing TDI with information more quickly. This shorter time period will allow a more efficient application process, making URAs more quickly available to the Texas consumer.

Additionally, there is a cost saving mechanism proposed as part of §19.1704(f) and §19.2004(f) that is available to small and micro business URAs. If a small or micro business URA is unable to comply with the prescribed time limits for correction of errors or deficiencies in the application, the rule enables a URA to apply for a waiver of the time limits. TDI determined that this waiver is a sufficient remedy for those small and micro business URAs that are unable to meet the 15 working day deadline to correct errors or deficiencies in the application.

(ii) Reducing the information small and micro business URAs must submit to TDI for a waiver. TDI considered reducing the information that a URA must submit to obtain a waiver from the 15 working day limit for correction of errors or deficiencies in the application. The waiver only requires that a URA submit a request in writing for

additional time to correct the omissions or deficiencies in the application. These waiver request requirements are minimal and TDI is unable to reduce the content requirements for small and micro business URAs applying for a certification or registration for the first time. Further, the cost of submitting a waiver by mail to TDI is nominal.

(iii) Permitting small and micro business URAs to apply for a waiver electronically. TDI considered alternatives that could assist small or micro business URAs in obtaining waivers, for example, allowing small or micro business URAs to seek waivers through electronic applications. However, TDI concluded that these modifications would not adequately achieve the purpose of the proposed section. The purpose of requiring the mailing of waiver requests, rather than electronic filing, is to be consistent with current procedures. Permitting small and micro business URAs to make electronic filings of waiver requests, while declining to permit large URAs to do so, would impose additional costs on TDI for minimal savings to small or micro business URAs.

Section 19.1705(c) and §19.2005(c): Development of Screening Criteria.

TDI considered exempting small and micro business URAs from the requirements under §19.1705(c) and §19.2005(c). TDI determined that this option would not accomplish the objectives of §19.1705(c) and §19.2005(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

The purpose of these requirements is for URAs to utilize screening criteria that are evidence-based, scientifically valid, or outcome focused, or if evidence-based medicine is not available for a particular health care service provided, to utilize generally

accepted standards of medical practice recognized in the medical community. These screening criteria requirements are important for the following reasons: (a) to set the parameters for screening criteria, which will provide for more uniform and evidence-based utilization review for enrollees and injured employees; (b) to promote valid and sound decisions when credible and scientific guidelines are utilized; (c) to promote confidence in the URA's decisions because the URA can support and substantiate its decisions; and (d) to promote and ensure consistent decisions among all URAs regarding specific health care treatments and services.

Proposing the amendments to apply to all URAs, regardless of size, will result in consistent application of review criteria for all consumers involved in the URA process, regardless of the size of the URA utilized by the consumer. If TDI exempted small or micro business URAs from these requirements, those consumers who utilize URAs that are not required to acquire the additional screening criteria would be subject to a lesser quality of review, and would receive potentially lower quality health care than those utilizing the larger URAs that are required to comply with the screening criteria requirements.

Section 19.1705(f) and §19.2005(f): Complaint System. TDI considered exempting small and micro business URAs from the requirement to include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI in the written response. TDI determined that an exemption would not accomplish the objectives of §19.1705(f) and §19.2005(f) and would not be consistent with the health, safety, and environmental and economic

welfare of the state because: (i) the information is useful and should be available to all enrollees or injured employees whose health care has been subject to utilization review; and (ii) any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers.

(i) The information is useful and should be available to all enrollees or injured employees whose health care has been subject to utilization review. Providing TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI in the written response will be useful to the enrollee or injured employee. This information will inform them that they can file a complaint with TDI and provide the necessary contact information to do so. Exempting small and micro business URAs from this requirement could result in the enrollees and injured employees of these URAs not receiving this information. Awareness of the complaint process for all consumers who utilize URAs, not just those that utilize large URAs, is important. Complaints will assist TDI in monitoring URAs and ensuring utilization review decisions are being made in accord with Insurance Code Chapter 4201 and TDI rules.

(ii) Any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers. While compliance with the proposed additional information requirements in §19.1705(f) and §19.2005(f) may have an adverse economic impact on small or micro business URAs, TDI anticipates that the required compliance will have a minimal adverse economic impact. A minimal amount of additional time and work will be required to include the minimal additional information, that is, TDI's address and toll-free telephone number and a statement

explaining that a complainant is entitled to file a complaint with TDI. Under Insurance Code §4201.204, the complaints procedure must already include a written response to the complainant by the URA within 30 calendar days.

Sections 19.1703(8), 19.1706(b), 19.2003(8), and 19.2006(b): Requirements and Prohibitions Relating to Personnel. TDI considered exempting small and micro business URAs from the requirements under §§19.1703(8), 19.1706(b), 19.2003(8), and 19.2006(b). TDI determined that this exemption would not accomplish the objectives of §§19.1703(8), 19.1706(b), 19.2003(8), and 19.2006(b) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

These requirements are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of the prohibition is to prevent the physician who reviews the appeal from being improperly influenced by a relationship with the physician or doctor who issued the initial adverse determination, the enrollee, or injured employee, as applicable, who is requesting the appeal. Requiring all URAs, regardless of size, to comply with these requirements will result in a consistent prohibition on potential conflicts of interest that could undermine the utilization review appeals process. If TDI exempted small or micro business URAs from these requirements, enrollees or injured employees subject to small or micro business URA's utilization review could be subject to an appeal with a physician that is unduly influenced by the initial reviewer. This conflict of interest could result in denial of necessary medical care based on that undue influence, rather than independent medical judgment.

Section 19.1706(c) and §19.2006(c): Documentation of Information on Physicians, Doctors, and other Health Care Providers. TDI considered exempting small and micro business URAs from the requirement to provide the name, license number, and state of licensure of personnel to TDI under §19.1706(c) and §19.2006(c). TDI determined that an exemption would not accomplish the objectives of §19.1706(c) and §19.2006(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (i) the exemption could result in some consumers receiving a lesser quality of utilization review; and (ii) the requirement will have a minimal economic impact.

(i) The exemption could result in some consumers receiving a lesser quality of utilization review. The requirement to provide the name, license number, and state of licensure of personnel provides TDI with information to ensure that the URA is utilizing proper personnel to perform utilization review. Exempting small or micro business URAs from this requirement would impede TDI's ability to monitor whether proper personnel are performing utilization review and could foster a situation in which a URA could more easily utilize unqualified personnel. All consumers are entitled to utilization review by qualified personnel, including those enrollees and injured employees using small and micro business URAs. The performance of utilization review by lesser qualified personnel could result in consumers of small and micro business URAs failing to receive appropriate or necessary medical care.

(ii) The requirement will have a minimal economic impact. While compliance with the proposed new requirements may have an adverse economic impact on small or

micro business URAs, TDI anticipates that the required compliance will have a minimal adverse economic impact because URAs must already collect this information when credentialing their personnel.

Section 19.1709(d)(2) and §19.2009(a)(4): Preauthorization Numbers. TDI considered exempting small and micro business URAs from the requirements under §19.1709(d)(2) and §19.2009(a)(4). However, TDI determined that this exemption would not accomplish the objectives of §19.1709(d)(2) and §19.2009(a)(4) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

The purpose of these requirements is to establish a uniform system for preauthorization numbers among all URAs. Requiring all URAs, regardless of size, to comply with these requirements will result in a consistent format for preauthorization numbers for all consumers involved in the URA process, regardless of the size of the URA utilized by the consumer. If TDI exempted small or micro business URAs from these requirements, the formatting for preauthorization numbers could differ substantially, potentially leading to confusion regarding whether health care is preauthorized and causing delay in the consumer's health care. Allowing or requiring different standards would increase the complexity of the system and the costs associated with supporting different formats and protocols. This approach would require all insurance carriers to support duplicate and redundant systems, increasing the administrative costs associated with the receipt and processing of medical bills.

Section 19.1709(b) and §19.2009(b): Notice of Adverse Determinations

made in Prospective, Concurrent, or Retrospective Utilization Review. TDI considered exempting small and micro business URAs from the requirement to provide the additional requisite information under §19.1709(b) and §19.2009(b). TDI determined that an exemption would not accomplish the objectives of §19.1709(b) and §19.2009(b) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (i) the exemption could result in some consumers receiving less information in their notice of adverse determination, which may have a detrimental effect on their appeal; and (ii) any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers.

(i) The exemption could result in some consumers receiving less information in their notice of adverse determination, which may have a detrimental effect on their appeal. TDI determined that these additional notice elements are necessary for the enrollee or injured employee when receiving notice of the adverse determination. Additional information on the physician or doctor who made the adverse determination is for the enrollee's or injured employee's reference. Information regarding the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009 request for a review by an IRO, will inform the enrollee or injured employee of his or her additional options following an adverse determination. A description of the source of the screening criteria or guidelines will also inform the enrollee or injured employee of the criteria or guidelines on which the URA relied.

Collectively, this information will potentially assist enrollees or injured employees in submitting the appropriate documentation if they choose to appeal an adverse determination. Exempting small and micro business URAs from providing the additional requisite information may have a detrimental effect on enrollees and injured employees who utilize these URAs, in some cases even preventing them from receiving necessary medical care.

(ii) Any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers. TDI anticipates that the required compliance will have a minimal adverse economic impact because URAs are already required under existing rules and under Insurance Code §4201.303 to mail a notice of adverse determination and §19.1709(b) and §19.2009(b) only require additional notice elements.

Section 19.1710 and §19.2010: Documentation of Peer-to-Peer Discussion Requirements Prior to Issuing Adverse Determinations. Because of the similarity in the potential compliance costs for small and micro business URAs and in the potential impact on the health and economic welfare of enrollees and injured employees, TDI considered exempting small and micro business URAs from some or all of the proposed documentation, maintenance, and response requirements.

TDI determined that an exemption would not accomplish the objectives of the proposed requirements and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (i) the total or partial exemption could result in TDI's inability to monitor compliance with a significant

statutory requirement; and (ii) the costs to comply with the proposed requirements are nominal.

(i) The total or partial exemption could result in TDI's inability to monitor compliance with a significant statutory requirement. Insurance Code §4201.206 requires a URA to provide a peer-to-peer discussion opportunity prior to issuing an adverse determination. Under Insurance Code §4201.206, before a URA who questions the medical necessity or appropriateness of a health care service issues an adverse determination, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination. This peer-to-peer opportunity is important for the enrollee or injured employee, because it gives the provider of record a chance to discuss the individual's case and possibly influence the determination for a favorable outcome which would not otherwise have been possible. Requiring a URA, regardless of size, to maintain documentation that details the discussion opportunity provided to the provider of record, enables TDI or TDI-DWC to monitor each URA's compliance with the §4201.206 statutory requirement. If TDI is unable to monitor a small or micro business URA's compliance with this statutory requirement, it could be detrimental to the economic welfare or health of enrollees or injured employees utilizing the small or micro business URA. These enrollees or injured employees could be potentially deprived of a favorable determination for needed health care.

(ii) The cost to comply with the proposed requirements is nominal. While compliance with the proposed new requirements may have an adverse economic

impact on small or micro business URAs, TDI anticipates that the required compliance will have a minimal adverse economic impact. Under the proposed requirements, the URA must put in writing the actions that are required under Insurance Code §4201.206 concerning the peer-to-peer discussion before issuance of an adverse determination, to maintain this written documentation, and to provide it on request. TDI anticipates that the costs to comply with these proposed requirements will be nominal for all URAs, including small or micro business URAs.

Section 19.1711(a) and §19.2011(a): Written Procedures for Appeals of Prospective or Concurrent Review Adverse Determinations. TDI considered exempting small and micro business URAs from the requirements to develop and implement additional written procedures under §19.1711(a) and §19.2011(a). TDI determined that an exemption would not accomplish the objectives of §19.1711(a) and §19.2011(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state because the exemption would result in inconsistent URA written appeal procedures.

The additional written procedures are important for the health and economic welfare of Texas consumers. The requirements to set timeframes for filing an appeal and that appeal decisions must be made by a physician who has not previously reviewed the case are necessary to provide a fair appeal process for enrollees and injured employees. The follow-up letter to an expedited appeal determination provides written documentation for the enrollee or injured employee. The required response letter is necessary to provide the enrollee or injured employee information on the

screening criteria on which the decision was made, information on the physician who made the determination, a copy of Form No. LHL009 request for a review by an IRO, and procedures for filing a complaint in accord with Insurance Code §4201.204. All of these required procedures and information are essential to fully inform consumers and ensure that consumers are able to receive necessary health care. If small or micro business URAs were exempt from the proposed new requirements, the enrollees and injured employees who utilize small and micro business URAs would be deprived of several consumer protections that would be afforded to enrollees and injured employees of large URAs.

