SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY [~~REVIEW AGENTS~~]
28 TAC §§19.1701 – 19.1717, 19.1719 – 19.1721, 19.1723, and 19.1724

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE
28 TAC §§19.2001 – 19.2017 and 19.2019 - 19.2021

1. INTRODUCTION. The Texas Department of Insurance (Department) proposes amendments to §§19.1701 – 19.1717, 19.1719 – 19.1721, 19.1723, and 19.1724, concerning utilization review agents (URAs) for health care provided under a health benefit plan or health insurance policy (referred to hereafter as Subchapter R, collectively), and §§19.2001 – 19.2011, 19.2013, 19.2014, 19.2016, 19.2017, 19.2019 and 19.2020, and new §§19.2012, 19.2015, and 19.2021, concerning URAs for health care provided under workers' compensation insurance coverage (referred to hereafter as Subchapter U, collectively). These amendments and new sections are necessary to: (i) implement HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, which effectively revises the definitions of "adverse determination" and "utilization review" in the 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 the Department with the advice of the Utilization Review Advisory Committee (Advisory Committee), for clarity and effective implementation and enforcement of the Insurance Code Chapter 4201.

In conjunction with this proposal, the Department is proposing the repeal of §19.1718, concerning criminal penalties; §19.1722, concerning the utilization review

advisory committee; §19.2012, concerning appeal of adverse determination of URAs; §19.2015, concerning retrospective review of medical necessity; §19.2018, concerning criminal penalties; and §19.2021, concerning non-involvement of independent review organizations, which is also published in this issue of the *Texas Register*.

HB 4290

HB 4290 amends the definition of "utilization review" to specifically include retrospective review of the medical necessity and appropriateness of health care services. HB 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.

Proposed amendments in §19.1703(40) and §19.2003(34), and §19.1703(45) and §19.2003(40), concerning the definitions of "retrospective review," and "utilization review" respectively, are necessary to accurately include "retrospective review" as a form of "utilization review," as provided in HB 4290.

Proposed §19.1703(40) and proposed §19.2003(34) define "retrospective utilization review" as a form of utilization review for health care services that have been provided to an enrollee or injured employee, respectively. 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.

Amendments are proposed to the definition of "utilization review" in §19.1703(45) and §19.2003(40) to include 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.

Because HB 4290 clarifies that utilization review includes retrospective review, the Department is also proposing in Subchapters R and U several more specific amendments and new provisions governing retrospective review. New requirements are proposed to §§19.1711(c), 19.1712(b), 19.1715, 19.1720(h)(2), 19.2011(c), 19.2012(b), 19.2015, and 19.2020(h)(2).

Proposed amendments in §19.1703(2) and §19.2003(2), §19.1703(16) and §19.2003(13), and §19.1703(45) and §19.2003(40), concerning the definitions of "adverse determination," "experimental or investigational," and "utilization review" respectively, are necessary to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services as utilization review.

The proposed amendments to §19.1703(2) define the term "adverse determination" as 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 lack of prospective or concurrent utilization review. These proposed amendments, which are necessary to implement HB 4290, incorporate determinations on whether health care services are experimental or investigational into the definition of "adverse determination." The amendments are also necessary to clarify that the term does not include a denial of

health care services for which the enrollee should have sought prospective or concurrent utilization review.

The proposed amendments to §19.2003(2) define the term "adverse determination" as a determination by a URA made on behalf of any 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 lack of 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. This revised definition clarifies that the term does not include a denial of health care services for which the injured employee should have sought prospective or concurrent utilization review.

The proposed revised definition 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. Though this clarification is inconsistent with the statutory definition of "adverse determination" under the Insurance Code §4201.002(1), it is consistent with the Labor Code §408.021 and §413.014, and pursuant to the Insurance Code §4201.054, in the event of such a conflict, the Labor Code Title 5 prevails.

The 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 pursuant to the

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 Chapter 4201 of the Insurance Code and Chapter 408 of the Labor Code, it is nevertheless 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."

Proposed amendments to §19.1703(16) and §19.2003(13) add a definition of the term "experimental or investigational." These proposed amendments are necessary to ensure a uniform application of the term.

Amendments are proposed to the definition of "utilization review" in §19.1703(45) and §19.2003(40) to include a system for prospective, concurrent, or retrospective review *to determine the experimental or investigational nature of health care services*." These amendments incorporate determinations on whether health care services are experimental or investigational into the definition of "utilization review."

Throughout Subchapters R and U, the Department has also added a reference to "experimental or investigational" in provisions relating to utilization review determinations of the medical necessity or appropriateness of health care services. These additions are necessary because determinations of the experimental or

investigational nature of health care services are now also included in utilization review determinations. These changes result from the enactment of HB 4290 and are necessary to implement HB 4290.

Other Necessary Proposed Amendments

In addition to the need to implement HB 4290, the Department, with the advice of the Advisory Committee, has determined that other amendments are necessary for the effective compliance with and implementation and enforcement of the Insurance Code Chapter 4201. These other necessary proposed amendments are described in the remainder of this Introduction. The Insurance Code §4201.003 requires the Commissioner to appoint an advisory committee to advise the Commissioner on the development of rules regarding the administration of Chapter 4201. The Commissioner appointed representatives to the Advisory Committee, whose responsibilities are set forth in Title 28 Texas Administrative Code (28 TAC) §19.1722. The Advisory Committee met in a series of public meetings to discuss implementation of the Insurance Code Chapter 4201 and submitted a final advisory report to the Commissioner. The Advisory Committee's discussions and final report were key in developing these proposed amendments and new sections.

There are several changes made throughout the text of Subchapters R and U based on the recommendation of the Advisory Committee. These changes include changing the word "patient" to the word "enrollee" throughout the text of Subchapter R as a clarifying change. Also, changing the word "patient" to the word "injured employee"

throughout the text of Subchapter U is a clarifying change recommended by the Advisory Committee.

For both Subchapters R and U, the Advisory Committee also requested that the Department include a paragraph within specific sections to explain whether the section applies to a specialty URA. The Department has added the requested applicability provision in the relevant sections based on the Insurance Code §4201.452. Section 4201.452 provides that a specialty URA is not subject to §4201.151, relating to utilization review plan; §4201.152, relating to utilization review under direction of physician; §4201.206, relating to opportunity to discuss treatment before adverse determination; §4201.252, relating to Personnel; or §4201.356, relating to decision by physician required and specialty review. Therefore, those proposed provisions that implement any of these statutes do not apply to a specialty URA.

The Advisory Committee also recommended that when "medical necessity" or "medically necessary" is used throughout the rule text for both Subchapters R and U, a reference to "experimental or investigational" should also be added as applicable. This recommendation is consistent with HB 4290, which amends the definition of "utilization review" to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. For Subchapter R, references to "experimental or investigational" were also added in provisions addressing adverse determinations, as appropriate.

Additionally, the Department has determined with the advice of the Advisory Committee, that the text of Subchapters R and U should be consistent whenever

possible for the benefit of both the regulated entities and consumers. Pursuant to the Insurance Code §4201.054, the Labor Code Title 5 prevails in the event of a conflict between the Insurance Code Chapter 4201 and the Labor Code Title 5. Pursuant to the Insurance Code §1305.351, Chapter 1305 of the Insurance Code prevails in the event of a conflict between the Insurance Code Chapter 4201 and the Insurance Code Chapter 1305. Because there are statutes that specifically govern utilization review for workers' compensation coverage, there are necessary inconsistencies between the Subchapter R rules and the Subchapter U rules in order to implement and maintain consistency with the relevant statutes. However, because there are URAs that may be subject to both Subchapters R and U, the Department recognizes the importance of consistency for ease of interpretation and compliance. Additionally, uniform standards, to the extent possible, afford a more consistent and efficient utilization review process for enrollees and injured employees, who are equally entitled to the highest quality of utilization review, regardless of whether such review is conducted under a health benefit plan/health insurance policy or workers' compensation insurance coverage.

Proposed Nonsubstantive Editorial Corrections.

Additionally, there are numerous proposed nonsubstantive editorial revisions that are made throughout the text of both Subchapter R and Subchapter U. These nonsubstantive changes include updating statutory and rule citations, conforming to current nomenclature and agency style, reorganizing rule text, reformatting, amending for consistency and clarity, and correcting typographical and/or grammatical errors. For a more detailed description of the reorganization of the rule text, Figure: 28 TAC

Chapter 19—Preamble shows existing sections that have been deleted, redesignated, moved, or replaced:

FIGURE: 28 TAC Chapter 19—Preamble

Existing Sections	New Sections
§19.1702(b) deleted	N/A
§19.1702(c) redesignated as	§19.1702(b)
§19.1703(1) deleted	N/A
§19.1703(2) deleted	N/A
§19.1703(3) – (8) redesignated as	§19.1703(1) – (6)
§19.1703(9) redesignated as	§19.1703(8)
§19.1703(10) deleted and moved to	§19.1703(11)
§19.1703(11) – (12) redesignated as	§19.1703(9) – (10)
§19.1703(13) – (14) redesignated as	§19.1703(14) – (15)
§19.1703(15) redesignated as	§19.1703(17)
§19.1703(16) redesignated as	§19.1703(19)
§19.1703(17) redesignated as	§19.1703(21)
§19.1703(18) deleted	N/A
§19.1703(19) redesignated as	§19.1703(25)
§19.1703(20) redesignated as	§19.1703(28)
§19.1703(21) redesignated as	§19.1703(29)
§19.1703(21)(G) deleted	N/A
§19.1703(21)(H) - (N) redesignated as	§19.1703(29)(G) – (M)
§19.1703(22) redesignated as	§19.1703(30)
§19.1703(23) redesignated as	§19.1703(31)
§19.1703(24) – (25) deleted	N/A
§19.1703(26) redesignated as	§19.1703(32)
§19.1703(27) – (31) redesignated as	§19.1703(34) – (38)
§19.1703(32) – (35) redesignated as	§19.1703(40) – (43)
§19.1703(36) – (40) redesignated as	§19.1703(45) - (49)
§19.1704(a) redesignated as	§19.1704(c)(1)(A) and (3)
§19.1704(b) deleted and moved to	§19.1704(c)(3)
§19.1704(c) redesignated as	§19.1704(d)
§19.1704(c)(1) redesignated as	§19.1704(d)(1)
§19.1704(c)(2) deleted and replaced with	§19.1704(d)(2)(H)
§19.1704(c)(3) deleted and replaced with	§19.1704(d)(2)(L)
§19.1704(c)(4) deleted and replaced with	§19.1704(d)(2)(J)
§19.1704(c)(5) redesignated as	§19.1704(d)(6)
§19.1704(c)(6) deleted and replaced with	§19.1704(d)(2)(B)
§19.1704(c)(7) deleted and replaced with	§19.1704(d)(2)(I)

Existing Sections	New Sections
§19.1704(c)(8) deleted and replaced with	§19.1704(d)(3)
§19.1704(c)(9) deleted and replaced with	§19.1704(d)(2)(B)
§19.1704(c)(10) deleted and replaced with	19.1706(b)
§19.1704(c)(11) deleted and replaced with	§19.1704(d)(4)
§19.1704(c)(12) deleted and moved to	§19.1704(d)(5)
§19.1704(d) deleted and replaced with	§19.1716(a)
§19.1704(f) redesignated as	§19.1704(f)(1) and (2)
§19.1704(h)(1) deleted and replaced with	§19.1706(a)(3)
§19.1704(h)(2) deleted and replaced with	§19.1704(d)(6)
§19.1704(h)(3) deleted and replaced with	§19.1704(d)(2)(J)
§19.1704(h)(4) deleted and replaced with	§19.1704(d)(2)(I)
§19.1704(i) deleted	N/A
§19.1705 introductory paragraph redesignated as	§19.1705(a)
§19.1705(1) – (3) deleted and replaced with	§19.1705(b) – (g)
§19.1705(4) redesignated as	§19.1705(f)
§19.1706(a) redesignated as	§19.1706(a)(1) and (3)
§19.1706(b) redesignated as	§19.1706(b)(1) – (3)
§19.1706(c) redesignated as	§19.1706(d) and (e)(1)
§19.1706(d) redesignated as	§19.1706(g)
§19.1706(e) deleted and replaced with	§19.1720(c)
§19.1709(b) redesignated as	§19.1709(b), (c)(1) and (2)
§19.1710(b) redesignated as	§19.1710(b)(1)
§19.1710(c)(1) – (4) redesignated as	§19.1710(c)(1)(A) – (C), and (F)
§19.1710(c)(5) deleted and replaced with	§19.1710(c)(1)(I)
§19.1710(d)(1) – (3) redesignated as	§19.1710(c)(4)(A) – (C)
§19.1710(e) deleted and replaced with	§19.1721
§19.1711 redesignated as	§19.1711(b)(1) and (3)
§19.1712(a) – (c) redesignated as	§19.1712(a)(1) – (3)
§19.1712(b)(1) and (2) deleted and replaced with	§19.1712(a)(2)(B) and (C)
§19.1712(b)(3) redesignated as	§19.1712(a)(2)(D) and (F)
§19.1712(b)(4) redesignated as	§19.1712(a)(2)(G)
§19.1712(b)(5) redesignated as	§19.1712(a)(2)(H)
§19.1712(b)(5)(A) redesignated as	§19.1712(a)(2)(H)(i)
§19.1712(b)(6) redesignated as	§19.1712(a)(2)(I)
§19.1712(c) redesignated as	§19.1712(a)(3)
§19.1714(a) – (j) redesignated as	§19.1714(a)(1) – (10)
§19.1714(k) deleted and moved to	§19.1714(b)

Existing Sections	New Sections
§19.1714(l) – (n) redesignated as	§19.1714(a)(11) – (13)
§19.1715(b) deleted and replaced with	§19.1712
§19.1715(c) redesignated as	§19.1715(b)(3)
§19.1716(a) deleted and replaced with	§19.1705(g)
§19.1716(b) introductory paragraph is redesignated as	§19.1716(b)(1) - (3)
§19.1716(b)(1) – (3) redesignated as	§19.1716(b)(3)(A) – (C)
§19.1716(b)(4) deleted	N/A
§19.1716(b)(5)-(6) redesignated as	§19.1716(b)(3)(D) – (E)
§19.1716(b)(6)(A) – (C) redesignated as	§19.1716(b)(3)(E)(i) – (iii)
§19.1716(c)(1) – (5) deleted and replaced with	§19.1716(c)
§19.1716(d) deleted and replaced with	N/A
§19.1716(e) deleted	N/A
§19.1716(f) deleted	N/A
§19.1716(g) redesignated as	§19.1716(e)
§19.1716(g)(1) redesignated as	§19.1716(e)(1)(A)
§19.1716(g)(2) redesignated as	§19.1716(e)(2)
§19.1716(g)(3) deleted and replaced with	§19.1716(e)(1)(C)
§19.1716(g)(4) deleted	N/A
§19.1717(e) deleted and replaced with	§19.1717(a) and (d)
§19.1717(f) redesignated as	§19.1717(e)
§19.1718 is repealed	N/A
§19.1719(a)(1) deleted	N/A
§19.1719(b)(1) redesignated as	§19.1719(b)(2)
§19.1719(b)(2) deleted	N/A
§19.1719(b)(4) deleted	N/A
§19.1719(b)(3) redesignated as	§19.1719(b)(4)
§19.1720(a) and (b) redesignated as	§19.1720(b)(1) and (2)
§19.1720(d) and (e) deleted and replaced with	§19.1720(e)
§19.1720(f) redesignated as	§19.1720(d)(1) and (3)
§19.1720(h) redesignated as	§19.1720 (h)(1)(A)
§19.1721(a), (b), and (c) redesignated as	§19.1721(a)
§19.1721(c)(1) – (3) deleted and replaced with	§19.1721(a)(1)(B)
§19.1721(d), (e), and (g) – (i) redesignated as	§19.1721(b)(1) – (4)

Existing Sections	New Sections
§19.1721(f) deleted	N/A
§19.1721(j) and (k) redesignated as	§19.1721(b)(5)(A) and (B)
§19.1722 repealed	N/A
§19.2002 introductory paragraph redesignated as	§19.2002(a)
§19.2002 last sentence of introductory paragraph and §19.2002(1) redesignated as	§19.2002(c)
§19.2002(2) and (3) deleted	N/A
§19.2003(1) – (3) deleted	N/A
§19.2003(4) – (9) redesignated as	§19.2003(2) – (7)
§19.2003(10) deleted and moved to	§19.2003(10)
§19.2003(11) redesignated as	§19.2003(9)
§19.2003(13) – (15) redesignated as	§19.2003(14) – (16)
§19.2003(16) deleted	N/A
§19.2003(17) deleted	N/A
§19.2003(18) redesignated as	§19.2003(17)
§19.2003(19) deleted and replaced with	§19.2003(17)
§19.2003(20) - (21) redesignated as	§19.2003(19) - (20)
§19.2003(23) redesignated as	§19.2003(26)
§19.2003(24) deleted	N/A
§19.2003(25) – (27) redesignated as	§19.2003(29) – (31)
§19.2003(28) – (29) redesignated as	§19.2003(34) – (35)
§19.2003(30) – (31) redesignated as	§19.2003(38) – (39)
§19.2003(32) deleted	N/A
§19.2003(33) – (35) redesignated as	§19.2003(40) – (42)
§19.2003(36) redesignated as	§19.2003(47)
§19.2003(37) deleted and moved to	§19.2003(44)
§19.2003(38) deleted and moved to	§19.2003(8)
§19.2004(a) deleted and moved to	§19.2004(b)(3)
§19.2004(b) deleted and moved to	§19.2004(b)(3)
§19.2004(c)(2) deleted and replaced with	§19.2004(c)(2)(H)
§19.2004(c)(3) deleted in part and replaced with	§19.2004(c)(2)(A) and (L)
§19.2004(c)(4) deleted in part and replaced with	§19.2004(c)(2)(J)
§19.2004(c)(5) redesignated as	§19.2004(c)(7)
§19.2004(c)(6) deleted and replaced with	§19.2004(c)(2)(B)