Section 19.1711(b) and §19.2011(b): Written Procedures for Appeals of Retrospective Review Adverse Determinations. TDI considered exempting small and micro business URAs from §19.1712(b) and §19.2012(b) as a regulatory alternative. TDI determined that an exemption would not accomplish the objectives of the proposed requirements and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (i) the exemption would result in inconsistent URA written appeal procedures; and (ii) the requirement will have a minimal adverse economic impact.

(i) The exemption would result in inconsistent URA written appeal procedures.

The written procedures are important for the health and economic welfare of Texas consumers. The requirement that appeal procedures comport with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims) is important for conformity with that chapter and to ensure that URAs are in compliance with relevant

statutory requirements. It is important to incorporate the consumer protections afforded in the notice of determination for a retrospective review. These consumer protections include several required elements of information that are necessary for an enrollee or injured employee who receives an adverse determination and desires to appeal the adverse determination.

TDI intends for these written procedures to ensure that appeal of retrospective review adverse determinations are subject to a consistent process that provides the enrollee or injured employee, regardless of the size of the URA utilized by the enrollee or injured employee, with a fair procedure. Exempting small or micro businesses from this requirement could subject enrollees or injured employees who utilize small or micro business URAs to a substandard appeal process. A substandard appeal process without adequate consumer protections could adversely affect the outcome of the adverse determination appeal of these enrollees and injured employees and their access to necessary health care.

(ii) The requirement will have a minimal adverse economic impact. TDI anticipates that the required compliance will have a minimal adverse economic impact, because the required written procedures essentially incorporate other statutory or regulatory consumer protection provisions. Additionally, TDI determined that any additional cost to incorporate into the written procedures the proposed new requirements will be minimal. The only costs incurred will be to draft the written procedures; the underlying requirements should already be implemented pursuant to

Insurance Code Chapter 1305 and §4201.206; 28 TAC Chapter 10; Chapter 21, Subchapter T; Chapter 133; §19.1715; and §19.2015.

Section 19.1713(a)(3) and §19.2013(a)(3): Retention of Records. TDI considered exempting small and micro business URAs from the requirement to store the required information for four years under §19.1713(a)(3) and §19.2013(a)(3). TDI determined that this exemption would not accomplish the objectives of §19.1713(a)(3) and §19.2013(a)(3) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because the exemption would result in less effective examinations based on more limited information.

TDI generally conducts URA examinations triennially but does not always examine each URA exactly every three years, so the requirement that the URA maintain information for four years will ensure that TDI has the opportunity to review the information. Because this information is generated and obtained by a URA in the course of utilization review, it is valuable for TDI's monitoring purposes to ensure that enrollees or injured employees are afforded utilization review that is conducted in accord with the Insurance Code and applicable rules. If the URA is not required to store records for long enough to ensure TDI's access to the information, it renders TDI's examinations less effective, possibly resulting in a lesser quality of utilization review for enrollees or injured employees.

Section 19.1717(a) and §19.2017(a): Notification of Independent Review of Adverse Determinations Concerning Life-Threatening Conditions. TDI considered exempting small and micro business URAs from the requirements to include a copy of

Form No. LHL009 request for a review by an IRO under §19.1717(a) and §19.2017(a) and to use the “prudent layperson” standard. TDI determined that an exemption would not accomplish the objectives of §19.1717(a) and §19.2017(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (i) the exemption would result in some enrollees and injured employees not receiving a copy of Form No. LHL009 request for a review by an IRO; (ii) the exemption could result in inconsistent standards between §19.1717(a) and §19.2017(a) regarding the “prudent layperson” standard; and (iii) the requirement will have a minimal adverse economic impact.

(i) The exemption would result in some enrollees and injured employees not receiving a copy of Form No. LHL009 request for a review by an IRO. Including a copy of Form No. LHL009 request for a review by an IRO is important for enrollees or injured employees who utilize URAs regardless of the size of the URA, because they are entitled to an immediate appeal to an IRO in the event of an adverse determination and if they have a life-threatening condition, under Insurance Code §4201.360. The receipt of the form could facilitate the request for independent review by enabling the request to be made more efficiently and quickly than if the enrollees or injured employees had to find the form on their own. Exempting small or micro business URAs from this requirement could cause unnecessary and avoidable delays for enrollees and injured employees who utilize small or micro business URAs.

(ii) The exemption could result in inconsistent standards for enrollees or injured employees regarding the “prudent layperson” standard. Existing §19.1721 allows the

determination of the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the disease or condition is a life-threatening condition. Section 19.1717(a) and §19.2017(a) incorporate this same “prudent layperson” standard. Exempting small or micro business URAs from the “prudent layperson” standard would result in a different standard regarding who determines a life-threatening condition, based on whether the URA is subject to §19.1717(a) or §19.2017(a) and whether the patient is an enrollee or an injured employee. In the interest of equal consumer protection for both enrollees and injured employees, it is important that both of these categories of patients be entitled to an immediate appeal to an IRO in the event of a life-threatening condition, and that the same standard apply to both categories of patients for determining whether there is a life-threatening condition. Exempting small or micro business URAs from the “prudent layperson” standard would result in significant disparate consumer protections compared to those who utilize large URAs.

(iii) The requirement will have a minimal adverse economic impact. TDI anticipates that the required compliance will have a minimal adverse economic impact. The URA is already required under Insurance Code §4201.301 to send a notice of adverse determination, so the addition of a copy of the IRO form will involve nominal additional costs, as detailed in the Public Benefit/Cost Note part of this proposal. Although it is not possible to determine the total cost for the “prudent layperson” standard, it is possible that in many cases this standard is already being used. For those small and micro business URAs that are not currently utilizing the “prudent

layperson” standard, an exemption will not result in a cost savings outweighing the need for patients utilizing these URAs to an immediate appeal to an IRO in the event of a life-threatening condition on the basis of this standard.

B. Estimated Costs to Specialty URAs Only.

Section 19.1716(d) and §19.2016(d): Utilization Review Plan. TDI considered exempting small and micro business specialty URAs from the requirements under §19.1716(d) and §19.2016(d) to develop written procedures. TDI determined that this exemption would not accomplish the objectives of §19.1716(d) and §19.2016(d) and would not be consistent with the health, safety, and environmental and economic welfare of the state. The potential adverse impact that could result for Texas consumers of these small and micro business specialty URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements.

The requirement for written procedures is intended to ensure that the existing §19.1720(c) and §19.2020(c) requirements are implemented. Without written procedures, it is impossible for the procedures to be made available to consumers for informational purposes or to TDI for regulatory purposes. Enrollees and injured employees of small and micro business URAs should have the same consumer protections as the enrollees and injured employees of large URAs as a result of these proposed requirements. Exempting small or micro business specialty URAs could result in utilization review plans that are not properly developed, reviewed, and implemented. As a result, enrollees and injured employees utilizing small or micro

business specialty URAs could be provided a lesser quality of review that could result in inadequate health care or deprivation of necessary health care.

Additionally, because the underlying requirements are already set forth in existing rules and specialty URAs regardless of size must already comply with these requirements, the costs to small and micro business specialty URAs to develop written procedures are minimal.

Section 19.1716(f) and §19.2016(g): Documentation of Peer-to-Peer

Discussion Requirements Prior to Issuing Adverse Determinations. TDI considered exempting small and micro business specialty URAs from the requirements under §19.1716(f) and §19.2016(g) to develop written procedures. TDI determined that this exemption would not accomplish the objectives of §19.1716(f) and §19.2016(g) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (i) the total or partial exemption could result in TDI's inability to monitor compliance with a significant statutory requirement; and (ii) the costs to comply with the proposed requirements are nominal.

(i) The total or partial exemption could result in TDI's inability to monitor compliance with a significant statutory requirement. Under Insurance Code §4201.456, before a specialty URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service issues an adverse determination, the specialty URA must provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical

basis for the specialty URA's determination with a health care provider who is of the same specialty as the agent.

This peer-to-peer opportunity is important for the enrollee or injured employee, because it gives the provider of record a chance to discuss the individual's case and possibly influence the determination for a favorable outcome, which would not otherwise have been possible. Requiring a specialty URA, regardless of size, to maintain documentation that details the discussion opportunity provided to the provider of record, enables TDI or TDI-DWC to monitor each specialty URA's compliance with the §4201.456 statutory requirement. If TDI is unable to monitor a small or micro business specialty URA's compliance with this statutory requirement, it could be detrimental to the economic welfare and/or health of enrollees or injured employees utilizing the small or micro business specialty URA. Enrollees or injured employees could be potentially deprived of a favorable determination for needed health care.

(ii) The cost to comply with the proposed requirements is nominal. While compliance with the proposed new requirements may have an adverse economic impact on small or micro business specialty URAs, TDI anticipates that the required compliance will have a minimal adverse economic impact. Under the proposed requirements, the specialty URA must put in writing the actions that are required under Insurance Code §4201.456 to maintain this written documentation, and to provide it on request. TDI anticipates that the costs to comply with these proposed requirements will be nominal, as detailed in the Public Benefit/Cost Note part of this proposal, for all specialty URAs, including small or micro business specialty URAs.

II. Estimated Costs to URAs, Including HMO and Insurer URAs and Specialty URAs Subject to Additional Subchapter U Requirements that have not been Previously Discussed.

Section 19.2012(b): Requirement for a Written Description of Procedures for Responding to Requests for Drugs, Post-Stabilization Care and Pain Management Medication under Certain Circumstances. TDI considered exempting small and micro business URAs from the requirements under §19.2012(b) to provide a written description setting forth the requisite procedures. TDI determined that an exemption would not accomplish the objectives of §19.2012(b) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (i) these procedures are important to ensure access to injured employees to certain drugs and post-stabilization care and pain management medication; and (ii) these procedures complement existing rules.

(i) These procedures are important to ensure access to injured employees to certain drugs, post-stabilization care, and pain management medication. The requirement under §19.2012(b) to provide a written description setting forth the procedures that the URA will follow when responding to requests for drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could pose an unreasonable risk of a medical emergency is important to ensure that injured employees receive responses to requests for these drugs. Post-stabilization care and pain management medication immediately subsequent to surgery or emergency

treatment as requested by the treating physician or provider of record, is important to ensure that injured employees receive responses to requests for these drugs, post-stabilization care, or pain management medication. Exempting small or micro business URAs from these requirements could result in injured employees utilizing these small or micro business URAs receiving delayed responses to their requests for: (i) drugs that require preauthorization in certain high risk situations; and (ii) post-stabilization care and pain management medication in certain high risk situations. These delayed responses could adversely impact the health and welfare of the requesting injured employee and there is no justifiable reason for subjecting injured employees using small or micro business URAs to these unnecessary, and potentially harmful, delayed responses.

(ii) These procedures complement existing rules. This proposed requirement is necessary to complement the pharmacy closed formulary rules for both certified network and non-network claims in workers' compensation in 28 TAC Chapter 134, Subchapter F. This URA procedural requirement is necessary for those situations that may occur after the denial of a preauthorization request and is a precursor to a statutorily required closed formulary appeals process that includes the medical interlocutory order process identified in 28 TAC §134.550. An equivalent requirement is not included in the proposed Subchapter R rules.

The post-stabilization portion is intended to extend the preauthorization decision concerning facility-based surgeries (inpatient, outpatient, or ambulatory surgical center) to include necessary pain medication, which is often overlooked during the

preauthorization approval process and leads to confusion regarding the availability of necessary pain medications. TDI and TDI-DWC determined that injured employees who use small or micro business URAs are entitled to the same consumer protections provided in these requirements to injured employees who utilize large URAs. The requirements that are necessary to complement the existing pharmacy closed formulary rules for both certified network and non-network claims in workers' compensation and to extend the preauthorization decision are just as necessary for injured employees who use small or micro business URAs as for those injured employees who utilize large URAs.

Section 19.2014(b): Summary Report. TDI considered exempting small and micro business URAs from the requirements to provide the additional information in the summary report. TDI determined that an exemption would not accomplish the objectives of §19.2014(b) and would not be consistent with the health, safety, and environmental and economic welfare of the state because the exemption would result in inconsistent URA summary report information.

The exemption would result in inconsistent URA summary report information.