Existing Sections	New Sections
§19.2004(c)(7) deleted and replaced with	§19.2004(c)(2)(I)
§19.2004(c)(8) deleted and replaced with	§19.2004(c)(4)
§19.2004(c)(9) deleted and replaced with	§19.2004(c)(2)(B)
§19.2004(c)(10) deleted and replaced with	§19.2006(b) and §19.2004(c)(7)
§19.2004(c)(11)(A) – (D) deleted and replaced with	§19.2004(c)(2)(B) and (c)(5)
§19.2004(c)(12) deleted and moved to	§19.2004(c)(6)
§19.2004(d) deleted and moved to	§19.2016(a)
§19.2004(e)(1) – (4) redesignated as	§19.2004(d)(1) – (4)
§19.2004(f)(1) deleted and replaced with	§19.2004(c)(2)(B)
§19.2004(f)(2) deleted and replaced with	§19.2004(c)(7)
§19.2004(f)(3) deleted and replaced with	§19.2004(c)(2)(J)
§19.2004(f)(4) deleted and replaced with	§19.2004(c)(2)(I)
§19.2004(g) redesignated as	§19.2004(e)(1) and (2)
§19.2004(h) redesignated as	§19.2004(f)
§19.2004(i) deleted	N/A
§19.2004(j) deleted	N/A
§19.2005 introductory paragraph redesignated as	§19.2005(a)
§19.2005(1) – (3) deleted and replaced with	§19.2005(b) – (g)
§19.2005(4) redesignated as	§19.2005(f)
§19.2006(a) redesignated as	§19.2006(a)(1) and (3)
§19.2006(b) redesignated as	§19.2006(b)(1) – (3)
§19.2006(c) first sentence redesignated as	§19.2006(d)
§19.2006(c) second sentence redesignated as	§19.2006(e)(1)
§19.2006(d) redesignated as	§19.2006(f)
§19.2006(e) deleted	N/A
§19.2009(b) redesignated as	§19.2009(b) and §19.2009(c)(1) and (2)
§19.2010(b) deleted and replaced with	§19.2010(a)(1) and (2); §19.2010(b)(1)(A) and (B); and §19.2010(c)(3)
§19.2010(c)(1) and (2) redesignated as	§19.2010(c)(1)(A)(i) and (ii)
§19.2010(c)(4) redesignated as	§19.2010(c)(1)(A)(iv)
§19.2010(c)(3) deleted and replaced with	§19.2010(c)(1)(B) and (C)
§19.2010(c)(5) deleted and replaced with	§19.2010(c)(1)(A)(vii)
§19.2011 redesignated as	§19.2011(b)(1) and (3)
§19.2012 repealed and replaced with	§19.2012
§19.2014(a) – (j); (l), (m), and (n)	§19.2014(a)(1) – (13)

Existing Sections	New Sections
redesignated as	
§19.2014(k) deleted and moved to	§19.2014(b)
§19.2015 repealed and replaced with	§19.2015
§19.2016(a) deleted and replaced with	§19.2005(g)
§19.2016(b) introductory paragraph redesignated as	§19.2016(b)(1)
§19.2016(b)(1) – (3) deleted and moved to	§19.2016(b)(3)(E)(i) – (iii)
§19.2016(c)(1) – (3) redesignated as	§19.2016(b)(3)(A) – (C)
§19.2016(d)(1) – (4) deleted and replaced with	§19.2016(c)
§19.2016(f) deleted and replaced with	§19.2016(d)
§19.2016(g) deleted	N/A
§19.2016(h) redesignated as	§19.2016(f)
§19.2016(h)(4) deleted	N/A
§19.2017(a) – (e) redesignated as	§19.2017(a)(1) – (4)
§19.2018 repealed	N/A
§19.2019(a) deleted and replaced with	§19.2019(a)
§19.2020(a) and (b)	§19.2020(b)(1) and (2)
§19.2020(d) and (e) deleted and replaced with	§19.2020(e)
§19.2020(f) first two sentences deleted and moved to	§19.2020(d)(1)
§19.2020(f), other than first two sentences, redesignated as	§19.2020(d)(3)
§19.2021 repealed and replaced with	§19.2021

The following paragraphs include a description of all of the proposed amendments necessary to implement HB 4290 and to make the other changes that the Department, with the advice of the Advisory Committee, has determined are necessary for effective compliance with and effective implementation and enforcement of the Insurance Code Chapter 4201.

Subchapter R amendments and new sections.

Section 19.1701 addresses **General Provisions**. The proposed amendment to §19.1701(a) is necessary to change the existing provision relating to the statutory basis for the rules in Subchapter R to reflect that the new subchapter incorporates the most recent amendments to Chapter 4201 of the Insurance Code. The proposed amendment to §19.1701(b) amends the severability clause language to conform to current agency style. The addition of the word "medical" in §19.1701(c)(4) is a clarifying change. Proposed new §19.1701(d) provides that Subchapter U of 28 TAC Chapter 19 applies to utilization review performed under workers' compensation insurance coverage in lieu of the provisions of Subchapter R.

Section 19.1702 addresses **Limitations on Applicability**. The proposed amendments to §19.1702(a) delete existing subsection (a) and update the subsection to specify the applicability of Subchapter R to utilization review performed under a health benefit plan or a health insurance policy except as provided in the Insurance Code Chapter 4201. Existing §19.1702(b) is proposed for deletion because under these proposed rules only HMOs and insurers that conduct utilization review only for coverage for which they are the payors are exempt from obtaining certification. Section 19.1719 sets forth the responsibility of HMOs and insurers performing utilization review. The proposed amendments to §19.1702(b), which is existing §19.1702(c) relating to the non-applicability of Subchapter R, track statutory language. The Insurance Code §4201.051 provides that this chapter does not apply to a person who: (i) provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and (ii) does not determine whether a particular

health care service provided or to be provided to an enrollee is: (a) medically necessary or appropriate; or (b) experimental or investigational. Section 19.1702(b)(2) is proposed to be deleted because the provision is no longer applicable under the proposed rules; personnel employed by a URA are governed by §19.1706 under the proposed rules. Existing §19.1702(b)(3) is proposed to be deleted because it is repetitive of §19.1702(a) in the proposed rules.

Section 19.1703 addresses **Definitions**. A proposed amendment to the definition of "adverse determination" in §19.1703(2) adds the phrase "made on behalf of any payor." The inclusion of the phrase "made on behalf of any payor" clarifies that the definition includes those payors that conduct utilization review in-house. The change is necessary to reflect the Department's position that the term "adverse determination" includes determinations made on behalf of all payors. The addition of the phrase "or are experimental or investigational" is necessary to implement HB 4290. HB 4290 amends the definition of "adverse determination" to include determinations by a URA that health care services provided or proposed to be provided to a patient are experimental or investigational. The final proposed amendment to §19.1703(2) adds the provision that the term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. This proposed amendment is necessary to clarify that adverse determinations do not include denials of health care services due to the enrollee's or health care provider's failure to request prospective or concurrent utilization review, if such prospective or concurrent utilization review was required.

The proposed amendments to the definition of "appeal" in §19.1703(3) are to improve clarity. The proposed amendments to the definition of "certificate" in §19.1703(4) are necessary to provide a more detailed and accurate definition that reflects that an insurance carrier or HMO can 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. The proposed amendments to the definition of "complaint" in §19.1703(6) are necessary to clarify that a complaint does not include an expression of dissatisfaction with a specific adverse determination and also to replace the term "enrollee" with "complaining party" to include any party filing a complaint.

Proposed new §19.1703(7) is necessary to define the term "concurrent utilization review," which is a form of utilization review that is subject to these proposed rules. The proposed amendment to the definition of "declination" in §19.1703(8), replacing the word "carrier" with "benefit plan," is a clarifying change.

Proposed new §19.1703(12) is necessary to 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.

Proposed new §19.1703(13) adds a definition of "doctor." This definition mirrors the definition of "doctor" in existing 28 TAC §19.2003(12). The definition of "doctor" tracks the statutory language in the Labor Code §401.011(17), which provides that "doctor" means a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

Proposed new §19.1703(16) adds a definition of "experimental or investigational." This definition is consistent with Texas Labor Code §413.014(a), which provides "investigational or experimental service or device" means 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. The definition is also consistent with 28 TAC §134.600 and 28 TAC §12.5(12). Section 134.600, relating to injured employees non-emergency health care requiring preauthorization, specifies "any investigational or experimental 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." Section 12.5(12), relating to definitions for rules regulating IROs, defines "experimental or investigational" as "A 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."

The proposed amendments to the definition of "health benefit plan" in §19.1703(17) are necessary for consistency with the Insurance Code §4201.002(4). Section 4201.002(4) defines "health benefit plan" as a plan of benefits, other than a health insurance policy, that: (i) defines the coverage provisions for health care for enrollees; and (ii) is offered or provided by a public or private organization.

Proposed new §19.1703(18) adds a definition of "health care facility." This definition mirrors the definition of "health care facility" in existing 28 TAC §19.2003(15). This definition is consistent with the Labor Code §401.011(20), which defines "health care facility" as "a hospital, emergency clinic, outpatient clinic, or other facility providing health care."

The proposed amendment to delete "inquiry" in existing §19.1703(18) is necessary because the term "inquiry" is not used in the rule text in the context that the definition contemplates. The term "inquiry" is only used in §19.1716(d), and in that context the term refers to *Department* inquiries, not inquiries that would be considered a request for information or assistance from a URA.

Proposed amendments to the definition of "health care provider" in §19.1703(19) update the definition to track the statutory language. The Insurance Code §4201.002(5) provides that the term "health care provider" means a person, corporation, facility, or institution that is: (i) licensed by a state to provide or is otherwise lawfully providing health care services; and (ii) eligible for independent reimbursement for those health care services.

Proposed new §19.1703(20) adds a definition of "health coverage." This definition is necessary to provide a uniform understanding and application of what constitutes "health coverage" in implementing the Subchapter R rules.

The proposed amendment to the definition of "health insurance policy" in §19.1703(21), replacing "company" with "corporation," is necessary to track the statutory definition more closely. The Insurance Code §4001.002(6) provides, "(6)

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

Proposed new §19.1703(22) adds a definition of "health maintenance organization or HMO," which references the statutory definition in the Insurance Code §843.002. Proposed new §19.1703(23) adds a definition of "insurance carrier or insurer." This definition is added for consistency with the proposed amendments to §19.2003(17). The definitions, however, are not identical, because the proposed §19.2003(17) definition references workers' compensation insurance, which is not applicable under §19.1703(23). Proposed new §19.1703(24) adds the term "legal holiday," which is defined in accordance with the definition of a "national holiday" as defined in the Government Code §662.003(a).

Proposed new §19.1703(26) adds a definition of the term "medical emergency." This definition tracks the statutory language of the Insurance Code §1305.004(13), which provides that the term 'medical emergency' means 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: (i) placing the patient's health or bodily functions in serious jeopardy; or (ii) serious dysfunction of any body organ or part. This definition is necessary to uniformly implement the proposed Subchapter R rules.

Proposed new §19.1703(27) defines "medical records" as "The entire history of diagnosis and treatment, including but not limited to medical, mental health records as

allowed by law, dental, and other health care records from all disciplines rendering care to an enrollee." Except for the inclusion of the phrase "mental health records as allowed by law," and the change of the term "injured employee" to "enrollee," this definition is based on the Insurance Code §1305.004(14), which defines the term "medical records" for purposes of the Workers' Compensation Health Care Network Act. Section 1305.004(14) defines "medical records" to mean the history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee. The addition of the phrase "mental health records as allowed by law" was recommended by the Advisory Committee. This definition is necessary to uniformly implement the proposed Subchapter R rules.

Existing §19.1703(20), which defines "mental health medical record summary," is redesignated as §19.1703(28). A proposed amendment to the definition of "mental health therapist" in §19.1703(29) adds "as appropriate" to clarify that not all of the individuals licensed under subparagraphs (A) – (M) are authorized to diagnose, evaluate, or treat any mental or emotional condition or disorder. This addition was recommended by the Advisory Committee. Another amendment is proposed to delete existing paragraph "(G) a person licensed as a chemical dependency counselor by the Texas Commission on Alcohol and Drug Abuse," also at the recommendation of the Advisory Committee. The proposed deletion of existing subparagraph (G) results in the proposed redesignation of existing subparagraphs (H) – (N) in §19.1703(29).

The proposed amendment to the existing definition of "mental or emotional condition or disorder" in §19.1703(30) deletes the phrase "revision of the" in reference to the Diagnostic and Statistical Manual of Mental Disorders ("Manual"). The proposed amendment is necessary for clarification because both new "editions" and new "revisions" of the Manual are published.

The proposed amendment to the existing definition of "nurse" in §19.1703(31) adds an "or" between "registered" and "professional," clarifying that both a registered nurse and a professional nurse are included in the definition. This proposed amendment is consistent with the definition of "nurse" in the Insurance Code §4201.002(8), which defines "nurse" as "a professional *or* registered nurse, a licensed vocational nurse, or a licensed practical nurse."

The proposed deletion of the definition of "patient" in existing §19.1703(25) is necessary because the term "patient" is no longer used in the subchapter.

The proposed amendments to the definition of "payor" in §19.1703(32) are necessary to more closely track the statutory language. The Insurance Code §4201.002(10) defines "payor" as (i) an insurer that writes health insurance policies; (ii) a preferred provider organization, health maintenance organization, or self-insurance plan; or (iii) any other person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider in this state under a policy, plan, or contract."

Proposed new §19.1703(33) adds a definition of "peer review." This definition, which was recommended by the Advisory Committee, is necessary for uniform implementation of the Subchapter R rules.

The definition of the term "preauthorization" in §19.1703(36) is proposed to be amended to add the descriptor "form of prospective utilization review by a payor or its utilization review agent of. . . ." This addition results in the phrase "are medically necessary and appropriate" no longer being necessary because "utilization review" is proposed to be defined in §19.1703(45) as "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…." Thus, the concept "medically necessary and appropriate" is already incorporated by reference to the terminology "utilization review."

A proposed amendment to the existing definition of "preferred provider" in §19.1703(37) changes the term "carrier" to "benefit plan" for clarity and uniform implementation.

A proposed amendment to the existing definition of "provider of record" in §19.1703(38) clarifies that a doctor as well as a physician or other health provider does not necessarily have to render care, treatment, or services to be considered the provider of record. An amendment is also proposed to the existing definition to replace the terminology "care, treatment, and services" with "health care services" for consistency with other usages of this phrase throughout the text. Proposed new

§19.1703(39) adds a definition of the term "registration." Proposed amended §19.1719 sets forth the responsibility of an HMO and insurer performing utilization review, including the responsibility of those performing utilization review only for coverage for which they are the payor. HMOs and insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but are instead required to register. The proposed new definition clarifies that the registration process only applies to an HMO or insurer that performs utilization review solely for its own insureds or enrollees.

Proposed amendments to the existing definition of "retrospective review" in §19.1703(40) change the defined term to "retrospective utilization review" and incorporate the term "utilization review" into the definition, thereby removing the need to refer to "medical necessity and appropriateness" because the concept is included in the definition of the term "utilization review." The proposed addition of the phrase "that have been" in relation to health care services provided to an enrollee and the proposed deletion of the phrase "is performed for the first time subsequent to the completion of such health care services" are necessary for clarity and to avoid redundancy. The proposed addition of the phrase "or should have been previously conducted" in relation to what retrospective utilization review does not include is necessary for clarification.

Existing §19.1703(33), which defines "routine vision services," existing §19.1703(34), which defines "screening criteria," and existing §19.1703(35), which defines "single health care service plan" are redesignated as §19.1703(41), (42), and (43), respectively.

Proposed new §19.1703(44) adds a definition of "specialty utilization review agent." This definition is consistent with the Insurance Code §4201.451, which provides that for purposes of Subchapter J in Chapter 4201, relating to specialty URAs, the term "specialty utilization review agent" means a URA who conducts utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

The proposed amendments to the definition of the term "utilization review" in §19.1703(45) add the term "retrospective" review and the phrase "and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services" to the definition. The additions are necessary to implement HB 4290 which provides that utilization review applies to retrospective review and determinations of the experimental or investigational nature of health care services.

The addition of the phrase "holding a certificate of authority under the Insurance Code Chapter 4151" to subparagraph (C) of the existing definition of "utilization review agent" in §19.1703(46) clarifies the type of administrator to which the subparagraph refers. This amendment is necessary for uniform implementation of the Subchapter R rules.

Proposed amendments to the existing definition of "verification" in §19.1703(48) replace the term "carrier" with the term "benefit plan" throughout the definition for clarity and consistency. The amendment to change the word "title" to the word "subchapter" is necessary to conform to Department and Texas Register style. The proposed

amendment to the definition of "working day" in §19.1703(49) is necessary to update the definition to clarify that "legal" holidays are as defined by the Government Code §662.003(a) and provide consistency with 28 TAC §102.3, relating to computation of time under the general provisions of TDI-DWC. Under 28 TAC §102.3(b), use of the term "day," rather than "working day" means a calendar day.

Section 19.1704 addresses **Certification or Registration of Utilization Review Agents**. An amendment is proposed to the title of existing §19.1704 to include "registration" of URAs in the title. Proposed new §19.1704(a), which is added to implement the Insurance Code §4201.101, provides that a person acting as or holding itself out as a URA must be certified or registered under the Insurance Code Chapter 4201 and 28 TAC Chapter 19, Subchapter R. Section 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 of Chapter 4201.

Proposed new §19.1704(a)(1) and (2) add new provisions and are necessary to address certification and registration requirements for HMOs and insurers. Proposed new §19.1704(a)(1) provides that, pursuant to §19.1719(a)(2) and §19.1719(b)(3), if an HMO or insurer performs utilization review for an individual or entity subject to 28 TAC Chapter 19, Subchapter R, such HMO or insurer must have a valid certificate pursuant to the Insurance Code §4201.101 and §19.1704. This provision is consistent with the Insurance Code §4201.057(e) and §4201.058(c). The Insurance Code §4201.057(e) provides that an HMO that performs utilization review for a person or entity subject to the Insurance Code Chapter 4201, other than a person or entity for which the HMO is

the payor, must obtain a certificate of registration under Chapter 4201, Subchapter C, and shall comply with all of the provisions of Chapter 4201. The Insurance Code §4201.058(c) provides that an insurer that performs utilization review for a person or entity subject to the Insurance Code Chapter 4201, other than a person or entity for which the insurer is the payor, must obtain a certificate of registration under Chapter 4201, Subchapter C, and shall comply with all of the provisions of Chapter 4201.

Proposed new §19.1704(a)(2) provides that, pursuant to §19.1719(a)(3) and §19.1719(b)(4), 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 pursuant to §19.1704.

Proposed new §19.1704(b) adopts by reference Form No. LHL005 (Utilization Review Agent (URA) Application) to be used for application for a certification or registration and for renewal of a certification or registration as a URA in this state.

Sections 19.1704(c)(1) – (3), relating to application filing requirements, are in existing §19.1704(a), relating to where to file the application, with several amendments. The first proposed amendment to §19.1704(c) adds the title "Application Filing Requirements" for clarity and to conform to *Texas Register* style relating to subheadings. The second proposed amendment adds paragraph (1), entitled "Application for certification." Paragraphs (1) and (2) are necessary to distinguish between applications for *certification* and applications for *registration*. Paragraph (1)(A) provides that an application for certification of a URA must include Form No. LHL005, which is adopted by reference in §19.1704(b). Paragraph (1)(B) provides that an

application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19). Another proposed amendment to §19.1704(c) adds paragraph (2), entitled "Application for registration." Paragraph (2)(A) provides that an application for registration of a URA must include Form No. LHL005, which is adopted by reference in §19.1704(b). Paragraph (2)(B) provides that the fee requirement specified by §19.802(b)(19) does not apply to an applicant for registration. These provisions are consistent with proposed §19.1719(a)(3) and (b)(4).

An additional proposed amendment to §19.1704(c) redesignates existing §19.1704(a) as paragraph (3), entitled "Where to obtain and file the application form." Proposed amendments to this paragraph reference Form No. LHL005 and update the address with which the form must be filed.

The proposed amendments to §19.1704(d) reorganize the information that is required in Form No. LHL005 and impose some additional requirements pursuant to the Commissioner's authority to promulgate forms under the Insurance Code §4201.104 and under the Commissioner's authority in §4201.003 to adopt rules to implement Chapter 4201. Additionally, the proposed amendment to §19.1704(d)(1)(A) adds "or the experimental or investigational nature" to the requirement that the completed application include an adequate summary description of screening criteria and review procedures to be used to determine medical necessity or appropriateness of health care. This addition is necessary to implement HB 4290, which includes in the definition of "adverse determination" a determination by a URA that health care services provided or proposed to be provided to a patient are experimental or investigational.

Proposed amendments to §19.1706(d) require the URA to provide to the Department the name, number, type, license number and state of licensure, and qualifications of the personnel either employed or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information.

Proposed new §19.1704(d)(3) adds a new requirement that the application form include copies of template letters for notification of determinations made in utilization review that comply with §19.1710 and §19.1712.

Existing §19.1704(c)(9) is proposed for deletion because these prohibitions are addressed in proposed §19.1706(b). The URA is also required to certify in the application Form No. LHL005 that it is compliant with Texas rules. Existing §19.1704(c)(11) is proposed for deletion because proposed new §19.1704(d)(4) sets forth the organizational information that Form No. LHL005 requires, including (i) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state; (ii) a chart showing the internal organizational structure of the applicant's executives, officers, and directors and title of position held by each; and (iii) a letter of good standing from the Texas Comptroller of Public Accounts.

Existing §19.1704(c)(12) is proposed for deletion because the name and biographical information for each director, officer and executive of the applicant is required under proposed new §19.1704(d)(5). Additionally, proposed §19.1704(d)(5)

adds a new requirement that the application form include the name and 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). This change is necessary because, in accordance with §1.502(c) and (e) of this title, the Department has developed guidelines relating to the matters which the Department will consider in determining whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction, which include criminal background checks for each director, officer, and executive of the applicant.

The amendments to existing §19.1704(e) propose changes to the application process and are proposed pursuant to the Commissioner's general rulemaking authority under the Insurance Code §4201.003(a). The proposed addition of the phrase "a complete" to modify "application" in subsection (e)(1) clarifies that the 60 day time period does not begin until after the application is complete. Another amendment to subsection (e)(1) clarifies that the Department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

An amendment is proposed to §19.1704(e)(2) to change the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days of the date of the Department's latest notice of the omissions or deficiencies. This proposed reduction in time to correct the omissions or deficiencies is necessary to streamline the application process, providing the Department with

information more quickly. This shorter time period will allow a more efficient application process, thereby making more URAs more quickly available to the Texas consumer.

Amendments are proposed to §19.1704(e)(3) to provide that before the end of the 15 working days specified in paragraph (e)(2), the applicant may request in writing additional time to correct the omissions or deficiencies in the application. Under the proposed amendments, the request for the additional time must be approved by the Department in writing for the requested extension to be effective.

Amendments are proposed to §19.1704(e)(4) to rename what is now called an "application file" a "charter file." This file must be maintained by the Department. Under the proposed amendments, the file must contain approved application documents and requests for additional time and responses from the applicant. These documents are in addition to the documents relating to notices of omissions or deficiencies that are required to be maintained under the existing rule. Also, under the proposed amendments, the requirement that the charter file contain documents relating to "any written materials generated by any person that was considered by the Department in evaluating the application" is proposed to be deleted. This proposed deletion is necessary because it is overly broad, requiring retention of documents that will not be useful for future reference.

Proposed amendments to §19.1704(f)(1), relating to two-year renewal, clarify the requirements for the renewal process. The Insurance Code §4201.103 provides that certification may be renewed biennially by filing, not later than March 1, a renewal form with the Commissioner accompanied by a fee in an amount set by the Commissioner.

The Insurance Code §4201.104(a) authorizes the Commissioner to promulgate forms to be filed for a renewal certificate of registration. Proposed amendments to §19.1704(f)(2), relating to continued operation during Department review, provides that if a URA has filed the required information specified in subsection (f) and the fee required only for certification renewal with the Department 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 finally denied or issued by the Department.

Proposed new §19.1704(f)(3) specifies the requirements for renewal if the certification or registration has been expired for 90 days or less. Under proposed new §19.1704(f)(3), the URA may renew the certification or registration by filing a completed renewal application, fee as applicable for certification renewal, and the required information described in subsection (f). Proposed §19.1704(f)(3) prohibits the URA from operating from the time the certification or registration has expired until the time the Department has issued a renewal certification or registration. Proposed new §19.1704(f)(4) specifies the requirements if the certification or registration has been expired for longer than 90 days. Under proposed §19.1704(f)(4), 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 accordance with §19.1704. Under proposed §19.1704(f)(4), section 19.1704(e), relating to original application requirements and process, applies to applications made under paragraph (4).

The proposed deletion of existing §19.1704(h)(1) – (4), relating to evidence required by an applicant for a certificate, is necessary because the requirements specified in this subsection are addressed in proposed §19.1704(d)(2) with substantive amendments to some of the existing requirements.

The proposed deletion of existing §19.1704(i), relating to requirements for filing of changes in original applications of URAs that received their certificates prior to the 1992 adoption date of Subchapter R, is necessary because the requirement is obsolete.

Section 19.1705 addresses **General Standards of Utilization Review.** Proposed amendments to §19.1705(a) require the utilization review plan to be approved by a physician, periodically updated, and include input from both primary and specialty physicians, doctors, or other health care providers. The Insurance Code §4201.151 provides that a URA's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician. The proposed deletion of the components listed in existing §19.1705(1) – (3) that must be included in the utilization review plan is necessary because the Department establishes updated required components in proposed new subsections (b) – (g) of §19.1705 or the components are otherwise incorporated into other sections of the subchapter, and the retention of the provisions would therefore be repetitive.

Proposed new §19.1705(b) adds 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 the Insurance Code §4201.153, which requires that utilization review determinations be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria.

Proposed new §19.1705(c) adds a statutorily required prohibition related to performance tracking data. This provision is consistent with the Insurance Code §4201.556(a), which prohibits a URA from publishing data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

Proposed new §19.1705(d) adds statutorily required screening criteria provisions. It describes the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome focused, and that they comply with the Insurance Code §4201.153. The Insurance Code §4201.153(a) – (c) require: (a) that a URA use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers; (b) that a utilization review determination be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case

that may require deviation from the norm stated in the screening criteria; and (c) that screening criteria be: (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, proposed new §19.1705(d) requires that screening criteria 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. This provision recognizes that evidence-based medicine will not always be available. This provision is necessary to harmonize the Subchapter R screening criteria requirements with proposed §19.2005(d), which incorporates requirements of the Labor Code. Pursuant to the Commissioner's authority in §4201.003 to adopt rules to implement Chapter 4201, the Department determined this conforming change is necessary in Subchapter R rules to implement the existing requirements for screening criteria in accordance with §4201.153 while maintaining screening criteria standards that are consistent with the screening criteria standards under Subchapter U.

Proposed new §19.1705(e) adds a statutorily required provision related to referral and determination of adverse determinations. It requires that adverse determinations be referred to an appropriate physician or doctor.

Proposed new §19.1705(e) also provides that, in addition to determination of medical necessity or appropriateness, adverse determinations must be referred to and may only be determined by an appropriate physician or doctor to determine the

experimental or investigational nature of health care services. This requirement is the result of the enactment of HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, that effectively revise the definition of "adverse determination" in the Insurance Code Chapter 4201 to include determinations regarding the experimental or investigational nature of a service.

Proposed new §19.1705(g) adds statutorily required provisions related to the URA's complaint system. It requires the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with the Insurance Code §4201.204, which requires in pertinent part that a URA (i) establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review; (ii) to include a requirement in the complaint procedure that the URA provide a written response to the complainant within 30 days; and (iii) maintain a record of each complaint until the third anniversary of the date the complainant filed the complaint. Additionally, proposed §19.1705(g) adds a new requirement that the written response include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department. This information is necessary to inform the consumer that he or she has the right to file a complaint with the Department after the issuance of an adverse determination by the URA, and the process by which the consumer may speak to a Department representative regarding his or her claim to the URA.

Proposed new §19.1705(h) adds the Insurance Code §1369.056 requirement that the refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of Subchapter R if: (i) the drug is not included in a drug formulary used by the group health benefit plan; and (ii) the enrollee's physician has determined that the drug is medically necessary. This subsection is proposed to implement the Insurance Code §1369.056 and Chapter 4201. Under the Insurance Code §1369.057, the Commissioner may adopt rules to implement Chapter 1369, Subchapter B, of the Insurance Code. The Commissioner also has authority under §4201.003 to adopt rules to implement Chapter 4201.

Proposed new §19.1705(i) provides that §19.1705 applies to a specialty URA except for subsection (a), relating to utilization review plan requirements. While a specialty URA is required to have a utilization review plan pursuant to 19.1720(c), the specialty URA is exempt from the requirements that the utilization review plan be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other health care providers, including practicing health care providers. The reason that the specialty URAs are not subject to these requirements is that these requirements are based on the Insurance Code §4201.151 and pursuant to the Insurance Code §4201.452, specialty URAs are not subject to §4201.151. Specialty URAs are required, pursuant to 19.1720(c), to use only a health care provider of the appropriate specialty. Under the Insurance Code §4201.453 and §19.2020, a specialty URA must have the utilization review plan reviewed by a health care provider of the

appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Section 19.1706 addresses **Requirements and Prohibitions Relating to Personnel.** A proposed amendment to §19.1706(a)(1) replaces the term "Personnel" with "Physicians, doctors, and other health care providers" to clarify to whom this section applies. A new requirement is added in proposed new §19.1706(a)(2) to require personnel conducting utilization review to hold an unrestricted license or administrative license or to be otherwise authorized to provide health care by a licensing agency in the United States. This new requirement in proposed §19.1706(a)(2) was unanimously recommended by the Advisory Committee and is consistent with the provisions of the Insurance Code §4201.252(a). Section 4201.252(a) requires that "Personnel employed by or under contract with a URA to perform utilization review be appropriately trained and qualified."

A new prohibition is proposed in new §19.1706(c), relating to disqualifying associations. Proposed new §19.1706(c) prohibits a physician who reviews the appeal from having any disqualifying associations with the physician or doctor who issued the initial adverse determination or the enrollee who is requesting the appeal. The subsection also clarifies that being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not constitute a disqualifying association. Proposed new §19.1703(12) defines "disqualifying association." Both §19.1703(12) and §19.1706(c) are necessary to prohibit potential conflicts of interest that could undermine the appeals process for

adverse determinations. The purpose of proposed new §19.1703(12) and §19.1706(c) is to prohibit the physician who reviews the appeal from being improperly influenced based on a relationship that he or she has with the physician or doctor who issued the initial adverse determination or the enrollee who is requesting the appeal.

Proposed amendments to §19.1706(d) add requirements that the URA provide the name, license number and state of licensure of the personnel either employed by or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information, in addition to the information that is currently required.

The deletion of existing §19.1706(e), which requires utilization review dental plans to be reviewed by a dentist currently licensed by a state licensing agency in the United States, is proposed to avoid unnecessary redundancy. Review of dental plans are governed by §19.1720, relating to specialty URAs.

Proposed amendments to newly designated §19.1706(e) add a new paragraph (2) to require the URA to maintain documentation that demonstrates that physicians, doctors and other health care providers that are utilized to perform utilization review are licensed, qualified, and appropriately trained or experienced.

Proposed new §19.1706(f) adds a new requirement relating to training related to acquired brain injury treatment. It requires the URA to provide adequate training to personnel responsible for pre-certification, certification, and recertification of services or treatment related to acquired brain injury treatment. The basis for this requirement is the 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 if the physician or provider provides those services to the patient for whom the services are proposed. 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 is required 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. 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 is further required to prescribe by rule, in consultation with the Texas Traumatic Brain Injury Advisory Council, the basic requirements for the training. Although the Insurance Code §1352.004 contemplates the required training for a health benefit plan issuer and not for a URA specifically, proposed new §19.1706(e) will ensure that URA personnel will receive adequate training, as consistent with the intent of the Insurance Code §1352.004. The requirement that URA personnel receive the training is proposed under the Commissioner's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Newly designated §19.1706(g) is existing §19.1706(d), relating to the requirement that utilization review conducted by a URA be under the direction of a currently licensed physician, with minor nonsubstantive changes proposed for purposes of clarity and readability.

Proposed new §19.1706(h) provides that §19.1706 applies to a specialty URA except subsections (a), (d), (e) and (g). Specialty URA requirements relating to employed or contracted physicians, doctors, other health care providers, and personnel; information required to be filed with the Department; the URA's written procedures and maintenance of records; and the conducting of a utilization review under the direction of a physician, do not apply to specialty URAs because these specialty requirements are in proposed new §19.1720.

Section 19.1707 addresses **Prohibition of Certain Activities and Procedures Related to Health Care Providers and Enrollees**. Proposed new §19.1707(c) is necessary to provide that §19.1707 applies to a specialty URA.

Section 19.1708 addresses **Utilization Review Agent Contact with and Receipt of Information from Health Care Providers.** The proposed amendments to existing §19.1708 are nonsubstantive.

The proposed amendments to §19.1708(c) require the URA, when conducting utilization review, to request "all relevant and updated medical records" in order to complete the review. This proposed amendment is necessary to ensure that the URA utilizes the most recent and complete information possible to review the enrollee's treatment. While the treatment may vary on a case-by-case basis, the Department has determined that this proposed amendment will enable the most effective review to be conducted.

Proposed amendments to §19.1708(c) provide that the information required may include identifying information about the claim and about the treating physician, doctor,

or other health care provider. This additional information is necessary to clarify the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records in order to complete the review. Proposed amendments add "and diagnostic testing" to include diagnostic testing in the type of information that the URA may request. This additional information is necessary to assist the URA in making an informed determination.

An amendment is proposed to existing §19.1708(c)(2) to replace the reference to "prospective and concurrent review" with the general term "utilization review." This change is necessary to specifically include retrospective review, which is a type of "utilization review" under proposed §19.1703(45).

Additionally, a proposed amendment to existing §19.1708(d) deletes the reference to "regarding the appropriateness of certification" and substitutes "regarding the appropriateness of health care." This change is necessary to correct an inadvertent error in the existing rule.

Proposed new §19.1708(g) is necessary to provide that §19.1708 applies to a specialty URA.

Section 19.1709 addresses **On-Site Review by the Utilization Review Agent**. Proposed amendments to §19.1709(c), relating to on-site review at a health care facility, change the references to hospital to a "health care facility." The broader term "health care facility," which includes a hospital, emergency clinic, outpatient clinic, or other facility providing health care, is necessary for purposes of clarification and accuracy.

Proposed new §19.1709(d) provides that §19.1709 applies to a specialty URA.

Section 19.1710 addresses **Notice of Determinations Made in Prospective and Concurrent Utilization Review**. An amendment is proposed to the title of existing §19.1710, "Notice of Determinations Made by Utilization Review Agents," to clarify that the section regulates the notice of determinations in prospective and concurrent utilization review. Existing subsection (b) is reformatted as subsection (b)(1) with proposed amendments to clarify that the subsection notification requirements pertain only to favorable determinations.

Proposed new §19.1710(b)(2) adds a new requirement that 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 federal 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. These standards apply under federal law to health insurers and HMOs and therefore already apply to health insurers and HMOs conducting utilization review. For consistency among all URAs, the Department has 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.

A proposed amendment to §19.1710(c) adds a new subheading to clarify that the subsection regulates notices of adverse determination. Newly designated §19.1710(c)(1) sets forth additional required notice elements to be included in the

written notice of an adverse determination sent to the enrollee and the provider of record in all instances of a prospective or concurrent utilization review. Some of the notice elements in §19.1710(c)(1) are required by the Insurance Code §4201.303(a); these requirements, which are listed in existing and redesignated §19.1710(c)(1)(A), (B), (C), and (F) and proposed new paragraph (G) include: (i) the principal reasons for the adverse determination; (ii) the clinical basis for the adverse determination; (iii) a description of or the source of the screening criteria used as guidelines in making the adverse determination; (iv) a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review; and (v) a description of the URA's appeal process.

The proposed amendments to add new notice requirements in proposed new paragraphs §19.1710(c)(1)(D), (E), (H), and (I) include: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination; (iii) the date and time the URA offered the opportunity to discuss the adverse determination and the date and time the discussion, if any, took place; and (iv) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), with instructions on how to submit the form. The Department has determined that these additional notice elements

are necessary to provide important consumer information to the enrollee and the provider of record in the event that the adverse determination is appealed.

The additional notice element in proposed new §19.1710(c)(1)(D), relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the enrollee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination required in proposed new §19.1710(c)(1)(E), is necessary for the enrollee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the enrollee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

Consistent with the Insurance Code §4201.303(a), the requirement in proposed new §19.1710(c)(1)(G) and (I), regarding the provision of information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the enrollee of his or her additional options following an adverse determination. The information will inform the provider of record of what information is necessary for submission to the URA on behalf of the enrollee for the appeal of an adverse determination. The requirement in proposed new §19.1710(c)(1)(H) regarding the information on the date and time the URA offered the

opportunity to discuss the adverse determination and the date and time that the discussion, if any, occurred ,is also useful to inform the enrollee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to become aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA

Proposed new §19.1710(c)(2) adds a new requirement that mandates that the description of the URA's appeal process include a statement that explains the URA's process for circumstances involving an enrollee's life-threatening condition, and under the process, the enrollee must be provided an immediate independent review by an IRO and is not required to comply with procedures for an internal review of the adverse determination by a URA. This proposed provision is based on the requirement in the Insurance Code §4201.303(b).