The additional summary report information is important for the health and economic welfare of Texas consumers. Information on the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process will allow TDI to monitor how many appeals result in a favorable outcome to the injured employee. If these statistics indicate an unusually high number of appeals upholding the original

utilization review determination, TDI may follow up with the URA to determine whether the appeals procedures comply with the Insurance Code and applicable rules. Targeted auditing may prevent future denials of appeals in situations in which the injured employee is entitled to health care. Information and the required categorization on the subject matter of any complaint filed with the URA could also assist TDI in identifying areas in which the URA requires additional monitoring to ensure statutorily mandated and quality utilization review for consumers. If small or micro business URAs are exempted from the proposed amendments, small and micro business URAs would not be subject to the same level of monitoring by TDI. This lack of information from small and micro business URAs could result in TDI's inability to properly monitor and enforce Insurance Code provisions and applicable rules, possibly resulting in a lesser quality of utilization review and ultimately lack of coverage for necessary health care for the injured employee who uses a small or micro business URA.

5. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 24, 2012 to Sara Waitt, General Counsel, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Debra Diaz-Lara, Director, Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The commissioner will consider the adoption of the proposed new sections in a public hearing under Docket No. 2740 scheduled for September 26, 2012 at 9:30 a.m.

in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

6. STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 4201 (Utilization Review Agents), §38.001 (Data Collection and Reports: Inquiries), §843.151 (Regulation of Health Maintenance Organizations: Rules), §1301.007 (Preferred Provider Benefit Plans: Rules), §1305.007 (Workers' Compensation Health Care Networks: Rules), §1352.003(g) (Brain Injury: Required Coverages-Health Benefit Plans Other than Small Employer Health Benefit Plans), §1352.004(b) (Brain Injury: Training for Certain Personnel Required), §1369.057 (Benefits Related to Prescription Drugs and Devices and Related Services: Rules), and Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority).

Additionally, the new sections are proposed under Labor Code §401.011 (Definitions: General Definitions); Chapter 402 (Operation and Administration of Workers' Compensation System), including §§402.00111(b) (Relationship between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking), 402.00116 (Chief Executive), 402.00128 (General Powers and Duties of Commissioner), and 402.061 (Adoption of Rules); Chapter 408 (Workers' Compensation Benefits), including §§408.0043 (Professional Specialty Certification Required for Certain Review), 408.0044 (Review of Dental Services), 408.0045 (Review of Chiropractic Services), 408.0046 (Rules), 408.021 (Entitlement to Medical Benefits),

408.023 (List of Approved Doctors; Duties of Treating Doctors), and 408.0231 (Maintenance of List of Approved Doctors; Sanctions and Privileges Relating to Health Care); §412.0215 (Sanctions); Chapter 413 (Medical Review), including §§413.011 (Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols), 413.014 (Preauthorization Requirements; Concurrent Review and Certification of Health Care), 413.015 (Payment by Insurance Carriers; Audit and Review), 413.017 (Presumption of Reasonableness), 413.031 (Medical Dispute Resolution), 413.0511 (Medical Advisor), 413.0512 (Medical Quality Review Panel), 413.0513 (Confidentiality Requirements), 413.052 (Production of Documents); and the Occupations Code §155.001 (License to Practice Medicine: Examination Required).

The purpose of Chapter 4201 is stated in Subchapter A §4201.001, which is to:

- (i) promote the delivery of quality health care in a cost-effective manner;
- (ii) ensure that a URA adheres to reasonable standards for conducting utilization review;
- (iii) foster greater coordination and cooperation between a health care provider and URA;
- (iv) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and
- (v) ensure that a URA maintains the confidentiality of medical records in accord with applicable law.

Insurance Code §4201.002 defines the various terms used in the chapter, among them “adverse determination” in §4201.002(1) and “utilization review” in §4201.002(13), which are incorporated into the proposed rules. Section 4201.003 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter

4201. Section 4201.004 specifies the statutory requirements concerning telephone access to a URA.

Subchapter B (Applicability of Chapter) of Chapter 4201 addresses persons providing information about scope of coverage or benefits; certain contracts with the federal government; Medicaid and certain other state health or mental health programs; workers' compensation benefits; health care service provided under automobile insurance policies; employee welfare benefit plans; HMOs; and insurers. Regarding workers' compensation benefits, §4201.054(a) provides, in relevant part, "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." Section 4201.054(c) also states, "Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code." Section 4201.054(d) further provides, "The commissioner of workers' compensation may adopt rules as necessary to implement this section."

Subchapter C (Certification) specifies that a certification of registration is required to conduct utilization review; requirements for certification; certificate renewal; certification and renewal forms; fees; non-transferability of certificate; reporting material changes; and list of URAs. Section 4201.101 provides, "A utilization review agent may not conduct utilization review unless the commissioner [of insurance] issues a certificate of registration to the agent under this subchapter." Further, §4201.102(a) provides, "The commissioner [of insurance] may issue a certificate of registration only to an

applicant who has met all the requirements of this chapter and all the applicable rules adopted by the commissioner [of insurance]."

Subchapter D (Utilization Review: General Standards) sets forth statutory standards regarding utilization review plans under §4201.151; the mandate under §4201.152 that a utilization review must be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States; and the mandate under §4201.153 that screening criteria be objective, clinically valid, compatible with established principles of health care and flexible enough to allow a deviation from the norm when justified on a case-by-case basis. Section 4201.154 provides for review and inspection of screening criteria and review procedures. Section 4201.155 provides that a URA 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.

Subchapter E (Utilization Review: Relations with Patients and Health Care Providers) §§4201.201, 4201.202, 4201.203, 4201.204, 4201.205, 4201.206, and 4201.207 address utilization review relations with patients and health care providers, including repetitive contacts; frequency of reviews; observing or participating in patient's care; mental health therapy; complaint system of the URA; designated initial contact; and opportunity to discuss treatment before issuance of adverse determination.

Subchapter F (Utilization Review: Personnel) §§4201.251, 4201.252, and 4201.253 address personnel matters, including delegation of utilization review, appropriate training, qualification of employed or contracted personnel, and prohibited bases for employment, compensation, evaluation, or performance standards.

Subchapter G (Notice of Determinations) governs the notice of determinations specifying the general duty to notify under §4201.301, the general time for notice under §4201.302, what the contents of the notice of an adverse determination must include under §4201.303, the timeframes for notice of adverse determination under §4201.304, and what the notice of adverse determination for retrospective utilization review must include under §4201.305.

Subchapter H (Appeal of Adverse Determination) specifies the procedure for appeal of an adverse determination, including a provision in §4201.351 that for purposes of Subchapter H, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. Section 4201.352 requires a URA to maintain and make available a written description of the procedures for appealing an adverse determination, and §4201.353 mandates that these procedures be reasonable. Subchapter H further addresses requirements for persons or entities that may appeal in §4201.354, acknowledgement of appeal in §4201.355, specialty review procedures in §4201.356, expedited appeal for denial of emergency care or continued hospitalization in §4201.357, response letter to interested persons in §4201.358, written notice to the appealing party of the determination of the appeal as soon as practicable in §4201.359, and immediate appeal to an IRO in life-threatening circumstances in §4201.360.

Subchapter I (Independent Review of Adverse Determination) sets forth the statutory requirements for the independent review of an adverse determination, addressing the review by the IRO and the URA's compliance with the independent

determination in §4201.401, the information a URA must provide to the appropriate IRO in §4201.402, and payment for independent review in §4201.403.

Subchapter J (Specialty Utilization Review Agents) §4201.451 specifies definitions and requirements governing URAs that conduct utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Subchapter K (Claims Review of Medical Necessity and Appropriateness) of Chapter 4201 was repealed effective September 1, 2009.

Subchapter L (Confidentiality of Information; Access to Other Information) addresses general confidentiality requirements, consent requirements, providing information to affiliated entities, providing information to the commissioner of insurance, access to recorded personal information, publishing information identifiable to a health care provider, requirement to maintain data in a confidential manner, and destruction of certain confidential documents.

Subchapter M (Enforcement) concerns notice of suspected violation, compelling production of information, enforcement proceedings, and remedies and penalties for violation. Section 4201.602 authorizes the commissioner of insurance to initiate a proceeding under Subchapter M, which is a contested case for purposes of Government Code Chapter 2001. Under §4201.603, the commissioner of insurance may impose remedies and penalties for violations of Chapter 4201, which includes a sanction under Chapter 82, an issuance of a cease and desist order under Chapter 83, or an assessment of an administrative penalty under Chapter 84.

Insurance Code §38.001 provides, in relevant part, that TDI may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (i) the person's business condition; or (ii) any matter connected with the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties.

Insurance Code §843.151 provides, in relevant part, that the commissioner of insurance may adopt reasonable rules as necessary and proper to implement Insurance Code Chapter 843.

Insurance Code §1301.007 requires, in relevant part, the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1301.

Insurance Code §1305.007 provides that the commissioner of insurance may adopt rules as necessary to implement Insurance Code Chapter 1305.

Insurance Code §1352.003(g) requires the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1352.

Insurance Code §1352.004(b) requires the commissioner of insurance by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

Insurance Code §1369.057 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter 1369, Subchapter B (Coverage of Prescription Drugs Specified by Drug Formulary).

Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

Labor Code §401.011 specifies definitions used in the Texas Workers' Compensation Act. In particular, §401.011(17) defines the term "doctor"; §401.011(19) defines the term "health care," which includes a prescription drug, medicine, or other remedy under §401.011(19)(E); §401.011(20) defines "health care facility"; and §401.011(22-a) defines the terminology "health care reasonably required." Section 401.011(27) defines the term "insurance carrier"; §401.011(28) defines "insurance company"; and §401.011(44) defines "workers' compensation insurance coverage."

Labor Code §402.00111(b) provides that the commissioner of insurance may delegate to the commissioner of workers' compensation or to that person's designee and may redact any delegation, and the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the commissioner of workers' compensation and the authority to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the TDI-DWC or the commissioner of workers' compensation.

Labor Code §402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate and to assess and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5.

Labor Code §402.061 grants the commissioner of workers' compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §412.0215(a) provides that the TDI-DWC may impose sanctions against any person regulated by the TDI-DWC.

Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who performs health care services under Labor Code Title 5, as a doctor performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serves on the medical quality review panel or as a designated doctor for TDI-DWC. Labor Code §408.0043(b) requires that a person described by Labor Code §408.0043(a), who reviews a specific workers' compensation case, hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

Labor Code §408.0044 pertains to dentists who perform dental services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case be licensed to practice dentistry.

Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for TDI-DWC. Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case be licensed to engage in the practice of chiropractic services.

Labor Code §408.0046 authorizes the commissioner of workers' compensation to adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries, and the rules must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records. Labor Code §408.021(a) specifies that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

Labor Code §408.023(h) requires that a URA or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state. Section 408.023(n) requires the commissioner of workers' compensation to adopt rules to establish reasonable requirements for doctors and health care providers financially related to those doctors, including training, impairment rating testing, financial disclosure, and monitoring.

Labor Code §408.0231(g) requires the commissioner of workers' compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers. Those rules may include standards for peer review, imposition of sanctions on doctors performing peer review functions, including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system, and other issues important to the quality of peer review, as determined by the commissioner.

Labor Code §413.011 requires the commissioner of workers' compensation by rule to establish medical policies and guidelines relating to necessary treatment for injuries, designed to ensure the quality of medical care, and to achieve effective medical cost control.

Labor Code §413.014 requires preauthorization by insurance carriers for specified health care treatments and services. Section 413.014(a) defines the terminology "investigational or experimental service or device."

Labor Code §413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the TDI-DWC ensure compliance with the medical policies and fee guidelines through audit and review.

Labor Code §413.017 provides a presumption of reasonableness for medical services that are consistent with TDI-DWC medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent, or retrospective review as required by TDI-DWC policies and authorized by the insurance carrier.

Labor Code §413.031(d) provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner of workers' compensation rules promulgated under §413.014 or §413.011(g) be conducted by an IRO under Insurance Code Chapter 4202 in the same manner as reviews of utilization review decisions by health maintenance organizations.

Labor Code §413.0511(b) provides that the TDI-DWC medical advisor shall make recommendations regarding the adoption of rules and policies relating to medical benefits as required by the commissioner of workers' compensation.

Labor Code §413.0512(a) requires the TDI-DWC medical advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the required duties under §413.0511.

Labor Code §413.0513(a) provides that information collected, assembled, or maintained by or on behalf of TDI-DWC under §413.0511 or §413.0512 constitutes an investigation file for purposes of and may not be disclosed.

Labor Code §413.052 provides that the commissioner of workers' compensation by rule shall establish procedures to enable TDI-DWC to compel the production of documents.

Labor Code §504.053(b)(2) provides that if a political subdivision or a pool determines that a workers' compensation health care network certified under Insurance Code Chapter 1305 is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool by directly contracting with health

care providers or by contracting through a health benefits pool established under Local Government Code Chapter 172.

Labor Code §504.055(b) provides that §504.055 applies only to a first responder who sustains a serious bodily injury, as defined by Penal Code Section 1.07, in the course and scope of employment.