Proposed new §19.1710(c)(3) requires that the release of medical information to an IRO included in the request for review by an IRO be signed by the enrollee or the enrollee's legal guardian. This requirement is based on the 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.

Existing §19.1710(d)(1) – (3) are proposed to be redesignated as §19.1710(c)(4)(A) – (C). Proposed amendments to §19.1710(c)(4)(A) – (C) specify required time frames for notification of an adverse determination and revise existing time frame requirements to be consistent with the Insurance Code §4201.304. Section 4201.304 requires a URA to provide notice of an adverse determination required under Subchapter G of Chapter 4201: (A) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination; (B) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or (C) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent is required to provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

Existing §19.1710(e), which discusses notification of adverse determination for life-threatening conditions, is proposed to be deleted. Proposed §19.1721 (relating to

Independent Review of Adverse Determinations) addresses these requirements, and therefore, the retention of this subsection is unnecessary.

Proposed new §19.1710(d) specifies the requirements relating to a notice of determination concerning an acquired brain injury. Under proposed §19.1710(d), a URA is required to comply with the notice requirements in subsection (b), relating to notification of favorable determinations, and subsection (c), relating to notice of adverse determinations. Additionally, in regard to a determination concerning an acquired brain injury as defined by §21.3102, the URA must 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, provide notification of the determination through a direct telephone contact to the individual making the request. Proposed §19.1710(d) also provides that the subsection does not apply to a determination made pursuant to coverage under a small employer health benefit plan. This proposed provision is consistent with the Insurance Code §1352.006, relating to the determination of medical necessity and extension of coverage, which provides that (i) in §1352.006, the term "utilization review" has the meaning assigned by §4201.002; (ii) notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under the Insurance Code, a health benefit plan is required to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal; (iii) the person must make the request or submit the appeal in the manner prescribed by the

terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document; (iv) to comply with the requirements of §1352.006 the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer; and (v) §1352.006(b) does not apply to a small employer health benefit plan.

Proposed new §19.1710(e) specifies that §19.1710 applies to specialty URAs.

Section 19.1711 addresses **Requirements Prior to Issuing Adverse Determination**. An amendment is proposed to the title of existing §19.1711, "Requirements Prior to Adverse Determinations," to clarify that the section regulates the requirements prior to the issuance of adverse determinations. Proposed new §19.1711(a) defines the term "reasonable opportunity," for purposes of §19.1711, as at least one documented good faith attempt to contact the provider of record requesting the services (i) no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or (ii) no less than five working days prior to issuing a retrospective utilization review adverse determination. This definition is necessary to provide guidance regarding what constitutes a "reasonable opportunity" to ensure uniform implementation of the §19.1711(b)(1) requirements relating to prospective or concurrent utilization review adverse determination and subsection (c)(1) requirements relating to retrospective utilization review adverse determination. The proposed definition is also used in proposed new §19.1712(a)(2)(E) and (b)(4) and §19.1720(h)(1)(A) and (h)(2)(A), and it is necessary that all of these requirements are implemented on the basis of a uniform definition.

Proposed newly designated §19.1711(b) addresses requirements regarding 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 issuing a prospective or concurrent utilization review adverse determination. An amendment is proposed to §19.1711(b)(1) to require the URA, prior to issuance of an adverse determination, to afford "the provider of record" a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician or doctor. The amendment changes the existing rule which addresses such discussion opportunities with a physician or dentist. The inclusion of dental plans in the existing rule is proposed for deletion because dental plans are specialty health services that are subject to the peer-to-peer discussion requirements under §19.1720, relating to specialty URAs. An amendment is also proposed to §19.1711(b)(1) to clarify that the discussion must include, *at a minimum*, the clinical basis for the URA's decision in addition to the discussion of the plan of treatment for the enrollee. This clarification indicates that the required discussion may also include other matters as deemed necessary by the URA and/or provider of record.

Proposed new §19.1711(b)(2) adds a new requirement that when the URA provides the reasonable opportunity required under §19.1711(b)(1), 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. This requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event

that the provider of record wishes to discuss the pending adverse determination with the URA.

Proposed amendments to newly designated §19.1711(b)(3) provide more detailed requirements regarding these written procedures. The proposed amendments 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 time that the discussion, if any, took place, and the discussion outcome. Proposed new §19.1711(b)(4) adds a new requirement that the URA submit this required documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department 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.

Proposed new §19.1711(c) sets forth requirements prior to issuing retrospective review adverse determinations. The proposed new subsection imposes the same requirements for the peer-to-peer discussion regarding any instance in which a URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services provided, prior to the issuance of a retrospective adverse determination as those requirements prior to the issuance of an

adverse determination for prospective or concurrent utilization review specified in proposed §19.1711(b)(1), (3), and (4). Additional requirements are proposed in §19.1711(c)(2) for retrospective adverse determinations to (i) require that when the URA provides the reasonable opportunity required under §19.1711(c)(1), 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; and (ii) require the URA to allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.1711, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than five working days prior to issuing a retrospective utilization review.

These proposed requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements that result from the enactment of HB 4290. As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review" as a type of "utilization review." The Insurance Code §4201.206 provides that subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is

issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, 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 a "utilization review agent," as defined in the Insurance Code §4201.002, means "an entity that conducts utilization review…," and the term "utilization review" includes "retrospective review" as provided in §4201.002(13) of the Insurance Code, the §4201.206 provision requiring a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination prior to issuance of an adverse determination is applicable to URAs conducting retrospective review.

Proposed new §19.1711(d) provides that the §19.1711 requirements except subsections (b) and (c) apply to a specialty URA. The requirements under subsections (b) and (c) are not applicable because the underlying peer-to-peer requirement from which the other requirements are derived is based on the authority of the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.1720(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Section 19.1712 addresses **Appeal of Adverse Determination**. Existing §19.1712 contains three subsections: subsection (a) relating to maintenance and availability of the URA's written appeal procedures; subsection (b) relating to the

required provisions that must be included in the appeal procedures; and subsection (c) relating to appeals involving life threatening conditions. All three of these subsections are reformatted to be part of a new subsection (a)(1) – (3). The proposed amendments to existing §19.1712(a) are nonsubstantive and are necessary for clarification, internal consistency of terminology, and to redesignate the subsection as §19.1712(a)(1). Proposed amendments to §19.1712(a)(2), which is existing §19.1712(b), are necessary to clarify that each URA is required to comply with its written procedures for appeals. Proposed amendments to §19.1712(a)(2) also revise the information that is required to be in the written procedures for appeals.

Proposed new §19.1712(a)(2)(A) requires the URA's written procedures for appeals to include a statement specifying the time frames 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 time period for all enrollees to appeal an adverse determination. Under this provision, all enrollees will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review.

Existing §19.1712(b)(1) and (2) are proposed for deletion because the substantive requirements are moved to proposed new §19.1712(a)(2)(B) and (C). Proposed §19.1712(a)(2)(B) requires that the URA written appeal procedures include a provision 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. This provision is

similar to the existing §19.1712(b)(1). Proposed §19.1712(a)(2)(C)(i) – (iv) contain the same requirements relating to an appeal acknowledgement letter to be sent by the URA to the appealing party that are specified in existing §19.1712(b)(2).

Existing §19.1712(b)(3) is proposed to be divided into two separate provisions and redesignated as §19.1712(a)(2)(D) and (F) with the following proposed amendments. A proposed amendment to §19.1712(a)(2)(D) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician who has not previously reviewed the case. This provision is consistent with the 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. A proposed amendment to §19.1712(a)(2)(F) clarifies that the notification of appeal under the subparagraph must be in writing.

Proposed new §19.1712(a)(2)(E) adds a new requirement to be included in the URA's written procedures for appeals. The URA's written procedures must include a provision that 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, the URA before issuance of an adverse determination 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. This provision is consistent with the Insurance Code §4201.206, which provides that subject to the notice requirements of Subchapter

G of Chapter 4201, before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the URA is required to 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 agent's determination.

A proposed amendment to §19.1712(a)(2)(G) adds a requirement that the URA's written procedures for appeal must 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.

Existing §19.1712(b)(5), relating to procedures regarding the resolution of the appeal, is proposed to be redesignated as §19.1712(a)(2)(H). Proposed amendments to §19.1712(a)(2)(H) require the URA, after seeking review of the appeal of the adverse determination, to 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.

Proposed §19.1712(a)(2)(H)(i) – (vi) specify the elements of information that must be included in the response letter (i) a statement of the specific medical, dental, or contractual reasons for the resolution, as required in existing §19.1712(b)(5)(A); (ii) the medical or clinical basis for such decision, including screening criteria; (iii) a description of or the source of the screening criteria that were utilized in making the determination;

(iv) the professional specialty and state or states of licensure of the physician who made the determination; (v) a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (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; and (vi) procedures for filing a complaint in accordance with the Insurance Code §4201.204 and as described in §19.1705(g). These requirements are necessary to provide the enrollee with important information concerning the basis for the determination and the opportunity and procedures for filing a request for an independent review of the adverse determination. This required information will also be helpful to the appealing party in preparing the request for independent review. The requirements in proposed §19.1712(a)(2)(H)(ii), (iv), and (v) are consistent with the Insurance Code §4201.359.

The requirement in proposed new §19.1712(a)(2)(H)(vi) relating to procedures for filing a complaint is consistent with the Insurance Code §4201.204, which requires the URA to establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review. The requirements in proposed §19.1712(a)(2)(H)(i) and (iii) are proposed under the Department's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201. Existing §19.1712(b)(5)(A) is redesignated as proposed §19.1712(a)(2)(H)(i) and is similar to the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(1), proposed §19.1710(c)(1)(A), and proposed

§19.1715(b)(2)(A). These provisions require the URA to include the principal reasons for the adverse determination in the notice of an adverse determination.

The requirement under new §19.1712(a)(2)(H)(iii) mirrors the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(3), proposed §19.1710(c)(1)(C), and proposed §19.1715(b)(2)(C). These provisions require the URA to include a description of or the source of the screening criteria that were utilized as guidelines in making the determination in the notice of an adverse determination.

Existing §19.1712(b)(6), relating to notification of the determination of the appeal, is proposed to be redesignated as §19.1712(a)(2)(I). It is proposed to be amended to provide that the URA's written appeal procedures must include a provision that the appeal must be resolved as soon as practical, but, in accordance with the 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 §19.1712(a)(2)(C).

Existing §19.1712(c), relating to immediate appeals for life-threatening conditions, is proposed to be redesignated as §19.1712(a)(3). No amendments are proposed to redesignated §19.1712(a)(3).

Proposed new §19.1712(b) governs appeals of retrospective review adverse determinations. Proposed subsection (b) requires the URA to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with the

requirements in paragraphs (1) – (3) of subsection (b). Proposed subsection (b)(1) requires that the appeal procedures must be in accordance with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims). Proposed subsection (b)(2) requires that an appeal of an adverse determination relating to retrospective utilization review must comply with §19.1715. Proposed subsection (b)(3) requires that 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, as defined in §19.1711(a), to discuss the plan of treatment for the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the URA's decision.

Proposed new §19.1712(c) addresses appeals of adverse determinations concerning acquired brain injuries. Under proposed §19.1712(c), a URA is required to make a determination concerning an acquired brain injury 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. The notification of the determination must be provided through a direct telephone contact to the individual making the request. This provision is consistent with the Insurance Code §1352.006, which provides that (i) in §1352.006, "utilization review" has the meaning assigned by §4201.002; (ii) notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under Insurance Code, a health benefit plan is required to respond to a person requesting utilization review or appealing for an

extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal; (iii) the person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document; (iv) to comply with these requirements, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer; and (v) §1352.006(b) does not apply to a small employer health benefit plan."

Proposed new §19.1712(d) provides that §19.1712 applies to a specialty URA except subsection (a)(2)(D), relating to the requirement that appeal decisions of prospective or concurrent adverse determinations must be made by a physician who has not previously reviewed the case; subsection (a)(2)(E), relating to the requirement that before issuing a prospective or concurrent 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 subsection (b)(4), relating to the requirement that before issuing a retrospective 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 requirement under subsection (a)(2)(D) is not applicable because §19.1720(i) governs appeal procedures specifically for specialty URAs. Section §19.1720(i) require the decision in any appeal of an adverse determination by a specialty URA to 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. The requirements under subsection (a)(2)(E) and (b)(4) are not applicable because they are based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.1720(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Section 19.1713 addresses **Utilization Review Agent's Telephone Access**. An amendment is proposed to existing §19.1713(c) to clarify that a URA must implement its written description that it provides to the Commissioner setting forth procedures when responding to post-stabilization care subsequent to emergency treatment as requested by a treating physician, doctor, or other health care provider of record. Another amendment is proposed to existing §19.1713(c) to clarify that the procedure must comply with the Insurance Code §4201.004. The Insurance Code §4201.004(b) requires a URA to provide to the Commissioner a written description of the procedures to be used when responding with respect to post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider.

Proposed new §19.1713(d) clarifies that §19.1713 does not apply to an HMO or preferred provider benefit plan that is subject to §19.1723 (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and §19.1724 (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans), respectively. This exemption is necessary because §19.1723

and §19.1724 specify detailed telephone access requirements for HMOs or preferred provider benefit plans, respectively.

Proposed new §19.1713(e) provides that §19.1713 applies to a specialty URA.

Section 19.1714 addresses **Confidentiality**. Proposed §19.1714(a)(4), relating to requests for recorded personal information, requires the URA to respond to an individual's written request for access to recorded personal information about the individual within 10 *working* days, instead of 10 *business* days as provided in the existing rule. This amendment is proposed for clarity and uniformity of implementation; the term "working day" is defined in §19.1703(48), and the term "business day" is not defined.

Under proposed §19.1714(a)(12), which is existing subsection (m), the requirement that the 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" is proposed for deletion. An amendment is proposed that requires the information to be retained for at least *four* years without the qualifier in the existing rule "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." These amendments (i) broaden the 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; and (ii) extend the period the information is to be retained from two to four years. These

changes are necessary to broaden the type of information that is to be retained and to allow sufficient time for the Department to examine the information. The Department 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 the Department has the opportunity to review such information. Additionally, nonsubstantive amendments are made to clarify that the URA is required to retain the information.

As previously discussed, proposed new §19.1714(b), relating to a URA's written procedures on confidentiality, is existing §19.1714(k) with proposed nonsubstantive amendments for clarification. These proposed amendments include the clarification that the confidentiality requirements pertain to both the information received by the URA from the enrollee, the enrollee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties.

Proposed new §19.1714(c) provides that §19.1714 applies to a specialty URA.

Section 19.1715 addresses **Notice of Determination Made in Retrospective Review**. The title of existing §19.1715 is changed from "Retrospective Review of Medical Necessity" to "Notice of Determination Made in Retrospective Review" to more accurately reflect the provisions in the section. Existing §19.1715(a) is proposed for deletion and to be replaced with a new §19.1715(a), relating to required notice, to require a URA to notify the enrollee, or an individual acting on behalf of the enrollee, and the enrollee's provider of record of a determination made in a retrospective review of medical necessity or appropriateness of health care service or the experimental or

investigational nature of care. Proposed new §19.1715(b), relating to required procedures, requires the URA to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review to the enrollee and the provider of record, including the time frames for the notice of adverse determination.

Proposed §19.1715(b)(1) requires the notice of adverse determination to be in writing and sent to the provider of record, including the health care provider who rendered service, and the enrollee or the individual acting on behalf of the enrollee. This provision is consistent with the Insurance Code §4201.305, which provides that notwithstanding §4201.302 and §4201.304, if a retrospective utilization review is conducted, the URA is required to provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received.

Proposed §19.1715(b)(2) requires the notice of adverse determination to include several notice elements of information, including some statutory requirements. These statutory requirements are included in proposed §19.1715(b)(2)(A), (B), (C), (F), and (G).

In addition to the notice elements required by the Insurance Code §4201.303, proposed §19.1715(b)(2)(D), (E), (H), and (I) also require the following information be included in the notice of adverse determination for retrospective utilization review: (i) a description of documentation or evidence, if any, that can be submitted by the provider

of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination; (iii) the date and time the URA offered the opportunity to discuss the adverse determination, and the date and time that the discussion, if any, occurred; and (iv) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), with instructions on how to submit the form. These additional requirements are proposed pursuant to the rulemaking authority in the Insurance Code §4201.003, which provides that the Commissioner may adopt rules to implement Chapter 4201 of the Insurance Code. The Department has determined that these additional notice elements are necessary to provide important consumer information to the enrollee and the provider of record in the event that the adverse determination is appealed.

The additional notice element in proposed new §19.1715(b)(2)(D), relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the enrollee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination, required in proposed new §19.1715(b)(2)(E), is necessary for the enrollee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the enrollee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of

the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

Consistent with the Insurance Code §4201.303(a), the requirement in proposed new §19.1715(b)(2)(G), regarding the provision of information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the enrollee of his or her additional options following an adverse determination. The information will inform the provider of record of what information is necessary for submission to the URA on behalf of the enrollee for the appeal of an adverse determination. The requirement in proposed new §19.1715(b)(2)(H) regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination and the date and time that the discussion, if any, occurred, is also useful to inform the enrollee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to become aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA.

Existing §19.1715(c), relating to prohibiting a URA from requiring 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, is redesignated as §19.1715(b)(3). Redesignated §19.1715(b)(3) is retained with (i) proposed nonsubstantive editorial revisions and (ii) other necessary proposed

amendments that are made throughout the text. Additionally, an amendment is proposed to §19.1715(b)(3) to provide that the provisions in this paragraph also apply when a retrospective review of the experimental or investigational nature of health care service is made in relation to health coverage. This amendment is necessary because of the enactment of HB 4290.

Proposed new §19.1715(c), relating to a determination concerning an acquired brain injury, requires a URA to make a determination concerning an acquired brain injury 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. The URA is required to provide notification of the determination through a direct telephone contact to the individual making the request. The requirements do not apply to a determination made pursuant to coverage under a small employer health benefit plan. This proposed provision is consistent with the Insurance Code §1352.006, relating to the determination of medical necessity and extension of coverage, which provides that (i) in §1352.006, the term "utilization review" has the meaning assigned by §4201.002; (ii) notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under the Insurance Code, a health benefit plan is required to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal; (iii) the person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract,

evidence of coverage, or similar coverage document; (iv) to comply with the requirements of §1352.006, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer; and (v) §1352.006(b) does not apply to a small employer health benefit plan.

Proposed new §19.1715(d) provides that §19.1715 applies to specialty URAs.

Section 19.1716 addresses **"Regulatory Requirements Subsequent to Certification or Registration."** Proposed new §19.1716(a), relating to reporting of material changes in the application or latest renewal form, requires the URA to report to the Department, not later than the 30th day after the date on which the change takes effect, any material changes in such information. This provision implements the 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.

Proposed §19.1716(b)(1) requires that information related to complaints be included in the summary report but the proposed amendments clarify in the introductory paragraph that URAs must submit information related to *adverse determinations, appeals of adverse determinations, and any other related information requested by the Department in accordance with the Insurance Code §38.001*. This provision is proposed under the Insurance Code §4201.204(c) and the Insurance Code §38.001. The Insurance Code §4201.204(c) requires that a URA: (i) submit to the Commissioner a summary report of all complaints at the times and in the form specified by the Commissioner; and (ii) allow the Commissioner to examine the complaints and relevant

documents at any time. The Insurance Code §38.001 authorizes the Department to address inquiries to a holder of an authorization relating to (i) the person's business condition; or (ii) any matter connected with the person's transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties.

Proposed new §19.1716(b)(2) requires the summary report to be provided in the form required by the Commissioner and requires the URA to permit the Commissioner or the Commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the Department. This provision is also proposed under the Insurance Code §4201.204(c).

A proposed amendment to §19.1716(b)(3)(B) clarifies that "successor codes and modifiers" are applicable as part of that requirement. Existing §19.1716(c)(1) – (5), relating to complaints to the Department, is proposed for deletion because the Department has determined that the more detailed complaint procedure requirements in existing subsection (c)(1) – (5) are too restrictive and inconsistent with procedures that the Department follows for investigating and resolving other types of complaints.

Existing §19.1716(d), relating to the provision of evidence of corrective action, is proposed for deletion because the requirements under existing §19.1716(c)(4) and (5) that the URA's response include (i) corrective actions, if any, on the part of the URA which the commissioner or his or her designated representative finds appropriate and whether the URA has voluntarily agreed to take such action; and (ii) a time frame in which corrective actions should be completed, are proposed for deletion. Thus,

evidence of such corrective action is no longer required. Proposed new §19.1716(d), relating to Department inquiries, reiterates the Department's authority in the Insurance Code §38.001 to address inquiries to a URA related to any matter connected with the URA transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties. Under §38.001, a URA to which such an inquiry is addressed must respond in writing not later than the 10th day after the date the inquiry is received.

An amendment is proposed to newly designated §19.1716(e)(1)(A), which is existing §19.1716(g)(1), to clarify that an on-site review by the Department may be scheduled or un-scheduled. Under proposed new §19.1716(e)(1)(B), an on-site review will only be conducted during working days and normal business hours. Proposed new §19.1716(e)(1)(C) retains the provision in existing §19.1716(g)(3) that the URA is required to make available all records relating to its operation during the scheduled and unscheduled on-site review without a proposed substantive change. Existing §19.1716(g)(3) is proposed for deletion because this provision has been moved to proposed new §19.1716(e)(1)(C). Newly designated §19.1716(e)(2), which is existing §19.1716(g)(2), retains the provision that the URA will be notified of any scheduled on-site review by letter, with proposed nonsubstantive changes. The provision in proposed new §19.1716(e)(3), which is not in the existing rules, provides that, at a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by the Department's designated representative upon arrival.

Existing §19.1716(f), relating to lists of URAs, is proposed for deletion because the Department now maintains a list of certified URAs on its website, which is available to individuals or organizations interested in obtaining information on the certification status of a URA. This list is updated in real-time. Existing §19.1716(g)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is proposed for deletion. The Department has determined that this provision is no longer necessary because of the Insurance Code §4201.601 which authorizes the Department to take certain steps if it is believed that a person or entity conducting utilization review is in violation of Chapter 4201 or applicable rules. These steps include 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.

Proposed new §19.1716(f) provides that §19.1716 applies to specialty URAs.

Section 19.1717 addresses **Administrative Violations.** Existing §19.1717(e), relating to violations of provisions of the Insurance Code and Department rules other than those violations of Chapter 4201 and applicable rules, is proposed for deletion because the provisions in that subsection are included in revised existing §19.1717(a) and (d). The deletion of existing subsection (e) requires the re-designation of subsequent subsections. Additionally, an amendment is proposed to redesignated §19.1717(e), which is existing §19.1717(f) relating to commission of fraudulent or deceptive acts in obtaining or using a URA certification, to include the commission of fraudulent or deceptive acts in obtaining or using a URA registration. New proposed §19.1717(f) provides that §19.1717 applies to specialty URAs.

In conjunction with this proposal, existing §19.1718, concerning criminal penalties, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Section 19.1719 addresses **Responsibility of HMOs and Insurers Performing Utilization Review**. The proposed amendment to existing subsection (a)(1) provides that an HMO performing utilization review only for coverage for which it is the payor is subject to Subchapter R except for the *certification* requirements in §19.1704 of this title. This proposed provision is consistent with the Insurance Code §4201.057(c), which provides that as a condition of holding a certificate of authority to engage in the business of an HMO, an HMO that performs utilization review must: (i) comply with Chapter 4201, except Subchapter C, relating to certification; and (ii) submit to assessment of a maintenance tax under Chapter 258 of the Insurance Code to cover the costs of administering compliance with §4201.057(c).

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to existing §19.1719(a)(2), which requires an HMO performing utilization review for an individual or entity for which it is not the payor to have a valid certificate under Chapter 4201 of the Insurance Code and in accordance with §19.1704. This provision is consistent with the Insurance Code §4201.057(e), which provides that notwithstanding §4201.057(c)(1), an HMO that performs utilization review for a person or entity subject to Chapter 4201, for which the HMO is not the payor, must obtain a certificate of registration under Subchapter C of Chapter 4201 and must comply with all of the provisions of Chapter 4201.

Amendments are proposed to existing §19.1719(a)(3) to clarify that an HMO that performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor must have a valid registration pursuant to §19.1704 and to comply with the filing requirements under §19.1704. Under the proposed amendments to existing §19.1719(a)(3), the HMO is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health coverage for which it is the payor. These proposed amendments are necessary for the Department to obtain additional information about HMOs conducting utilization review for coverage for which they are the payor for purposes of monitoring and oversight.

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to existing §19.1719(a)(4), which provides that an HMO, including an HMO that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under the Human Resources Code Chapter 32, is subject to the Insurance Code Chapter 4201 and Subchapter R.

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to existing §19.1719(a)(5), which requires an HMO to submit to assessment of maintenance taxes under the Insurance Code Chapter 258 to cover the costs of administering compliance of HMOs under Chapter 4201 of the Insurance Code.

Section 19.1719(b) in both the existing rules and the proposed rules addresses requirements for insurers performing utilization review. Existing §19.1719(b)(1), relating

to the tax requirements to which such insurers are subject, is proposed to be redesignated as new §19.1719(b)(2). Proposed new §19.1719(b)(1) provides that an insurer performing utilization review under the Insurance Code Chapter 4201 is subject to Subchapter R, except, pursuant to the Insurance Code §4201.058, an insurer performing utilization review under the Insurance Code Chapter 4201 is not subject to the certification requirements in §19.1704 if the insurer performs utilization review only for coverage for which it is the payor. Existing §19.1719(b)(2), to which insurers performing utilization review are subject, is proposed for deletion because it is obsolete. Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to newly designated §19.1719(b)(2) which requires that an insurer that delivers or issues for delivery a health insurance policy in Texas and that performs utilization review is subject to assessment of maintenance tax under the Insurance Code Chapter 257. These proposed provisions are consistent with the Insurance Code §4201.058, which provides that as a condition of holding a certificate of authority to engage in the business of insurance, an insurer that performs utilization review must: (i) comply with Chapter 4201, except Subchapter C, relating to certification; and (ii) submit to assessment of a maintenance tax under Chapter 257 of the Insurance Code to cover the costs of administering compliance with §4201.058(a).

New §19.1719(b)(3) requires an insurer performing utilization review for an individual or entity for which it is not the payor to have a valid certificate as provided under Chapter 4201 of the Insurance Code and in accordance with §19.1704 of this subchapter. This requirement is consistent with the Insurance Code §4201.058(c),

which provides that notwithstanding §4201.058(a), an insurer subject to the Insurance Code that performs utilization review for a person or entity subject to Chapter 4201, other than a person or entity for which the insurer is the payor, must obtain a certificate of registration under Subchapter C of Chapter 4201 and is required to comply with all of the provisions of Chapter 4201.

Existing §19.1719(b)(4) pertains to requirements for registration of insurers and is proposed for deletion. Existing §19.1719(b)(3) is proposed to be redesignated as §19.1719(b)(4) and requires an insurer that performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor to have a valid registration pursuant to §19.1704 and to comply with the filing requirements under §19.1704. Under proposed §19.1719(b)(4), the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health coverage for which it is the payor. These proposed amendments are necessary for the Department to obtain additional information about insurers conducting utilization review for coverage for which they are the payor for purposes of monitoring and oversight.

Proposed new §19.1719(c) provides that §19.1719 applies to specialty URAs.

Section 19.1720 addresses **Specialty Utilization Review Agent**. Proposed new §19.1720(a) requires a specialty URA, in order to be certified or registered as a specialty URA, to submit to the Department the application and information required in §19.1704. Proposed §19.1720(b)(1) provides that a specialty URA is subject to the requirements of the Insurance Code Chapter 4201, except as specified in the proposed

amendments. Proposed §19.1720(b)(2) provides that a specialty URA is subject to the requirements of Subchapter R, except for those requirements related to the statutes referenced in §19.1720(b)(1), including: §§19.1705(a); 19.1706(a), (d), (e), and (g); 19.1711(b) and (c); and 19.1712(a)(2)(D) and (E) and (b)(3). These amendments in §19.1720(b)(1) and (2) are consistent with the 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.

Proposed §19.1720(c) specifies requirements relating to the specialty URA's utilization review plan. These requirements are consistent with the Insurance Code §4201.453, which provides that a specialty URA's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Proposed new §19.1720(d) addresses requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Proposed §19.1720(d)(1) adds "physicians, doctors, and other health care providers" to existing §19.1720(f) to clarify that those individuals and entities employed by or under contract with the specialty URA must also be appropriately trained, qualified, and currently licensed. The phrase "if applicable," is proposed for deletion to clarify that the licenses of these individuals and entities should always be current.

Proposed new §19.1720(d)(2) requires personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by the Texas

Medical Board or be otherwise authorized to provide health care services by a licensing agency in the United States. This requirement is based on an Advisory Committee recommendation and is necessary to ensure that all such personnel are appropriately trained and qualified to conduct specialty utilization review.

A new requirement is proposed in new §19.1720(e), relating to information required to be filed with the Department. Proposed new §19.1720(e) requires the specialty 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 the Department upon filing an original application or renewal application or upon providing updated information. This requirement is necessary to enable the Department to monitor and ensure that appropriate personnel are conducting utilization review, which should result in a higher quality of utilization review for the enrollee. The Department has authority to require this information under the Insurance Code §4201.104, which requires the Commissioner to promulgate forms to be filed for a URA's initial certification and renewal certification. Additionally, the Insurance Code §4201.107 requires the URA to report to the Department any material changes to information disclosed in the application form.

Proposed new §19.1720(f) requires the specialty URA to: (i) develop and implement written procedures for determining if physicians, doctors, or other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced; and (ii) to maintain documentation demonstrating that physicians, doctors, and other health care providers that are utilized to perform utilization review are

licensed, qualified, and appropriately trained or experienced. The requirements are necessary to create a written record that the URA can provide to the Department upon request to enable the Department to determine whether the physicians, doctors, or other health care providers are licensed, qualified, and appropriately trained or experienced. The requirements should ultimately result in a higher quality of utilization review for the enrollee. These requirements are consistent with the Insurance Code §4201.454, which requires personnel who are employed by or under contract with a specialty URA to perform utilization review to be appropriately trained and qualified.

A proposed amendment to §19.1720(g) clarifies that the physician, doctor, or health care provider may be employed by or under contract to the specialty URA. This proposed amendment is necessary to avoid any ambiguity or misunderstanding regarding the type of business relationship that the URA may have with the directing physician, doctor, or other health care provider.

A new requirement is proposed in new §19.1720(h)(1)(B) to require that a discussion under subsection (h) prior to the issuance of an adverse determination include the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision required under subsection (h)(1)(A), as deemed necessary by the URA and/or provider of record. This requirement is consistent with the Insurance Code §4201.456, which provides that subject to the notice requirement of Subchapter G of Chapter 4201,

before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the URA is required to provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the enrollee's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the agent.

A new requirement in proposed new §19.1720(h)(1)(C) provides that when the specialty URA provides the reasonable opportunity required under §19.1720(h)(1)(A), the specialty URA must include the specialty URA's 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 in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA.

A new requirement is proposed in new §19.1720(h)(1)(D) to 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. Proposed new §19.1720(h)(1)(E) requires the specialty URA to submit the subsection(h)(1)(D) documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department 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.

Proposed new §19.1720(h)(2)(A) requires a specialty URA, before issuing a retrospective review adverse determination, to provide the provider of record a reasonable opportunity to discuss the treatment provided to the enrollee with a health care provider of the same specialty as the URA. Proposed new §19.1720(h)(2)(B) requires the discussion to include, at a minimum, the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision as deemed necessary by the URA and/or provider of record.

New §19.1720(h)(2)(C) proposes new requirements that the reasonable opportunity required under §19.1720(h)(2)(A) include the specialty URA's phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. Under the proposed requirements, the specialty URA must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA. The second requirement is necessary for consistency with the

definition of "reasonable opportunity" in §19.1711, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than five working days prior to issuing a retrospective utilization review.

Proposed new §19.1720(h)(2)(D) requires that the specialty URA 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. Proposed new §19.1720(h)(2)(E) requires that the specialty URA submit the §19.1720(h)(2)(D) documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department 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. Both of these requirements are necessary to ensure that the proper consumer protection is afforded to enrollees who are using specialty URAs for utilization review.

The portion of existing §19.1720(i), relating to the requirement that the specialty review must be completed within 15 working days of receipt of the request, is proposed for deletion. This existing requirement mirrored the requirement under the Insurance Code §4201.356(b), which provided a process for requesting a particular type of

specialty provider to review a case and required the specialty review to be completed within 15 working days. However, under the Insurance Code §4201.452, the Insurance Code §4201.356 does not apply to specialty URAs. The Insurance Code §4201.457 governs the appeal decisions for specialty URAs. Therefore, the 15 working day requirement is not statutorily required and is proposed for deletion.

Section 19.1721 addresses **Independent Review of Adverse Determinations**. Existing §19.1721(a), (b), and (c) are re-formatted under a single subsection (a), relating to life-threatening conditions, with both proposed substantive and nonsubstantive amendments. Newly designated §19.1721(a)(1) addresses notification for life-threatening conditions. Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to newly designated §19.1721(a)(1)(A), which is in existing §19.1721(a); an amendment is also proposed to clarify that the notification of adverse determination subject to the time frames discussed in §19.1721(a)(1)(A) relate to notice of determinations made in *prospective and concurrent* utilization review.

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to newly designated §19.1721(a)(1)(B), which is also part of existing §19.1721(a). Also, an amendment is proposed to §19.1721(a)(1)(B) to add a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process and a copy of Form No. LHL009. This requirement is necessary to inform the enrollee of the process for independent review of the adverse determination in the event of life-threatening conditions. The provision of

the copy of Form No. LHL009 will inform the enrollee of his or her additional options following an adverse determination and enable the enrollee to more quickly and efficiently request independent review.

Existing §19.1721(b) is proposed to be redesignated as §19.1721(a)(1)(C). Nonsubstantive editorial revisions are proposed to be redesignated §19.1721(a)(1)(C), which retains the existing §19.1721(b) prudent layperson standard for determining the existence of a life-threatening condition.

An amendment is proposed to §19.1721(a)(2) to clarify that a party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA is entitled to review of that determination or denial by an IRO. This provision is necessary to implement the Insurance Code §4201.360, which provides that notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is: (i) entitled to an immediate appeal to an IRO as provided by Subchapter I of Chapter 4201; and (ii) not required to comply with procedures for an internal review of the URA's adverse determination.

Proposed deletions of existing §19.1721(c)(1) – (3) are necessary because the requirements to provide a notification of the independent review process, a copy of the Form No. LHL009, and a description of how to obtain independent review are moved to proposed §19.1721(a)(1)(B).

Existing §19.1721(d), (e), and (g) – (h) are redesignated as §19.1721(b)(1) – (5), relating to independent review involving life-threatening and non-life threatening

conditions. Proposed §19.1721(b)(1) addresses the request for independent review. Proposed §19.1721(b)(1)(A) proposes an amendment to existing subsection (d) to require the URA to notify the Department within one working day from the date the request for an independent review is received. The existing requirement in §19.1721(d) is that the notification be made by the URA "upon receipt of the request." The proposed amendment will allow the URA additional time, as well as a reasonable amount of time, to notify the Department. A "working day" is defined by §19.1703(48). The Department has determined that this additional time is necessary to avoid impractical deadlines in situations such as when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Proposed §19.1721(b)(1)(B), which is part of existing §19.1721(e) with proposed amendments, requires the URA to provide the Department the completed Form No. LHL009 that is submitted to the URA by the party requesting independent review. The submission of this completed form is in lieu of the requirement in existing §19.1721(e) that the URA provide to the Department the "information contained in the form prescribed by the commissioner. . . ." This requirement is necessary to clarify that while the same information is required to be provided as in the existing rule, the information must be provided in a copy of the completed Form No. LHL009 itself. This should result in greater efficiency and less time for the URA and in quicker response time for the enrollee who is requesting the independent review. Proposed §19.1721(b)(1)(C) which is also part of existing §19.1721(e), requires the URA to submit the completed Form No. LHL009 via the Department's Internet website. This amendment is necessary to update

the existing requirement that the information be submitted via modem or, in the event that the modem is unavailable, through facsimile.

Existing §19.1721(f) is proposed for deletion because the provision that the URA may access the Department on working days between 7:00 a.m. and 6:00 p.m. Central Time, Monday through Friday, is no longer accurate. This proposed amendment is necessary because Department staff is not available during all of those hours.