Labor Code §504.055(c), states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection (b)."

Labor Code §504.056 provides that the purpose of Labor Code §504.055 is to ensure that an injured first responder's claim for medical benefits is accelerated by a political subdivision, insurance carrier, and the division to the full extent authorized by current law.

The Occupations Code §155.001 provides that a person may not practice medicine in this state unless the person holds a license issued under Occupations Code, Title 3, Subtitle B.

8. CROSS REFERENCE TO STATUTE.

Subchapter R rules affect the following statutes: (i) §19.1701 affects Insurance Code §4201.001 and §4201.003; (ii) §19.1702 affects Insurance Code Chapter 4201, Subchapter B; (iii) §19.1703 affects Insurance Code §§843.002(14), 1301.001(8), 1305.004(14), 4201.002, 4201.153, and Labor Code Chapter 401; (iv) §19.1704 affects

Insurance Code Chapter 4201, Subchapter C, Insurance Code §4201.057(e), and §4201.058(c); (v) §19.1705 affects Insurance Code Chapter 4201, Subchapter D and Insurance Code §4201.204 and §4201.251; (vi) §19.1706 affects Insurance Code §1352.004 and §4201.252; (vii) §19.1707 affects Insurance Code §4201.207 and §4201.203; (viii) §19.1708 affects Insurance Code Chapter 4201; (ix) §19.1709 affects Insurance Code §§1352.006, 4201.302 – 4201.305, and 4201.203; (x) §19.1710 affects Insurance Code §4201.206; (xi) §19.1711 affects Insurance Code §§1352.006, 4201.206, and 4201.352 – 4201.360; (xii) §19.1712 affects Insurance Code §4201.004; (xiii) §19.1713 affects Insurance Code §§ 4201.551 – 4201.558; (xiv) §19.1714 affects Insurance Code §38.001 and §4201.204; (xv) §19.1715 affects Insurance Code §§4201.601 – 4201.603; (xvi) §19.1716 affects Insurance Code Chapter 4201, Subchapter J, Insurance Code §4201.101; (xvii) §19.1717 affects Insurance Code §§4201.304, 4201.352, 4201.360, 4201.401 – 4201.403; (xviii) §19.1718 affects Insurance Code §§843.308, 1301.135, and 4201.304; and (xix) §19.1719 affects Insurance Code §843.347 and §1301.133.

Subchapter U rules affect the following statutes: (i) §19.2001 affects Insurance Code §4201.001, §4201.003, Chapter 1305, and Labor Code Title 5; (ii) §19.2002 affects Insurance Code §4201.051, §4201.054(a) and (c), Chapter 1305, and Labor Code Title 5; (iii) §19.2003 affects Insurance Code §§1305.002, 1305.004, 4201.002, 4201.153, 4201.451, and Labor Code §§401.011, 413.014(a), and 504.053; (iv) §19.2004 affects Insurance Code Chapter 4201, Subchapter C, §4201.057(e), and §4201.058(c); (v) §19.2005 affects Insurance Code Chapter 4201, Subchapter D,

§4201.204, and §4201.251, and Labor Code Title 5, §§401.011(22-a), 408.0043, 408.0044, 408.0045, and 504.055; (vi) §19.2006 affects Insurance Code §§1305.351, 4201.152, 4201.252, 4201.253, and Labor Code §408.0231(g) and §408.023(h); (vii) §19.2007 affects Insurance Code §4201.207 and §4201.203; (viii) §19.2008 affects Insurance Code Chapter 4201; (ix) §19.2009 affects Insurance Code Chapter 4201, Subchapter G, and §1305.353; (x) §19.2010 affects Insurance Code §4201.206; (xi) §19.2011 affects Insurance Code Chapter 4201, Subchapter H, §§1305.353, 1305.354, 4201.054, 4201.204, 4201.206, 4201.303; and Labor Code §413.014; (xii) §19.2012 affects Insurance Code §4201.004; (xiii) §19.2013 affects Insurance Code §§ 4201.551 – 4201.558; (xiv) §19.2014 affects Insurance Code §38.001 and §4201.204, and Labor Code §402.00128 and 413.052; (xv) §19.2015 affects Insurance Code §§4201.601 – 4201.603, and Labor Code Chapter 415; (xvi) §19.2016 affects Insurance Code Chapter 4201, Subchapter J, §1305.351, §4201.101, and Labor Code §408.023(h); and (xvii) §19.2017 affects Insurance Code §§1305.003(b), 1305.353, 4201.304, 4201.352, 4201.360, and 4201.401 – 4201.403.

9. TEXT.

**SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE
PROVIDED UNDER A HEALTH BENEFIT PLAN OR
HEALTH INSURANCE POLICY
28 TAC §§19.1701 – 19.1719**

§19.1701. General Provisions.

(a) Statutory basis. This subchapter implements Insurance Code Chapter 4201, concerning Utilization Review Agents.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of this subchapter is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of enrollee safety;

(2) ensure that URAs adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and URAs;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that URAs maintain the confidentiality of medical records in accordance with applicable law.

§19.1702. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, this subchapter applies to utilization review performed under a health benefit plan or a health insurance policy.

(1) This subchapter does not apply to utilization review performed under workers' compensation insurance coverage.

(2) This subchapter does not apply to a person that provides information to an enrollee; an individual acting on behalf of an enrollee; or an enrollee's physician, doctor, or other health care provider about scope of coverage or benefits, but that does not determine medical necessity or appropriateness or the experimental or investigational nature of health care services.

(b) Applicability of other law. In addition to the requirements of this subchapter, provisions of Insurance Code Chapter 843, concerning Health Maintenance Organizations; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; and Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to this subchapter.

§19.1703. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201, have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to an

enrollee are not medically necessary or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(2) Appeal--A URA's formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.

(3) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier or health maintenance organization that is registered as a URA under §19.1704 of this title (relating to Certification or Registration of URAs).

(4) Commissioner--As defined in Insurance Code §31.001.

(5) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(6) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(7) Declination--A response to a request for verification in which an HMO or preferred provider benefit plan does not issue a verification for proposed medical care or health care services. A declination is not necessarily a determination that a claim resulting from the proposed services will not ultimately be paid.

(8) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Insurance Code or applicable TDI rules, or any other association with the enrollee, employer, insurance carrier or HMO that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(9) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(10) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

(11) Form No. LHL005 URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(12) Form No. LHL009 request for a review by an IRO--Form to request a review by an independent review organization. Form No. LHL009 is completed by the requesting party and submitted to the URA.

(13) Form No. 11 biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to Form No. LHL005 URA application.

(14) Health care facility--A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(15) Health coverage--Payment for health care services provided under a health benefit plan or a health insurance policy.

(16) Health maintenance organization or HMO--As defined in Insurance Code §843.002.

(17) Insurance carrier or insurer--An entity authorized and admitted to do the business of insurance in Texas under a certificate of authority issued by TDI.

(18) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(19) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a);

(B) the Friday after Thanksgiving Day;

(C) December 24th; and

(D) December 26th.

(20) Medical records--The entire history of diagnosis and treatment, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an enrollee.

(21) Mental health medical record summary--A summary of process or progress notes relevant to understanding the enrollee's need for treatment of a mental or emotional condition or disorder, including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of enrollee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(22) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, a psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(23) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

(24) Person--Any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, limited liability partnership, and the statewide rural health care system under Insurance Code Chapter 845.

(25) Preauthorization--A form of prospective utilization review by a payor or its URA of health care services proposed to be provided to an enrollee.

(26) Preferred provider--

(A) with regard to a preferred provider benefit plan, a preferred provider as defined in Insurance Code Chapter 1301.

(B) with regard to an HMO:

(i) a physician, as defined in Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined in Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(27) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the enrollee or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to

the enrollee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(28) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(29) Registration--The process for a licensed insurance carrier or HMO to register with TDI to perform utilization review solely for its own enrollees.

(30) Retrospective utilization review--A form of utilization review for health care services that have been provided to an enrollee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(31) Routine vision services--A routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(32) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by the URA as part of the utilization review process.

(33) TDI--The Texas Department of Insurance.

(34) URA--Utilization review agent.

(35) Verification--A guarantee by an HMO or preferred provider benefit plan that the HMO or preferred provider benefit plan will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the enrollee for whom the services are proposed. The term includes pre-certification, certification, re-certification and any other term that would be a reliable representation by an HMO or preferred provider benefit plan to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

§19.1704. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code Chapter 4201 and this subchapter.

(1) If an insurance carrier or HMO performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier or HMO must be certified.

(2) If an insurance carrier or HMO performs utilization review only for coverage for which it is the payor, the insurance carrier or HMO must be registered.

(b) Application form. The commissioner adopts by reference:

(1) Form No. LHL005 URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Form No. 11 biographical affidavit, to be used as an attachment to Form No. LHL005 URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application or request additional time in writing within 15 working

days of the date of TDI's latest notice of the omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting Form No. LHL005 URA application to TDI. The URA must also submit a renewal fee in the amount specified by §19.802(b)(19) of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, a URA may renew the certification or registration by sending a completed renewal application and fee, as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

§19.1705. General Standards of Utilization Review.

(a) Review of utilization review plan. The utilization review plan must be reviewed and approved by a physician and conducted under standards developed and periodically updated with input from both primary and specialty physicians, doctors, and other health care providers, as appropriate.

(b) Special circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require

deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence-based, scientifically valid, outcome focused, and that comply with the requirements in Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community.

(d) Referral and determination of adverse determinations. Adverse determinations must be referred to and may only be determined by an appropriate physician, doctor, or other health care provider with appropriate credentials under §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

(e) Delegation of review. A URA, including a specialty URA, may delegate the review to qualified personnel in a hospital utilization review program or a qualified health care provider. The delegation does not relieve the URA of full responsibility for compliance with this subchapter and Insurance Code Chapter 4201, including the conduct of those to whom utilization review has been delegated.

(f) Complaint system. The URA must develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, individuals acting on behalf

of the enrollee, or health care providers concerning the utilization review. The URA must maintain records of complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

§19.1706. Requirements and Prohibitions Relating to Personnel.

(a) Qualification requirements. Physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review must be appropriately trained, qualified, and currently licensed. Personnel conducting utilization review must hold an unrestricted license, an administrative license, or be otherwise authorized to provide health care services by a licensing agency in the United States.

(b) Disqualifying associations. For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association. A physician, doctor, or health care provider who conducts utilization review must not have any disqualifying associations with the:

(1) enrollee or health care provider who is requesting the utilization review or an appeal; or

(2) physician, doctor, or other health care provider who issued the initial adverse determination.

(c) Information to be sent to TDI. The URA must send to TDI the name, number, type, license number, state of licensure, and qualifications of the personnel either employed or under contract to perform the utilization review with an original or renewal application.

(d) Written procedures and maintenance of records. URAs must develop and implement written procedures and maintain documentation to demonstrate that all physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Training related to acquired brain injury treatment. A URA must provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury in accordance with Insurance Code §1352.004. The purpose of the training is to prevent denial of coverage in violation of Insurance Code §1352.003 and to avoid confusion of medical benefits with mental health benefits.

§19.1707. URA Contact with and Receipt of Information from Health Care Providers.

(a) If a URA must reimburse health care providers for providing medical information under Insurance Code §4201.207, reimbursement is limited to the reasonable costs for providing medical records relevant to the utilization review that

were requested by the URA in writing. A health care provider's charge for providing medical information to a URA must comply with §134.120 of this title (relating to Reimbursement for Medical Documentation) and may not include any costs that are recouped as a part of the charge for health care.

(b) When conducting routine utilization review, the URA must request all relevant and updated information and medical records to complete the review.

(1) This information may include identifying information about the enrollee; the benefit plan or claim; the treating physician, doctor, or other health care provider; or the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the enrollee and the medical history of the enrollee relevant to the diagnoses; the enrollee's prognosis; or the plan of treatment prescribed by the provider of record, along with the provider of record's justification for the plan of treatment. The required information should be obtained from the appropriate source.

(2) URAs must not routinely request copies of all medical records on enrollees reviewed. During utilization review, copies of the necessary or pertinent sections of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate, or experimental or investigational.

(c) The URA must share among its various divisions all clinical and demographic information on individual enrollees to avoid duplicate requests for information from enrollees, physicians, doctors, and other health care providers.

(d) A URA may not require as a condition of approval of a health care service, 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 that relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude the URA from requiring submission of:

(1) an enrollee's mental health medical record summary; or

(2) medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

§19.1708. On-Site Review by the URA.