Existing §19.1721(g) is redesignated as §19.1721(b)(2), relating to the assignment of the independent review by the Department. The existing requirement that the Department must, within one working day of receipt of the request for independent review, randomly assign an IRO and notify the URA, IRO, the enrollee or individual acting on behalf of the enrollee, and the enrollee's provider of record is retained in the proposal with two proposed amendments in addition to nonsubstantive editorial revisions, which are discussed in the early part of this Introduction. The two proposed amendments add the "payor" and "any other providers listed by the URA as having records relevant to the review of the assignment" to those who must be notified by the Department. Existing §19.1721(h)(1) – (5) is redesignated as §19.1721(b)(3)(A) – (E), relating to the information required to be provided to the assigned IRO. Proposed §19.1721(b)(3) includes requirements that information in the possession of the health benefit plan be provided to the assigned IRO. No other substantive amendments are proposed to §19.1721(b)(3)(A) – (E); however, nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to these provisions.

Existing §19.1721(i) is redesignated as §19.1721(b)(4). An amendment is proposed to §19.1721(b)(4), relating to payor and URA compliance, to change the existing requirement that the URA must comply with the IRO's determination to provide that *the payor and* URA must comply with the IRO's determination. This amendment is necessary to require that all relevant parties are required to comply with the IRO's determination.

Existing §19.1721(j) and (k) are redesignated as §19.1721(b)(5)(A) and (B), relating to payment and recovery of costs for the independent review. Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to the redesignated §19.1721(b)(5)(A) and (B).

In conjunction with this proposal, existing §19.1722, concerning the utilization review advisory committee, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Section 19.1723 addresses **Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans**. An amendment is proposed to the title of existing §19.1723 to clarify that the section addresses preauthorization for HMOs and preferred provider benefit plans. In addition to proposed nonsubstantive editorial amendments throughout §19.1723, other amendments are proposed to existing §19.1723(b), (f)(2), and (d)(2), and a new subsection (k) is proposed. In existing §19.1723(b) and (f)(2), the term "business day" is changed to "working day." These changes are necessary for consistency with the defined term in §19.1703(49) and with other rule provisions that contain the "working day" requirement. An amendment is

proposed to §19.1723(d)(2) to add a new 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. Proposed new §19.1723(k) provides that §19.1723 applies to specialty URAs.

Section 19.1724 addresses **Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans**. An amendment is proposed to the title of existing §19.1724 to clarify that the section addresses verification for HMOs and preferred provider benefit plans. In addition to proposed nonsubstantive editorial amendments throughout §19.1724, other amendments are proposed to existing §19.1724(d), and a new subsection (n) is proposed. In existing §19.1724(d)(2), the term "business day" is changed to "working day." This change is necessary for consistency with the defined term in §19.1703(49) and with other rule provisions that contain the "working day" requirement. Proposed new §19.1723(n) provides that §19.1724 applies to specialty URAs.

Subchapter U amendments and new sections.

Section 19.2001 addresses **General Provisions**. The proposed amendment to §19.2001(a) is necessary to change the existing provision relating to the statutory basis for the rules in Subchapter U to reflect that the new subchapter incorporates the most

recent amendments to Chapter 4201 of the Insurance Code and the most recent statutory provisions under the Insurance Code Chapter 1305 and the Labor Code Title 5. The proposed amendment to §19.2001(b) amends the severability clause language to conform to current agency style. The addition of the phrase "concerned before expenses are incurred" in §19.2001(c)(4) is a clarifying change.

Proposed new §19.2001(d) provides that Subchapter R of 28 TAC Chapter 19 applies to utilization review performed under a health benefit plan or health insurance policy.

Section 19.2002 addresses **Limitations on Applicability**. Proposed §19.2002(a) specifies the applicability of Subchapter U to utilization review performed under workers' compensation insurance coverage, except as provided in the Insurance Code Chapter 4201.

An amendment is proposed to add new §19.2002(b) to provide that health care providers performing peer reviews regarding the prospective, concurrent or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and requires such health care providers to comply with this subchapter, the Labor Code Title 5, and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to, 28 TAC Chapter 180 (relating to Monitoring and Enforcement). This new provision is needed for clarification that peer review can be a type of utilization review. Pursuant to the Insurance Code §4201.054(c), this new subsection further 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 the 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 Title 5, Labor Code. Additionally, the Insurance Code §4201.054(c) provides that Title 5 of the Labor Code, prevails in the event of a conflict between Chapter 4201 and Title 5, Labor Code.

Proposed §19.2002(c) provides that Subchapter U does not apply to a person that only provides information to injured employees, their representatives or their physicians, doctors, or other health care providers about scope of coverage or benefits provided under workers' compensation insurance coverage but that does not determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. The proposed amendments are necessary to track the Insurance Code §4201.051, which provides that Chapter 4201 does not apply to a person who provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and who does not determine whether a particular health care service provided or to be provided to an enrollee is: (a) medically necessary or appropriate; or (b) experimental or investigational.

Section 19.2002(2) is proposed to be deleted because the provision is no longer applicable under the proposed rules; personnel employed by a URA are governed by §19.2006 under the proposed rules. Existing §19.2002(3)(A) – (D) are proposed to be

deleted because none of the categories of reviews under existing §19.2002(3) pertain to workers' compensation coverage.

Section 19.2003 addresses **Definitions**. Proposed new §19.2003(1) adds a definition of an "administrator" because the term is used in the proposed amended rules. This definition is consistent with Subchapter R.

A proposed amendment to the definition of "adverse determination" in §19.2003(2) adds the phrase "made on behalf of any payor." The inclusion of the phrase "made on behalf of any payor" clarifies that the definition includes those payors that conduct utilization review in-house. The change is necessary to reflect the Department's position that the term "adverse determination" includes determinations made on behalf of all payors. Also, an amendment is proposed to the existing definition to clarify that the term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. This proposed amendment is necessary to clarify that adverse determinations do not include denials of health care services due to the injured employee's or health care provider's failure to request prospective or concurrent utilization review, if such prospective or concurrent utilization review was required. Another amendment is proposed to clarify that for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. The reasoned justification for this proposed amendment is discussed in detail in the earlier part of this Introduction under the subheading "HB 4290."

The proposed amendments to the definition of "appeal" in §19.2003(3) are necessary to update the existing definition and to clarify that the term "appeal" used in Subchapter U (i) refers to the URA's formal process in which an injured employee, an injured employee's representative, or the injured employee's provider of record may request reconsideration of an adverse determination; and (ii) also applies to reconsideration processes prescribed by the Labor Code Title 5 and applicable rules for workers' compensation.

The proposed amendments to the definition of "certificate" in §19.2003(4) are necessary to provide a more detailed and accurate definition that reflects that an insurance carrier can be certified or registered, but that a "certificate" is not issued to an insurance carrier that is registered as a URA under §19.2004.

Proposed new §19.2003(8) replaces the term "concurrent review" with the term "concurrent utilization review" which is defined as a form of utilization review that is subject to these proposed rules.

Proposed new §19.2003(11) is necessary to 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.

Proposed new §19.2003(13) adds a definition of "experimental or investigational." This definition is consistent with the Labor Code §413.014(a), 28 TAC §134.600, and 28 TAC §12.5(12).

Proposed §19.2003(14)(F) is amended 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 of "health care" in the Labor Code §401.011.

The proposed amendments to the definition of "health care provider" in §19.2003(16) update the definition to track the statutory language in the Insurance Code §4201.002(5).

Existing §19.2003(16) is proposed to be deleted because the definition of "injured employee" is not necessary and is arguably ambiguous because in the event that an injured employee's compensability is in dispute, the inclusion of the definition could result in confusion regarding whether that injured employee would be considered an injured employee for the purposes of this definition.

The proposed amendment to delete "inquiry" in §19.2003(17) is necessary because the term "inquiry" is not used in the rule text in the context that the definition contemplates. The term "inquiry" is only used in §19.2016(d), and in that context the term refers to *Department* inquiries, not inquiries that would be considered a request for information or assistance from a URA.

Proposed §19.2003(17) is amended to add "or insurer" to the term "insurance carrier," in order to indicate that the terms have the same meaning for purposes of Subchapter U. An amendment is proposed §19.2003(17)(A) to delete "an insurance company," replacing it with "a person authorized and admitted by the Texas Department of Insurance to do the business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance." This language incorporates the definition of an "insurance company," which is defined in existing

§19.2003(19) and is proposed for deletion. An amendment is also proposed to §19.2003(17) to include "a certified self-insurance group under Chapter 407A" in the definition. This proposed amendment is consistent with the Labor Code §401.011(27).

Proposed new §19.2003(18) adds the term "legal holiday," which is defined in accordance with the definition of a "national holiday" defined in the Government Code §662.003(a).

Proposed new §19.2003(21) adds a definition of "medical emergency." This definition tracks the Insurance Code §1305.004(13). This definition is necessary to uniformly implement the proposed Subchapter U rules.

The proposed amendment to §19.2003(22) adds "mental health records as allowed by law" to the definition of "medical records." The definition of the term "medical records" is primarily based on the definition in the Insurance Code §1305.004(14), which defines the term "medical records" for purposes of the Workers' Compensation Health Care Network Act. The addition, however, of the phrase "mental health records as allowed by law" to the statutory definition was recommended by the Advisory Committee. This proposed amendment is necessary to include certain mental health records in the implementation of the provisions of the Subchapter U rules relating to "medical records" in order to ensure the availability of mental health records when allowed. This amendment is proposed pursuant to the Commissioner's rulemaking authority under the Insurance Code §4201.003(a) to adopt rules to implement Chapter 4201.

Proposed new §19.2003(23) adds a definition of "mental health medical record summary." This term is defined in the existing Subchapter R rules, and the Advisory Committee recommended adding the definition to the Subchapter U rules for uniformity.

Proposed new §19.2003(24) defines "mental health therapist." This definition mirrors the definition in proposed §19.1703(29) and incorporates the Advisory Committee recommendation to add the qualifier "as appropriate" to indicate that not all of the individuals licensed under subparagraphs (A) – (M) are authorized to diagnose, evaluate, or treat any mental or emotional condition or disorder.

Proposed new §19.2003(25) adds a definition for the term "mental or emotional condition or disorder." This definition mirrors the definition in proposed §19.1703(30) and is added based on a recommendation of the Advisory Committee.

Proposed new §19.2003(27) adds a definition of "payor." This proposed definition provides that a "payor" for purposes of Subchapter U is 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 in this state under a policy, plan, or contract. This definition is consistent with the Insurance Code §4201.002(10)(C).

Proposed new §19.2003(28) adds a definition of "peer review." This definition, which was recommended by the Advisory Committee, is necessary for uniform implementation of the Subchapter U rules.

The definition of the term "preauthorization" in §19.2003(31) is proposed to be amended: "A form of prospective utilization review by a payor or its utilization review

agent of health care services proposed to be provided to an injured employee." This proposed definition clarifies that preauthorization is a form of utilization review and is more consistent with the definition in proposed §19.1703(36).

Proposed new §19.2003(32) adds a definition of "provider of record." This definition mirrors the definition in proposed §19.1703(38) and is necessary to track the Insurance Code §4201.002(12). Section 4201.002(12) defines "provider of record" as the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis.

Proposed new §19.2003(33) adds a definition of the term "registration." Proposed §19.2019 sets forth the responsibility of an insurer performing utilization review, including the responsibility of those performing utilization review only for coverage for which they are the payor. Insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but are instead required to register. The proposed new definition clarifies that the registration process only applies to an insurer that performs utilization review solely for its own insureds or injured employees.

Proposed amendments to the existing definition of "retrospective review" in redesignated §19.2003(34) change the defined term to "retrospective utilization review" and incorporate the term "utilization review" into the definition, thereby removing the need to refer to "medically reasonable and necessary" because the concept is included in the definition of the term "utilization review." The proposed 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" is necessary to clarify that health care services which require preauthorization are not subject to retrospective review.

Proposed §19.2003(35) amends the definition of "screening criteria" to provide a general definition of "screening criteria" and for more consistency with the definition of "screening criteria" in §19.1703(42). Proposed new §19.2003(36) adds a definition of "specialty utilization review agent." This definition is consistent with the Insurance Code §4201.451.

The proposed amendments to the definition of the term "utilization review" in §19.2003(40) add the term "retrospective review" and the phrase "a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services" to the definition. The additions are necessary to implement HB 4290. The change from "preauthorization" to "prospective" is necessary for consistency of terminology in Subchapters R and U.

The amendments to proposed §19.2003(40) defining "utilization review agent," are necessary for consistency with the definition in §19.1703(46). These amendments are also consistent with the Insurance Code §4201.002(14).

Proposed new §19.2003(43) adds a definition of "workers' compensation health care network." This definition is consistent with the Insurance Code §1305.004(16).

Proposed §19.2003(44) amends the definition of "workers' compensation insurance coverage" to be the same as defined in the Labor Code §401.011.

Proposed new §19.2003(45) adds a definition for "workers' compensation network coverage." Proposed new §19.2003(46) adds a definition for "workers' compensation non-network coverage."

The proposed amendments to the definition of "working day" in §19.2003(47) are necessary to update the definition to clarify "legal" holidays are as defined by the Government Code §662.003(a) and to provide consistency with 28 TAC §102.3, relating to computation of time under the general provisions of TDI-DWC. Under 28 TAC §102.3(b), use of the term "day," rather than "working day," means a calendar day.

Section 19.2004 addresses **Certification or Registration of Utilization Review Agents**. Proposed new §19.2004(a), which is added to implement the Insurance Code §4201.101, provides that a person acting as or holding itself out as a URA must be certified or registered under the Insurance Code Chapter 4201 and 28 TAC Chapter 19, Subchapter U and must comply with all requirements in §19.2004. Section 4201.101 provides that a URA may not conduct utilization review unless the Commissioner issues a certificate of registration to the agent in accordance with Subchapter C of Chapter 4201.

Proposed new §19.2004(a)(1) and (2) add new provisions and are necessary to address certification and registration requirements for insurance carriers. Proposed new §19.2004(a)(1) provides that, pursuant to §19.2019(b), if an insurance carrier performs utilization review for an individual or entity subject to 28 TAC Chapter 19, Subchapter U, such insurance carrier must have a valid certificate pursuant to the

Insurance Code §4201.101 and §19.2004. This provision is consistent with the Insurance Code §4201.058(c).

Proposed new §19.2004(a)(2) provides that, pursuant to §19.2019(c), if an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must have a valid registration pursuant to §19.2004.

Proposed new §19.2004(b) is entitled "Application Filing Requirements." Proposed new paragraph (1) in §19.2004(b) addresses requirements relating to the application for certification. Paragraph (1)(A) provides that an application for certification of a URA must include Form No. LHL005. Paragraph (1)(B) provides that an application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19).

Proposed new paragraph (2) in §19.2004(b) addresses requirements relating to the application for registration. Paragraph (2)(A) provides that an application for registration of a URA must include Form No. LHL005, which is adopted by reference in §19.1704(b). Paragraph (2)(B) provides that the fee requirement specified by §19.802(b)(19) does not apply to an applicant for registration. These provisions are consistent with proposed §19.2019(c).

Proposed new paragraph (3) in §19.2004(b) provides information on where to obtain and file the application form.

The proposed amendments to §19.2004(c) reorganize the provisions relating to the information that is required in Form No. LHL005 and impose additional requirements in proposed new §19.2004(c)(2) – (6) pursuant to the Commissioner's authority to

promulgate forms under the Insurance Code §4201.104. Additionally, the proposed amendment to §19.2004(c)(1)(A) adds "or appropriate, or experimental or investigational in nature" to the requirement that the completed application include an adequate summary description of screening criteria and review procedures to be used to determine medical necessity of health care. The addition of "or appropriate" is necessary for consistency with the definition of "adverse determination" in §19.2003(2). The addition of "or experimental or investigational in nature" is necessary to implement HB 4290.

Proposed new §19.2004(c)(2)(A) - (O) require the written policies of the utilization review plan to evidence compliance with the specified list of Subchapter U rules.

Proposed new §19.2004(c)(2)(A) requires Form No. LHL005 to include utilization review plan written policies that evidence compliance with §19.2005. Proposed new §19.2004(c)(2)(L) requires Form No. LHL005 to include utilization review plan written policies that evidence compliance with §19.2016.

Proposed new §19.2004(c)(3) requires utilization review plan written policies which attest that peer reviews will comply with the Texas Workers' Compensation Act and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to 28 TAC Chapter 133, Subchapter D; 28 TAC Chapter 134, Subchapter G; 28 TAC Chapter 137; and 28 TAC Chapter 180, Subchapter B. These requirements reference other statutes and rules with which compliance is also necessary.

Proposed new §19.2004(c)(4) adds a new requirement that the application form must include copies of template letters for notification of determinations made in utilization review that comply with §19.2010 and §19.2012. This new requirement is necessary to enable the Department to monitor each URA's compliance with the §19.2010 and §19.2012 requirements and to assist the URA in coming into compliance with the requirements or to take enforcement action as deemed necessary.

Proposed new §19.2004(c)(5) specifies three items of organizational information that must be included with the Form No. LHL005. Proposed new §19.2004(c)(5)(A) adds a new requirement that the application form must include written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state.

Proposed new §19.2004(c)(5)(B) is proposed to require a chart showing the organizational structure of the applicant's executives, officers, and directors, replacing the existing requirement in §19.2004(c)(11)(C) that the applicant provide a chart showing the internal organization structure of the applicant's management and administrative staff. This change is necessary to require the URA to provide organizational structure information that is consistent with the proposed new §19.2004(c)(6) requirement that the URA provide fingerprints for its executives, officers, and directors.

Proposed new §19.2004(c)(5)(C) adds a new requirement that the URA application form include a letter of good standing from the Texas Comptroller of Public Accounts. This change is necessary for the Department to verify that the applicant is not delinquent in its state taxes.

Proposed new §19.2004(c)(6) adds a new requirement that the application form include the name and 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). This change is necessary because, in accordance with 28 TAC §1.502(c) and (e), the Department has developed guidelines relating to the matters which the Department will consider in determining whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction, which include criminal background checks for each director, officer, and executive of the applicant.

Existing §19.2004(c)(9) is proposed for deletion because TDI-DWC has determined that in lieu of that requirement, the §19.2004(c)(2)(B) requirement that the written policies in the utilization review plan to evidence compliance with §19.2006 is sufficient. The requirements of §19.2006 are discussed later in this Introduction.

Existing subsection (c)(10) is proposed for deletion because the requirement is no longer needed. The TDI-DWC has determined that in lieu of that requirement, the prohibitions in §19.2006(b) and the requirement in §19.2004(c)(7) that the URA certify in the application Form No. LHL005 that it is compliant with TDI-DWC rules are sufficient.