(a) Identification of URAs. If a URA's staff member is conducting an on-site or off-site review, each staff member must provide his or her name, the name of his or her organization, must show photo identification, and the URA identification card with the certification or registration number assigned by TDI when requested by an individual, including an enrollee or health care provider.

(b) On-site review. For on-site review conducted at a health care facility, URAs:

(1) must ensure that their on-site review staff:

(A) register with the appropriate contact individual, if available, prior to requesting any clinical information or assistance from health care facility staff;

and

(B) wear appropriate health care facility supplied identification tags while on the health care facility premises.

(2) must agree, if so requested, that the medical records remain available in the designated areas during the on-site review and that reasonable health care facility administrative procedures will be followed by on-site review staff to avoid disrupting health care facility operations or enrollee care. The procedures, however, should not obstruct or limit the ability of the URA to efficiently conduct the necessary review.

§19.1709. Notice of Determinations Made in Utilization Review.

(a) Notice requirements. A URA must send written notification to the enrollee or an individual acting on behalf of the enrollee and the enrollee's provider of record, including the health care provider who rendered the service, of a determination made in a utilization review.

(b) Required notice elements. In all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description or the source of the screening criteria that were utilized as guidelines in making the determination;

(4) the professional specialty of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.1705 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination);

(7) a copy of Form No. LHL009 request for a review by an IRO, available at www.tdi.texas.gov/forms;

(8) notice of the independent review process with instructions that:

(A) Form No. LHL009 request for a review by an IRO must be completed by the enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to insurance carrier or URA that made the adverse determination to begin the independent review process; and

(B) the release of medical information to the IRO, which is included as part of the independent review request Form No. LHL009 request for a review by an IRO, must be signed by the enrollee or the enrollee's legal guardian; and

(9) a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an enrollee who has a life-threatening condition.

(c) Determination concerning an acquired brain injury. In addition to the notification required by this section, a URA must comply with this paragraph in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on

medical necessity or appropriateness, a URA must provide notification of the determination through a direct telephone contact to the individual making the request.

This paragraph does not apply to a determination made for coverage under a small employer health benefit plan.

(d) Prospective and concurrent review.

(1) Favorable determinations. The written notification of a favorable determination made in utilization review must be mailed or electronically transmitted as required by Insurance Code §4201.302.

(2) Preauthorization numbers. A URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 Code of Federal Regulations §162.1102, (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction), based on the type of service in the preauthorization request.

(3) Required timeframes. Except as otherwise provided by the Insurance Code, the timeframes for notification of the adverse determination begin from the date of the request and must comply with Insurance Code §4201.304. A URA must provide the notice to the provider of record or other health care provider not later than one hour after the time of the request when denying post-stabilization care subsequent to emergency treatment as requested by a provider of record or other health care provider. The URA must send written notification within three working days of the telephone or electronic transmission.

(e) Retrospective review.

(1) The URA must develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the timeframes for the notice of adverse determination, that comply with Insurance Code §4201.305 and this section.

(2) When a retrospective review of the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services is made in relation to health coverage, the URA may not require the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude requiring submission of:

(A) an enrollee's mental health medical record summary; or

(B) medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

§19.1710. Requirements Prior to Issuing Adverse Determination. In any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to the issuance of an adverse determination, the URA must afford the provider of record a reasonable

opportunity to discuss the plan of treatment for the enrollee with a physician. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(1) The URA must provide the URA's telephone number so that the provider of record may contact the URA to discuss the pending adverse determination.

(2) The URA must maintain, and submit to TDI on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

§19.1711. Written Procedures for Appeal of Adverse Determinations.

(a) Appeal of prospective or concurrent review adverse determinations. Each URA must comply with its written procedures for appeals. The written procedures for appeals must comply with Insurance Code Chapter 4201, Subchapter H, concerning Appeal of Adverse Determination, and must include provisions that specify the following:

(1) timeframes for filing the written or oral appeal, which may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination;

(2) an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing;

(3) an appeal acknowledgement letter must:

(A) be sent to the appealing party within five working days from receipt of the appeal;

(B) acknowledge the date the URA received the appeal;

(C) include a list of relevant documents that must be submitted by the appealing party to the URA; and

(D) include a one-page appeal form to be filled out by the appealing party when the URA receives an oral appeal of an adverse determination.

(4) Appeal decisions must be made by a physician who has not previously reviewed the case.

(5) In any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. The provision must require that the discussion include, at a minimum, the clinical basis for the URA's decision.

(6) If an appeal is denied and, within 10 working days from the denial, the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial must be reviewed by a health care provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination. The specialty review must be completed within 15 working days of

receipt of the request. The provision must state that notification of the appeal under this paragraph must be in writing.

(7) In addition to the written appeal, a method for expedited appeals for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized enrollees is available. The provision must state that:

(A) the procedure must include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review;

(B) an expedited appeal must be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received; and

(C) an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification;

(8) After the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter to the enrollee or an individual acting on behalf of the enrollee, and the provider of record, explaining the resolution of the appeal. The provision must state that the letter must include:

(A) a statement of the specific medical, dental, or contractual reasons for the resolution;

(B) the clinical basis for the decision;

(C) a description of or the source of the screening criteria that were utilized in making the determination;

(D) the professional specialty of the physician who made the determination;

(E) notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.1717 of this title (relating to Independent Review of Adverse Determinations);

(F) notice of the independent review process;

(G) a copy of Form No. LHL009 request for a review by an IRO;
and

(H) procedures for filing a complaint as described in §19.1705(f) of this title (relating to General Standards of Utilization Review).

(9) A statement that the appeal must be resolved as soon as practical, but, under Insurance Code §4201.359 and §1352.006, in no case later than 30 calendar days after the date the URA receives the written appeal or the one-page appeal form from the appealing party referenced under paragraph (3) of this subsection.

(10) In a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an appeal of the URA's adverse determination.

(b) Appeal of retrospective review adverse determinations. A URA must maintain and make available a written description of the appeal procedures involving an

adverse determination in a retrospective review. The written procedures for appeals must specify that an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing. The appeal procedures must comply with:

(1) Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims), if applicable;

(2) Section 19.1709 of this title (relating to Notice of Determinations Made in Utilization Review), for retrospective utilization review adverse determination appeals;
and

(2) Insurance Code §4201.359.

(c) Appeals concerning an acquired brain injury. A URA must comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a URA must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made for coverage under a small employer health benefit plan.

§19.1712. URA's Telephone Access.

(a) Except as otherwise provided by the Insurance Code, a URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per

week during normal business hours in both Central Time and Mountain Time, to discuss enrollees' care and to respond to telephone review requests.

(b) This section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1718 of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) or §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

§19.1713. Confidentiality.

(a) Confidentiality requirements. To ensure confidentiality, a URA must, when contacting a physician's, doctor's, or other health care provider's office, provide its certification number, name, and professional qualifications.

(1) If requested by the physician, doctor, or other health care provider, the URA must present written documentation that it is acting as an agent of the payor for the relevant enrollee.

(2) Medical records and enrollee specific information must be maintained by the URA in a secure area with access limited to essential personnel only.

(3) A URA must retain information generated and obtained by a URA in the course of utilization review for at least four years.

(4) A URA's charges for providing a copy of recorded personal information to individuals may not exceed 10 cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(b) Written procedures on confidentiality.

(1) The URA must specify in writing the procedures that the URA will implement pertaining to confidentiality of information received from the enrollee; the individual acting on behalf of the enrollee; and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting utilization review. These procedures must specify that:

(A) specific information received from the enrollee; the individual acting on behalf of the enrollee; and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting reviews will be considered confidential, be used by the review agent solely for utilization review, and be shared by the URA with only those third parties who have authority to receive the information, for example, the claim administrator; and

(B) the URA has procedures in place to address confidentiality and that the URA agrees to abide by any federal and state laws governing the issue of confidentiality.

(2) Summary data which does not provide sufficient information to allow identification of individual enrollees, physicians, doctors, or other health care providers is not considered confidential.

§19.1714. Regulatory Requirements Subsequent to Certification or Registration.

(a) Summary report to TDI. By March 1 of each year, each URA certified or registered under this subchapter must submit to TDI through TDI's internet website a

complete summary report of information related to complaints, adverse determinations, and appeals of adverse determinations.

(b) Contents of summary report. The summary report required by this section must cover reviews performed by the URA during the preceding calendar year and must include:

(1) the total number of written notices of adverse determinations;

(2) a listing of appeals of adverse determinations, by the medical condition that is the source of the dispute using the approved physical diagnosis or DSM-IV (mental health diagnosis) coding that is in effect at the time, or successor codes and modifiers, and by the treatment in dispute, if any, using CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure;

(3) the classification of appellant, for example, "health care provider" or "enrollee";

(4) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level within the internal utilization review process; and

(5) the subject matter of any complaint filed with the URA.

(c) Complaints included in the summary report. Complaints listed in the summary report under subsection (b)(5) of this section must be categorized as follows:

(1) administration, for example, copies of medical records not paid for; too many calls or written requests for information from provider, or too much information requested from provider;

(2) qualifications of URA's personnel; or

(3) appeal or complaint process, for example, the treating physician is unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, or written procedures for appeal not provided.

(d) Complaints to TDI. Complaints received by TDI against a URA must be processed under TDI's established procedures for investigation and resolution of complaints.

(e) TDI inquiries. TDI may address inquiries to a URA related to any matter connected with URA transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA that receives an inquiry from TDI must respond to the inquiry in writing not later than the 10th day after the date the inquiry is received.

(f) On-site review by TDI. For scheduled and unscheduled on-site reviews, TDI may make a complete on-site review of the operations of each URA at the principal place of business for each agent as often as is deemed necessary. An on-site review will only be conducted during working days and normal business hours. The URA must make available all records relating to its operation during any scheduled and unscheduled on-site review.

(1) Scheduled on-site reviews. URAs will be notified of any scheduled on-site review by letter, which will specify, at a minimum, the identity of TDI's designated representative and the expected arrival date and time.

(2) Unscheduled on-site reviews. At a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

§19.1715. Administrative Violations. A fraudulent or deceptive act or omission in obtaining, attempting to obtain, or use of certification or registration as a URA is a violation of Insurance Code Chapter 4201. The commissioner's authority under this subchapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law, including remedies under Insurance Code Chapter 4201, Subchapter M, concerning Enforcement.

§19.1716. Specialty URA.

(a) Application. To be certified or registered as a specialty URA, an applicant must submit to TDI the application, information, and fee required in §19.1704 of this title (relating to Certification or Registration of URAs).

(b) Same specialty required. A specialty URA must 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

by a state licensing agency in the United States. To conduct utilization review, a specialty URA must be of the same specialty as the health care provider who ordered the service. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery.

(c) Rule requirements. A specialty URA is subject to the requirements of this subchapter, except for the following provisions:

(1) Section 19.1705(a) of this title (relating to General Standards of Utilization Review);

(2) Section 19.1706(a), (c), and (d) of this title (relating to Requirements and Prohibitions Relating to Personnel);

(3) Section 19.1710 of this title (relating to Requirements Prior to Issuing Adverse Determination); and

(4) Section 19.1711(a)(4) - (6) of this title (relating to Written Procedures for Appeal of Adverse Determination).

(d) Utilization review plan. A specialty URA must have its utilization review plan, including appeal requirements, reviewed by a health care provider of the appropriate specialty, and the plan must be implemented under standards developed with input from a health care provider of the appropriate specialty. The specialty URA must have written procedures to ensure that these requirements are implemented.

(e) Requirements of employed or contracted physicians, doctors, other health care providers, and personnel.

(1) Physicians, doctors, other health care providers, and personnel employed by or under contract with the specialty URA to perform utilization review must be appropriately trained, qualified, and currently licensed.

(2) Personnel conducting specialty utilization review must hold an unrestricted license, an administrative license issued by a state licensing board, or be otherwise authorized to provide health care services by a licensing agency in the United States.

(f) Reasonable opportunity for discussion. In any instance in which a specialty URA questions the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, the health care provider of record must, prior to the issuance of an adverse determination, be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision of the URA with a health care provider of the same specialty as the URA. The discussion must include, at a minimum, the clinical basis for the specialty URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(1) The specialty URA's telephone number must be provided to the provider of record so that the provider of record may contact the specialty URA to discuss the pending adverse determination. For a retrospective utilization review, the specialty URA must allow the provider of record five working days to respond orally or in writing.

(2) The specialty URA must maintain, and submit to TDI on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination; the date and time that the discussion, if any, took place; and the discussion outcome.

(g) Appeal. The decision in any appeal of an adverse determination by a specialty URA must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination.

§19.1717. Independent Review of Adverse Determinations.

(a) Notification for life-threatening conditions. For life-threatening conditions, notification of adverse determination by a URA must be provided within the timeframes specified in §19.1709(d)(3) of this title (relating to Notice of Determinations Made in Utilization Review).

(1) At the time of notification of the adverse determination, the URA must provide to the enrollee or individual acting on behalf of the enrollee, and to the enrollee's provider of record, the notice of the independent review process and a copy of Form No. LHL009 request for a review by an IRO. The notice must describe how to obtain independent review of the adverse determination.

(2) The enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record must determine the existence of a life-threatening condition

on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's disease or condition is a life-threatening condition.

(b) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA may seek review of that determination or denial by an IRO assigned under Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(c) Independent review involving life-threatening and non life-threatening conditions. A URA must notify TDI within one working day from the date the request for an independent review is received. The URA must submit completed Form No. LHL009 request for a review by an IRO to TDI through TDI's internet website.

(1) Assignment of IRO. TDI will, within one working day of receipt of a complete request for independent review, randomly assign an IRO to conduct an independent review and notify the URA, payor, IRO, the enrollee or individual acting on behalf of the enrollee, enrollee's provider of record, and any other providers listed by the URA as having records relevant to the review of the assignment.

(2) Payor and URA compliance. The payor and URA must comply with the IRO's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services for an enrollee.

(3) Costs of independent review. The URA must pay for the independent review and may recover costs associated with the independent review from the payor.

§19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The words and terms defined in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in this section, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) An HMO or preferred provider benefit plan that requires preauthorization as a condition of payment to a preferred provider must comply with the procedures of this section for determinations of medical necessity or appropriateness, or the experimental or investigational nature, of care for those services the HMO or preferred provider benefit plan identifies under subsection (c) of this section.

(c) An HMO or preferred provider benefit plan that uses a preauthorization process for medical care and health care services must provide to each contracted preferred provider, not later than the 10th working day after the date a request is made, a list of medical care and health care services that allows a preferred provider to determine which services require preauthorization and information concerning the preauthorization process.

(d) An HMO or preferred provider benefit plan must issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. This determination must be issued and transmitted once a

preauthorization request for proposed services that require preauthorization is received from a preferred provider. The HMO or preferred provider benefit plan must respond to a request for preauthorization within the following time periods:

(1) For services not included under paragraphs (2) and (3) of this subsection, a determination must be issued and transmitted not later than the third calendar day after the date the request is received by the HMO or preferred provider benefit plan. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within three calendar days from the beginning of the next time period requiring appropriate personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request, followed within three working days after the transmittal of the determination by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. If the request for medical or health care services for concurrent hospitalization care is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within 24 hours from the beginning of the next time period requiring appropriate personnel.

(3) If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this title

(relating to Definitions), the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee, but in no case to exceed one hour from receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring appropriate personnel. The determination must be provided to the provider of record. If the HMO or preferred provider benefit plan issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the HMO or preferred provider benefit plan must provide to the enrollee or individual acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1717(a) and (b) of this title (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may request a preauthorization determination via telephone from the HMO or preferred provider benefit plan. An HMO or preferred provider benefit plan must have appropriate personnel as described in §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) reasonably available at a toll-free telephone number to provide the determination between 6:00 a.m. and 6:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon, Central Time, on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan must have a telephone

system capable of accepting or recording incoming requests after 6:00 p.m., Central Time, Monday through Friday and after noon, Central Time, on Saturday, Sunday, and legal holidays and must acknowledge each of those calls not later than 24 hours after the call is received. An HMO or preferred provider benefit plan providing a preauthorization determination under subsection (d) of this section must, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(f) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (e) of this section with respect to those services. An HMO providing routine vision services or dental health care services as a single health care service plan must:

(1) have appropriate personnel as described in §19.1706 of this title reasonably available at a toll-free telephone number to provide the preauthorization determination between 8:00 a.m. and 5:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming requests after 5:00 p.m., Central Time, Monday through Friday and all day on Saturday, Sunday, and legal holidays, and must acknowledge each of those calls not later than the next working day after the call is received; and

(3) when providing a preauthorization determination under subsection (d) of this section, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(g) If an HMO or preferred provider benefit plan has preauthorized medical care or health care services, the HMO or preferred provider benefit plan may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness, or the experimental or investigational nature, of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the preauthorized medical or health care services.

(h) If an HMO or preferred provider benefit plan issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1709 of this title (relating to Notice of Determinations Made in Utilization Review) and §19.1710 of this title (relating to Requirements Prior to Issuing Adverse Determination) must be provided to the enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record. An enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record may appeal any adverse determination under §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination).

(i) This section applies to an agent or other person with whom an HMO or preferred provider benefit plan contracts to perform utilization review, or to whom the HMO or preferred provider benefit plan delegates the performance of preauthorization of proposed medical or health care services. Delegation of preauthorization services does not limit in any way the HMO or preferred provider benefit plan's responsibility to comply with all statutory and regulatory requirements.

§19.1719. Verification for Health Maintenance Organizations and Preferred

Provider Benefit Plans.

(a) The words and terms defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and Chapter 843, concerning Health Maintenance Organizations, have the same meaning when used in this section, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise. This section applies to:

(1) HMOs;

(2) preferred provider benefit plans;

(3) preferred providers; and

(4) physicians, doctors, or other health care providers that provide to an enrollee of an HMO or preferred provider benefit plan:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the HMO, preferred provider benefit plan, or a preferred provider because the services are not reasonably available from a preferred provider who is included in the HMO or preferred provider benefit plan's network.

(b) An HMO or preferred provider benefit plan must be able to receive a request for verification of proposed medical care or health care services:

(1) by telephone call;

(2) in writing; and

(3) by other means, including the Internet, as agreed to by the preferred provider and the HMO or preferred provider benefit plan, provided that the agreement may not limit the preferred provider's option to request a verification by telephone call.

(c) An HMO or preferred provider benefit plan must have appropriate personnel reasonably available at a toll-free telephone number under Insurance Code §1301.133.

The HMO or preferred provider benefit plan must acknowledge calls not later than:

(1) for requests relating to post-stabilization care or a life-threatening condition, within one hour after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number;

(2) for requests relating to concurrent hospitalization, within 24 hours after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number; and

(3) for all other requests, within two calendar days after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number.

(d) Any request for verification must contain the following information:

(1) enrollee name;

(2) enrollee ID number, if included on an identification card issued by the HMO or preferred provider benefit plan;

(3) enrollee date of birth;

(4) name of enrollee or subscriber, if included on an identification card issued by the HMO or preferred provider benefit plan;

(5) enrollee relationship to enrollee or subscriber;

(6) presumptive diagnosis, if known; otherwise presenting symptoms;

(7) description of proposed procedures or procedure codes;

(8) place of service code where services will be provided and, if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided;

(9) proposed date of service;

(10) group number, if included on an identification card issued by the HMO or preferred provider benefit plan;

(11) if known to the provider, name and contact information of any other carrier, including the name, address, and telephone number; name of enrollee; plan or ID number; group number (if applicable); and group name (if applicable);

(12) name of provider providing the proposed services; and

(13) provider's federal tax ID number.

(e) Receipt of a written request or a written response to a request for verification under this section is subject to the provisions of §21.2816 of this title (relating to Date of Receipt).

(f) If necessary to verify proposed medical care or health care services, an HMO or preferred provider benefit plan may, within one day of receipt of a request for verification, request information from the preferred provider in addition to the information

provided in the request for verification. An HMO or preferred provider benefit plan may make only one request for additional information from the requesting preferred provider under this section.

(g) A request for information under subsection (f) of this section must:

(1) be specific to the verification request;

(2) describe with specificity the clinical and other information to be included in the response;

(3) be relevant and necessary for the resolution of the request; and

(4) be for information contained in or in the process of being incorporated into the enrollee's medical or billing record maintained by the preferred provider.

(h) On receipt of a request for verification from a preferred provider, an HMO or preferred provider benefit plan must issue a verification or declination. The HMO or preferred provider benefit plan must issue the verification or declination within the following time periods.

(1) Except as provided in paragraphs (2) and (3) of this subsection, an HMO or preferred provider benefit plan must provide a verification or declination in response to a request for verification without delay, and as appropriate to the circumstances of the particular request, but not later than five calendar days after the date of receipt of the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsection (c) of this section, the determination must be provided within five calendar days from the beginning of the next time period requiring appropriate personnel.

(2) If the request is related to a concurrent hospitalization, the response must be sent to the preferred provider without delay but not later than 24 hours after the HMO or preferred provider benefit plan received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsection (c) of this section, the determination must be provided within 24 hours from the beginning of the next time period requiring appropriate personnel.

(3) If the request is related to post-stabilization care or a life-threatening condition, the response must be sent to the preferred provider without delay but not later than one hour after the HMO or preferred provider benefit plan received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (c) and (d) of this section, the determination must be provided within one hour from the beginning of the next time period requiring appropriate personnel.

(i) If the request involves services for which preauthorization is required, the HMO or preferred provider benefit plan must implement the procedures set forth in §19.1718 of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and respond regarding the preauthorization request in compliance with that section.

(j) A verification or declination may be delivered via telephone call, in writing, or by other means, including the Internet, as agreed to by the preferred provider and the HMO or preferred provider benefit plan. If a verification or declination is delivered via

telephone call, the HMO or preferred provider benefit plan must, within three calendar days of providing a verbal response, provide a written response which must include, at a minimum:

(1) enrollee name;

(2) enrollee ID number;

(3) requesting provider's name;

(4) hospital or other facility name, if applicable;

(5) a specific description, including relevant procedure codes, of the services that are verified or declined;

(6) if the services are verified, the effective period for the verification, which must not be less than 30 calendar days from the date of verification;

(7) if the services are verified, any applicable deductibles, copayments, or coinsurance for which the enrollee is responsible;

(8) if the verification is declined, the specific reason for the declination;

(9) a unique verification number that allows the HMO or preferred provider benefit plan to match the verification and subsequent claims related to the proposed service; and

(10) a statement that the proposed services are being verified or declined.

**SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED
UNDER WORKERS' COMPENSATION INSURANCE COVERAGE
28 TAC §§19.2001 – 19.2017**

§19.2001. General Provisions.

(a) Statutory basis. This subchapter implements Insurance Code Chapter 4201, concerning Utilization Review Agents; Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks; and Labor Code Title 5, concerning Workers' Compensation.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of this subchapter is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of injured employee safety;

(2) ensure that URAs adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and URAs;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that URAs maintain the confidentiality of medical records under applicable law.

§19.2002. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, this subchapter applies to utilization review performed under workers' compensation insurance coverage. This subchapter does not affect the authority of TDI-DWC to exercise the powers granted to it under Labor Code Title 5 and Insurance Code Chapter 4201. This subchapter applies to utilization review as set forth in Insurance Code Chapters 1305 and 4201 and Labor Code Title 5.

(1) This subchapter does not apply to utilization review performed under a health benefit plan or a health insurance policy.

(2) This subchapter does not apply to a person that provides information to an injured employee or an injured employee's representative, physician, doctor, or other health care provider about scope of coverage or benefits provided for under workers' compensation insurance coverage, but that does not determine medical necessity or appropriateness or the experimental or investigational nature of health care services.

(b) Applicability of other law.

(1) Health care providers performing peer reviews or required medical examinations under Labor Code §408.004 regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. Peer reviewers must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement). Required medical examination doctors must

comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 126 of this title (relating to General Provisions Applicable to All Benefits); Chapter 134, Subchapter B, of this title (relating to Miscellaneous Reimbursement); and Chapter 180 of this title.

(2) Insurance carriers must process medical bills as required by Labor Code Title 5 and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 133, Subchapter A, of this title (relating to General Rules for Medical Billing and Processing).

(3) If there is a conflict between this subchapter and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail.

(4) If there is a conflict between this subchapter and the rules in Chapter 10 of this title, regarding Workers' Compensation Health Care Networks, the rules in Chapter 10 of this title prevail.

§19.2003. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational.

(2) Appeal--The URA's formal process by which an injured employee, an injured employee's representative, or an injured employee's provider of record may request reconsideration of an adverse determination. For the purposes of this subchapter the term also applies to reconsideration processes prescribed by Labor Code Title 5 and applicable rules for workers' compensation.

(3) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier that is registered as a URA under §19.2004 of this title (relating to Certification or Registration of URAs).

(4) Commissioner--As defined in Insurance Code §31.001.

(5) Compensable injury--As defined in Labor Code §401.011.