Existing §19.2004(c)(11)(A) – (D), relating to URA organizational information, documents, and amendments, are proposed for deletion. These requirements are proposed for deletion because the URA would already have filed the appropriate paperwork to conduct business in Texas with the Secretary of State, and is required to provide evidence of the filings to the Department in accordance with proposed new §19.2004(c)(5)(a). The Department has determined that the new requirement relating to the filing of biographical affidavits and complete sets of fingerprints of the executives, officers, and directors of the URA under these rules is sufficient and that similar requirements are proposed in new §19.2004(c)(5).

Existing §19.2004(c)(11)(D), is proposed for deletion because proposed new §19.2004(c)(2)(B) requires the application to include utilization review plan written policies that evidence compliance with §19.2006 and the Department has determined that the information required by proposed §19.2006 is sufficient to determine the URA's contractual arrangements.

Both substantive and nonsubstantive amendments are proposed to §19.2004(d)(1) – (4). The amendments to §19.2004(d)(1) – (4) propose changes to the application process pursuant to the Commissioner's general rulemaking authority under the Insurance Code §4201.003(a).

A proposed amendment to §19.2004(d)(1) adds the phrase "a complete" to modify "application" to clarify that the 60 day time period does not begin until after the application is complete. Another proposed amendment to subsection (d)(1) clarifies that

the Department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

An amendment is proposed to §19.2004(d)(2) to change the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days of the date of the Department's latest notice of the omissions or deficiencies. This proposed reduction in time to correct the omissions or deficiencies is necessary to streamline the application process and to provide the Department with information more quickly. This shorter time period will allow a more efficient application process, thereby making more URAs more quickly available to the Texas consumer.

Amendments are proposed to §19.2004(d)(3) to provide that before the end of the 15 working days specified in paragraph (d)(2), the applicant may request in writing additional time to correct the omissions or deficiencies in the application. Under the proposed amendments, the request for the additional time must be approved by the Department in writing for the requested extension to be effective.

Amendments are proposed to §19.2004(d)(4) to rename what is now called an "application file" a "charter file." This file must be maintained by the Department. Under the proposed amendments, the file must contain approved application documents and requests for additional time and responses from the applicant. These documents are in addition to the documents relating to notices of omissions or deficiencies that are required to be maintained under the existing rule. Also, under the proposed amendments, the requirement that the charter file contain documents relating to "any written materials generated by any person that was considered by the Department in

evaluating the application" is proposed to be deleted. This proposed deletion is necessary because it is overly broad, requiring retention of documents that will not be useful for future reference.

Proposed new §19.2004(e) states that paragraphs (1) – (4) of the subsection specify the requirements for entities that are renewing a certification or registration.

Proposed amendments to §19.2004(e)(1), relating to two-year renewal, clarify the requirements for the renewal process. The Insurance Code §4201.103 provides that certification may be renewed biennially by filing, not later than March 1, a renewal form with the Commissioner accompanied by a fee in an amount set by the Commissioner. The Insurance Code §4201.104(a) authorizes the Commissioner to promulgate forms to be filed for a renewal certificate of registration. Proposed amendments to §19.2004(e)(2), relating to continued operation of the URA during Department review, provides that if a URA has filed the required information specified in subsection (e) and submitted the fee required only for certification renewal with the Department 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 finally denied or issued by the Department. Proposed new §19.2004(e)(3) specifies the requirements for renewal if the certification or registration has been expired for 90 days or less. Under proposed new §19.2004(e)(3), the URA may renew the certification or registration by filing a completed renewal application, submitting the fee as applicable for certification renewal, and providing the required information described in subsection (e). Proposed §19.2004(e)(3) prohibits the URA

from operating from the time the certification or registration has expired until the time the Department has issued a renewal certification or registration. Proposed new §19.2004(e)(4) specifies the requirements if the certification or registration has been expired for longer than 90 days. Under proposed §19.2004(e)(4), 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 accordance with §19.2004. Under proposed §19.2004(e)(4), §19.2004(d), relating to original application requirements and process, applies to applications made under paragraph (4).

The proposed deletion of existing §19.2004(i), relating to requirements for filing of changes in original applications of URAs that received their certificates prior to the 1998 effective date of Subchapter U, is necessary because the requirement is obsolete.

The proposed deletion of existing §19.2004(j), relating to the requirement for a single application and fee payment for one certification to cover all lines of utilization review business, is necessary because the requirement is obsolete.

Section 19.2005 addresses **General Standards of Utilization Review.** The proposed amendments to §19.2005(a) require that the utilization review plan be approved by the physician, periodically updated, and include input from both primary and specialty physicians, doctors, or other health care providers, in accordance with the Insurance Code §4201.151. The proposed deletion of the components listed in existing §19.2005(1) – (3) that must be included in the utilization review plan is necessary because the Department proposes updated required components in subsections (b) –

(g) of §19.2005 or the components are otherwise incorporated into other sections of Subchapter U, and the retention of the provisions would therefore be repetitive.

Proposed new §19.2005(b) adds 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 the Insurance Code §4201.153, which requires that utilization review determinations be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria. Proposed new §19.2005(b) also provides that for purposes of §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.

Proposed new §19.2005(c) adds a statutorily required prohibition related to performance tracking data. This provision is consistent with the Insurance Code §4201.556(a), which prohibits a URA from publishing data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

Proposed new §19.2005(d) adds statutorily required screening criteria provisions. It describes the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome focused, and that they comply with the Insurance Code §4201.153. The Insurance Code §4201.153(a) – (c) require: (a) that a URA use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers; (b) that a utilization review determination be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria; and (c) that screening criteria be: (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, proposed new §19.2005(d) requires that screening criteria 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. This provision recognizes that evidence-based medicine will not always be available. This provision is necessary to incorporate requirements of §401.011(22-a) of the Labor Code. The Insurance Code §4201.054(c) states that Title 5 of the Labor Code prevails in the event of a conflict between Chapter 4201 of the Insurance Code and Title 5 of the Labor Code.

Proposed new §19.2005(e) adds a provision related to referral and determination of adverse determinations. It requires that adverse determinations be referred to an appropriate physician or doctor.

Proposed new §19.2005(e) also requires that physicians and doctors performing utilization review be in compliance with the Labor Code §§408.0043, 408.0044, and 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.

Proposed new §19.2005(g) adds statutorily required provisions related to the URA's complaint system. It requires the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with the Insurance Code §4201.204. Additionally, proposed §19.2005(g) adds a new requirement that the written response include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department. This information is necessary to inform the consumer that he or she has the right to file a complaint with the Department after the issuance of an adverse determination by the URA, and the process by which the consumer may speak to a Department representative regarding his or her complaint to the URA.

Proposed new §19.2005(h) provides that §19.2005 applies to a specialty URA except for subsection (a), relating to utilization review plan requirements. While a specialty URA is required to have a utilization review plan pursuant to §19.2020(c) the

specialty URA is exempt from the requirements that the utilization review plan be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other health care providers, including practicing health care providers. The reason that the specialty URAs are not subject to these requirements is that these requirements are based on the Insurance Code §4201.151, and pursuant to the Insurance Code §4201.452, specialty URAs are not subject to §4201.151. Specialty URAs are required, pursuant to 19.2020(c), to use only a health care provider of the appropriate specialty. Under the Insurance Code §4201.453 and §19.2020, a specialty URA must have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Section 19.2006 addresses **Requirements and Prohibitions Relating to Personnel**. A proposed amendment to §19.2006(a)(1) replaces the term "Personnel" with "Physicians, doctors, and other health care providers" to clarify to whom this section applies. A new requirement is added in proposed new §19.2006(a)(2) to require personnel conducting utilization review to hold an unrestricted license or administrative license in Texas or be otherwise authorized to provide health care by a licensing agency in Texas. This new requirement in §19.2006(a)(2) was unanimously recommended by the Advisory Committee and is consistent with the provisions of the Insurance Code §1305.351 and the Labor Code §408.023(h).

A new prohibition is proposed in new §19.2006(c), relating to disqualifying associations. Proposed new §19.2006(c) prohibits a physician who reviews the appeal from having any disqualifying associations with the physician or doctor who issued the initial adverse determination or the injured employee who is requesting the appeal. The subsection also clarifies that being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not constitute a disqualifying association. However, just because two physicians or doctors employed by or under contract with the same URA are not disqualified for that reason does not mean there may not be another disqualifying relationship between them. Proposed new §19.2003(11) defines "disqualifying association." Both §19.2003(11) and §19.2006(c) are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of the proposed new prohibition is to prevent the physician who reviews the appeal from being improperly influenced based on a relationship that he or she has with the physician or doctor who issued the initial adverse determination or the injured employee who is requesting the appeal.

Proposed amendments to §19.2006(d) clarify that the personnel information is to be provided to the Department upon filing an original application or renewal application or upon providing updated information and add a requirement that the URA file with the Department the Texas license number of the personnel either employed by or under contract to perform the utilization review, in addition to the information that is currently required. The second sentence in existing §19.2006(c) requires URAs to adopt written

procedures to determine if doctors or other health care providers utilized by the URA are licensed, qualified, and appropriately trained or experienced, and to maintain records on such.

Proposed amendments to §19.2006(e) delete the existing requirement that a URA that uses doctors to perform reviews of health care services provided under a workers' compensation policy may use doctors licensed by another state. This amendment is necessary to implement the Insurance Code §1305.351 and the Labor Code §408.023(h), which were amended by HB 1006, 80th Legislature, Regular Session, effective September 1, 2007, to provide that only doctors licensed to practice in this state may be used for utilization review.

Existing §19.2006(e), which requires utilization review dental plans to be reviewed by a dentist currently licensed by a state licensing agency in the United States, is proposed to be deleted to avoid redundancy. Review of dental plans are governed by §19.2020(c), relating to specialty URAs.

Proposed new §19.2006(g) provides that §19.2006 applies to specialty URAs, except subsections (a), (d), (e) and (f). Specialty URA requirements relating to employed or contracted physicians, doctors, other health care providers, and personnel; information required to be filed with the Department; the URA's written procedures and maintenance of records; and the conducting of a utilization review under the direction of a physician, do not apply to specialty URAs because these specialty URA requirements are in proposed new §19.2020.

Section 19.2007 addresses **Prohibition of Certain Activities and Procedures Related to Health Care Providers and Injured Employees**. Amendments are proposed to §19.2007(a) to require the URA to alternatively base the frequency of contacts or reviews on "the need for medical documentation to support the necessity of the treatment requested or rendered" in lieu of the existing alternative basis of "necessary treatment and return to work planning activity." This proposed amendment was recommended by the Advisory Committee and is necessary to facilitate communication between the URA and the health care provider and avoid undue influences.

Proposed new §19.2007(c) is necessary to provide that §19.2007 applies to a specialty URA.

Section 19.2008 addresses **Utilization Review Agent Contact with and Receipt of Information from Health Care Providers.** The proposed amendments to §19.2008(a) are nonsubstantive. The first proposed amendment to existing §19.2008(c) require the URA, when conducting utilization review, to request "all relevant and updated medical records" in order to complete the review. This proposed amendment is necessary to ensure that the URA utilizes the most recent and complete information possible to review the injured employee's treatment. While the treatment may vary on a case-by-case basis, the Department has determined that this proposed amendment will enable the most effective review to be conducted.

Proposed amendments to §19.2008(c) also provides that the information required may include identifying information about the claim and about the treating

physician, doctor, or other health care provider. This information is necessary to clarify the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records in order to complete the review. Proposed amendments add "diagnostic testing" to the type of information that the URA may request under §19.2008(c). This additional information is necessary to assist the URA in making an informed determination.

The proposed amendments to §19.2008(f) 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 clarify that the mental health therapist's process or progress notes are the subject of the prohibition. The proposed amendments also add a new provision to 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.

Amendments are proposed to subsection (f)(1), to provide that this prohibition does not preclude the URA from requiring submission of an injured employee's mental health medical record summary. Proposed new subsection (f)(2) provides 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. These amendments are necessary for purposes of clarification, ease of compliance, and consistency with §19.1708(f) in Subchapter R and were recommended by the Advisory Committee. The consistency between the Subchapter R and Subchapter U rule amendments is necessary because

the rules are based on the same underlying statute. The Insurance Code §4201.203 provides that (i) a URA may not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes; and (ii) notwithstanding the Insurance Code §4201.203, a URA may require submission of a patient's medical record summary.

Proposed new §19.2008(g) is necessary to provide that §19.2008 applies to a specialty URA.

Section 19.2009 addresses **On-Site Review by the Utilization Review Agent**. In addition to the proposed amendments for purposes of internal consistency of terminology and clarification, an amendment is proposed to §19.2009(c)(1)(A) and (B) and (2), relating to on-site review at a health care facility, change the references from hospital to a "health care facility." The broader term "health care facility," which includes a hospital, emergency clinic, outpatient clinic, or other facility providing health care, is necessary for purposes of clarification and accuracy.

Proposed new §19.2009(d) provides that §19.2009 applies to a specialty URA.

Section 19.2010 addresses **Notice of Determinations Made in Prospective and Concurrent Utilization Review**. An amendment is proposed to the title of existing §19.2010, "Notice of Determinations Made by Utilization Review Agents, Excluding Retrospective Review," to clarify that the section regulates the notice of determinations in prospective and concurrent utilization review. Clarifying amendments are proposed

to existing §19.2010(a), relating to notification of a determination made in a utilization review, including the addition of new subsection (a)(1) – (2).

Proposed new §19.2010(a)(1) sets forth time frames required for sending written notification of a favorable or adverse determination to individuals with workers' compensation non-network coverage, and proposed new §19.2010(a)(2) specifies the time frames for individuals with workers' compensation network coverage. The proposed time frames are the same as those in 28 TAC §134.600 for workers' compensation non-network coverage and the Insurance Code §1305.353 and 28 TAC §10.102, for workers' compensation network coverage.

Proposed new §19.2010(b) addresses notification requirements that pertain only to favorable determinations. Proposed new §19.2010(b)(1) provides that the written notification for favorable determinations must be mailed or electronically transmitted within certain time frames. Proposed new §19.2010(b)(1)(A) specifies that the notification of favorable determinations for workers' compensation non-network coverage must be provided within the time frames in 28 TAC §134.600. Proposed new §19.2010(b)(1)(B) specifies that such notifications for workers' compensation network coverage must be provided within the time frames in the Insurance Code §1305.353 and 28 TAC §10.102.

Proposed new §19.2010(b)(2) adds a new requirement that the URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the 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. These standards currently apply under federal law to health insurers and therefore already apply to health insurers conducting utilization review. For consistency among all URAs, the Department has determined that it is necessary to require preauthorization numbers issued by all URAs to comply with the federal data and format requirements. This requirement is necessary to ensure the use of the same preauthorization numbering systems for ease of use by URAs and providers. The requirement was also added for consistency with newly adopted TDI-DWC rules in Chapter 133 Subchapter G, relating to Electronic Medical Billing, Reimbursement, and Documentation.

Some of the notice elements required in §19.2010(c)(1) are required by the Insurance Code §4201.303(a). These requirements, which are listed in §19.2010(c)(1)(A)(i), (ii), (vi), (vii), and (ix); (B); and (C) include: (i) the principal reasons for the adverse determination; (ii) the clinical basis for the adverse determination; (iii) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and (iv) a description of the procedure for the complaint and appeal process, including notice to the injured employee of the injured employee's right to appeal an adverse determination to an IRO and of the procedures to obtain that review.

The proposed amendments to add new notice requirements in §19.2010(c)(1)(A)(iii), (v), and (viii), include: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal,

might lead to a different utilization review decision; (ii) the professional specialty and Texas licensure of the physician or doctor who made the adverse determination; and (iii) the date and time the URA offered the opportunity to discuss the adverse determination. The Department has determined that these additional notice elements are necessary for the injured employee and the provider of record in the event that the adverse determination is appealed.

The new required notice element in §19.2010(c)(1)(A)(iii), relating to documentation or evidence that can be submitted upon appeal of the adverse determination that might lead to a different utilization review decision, is important for the injured employee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and Texas license number of the physician or doctor who made the adverse determination required in proposed new §19.2010(c)(1)(A)(v), is necessary for the injured employee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the injured employee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal of the adverse determination is filed.

Consistent with the Insurance Code §4201.303(a), the requirements in proposed new §19.2010(c)(1)(A)(vii) and (ix), regarding the provision of information on the URA's appeal process and notice of the independent review process, along with a copy of

Form No. LHL009, will inform the injured employee of his or her additional options following an adverse determination. The information is necessary to inform the provider of record of the procedures involved in appealing the adverse determination and the kind of information that is needed for submission to the URA on behalf of the injured employee for the appeal of an adverse determination.

Also necessary for ensuring that an injured employee who is appealing an adverse determination is well informed is the information required in proposed new §19.2010(c)(1)(A)(viii) regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination. This information is useful to inform the injured employee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to be aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA.

Proposed new §19.2010(c)(1)(B), relating to the written notification of the adverse determination by the URA, specifies that for workers' compensation network coverage, in addition to the requirements in paragraph (A), the written notification of the adverse determination by the URA must also include a description of or the source of the screening criteria that were utilized in making the determination.

Proposed new §19.2010(c)(1)(C), relating to the written notification of the adverse determination by the URA, specifies that for workers' compensation non-

network coverage, in addition to the requirements in paragraph (A), the written notification of the adverse determination by the URA must also include a description of guidelines utilized in accordance with 28 TAC Chapter 137 in making the determination.

Proposed new §19.2010(c)(2) adds a new requirement that mandates that the description of the URA's appeal process include a statement that explains the URA's process for circumstances involving an injured employee's life-threatening condition, and under the process, the injured employee must be provided an immediate independent review by an IRO and is not required to comply with procedures for an internal review of the adverse determination by a URA. This provision is based on the requirement in the Insurance Code §4201.303(b).

Proposed new §19.2010(c)(3) specifies required time frames for notification of an adverse determination and proposes time frame requirements to be consistent with 28 TAC §134.600 for workers' compensation non-network coverage; and the Insurance Code §1305.353 and 28 TAC §10.102 for workers' compensation network coverage.

Proposed new §19.2010(c)(4) requires that the notice of adverse determination for non-network workers' compensation coverage comply with the requirements of 28 TAC §134.600 in addition to the requirements in §19.2010(c)(1).

Proposed new §19.2010(c)(5) 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 meets 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 required notice elements under both §19.2010(c) and 28 TAC §180.28.

Proposed new §19.2010(d) specifies that §19.2010 applies to specialty URAs.