(6) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(7) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(8) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under Labor Code or applicable TDI-DWC rules, Insurance Code or applicable TDI rules, or any other association with the injured employee, employer, or insurance carrier that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(9) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(10) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

(11) Form No. LHL005 URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(12) Form No. LHL009 request for a review by an IRO--Form to request a review by an independent review organization. Form LHL009 is completed by the requesting party and submitted to the URA.

(13) Form No. 11 biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to Form No. LHL005 URA application.

(14) Health care--As defined in Labor Code §401.011.

(15) Health care facility--As defined in Labor Code §401.011.

(16) Insurance carrier or insurer--As defined in Labor Code §401.011.

(17) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(18) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a);

(B) the Friday after Thanksgiving Day;

(C) December 24th; and

(D) December 26th.

(19) Medical benefit--As defined in Labor Code §401.011.

(20) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the injured employee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(21) Medical records--The entire history of diagnosis of and treatment for a compensable injury, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an injured employee.

(22) Mental health medical record summary--A summary of process or progress notes relevant to understanding the injured employee's need for treatment of a mental or emotional condition or disorder including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of injured employee behaviors
or thought processes that affect level of care needs; and

(iv) discharge plan.

(23) Mental health therapist--Any of the following individuals who, in the
ordinary course of business or professional practice, as appropriate, diagnose,
evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice
medicine in this state;

(B) an individual licensed as a psychologist, psychological
associate, or a specialist in school psychology by the Texas State Board of Examiners
of Psychologists;

(C) an individual licensed as a marriage and family therapist by the
Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas
State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State
Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas
Medical Board;

(G) an individual licensed as a registered professional nurse by the
Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(24) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

(25) Payor--Any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits, including workers' compensation benefits, to an individual treated by a health care provider under a policy, plan, or contract.

(26) Peer review--An administrative review by a health care provider performed at insurance carrier's request without a physical examination of the injured employee.

(27) Person--Any natural or artificial person, including a political subdivision of this state, individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, limited liability partnership, and the statewide rural health care system under Insurance Code Chapter 845.

(28) Preauthorization--A form of prospective utilization review by a payor or a payor's URA of health care services proposed to be provided to an injured employee.

(29) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of an injured employee, or a physician, doctor, or other health care provider that has rendered or has been requested to provide health care services to an injured employee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(30) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(31) Registration--The process for an insurance carrier to register with TDI to perform utilization review solely for injured employees covered by workers' compensation insurance coverage issued by Insurance carrier.

(32) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization

review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(33) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by a URA as part of the utilization review process.

(34) TDI--The Texas Department of Insurance.

(35) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(36) Texas Workers' Compensation Act--Labor Code Title 5, Subtitle A.

(37) Treating doctor--As defined in Labor Code §401.011.

(38) URA--Utilization review agent.

(39) Workers' compensation health care network--As defined in Insurance Code §1305.004.

(40) Workers' compensation health plan--Health care provided by a political subdivision contracting directly with health care providers or through a health benefits pool, under Labor Code §504.053(b)(2).

(41) Workers' compensation insurance coverage--As defined in Labor Code §401.011.

(42) Workers' compensation network coverage--Health care provided under a workers' compensation health care network.

(43) Workers' compensation non-network coverage--Health care delivered under Labor Code Title 5, excluding health care provided under Insurance Code Chapter 1305.

§19.2004. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code Chapter 4201 and this subchapter.

(1) If an insurance carrier performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier must be certified.

(2) If an insurance carrier performs utilization review only for coverage for which it is the payor, Insurance carrier must be registered.

(b) Application form. The commissioner adopts by reference:

(1) Form No. LHL005 URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Form No. 11 biographical affidavit, to be used as an attachment to Form No. LHL005 URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application, or request additional time in writing, within 15 working days of the date of TDI's latest notice of omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting Form No. LHL005 URA application to TDI. A URA must also submit a renewal fee in the amount specified

by §19.802 of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, the URA may renew the certification or registration by sending a completed renewal application and fee as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to

comply with this subchapter within 90 calendar days after the effective date of this rule.

However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

§19.2005. General Standards of Utilization Review.

(a) Review of utilization review plan. A utilization review plan must be reviewed and approved by a physician and conducted under standards developed and periodically updated with input from both primary and specialty physicians, doctors, and other health care providers, including practicing health care providers, as appropriate.

(b) Special circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. For the purposes of this section, disability must not be construed to mean an injured employee who is off work or receiving income benefits.

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. For workers' compensation network coverage, screening criteria must comply with Insurance Code Chapter 1305 and §10.101 of this

title (relating to General Standards for Utilization Review and Retrospective Review); for workers' compensation non-network coverage and workers' compensation health plan, screening criteria must comply with Labor Code §§401.011, 413.011, and 413.014, and Chapters 133, 134, and 137 of this title (relating to General Medical Provisions; Benefits-Guidelines for Medical Services, Charges, and Payments; and Disability Management, respectively).

(d) Referral and determination of adverse determinations. Adverse determinations must be referred to and may only be determined by a physician, doctor, or other health care provider with appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement) and §19.2006 of this title (relating to Requirements and Prohibitions Relating to Personnel). Physicians and doctors performing utilization review must also be in compliance with Labor Code §§408.0043, 408.0044, and 408.0045.

(e) Delegation of review. A URA, including a specialty URA, may delegate the review to qualified personnel in a hospital utilization review program or a qualified health care provider. The delegation does not relieve the URA of full responsibility for compliance with this subchapter, Insurance Code Chapter 4201, the Texas Workers' Compensation Act, and applicable TDI-DWC rules, including responsibility for the conduct of those to whom utilization review has been delegated.

(f) Complaint system. The URA must develop and implement procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers concerning the utilization review. The URA

must maintain records of complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

(g) Compliance with Labor Code §504.055. Utilization review plan written policies must evidence compliance with Labor Code §504.055, concerning Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responder in Course and Scope of Employment.

§19.2006. Requirements and Prohibitions Relating to Personnel.

(a) Qualification requirements. Physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review must be appropriately trained, qualified, and currently licensed. Personnel conducting utilization review must hold an unrestricted license or an administrative license in Texas or be otherwise authorized to provide health care services in Texas. Physicians and doctors conducting utilization review must hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving as required by Labor Code §§408.0043, 408.0044, and 408.0045. Physicians, doctors, and other health care providers conducting utilization review must have the appropriate credentials as required by Chapter 180 of this title (relating to Monitoring and Enforcement).

(b) Disqualifying associations. For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association. A physician, doctor, or other health care provider who conducts utilization review must not have any disqualifying associations with the:

(1) injured employee or health care provider who is requesting utilization review or an appeal; or

(2) physician, doctor, or other health care provider who issued the initial adverse determination.

(c) Information a URA must send to TDI. A URA must send to TDI the name, number, type, Texas license number, and qualifications of the personnel either employed or under contract to perform utilization review with an original or renewal application.

(d) Written procedures and maintenance of records. A URA must develop and implement written procedures, and maintain documentation, to demonstrate that all physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Physician direction requirement. Utilization review conducted by a URA must be under the direction of a physician currently licensed without restriction to practice medicine in Texas. The physician must be employed by or under contract with the URA.

§19.2007. URA Contact with and Receipt of Information from Health Care

Providers.

(a) If a URA must reimburse health care providers for providing medical information under Insurance Code §4201.207, reimbursement is limited to the reasonable costs for providing medical records relevant to the utilization review that were requested by the URA in writing. A health care provider's charge for providing medical information to a URA must comply with §134.120 of this title (relating to Reimbursement for Medical Documentation) and may not include any costs that are recouped as a part of the charge for health care. A health care provider must provide information to substantiate the medical necessity of health care requested under Chapter 134 of this title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments) or to submit required documentation when submitting a medical bill under Chapter 133 of this title (relating to General Medical Provisions).

(b) When conducting utilization review, a URA must request all relevant and updated information and medical records to complete the review.

(1) This information may include identifying information about the injured employee; the claim; the treating physician, doctor, or other health care provider; and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the injured employee and the medical history of the injured employee relevant to the diagnoses and the compensable injury, the injured employee's prognosis, and the plan of treatment prescribed by the provider of record,

along with the provider of record's justification for the plan of treatment. The required information should be requested from the appropriate sources.

(2) A URA must not routinely request copies of all medical records on injured employees reviewed. During utilization review, copies of the necessary or pertinent sections of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate or experimental or investigational in nature.

(c) The URA must share among its various divisions all clinical and demographic information on individual injured employees to avoid duplicate requests for information from injured employees, physicians, doctors, and other health care providers.

(d) A URA may not require as a condition of approval of a health care service, 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 that relate to the mental health therapist's treatment of an injured employee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude the URA from requiring submission of:

(1) an injured employee's mental health medical record summary; or

(2) medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

§19.2008. On-Site Review by a URA.

(a) Identification of URAs. If a URA's staff member is conducting an on-site or off-site review, each staff member must provide his or her name, the name of his or her organization, must show photo identification, and a URA identification card with the certification or registration number assigned by TDI when requested by an individual, including an injured employee or health care provider.

(b) On-site review. For on-site review conducted at a health care facility, a URA:

(1) must ensure that on-site review staff:

(A) register with the appropriate contact individual, if available, prior to requesting any clinical information or assistance from health care facility staff; and

(B) wear appropriate health care facility supplied identification tags while on the health care facility premises.

(2) must agree, if so requested, that the medical records remain available in the designated areas during the on-site review and that reasonable health care facility administrative procedures will be followed by on-site review staff to avoid disrupting health care facility operations or injured employee care. The procedures, however, should not obstruct or limit the ability of the URA to efficiently conduct the necessary review.

§19.2009. Notice of Determinations Made in Utilization Review.

(a) Notice requirements of favorable or adverse determinations.

(1) A URA must send written notification of a determination made in utilization review to the individuals specified in and within the timeframes required for utilization review.

(2) For prospective and concurrent review, the timeframes are specified by:

(A) Section 134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care), for workers' compensation non-network coverage; and

(B) Insurance Code §1305.353, concerning Notice of Certain Utilization Review Determinations; Preauthorization Requirements; and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements), for workers' compensation network coverage.

(3) For retrospective review, the timeframes are specified by:

(A) Sections 133.240 and 133.250 of this title (relating to Medical Payment and Denials, and Reconsideration for Payment of Medical Bills, respectively), for workers' compensation non-network coverage;

(B) Sections 133.240, 133.250, and 10.102 of this title, for workers' compensation network coverage.

(4) For workers' compensation non-network coverage and network coverage, a URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by

the U.S. Department of Health and Human Services in 45 Code of Federal Regulations §162.1102 (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction), based on the type of service in the preauthorization request.

(b) Required notice elements. In all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of the procedure for filing a complaint with TDI;

(4) the professional specialty and Texas license number of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.2005 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determination), and a statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination by an IRO and is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review;

(7) for workers' compensation network coverage, a description or the source of the screening criteria that were utilized in making the determination, including a description of treatment guidelines utilized, as applicable;

(8) for workers' compensation non-network coverage, a description of treatment guidelines utilized under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b) in making a determination; and

(9) notice of the independent review process. The notice of the independent review process required under this paragraph must include:

(A) a statement that:

(i) Form No. LHL009 request for a review by an IRO must be completed by the injured employee, the injured employee's representative, or the injured employee's provider of record and be returned to insurance carrier or URA that made the adverse determination to begin the independent review process;

(ii) a request for independent review of an adverse determination made under workers' compensation non-network coverage must be timely filed by the requestor consistent with §133.308 of this title (relating to MDR of Medical Necessity Disputes); and

(iii) a request for independent review of an adverse determination made under workers' compensation network coverage must be timely filed by the requestor consistent with §10.104 of this title (relating to Independent Review of Adverse Determination); and

(B) either of the following:

(i) a copy of Form No. LHL009 request for a review by an IRO, available at www.tdi.texas.gov/forms; or

(ii) notice in at least 12 point font that the injured employee can obtain a copy of Form No. LHL009 request for a review by an IRO by:

(I) accessing TDI's website at www.tdi.texas.gov/forms; or

(II) calling [insert URA's telephone number] to request a copy of the form, at which time the URA will send a copy of Form No. LHL009 request for a review by an IRO to the injured employee.

(c) Peer review reports. The notice of determination made in utilization review required under this section and the peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) may be combined into one document if all the requirements of both sections are met.

§19.2010. Requirements Prior to Issuing Adverse Determination. In any instance in which a URA is questioning the medical necessity or appropriateness of the health care services prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the

services in question are within the scope of the chiropractor's license to practice chiropractic. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(1) The URA must provide the URA's telephone number so that the provider of record may contact the URA to discuss the pending adverse determination.

(2) The URA must maintain, and submit to TDI or TDI-DWC on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

§19.2011. Written Procedures for Appeal of Adverse Determinations.

(a) Appeal of prospective or concurrent review adverse determinations. Each URA must comply with its written procedures for appeals. The written procedures for appeals must comply with Insurance Code Chapter 4201, Subchapter H, concerning Appeal of Adverse Determination, and must include the following provisions:

(1) For workers' compensation network coverage, a URA must include in its written procedures a statement specifying the timeframes for requesting the appeal under Insurance Code §1305.354, which may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination.

(2) For workers' compensation non-network coverage and workers' compensation health plan, a URA must include in its written procedures a statement specifying that the timeframes for requesting the appeal of the adverse determination must be consistent with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) and Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) An injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing.

(4) Appeal decisions must be made by a physician, dentist or chiropractor who has not previously reviewed the case, as required by Chapter 180 of this title (relating to Monitoring and Enforcement); Insurance Code §1305.354; and §10.103 of this title (relating to Reconsideration of Adverse Determination). If the health care services in question are dental services, then a dentist may make the appeal decision if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may make the appeal decision if the services in question are within the scope of the chiropractor's license to practice chiropractic.

(5) Subject to the notice requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review), in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured

employee with a physician. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the services in question are within the scope of the chiropractor's license to practice chiropractic. The provision must state that the discussion must include, at a minimum, the clinical basis for the URA's decision.

(6) After the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter explaining the resolution of the appeal to individuals specified in §19.2009(a) of this title (relating to Notice of Determinations Made in Utilization Review).

(7) The response letter required in paragraph (6) of this subsection, for both workers' compensation network coverage and for workers' compensation non-network coverage, must include:

(A) a statement of the specific medical or dental reasons for the resolution;

(B) the clinical basis for the decision;

(C) the professional specialty and Texas license number of the physician who made the determination;

(D) notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.2017 of this title (relating to Independent

Review of Adverse Determinations), the notice of the independent review process, and either of the following:

(i) a copy of Form No. LHL009 request for a review by an IRO, available at www.tdi.texas.gov/forms; or

(ii) notice in at least 12 point font that the injured employee can obtain a copy of Form No. LHL009 request for a review by an IRO by:

(I) accessing TDI's website, at www.tdi.texas.gov/forms; or

(II) calling [insert URA's telephone number] to request a copy of the form, at which time the URA will send a copy of Form No. LHL009 request for a review by an IRO to the injured employee or health care provider;

(E) procedures for filing a complaint as described in §19.2005(f) of this title (relating to General Standards of Utilization Review);

(F) for workers' compensation network coverage only, a description or the source of the screening criteria that were utilized in making the determination, including a description of the network adopted treatment guidelines, if any; and

(G) for workers' compensation non-network coverage only, a description of treatment guidelines utilized under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b) in making a determination;

(8) Timeframes required for written notifications to the appealing party of the determination of the appeal:

(A) must be resolved as specified in §10.103 of this title for workers' compensation network coverage; and

(B) must be resolved as specified in §134.600 of this title for workers' compensation non-network coverage.

(9) In a circumstance involving an injured employee's life-threatening condition, or involving a request for a medical interlocutory order under §134.550 of this title (Medical Interlocutory Order), the injured employee is entitled to an immediate review by an IRO of the adverse determination and is not required to comply with procedures for an appeal of the adverse determination by the URA.

(b) Appeal of retrospective review adverse determinations. A URA must maintain and make available a written description of appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with §19.2009 of this title for retrospective utilization review adverse determination appeals and Insurance Code §4201.359. The written procedures for appeals must specify that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing.

(1) Workers' compensation network coverage. For workers' compensation network coverage, appeal procedures must comply with the requirements in Insurance Code Chapter 1305, §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements), and §133.250 of this title (relating to Reconsideration for Payment of Medical Bills).

(2) Workers' compensation non-network coverage. For workers' compensation non-network coverage, the appeal procedures must comply with the requirements of §133.250 of this title.

§19.2012. URA's Telephone Access and Procedures for Certain Drug Requests.

(a) A URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central Time and Mountain Time, to discuss an injured employee's care and to respond to telephone review requests.

(b) A URA must have procedures that the URA will implement when responding to requests for:

(1) drugs that require preauthorization, in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency; and

(2) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment, as requested by the treating physician or provider of record.

§19.2013. Confidentiality.

(a) Confidentiality requirements. To ensure confidentiality, a URA must, when contacting a physician's, doctor's, or other health care provider's office, provide its certification number, name, and professional qualifications.

(1) If requested by the physician, doctor, or other health care provider, the URA must present written documentation that it is acting as an agent of the insurance carrier for the relevant injured employee.

(2) Medical records and injured employee specific information must be maintained by a URA in a secure area with access limited to essential personnel only.

(3) A URA must retain information generated and obtained by the URA in the course of utilization review for at least four years.

(4) A URA's charges for providing a copy of recorded personal information to individuals may not exceed 10 cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(b) Written procedures on confidentiality.

(1) A URA must specify in writing the procedures that the URA will implement pertaining to confidentiality of information received from the injured employee, the injured employee's representative, and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting utilization review. These procedures must specify that:

(A) specific information received from the injured employee, the injured employee's representative, and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for utilization review, and be shared by the URA with only those third

parties who have authority to receive the information, for example, the claim administrator; and

(B) the URA has procedures in place to address confidentiality, and that the URA agrees to abide by any federal and state laws governing the issue of confidentiality.

(2) Summary data which does not provide sufficient information to allow identification of individual injured employees, physicians, doctors, or other health care providers is not considered confidential.

§19.2014. Regulatory Requirements Subsequent to Certification or Registration.

(a) Summary report to TDI. By March 1 of each year, each URA certified or registered under this subchapter must submit to TDI through TDI's internet website a complete summary report of information related to complaints, adverse determinations, and appeals of adverse determinations.

(b) Contents of summary report. The summary report required by this section must cover reviews performed by the URA during the preceding calendar year and must include:

- (1) the total number of written notices of adverse determinations;
- (2) a listing of adverse determinations for preauthorization, by the medical condition and treatment using the physical diagnosis or DSM-IV (mental health diagnosis) coding that is in effect at the time, or successor codes and modifiers, and CPT (procedure) code or other relevant procedure code if a CPT designation is not

available, or any other nationally recognized numerically codified diagnosis or procedure;

(3) the classification of party requesting review, for example, a health care provider; injured employee; or their representative;

(4) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level within the internal utilization review process; and

(5) the subject matter of any complaint filed with the URA.

(c) Complaints included in summary report. Complaints listed in the summary report under subsection (b)(5) of this section must be categorized as follows:

(1) administration, for example, copies of medical records not paid for; too many calls or written requests for information from provider; and too much information requested from provider;

(2) qualifications of URA's personnel; or

(3) appeal or complaint process, for example, a treating physician unable to discuss the plan of treatment with a utilization review physician; no notice of adverse determination; no notice of clinical basis for adverse determination; and written procedures for appeal not provided.

(d) Complaints to TDI. Complaints received by TDI against a URA must be processed under TDI's established procedures for investigation and resolution of complaints.

(e) TDI inquiries. TDI may address inquiries to a URA related to any matter connected with URA transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA that receives an inquiry from TDI must respond to the inquiry in writing not later than the 10th calendar day after the date the inquiry is received.

(f) TDI-DWC inquiries. This section does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5, Insurance Code, or applicable TDI-DWC rules.

(g) On-site review by TDI. For scheduled and unscheduled on-site reviews, TDI may make a complete on-site review of the operations of each URA at the principal place of business for each agent as often as is deemed necessary. An on-site review will only be conducted during working days and normal business hours. A URA must make available all records relating to its operation during any scheduled or unscheduled on-site reviews.

(1) Scheduled on-site reviews. A URA will be notified of any scheduled on-site review by letter, which will specify, at a minimum, the identity of TDI's designated representative and the expected arrival date and time.

(2) Unscheduled on-site reviews. At a minimum, notice of an on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

§19.2015. Administrative Violations.

(a) A fraudulent or deceptive act or omission in obtaining, attempting to obtain, or use of certification or registration as a URA is a violation of Insurance Code Chapter 4201.

(b) The commissioner's authority under this subchapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law, including remedies under Insurance Code Chapter 4201, Subchapter M, concerning Enforcement.

(c) This section does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5 or TDI-DWC rules. Nothing in this section prohibits joint enforcement actions by TDI and TDI-DWC or delegations of authority between TDI and TDI-DWC to enforce relevant statutes or rules.

§19.2016. Specialty URA.

(a) Application. To be certified or registered as a specialty URA, an applicant must submit to TDI the application, information, and fee required in §19.2004 of this title (Certification or Registration of URAs).

(b) Same specialty required. A specialty URA must 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 by a state licensing agency in the United States. To conduct utilization review, a specialty URA must be of the same specialty as the health care provider who ordered the service. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery.

(c) Rule requirements. A specialty URA is subject to the requirements of this subchapter, except for the following provisions:

(1) §19.2005(a) of this title (relating to General Standards of Utilization Review);

(2) §19.2006(a), (c), (d), and (e) of this title (relating to Requirements and Prohibitions Relating to Personnel);

(3) §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination); and

(4) §19.2011(a)(4) and (5) of this title (relating to Written Procedures for Appeal of Adverse Determination).

(d) Utilization review plan. A specialty URA must have its utilization review plan, including appeal requirements, reviewed by a physician, doctor, or other health care provider of the appropriate specialty, and the plan must be implemented under standards developed with input from a physician, doctor, or other health care provider of

the appropriate specialty. The specialty URA must have written procedures to ensure that these requirements are implemented.

(e) Requirements of employed or contracted physicians, doctors, other health care providers, and personnel.

(1) Physicians, doctors, other health care providers, and personnel employed by or under contract with a specialty URA to perform workers' compensation utilization review must be appropriately trained, qualified, and currently licensed as specified in Chapter 180 of this title (relating to Monitoring and Enforcement).

(2) Personnel conducting utilization review must hold an unrestricted license, an administrative license issued by a state licensing board in Texas, or be otherwise authorized to provide health care services in Texas.

(f) Utilization review by a specialty URA. Utilization review conducted by a specialty URA must be under the direction of a physician, doctor, or other health care provider of the same specialty and the physician, doctor, or other health care provider must be currently licensed to provide the specialty health care service in Texas. The physician, doctor, or other health care provider may be employed by or under contract to the URA.

(g) Reasonable opportunity for discussion. In any instance in which a specialty URA questions whether the health care is medically necessary or appropriate, the health care provider that ordered the services must, prior to the issuance of an adverse determination, be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision of the URA with a health care provider

of the same specialty as the URA. The discussion must include, at a minimum, the clinical basis for the specialty URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(1) A specialty URA's telephone number must be provided to the provider of record so that the provider of record may contact the specialty URA to discuss the pending adverse determination.

(2) A specialty URA must maintain, and submit to TDI or TDI-DWC on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome. The specialty URA must allow the provider of record five working days to respond orally or in writing.

(h) Appeal. The decision in an appeal of any adverse determination by a specialty URA must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination.

§19.2017. Independent Review of Adverse Determinations.

(a) Life-threatening conditions.

(1) Notification for life-threatening conditions. For life-threatening conditions, notification of an adverse determination by a URA must comply with:

(A) Section 134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) for workers' compensation non-network coverage;

(B) Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements) for workers' compensation network coverage; and

(C) Section 19.2009(a)(2) of this title (relating to Notice of Determinations Made in Utilization Review), including notice of the independent review process and the procedure for obtaining a copy of Form No. LHL009 request for a review by an IRO. The notice must describe how to obtain independent review of the adverse determination and how TDI assigns a request for independent review to an IRO.

(2) Existence of life-threatening condition. An injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition.

(3) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek review of the adverse determination by an IRO assigned

under Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(b) Independent review involving life-threatening and non-life threatening conditions. A URA must notify TDI within one working day from the date a request for an independent review is received. The URA must submit the completed Form No. LHL009 request for a review by an IRO to TDI through TDI's internet website.

(1) Assignment of IRO. Within one working day of receipt of a complete request for independent review, TDI will randomly assign an IRO to conduct the independent review and notify the URA, payor, the IRO, injured employee or the injured employee's representative, injured employee's provider of record and any other providers listed by the URA as having records relevant to the review of the assignment.

(2) Workers' compensation non-network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation non-network coverage review are governed by the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) Workers' compensation network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation network coverage review are governed by Insurance Code Chapter 1305, TDI rules, and TDI-DWC rules, including but not limited to Chapter 10, Subchapter F, of this title (relating to Utilization Review and Retrospective Review) and Chapter 133, Subchapter D, of this title.