Section 19.2011 addresses **Requirements Prior to Issuing Adverse Determination**. An amendment is proposed to the title of existing §19.2011, "Requirements Prior to Adverse Determinations," to clarify that the section regulates the requirements prior to the issuance of adverse determinations. Proposed new §19.2011(a) defines the term "reasonable opportunity" for purposes of §19.2011 as at least one documented good faith attempt to contact the provider of record requesting the services (i) no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or (ii) no less than five working days prior to issuing a retrospective utilization review adverse determination. This definition is necessary to provide guidance regarding what constitutes a "reasonable opportunity" to ensure uniform implementation of the §19.2011(b)(1) requirements relating to prospective or concurrent utilization review adverse determination and subsection (c)(1) requirements relating to retrospective utilization review adverse determination. The proposed definition is also used in proposed new §19.2012(a)(2)(D) and (b)(1)(B) and §19.2020(h)(1)(A) and (h)(2)(A), and it is necessary that all of these requirements are implemented on the basis of a uniform definition.

Proposed newly designated §19.2011(b)(1) addresses requirements regarding any instance in which the URA is questioning the medical necessity or appropriateness of the health care services prior to issuing a prospective or concurrent utilization review

adverse determination. An amendment is proposed to §19.2011(b)(1) to require the URA, prior to issuance of an adverse determination, to afford "the provider of record" a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician or doctor. The amendment changes the existing rule which addresses such discussion opportunities with "the appropriate doctor or health care provider performing the review." An amendment is proposed to §19.2011(b)(1) to clarify that the discussion must include, "at a minimum, the clinical basis" for the URA's decision in addition to the discussion of the plan of treatment for the injured employee. This amendment is needed to clarify that the required discussion may also include other matters as deemed necessary by the URA and/or provider of record.

Proposed new §19.2011(b)(2) adds a new requirement that when the URA provides the reasonable opportunity required under §19.2011(b)(1), 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. This requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the URA.

Proposed amendments to newly designated §19.2011(b)(3) provide more detailed requirements regarding these written procedures. The proposed amendments 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 discussion outcome. Proposed new §19.2011(b)(4) adds a new requirement that the URA submit this required documentation to the Department or TDI-DWC upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department 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.

Proposed new §19.2011(c) sets forth requirements prior to issuing retrospective review adverse determinations. The proposed new subsection imposes the same requirements for the peer-to-peer discussion regarding any instance in which a URA is questioning the medical necessity or appropriateness of the health care services provided, prior to the issuance of a retrospective review adverse determination as those requirements prior to the issuance of an adverse determination for prospective or concurrent utilization review specified in proposed §19.2011(b)(1), (3), and (4). Additional requirements are proposed in §19.2011(c)(2) for retrospective review adverse determinations to (i) require that when the URA provides the reasonable opportunity required under subsection (c)(1), 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; and (ii) require the URA to allow the provider of record five working days from receipt of the notification to respond orally or in writing to the

notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.2011, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record who provided the services no less than five working days prior to issuing a retrospective utilization review.

These proposed requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements that result from the enactment of HB 4290. As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review" as a type of "utilization review." The Insurance Code §4201.206 provides that subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, 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 a "utilization review agent," as defined in the Insurance Code §4201.002, means "an entity that conducts utilization review…," and "utilization review" includes "retrospective review," as provided in §4201.002(13) of the Insurance Code, the §4201.206 provision requiring a reasonable opportunity to discuss with a physician

the patient's treatment plan and the clinical basis for the URA's determination prior to issuance of an adverse determination now applies to URAs conducting retrospective review.

Proposed new §19.2011(d) provides that the §19.2011 requirements except subsections (b) and (c) apply to a specialty URA. The requirements under subsections (b) and (c) are not applicable because the underlying peer-to-peer requirement from which the other requirements are derived is based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.2020(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Proposed new §19.2012 replaces existing §19.2012; both sections address requirements and procedures for the appeal of adverse determinations of URAs. In conjunction with this proposal, existing §19.2012 is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register*.

Proposed new §19.2012 addresses **Appeal of Adverse Determination**.

Proposed new §19.2012(a) governs appeal of prospective or concurrent adverse determinations. A new requirement is added in proposed new §19.2012(a)(1), providing that the URA must maintain and make available a written description of the appeal procedures involving an adverse determination that are used by the URA. This requirement is consistent with the Insurance Code §4201.352.

A new requirement is added in proposed new §19.2012(a)(2), providing that each URA must comply with its written procedures for appeals. Proposed new §19.2012(a)(2) also sets forth the information that is required to be contained in the written procedures for appeals and requires the procedures to be reasonable.

Proposed new §19.2012(a)(2)(A)(i) addresses the time frames for filing the appeal for workers' compensation network coverage. It requires the URA's written procedures for appeals to include a statement specifying the time frames for filing the oral or written appeal in accordance with the 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 this provision, all injured employees will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review. This provision is also consistent with the Insurance Code §4201.353, which provides that the procedures for appealing an adverse determination must be reasonable.

Proposed new §19.2012(a)(2)(A)(ii) addresses the time frames 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 time frames 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). Proposed new

§19.2012(a)(2)(B) requires the URA's written procedures for appeals to include a provision that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination by making an oral or written request. This is consistent with the Insurance Code §4201.354. Proposed new §19.2012(a)(2)(B) also provides that if the health care provider sets forth in the request good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review. This provision allows the injured employee an opportunity for a health care provider in the same or similar specialty to review the injured employee's case under certain circumstances.

Proposed new §19.2012(a)(2)(C) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician who has not previously reviewed the case. This provision is consistent with the Insurance Code §4201.356(a), the Insurance Code §1305.354, and 28 TAC §10.103. This requirement provides consistency of utilization reviews for all injured employees.

Proposed new §19.2012(a)(2)(D) requires that 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, as defined in proposed §19.2011(a), to discuss the

plan of treatment for the injured employee with a physician. The discussion must include, at a minimum, the clinical basis for the URA's decision.

Proposed new §19.2012(a)(2)(E) requires the URA's written procedures for appeals to include a provision that, after the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter explaining the resolution to the appeal to certain specified individuals for workers' compensation non-network coverage as provided in §19.2012(a)(2)(E)(i) and to other specified individuals for workers' compensation network coverage as provided in §19.2012(a)(2)(E)(ii).

The requirements in proposed §19.2012(a)(2)(F)(i)(I) – (IV) are consistent with the Insurance Code §4201.359. The requirement in proposed new §19.2012(a)(2)(F)(i)(V), relating to procedures for filing a complaint, is consistent with the Insurance Code §4201.204. The requirements in proposed §19.2012(a)(2)(F)(i)(I) and (III) are proposed under the Department's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201. The requirement under §19.2012(a)(2)(F)(i)(I) is similar to the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(1), proposed §19.2010(c)(1), and proposed §19.2015(b)(2). These provisions require the URA to include the principal reasons for the adverse determination in the notice of an adverse determination.

Proposed new §19.2012(a)(2)(F)(ii) requires that for workers' compensation network coverage, a description of 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, be included in the response letter. The requirement under proposed new §19.2012(a)(2)(F)(ii) is consistent with the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(3), proposed §19.2010(c)(1)(B), and proposed §19.2015(b)(2)(D). These provisions require the URA conducting utilization review for workers' compensation network coverage to include a description of or the source of the screening criteria that were utilized as guidelines in making the determination in the notice of an adverse determination.

Proposed §19.2012(a)(2)(F)(iii) requires that for workers' compensation non-network coverage, a description of guidelines utilized in accordance with 28 TAC Chapter 137 in making a determination be included in the response letter. These requirements are necessary to provide the injured employee with important information concerning the basis for the determination. The requirement under proposed new §19.2012(a)(2)(F)(iii) is consistent with the required notice element for the notice of an adverse determination under proposed §19.2010(c)(1)(C) and proposed §19.2015(b)(2)(E). These provisions require the URA conducting utilization review for workers' compensation non-network coverage to include a description of guidelines utilized in accordance with 28 TAC Chapter 137 (relating to Disability Management) in making a determination.

Proposed new §19.2012(a)(2)(G)(i) and (ii) specify the time frames for written notifications to the appealing party of the determination of the appeal. These appeals must be resolved in accordance with 28 TAC §10.103 for workers' compensation

network coverage, and 28 TAC §134.600 for workers' compensation non-network coverage.

Proposed new §19.2012(a)(3) provides for an immediate review by an IRO of an adverse determination in a circumstance involving an injured employee's life-threatening condition. This provision is consistent with the Insurance Code §4201.360.

Proposed new §19.2012(a)(4) provides that §19.2012 applies to a specialty URA except subsection (a)(2)(C) and (D), relating to the requirement that appeal decisions of prospective or concurrent adverse determinations must be made by a physician who has not previously reviewed the case. The requirement under subsection (a)(2)(C) is not applicable because §19.2020(i) governs appeal procedures specifically for specialty URAs. The requirements under subsection (a)(2)(D) are not applicable because they are based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.2020(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Proposed new §19.2012(b)(1) – (4) govern appeals of retrospective review adverse determinations. Subsection (b)(1) applies to both workers' compensation network and non-network coverage. Subsection (b)(1) requires the URA to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. Appeal procedures must comply with the requirements in subparagraphs (A) and (B) of paragraph (1). Proposed subsection

(b)(1)(A) requires that an appeal of an adverse determination relating to retrospective utilization review must comply with §19.2015. Proposed subsection (b)(1)(B) requires that in any instance in which the URA is questioning the medical necessity or appropriateness, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity, as defined in §19.2011(a), to discuss the plan of treatment for the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the URA's decision.

Proposed new §19.2012(b)(2) requires workers' compensation network coverage appeal procedures to comply with the requirements in the Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133.

Proposed new §19.2012(b)(3) requires workers' compensation non-network coverage appeal procedures to comply with the requirements of 28 TAC Chapter 133.

Proposed new §19.2012(b)(4) provides that §19.2012 applies to a specialty URA except subsection (b)(1)(B), relating to the requirement that before issuing a retrospective 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. The requirements under subsection (b)(1)(B) are not applicable because they are based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.2020(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs

Section 19.2013 addresses **Utilization Review Agent's Telephone Access**. Proposed new §19.2013(c) requires a URA to provide a written description to the Commissioner of the procedures that the URA will implement 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 lead to a medical emergency; and (ii) 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 proposed requirement in §19.2013(c)(1) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, relating to Pharmaceutical Benefits, for both certified network and non-network claims in workers' compensation. This URA procedural requirement is necessary for those situations that may occur after the denial of a preauthorization request and is a precursor to statutorily required closed formulary appeals process that includes the medical interlocutory order process identified in 28 TAC §134.550 (relating to Medical Interlocutory Order). Section 134.550 provides a prescribing doctor of 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 the Insurance Code §1305.004(a)(13). An equivalent requirement is not included in the proposed Subchapter R rules because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy.

In addition, the post-stabilization portion in §19.2013(c)(2) will 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 results in confusion regarding the availability of necessary pain medications.

Proposed new §19.2013(c) is based on the Insurance Code §4201.004(b), which requires a URA to provide to the Commissioner a written description of the procedures to be used when responding with respect to post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider.

Proposed new §19.2013(d) provides that §19.2013 applies to a specialty URA.

Section 19.2014 addresses **Confidentiality**. Proposed §19.2014(a)(4) relating to requests for recorded personal information, requires the URA to respond to an individual's written request for access to recorded personal information about the individual within 10 *working* days, instead of 10 *business* days as provided in the existing rule. This amendment is proposed for clarity and uniformity of implementation; the term "working day" is defined in §19.2003(47), and the term "business day" is not defined.

Proposed §19.2014(a)(12) relating to period of record retention, requires the information generated and obtained by a URA in the course of utilization review to be retained for at least *four* years, instead of the existing requirement of two years. The proposed amendment also deletes the qualifier in the existing rule "from the date of the final decision in the utilization review." The deletion of this qualifier will result in the

calculation of time beginning from the onset of the utilization review for a given case. The deletion was necessary to clarify that all information must be retained, not just information relating to cases for which a final decision has been rendered. These changes are necessary to broaden the type of information that is to be retained and to allow sufficient time for the Department to examine the information. The Department 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 the Department has the opportunity to review such information.

Proposed §19.2014(b), relating to a URA's written procedures on confidentiality, clarify that the confidentiality requirements pertain to both the information received by the URA from the injured employee, the injured employee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties.

Proposed new §19.2014(c) provides that §19.2014 applies to a specialty URA.

Proposed new §19.2015 replaces existing §19.2015. In conjunction with this proposal, existing §19.2015, concerning retrospective review of medical necessity, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register*.

Proposed new §19.2015 addresses **Notice of Determination Made in Retrospective Review**. Proposed new §19.2015(a), relating to required notice, requires a URA to provide notice of a determination made in a retrospective review to

the following: (i) for workers' compensation non-network coverage the individuals specified by 28 TAC §133.240 (relating to Medical Payment and Denials); and (ii) for workers' compensation network coverage, the individuals specified by 28 TAC §133.240 and 28 TAC §10.102 (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

Proposed new §19.2015(b), relating to required procedures, requires the URA to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the time frames for the notice of adverse determination, in compliance with the Insurance Code §4201.305 and the requirements specified in paragraphs (1) – (5) of subsection (b).

Proposed new §19.2015(b)(1) requires the notice of adverse determination to be in writing and provided within the timeframes specified by (i) department 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; or (ii) TDI-DWC rules in 28 TAC Chapter 133 for workers' compensation non-network coverage. This provision is consistent with the Insurance Code §4201.305.

Proposed new §19.2015(b)(2) requires the notice of adverse determination to include several notice elements of information, including some statutory requirements. These statutory requirements are included in proposed §19.2015(b)(2)(A), (B), (D), (E), (G), (H), and (J).

In addition to the notice elements required by the Insurance Code §4201.303, proposed new §19.2015(b)(2)(C), (F), and (I) also require the following information be included in the notice of adverse determination for retrospective utilization review: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and Texas license number of the physician or doctor who made the adverse determination; and (iii) the date and time the URA offered the opportunity to discuss the adverse determination, and the date and time the discussion, if any, took place. The Department has determined that these additional notice elements are necessary to provide important consumer information to the injured employee in the event that the adverse determination is appealed. The additional notice element in proposed new §19.2015(b)(2)(C), relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the injured employee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and Texas license number of the physician or doctor who made the adverse determination, required in proposed new §19.2015(b)(2)(F), is necessary for the injured employee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the injured employee would benefit from requesting a physician or doctor of a particular specialty,

other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

The requirement in proposed new §19.2015(b)(2)(I), regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination and the date and time that the discussion, if any, occurred, is also useful, to inform the injured employee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to become aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA.

Proposed §19.2015(b)(3) clarifies that the notice of determination required under this section may constitute a peer review report required by 28 TAC §180.28 (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section.

Proposed new §19.2015(c) provides that §19.2015 applies to specialty URAs.

Section 19.2016 addresses **Regulatory Requirements Subsequent to Certification or Registration**.

Proposed new §19.2016(a), relating to reporting of material changes in the application or latest renewal form, requires the URA to report to the Department, not later than the 30th day after the date on which the change takes effect, any material

changes in such information. This provision implements the Insurance Code §4201.107.

Proposed §19.2016(b)(1) continues to require that information related to complaints be included in the summary report but the proposed amendments broaden the types of information that the URA is required to provide in the summary report. The proposed amendments require URAs to also submit information related to adverse determinations, appeals of adverse determinations, and any other related information requested by the Department in accordance with the Insurance Code §38.001. This provision is proposed under the Insurance Code §4201.204(c) and the Insurance Code §38.001.

Proposed new §19.2016(b)(2) requires the summary report to be provided in the form required by the Commissioner and requires the URA to permit the Commissioner or the Commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the Department. This provision is also proposed under the Insurance Code §4201.204(c).

A proposed amendment to §19.2016(b)(3)(B), relating to the requirement to list adverse determinations for preauthorization, clarifies that "successor codes and modifiers" are applicable as part of that requirement.

Proposed new §19.2016(b)(3)(D) broadens the types of information that the URA is required to provide in the summary report that must be submitted to the Department annually to include 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.

These proposed additional information requirements in §19.2016(b)(3)(D) are necessary for consistency with the information requirements for a URA for utilization review for health care provided under a health benefit plan or health insurance policy and subject to proposed §19.1716(b)(3). The need for this consistency between the Subchapter R requirements and the Subchapter U requirements is discussed in the early part of this Introduction. This information will be useful to the Department in assembling and monitoring information related to the appeals of adverse determinations. This information will assist the Department in determining the results and the frequency and volume of such appeals.

Existing §19.2016(d)(1) – (4), relating to complaints to the Department, is proposed for deletion because the Department has determined that the detailed complaint procedure requirements in existing subsection (d)(1) – (4) are not necessary. The Department has determined that the Department's established procedures for investigation and resolution of other types of complaints are the more appropriate means for handling the URA complaints to the Department.

Proposed new §19.2016(d), relating to Department inquiries, reiterates the Department's authority in the Insurance Code §38.001 to address inquiries to a URA related to any matter connected with the URA transactions that the Department considers necessary for the public good or for the proper discharge of the Department's

duties. Consistent with §38.001, a URA to which such an inquiry is addressed must respond in writing not later than the 10th day after the date the inquiry is received.

Existing §19.2016(e) requires the URA to provide evidence of corrective action within the specified time frame to the Commissioner or his or her representative. Because this requirement operates in conjunction with the existing §19.2016(d)(1) – (4) requirements, existing §19.2016(e) is also proposed for deletion.

Proposed new §19.2016(e) provides 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 by or under contract 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 set forth in Subchapter U.

The requirement in existing §19.2016(g) that the Commissioner maintain and update monthly a list of URAs issued certificates and the renewal date for those certificates is proposed for deletion because the Department now maintains a list of certified URAs on its website, which is available to individuals or organizations interested in obtaining information on the certification status of a URA. This list is updated in real-time. However, this requirement is still imposed by statute under the Insurance Code §4201.108.

Proposed §19.2016(f)(1)(A) clarifies that an on-site review by the Department may be scheduled or un-scheduled. Under proposed new §19.2016(f)(1)(B), an on-site

review will only be conducted during working days and normal business hours. Proposed new §19.2016(f)(1)(C) retains the existing provision that the URA is required to make available all records relating to its operation during the scheduled and unscheduled on-site review without a proposed substantive change. Proposed §19.2016(f)(2) retains the existing provision that the URA will be notified of any scheduled on-site review by letter. Proposed new §19.2016(f)(3) provides that, at a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by the Department's designated representative upon arrival. Existing §19.2016(h)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is proposed for deletion. The Department has determined that this provision is no longer necessary because of the Insurance Code §4201.601, which authorizes the Department to take certain steps if it is believed that a person or entity conducting utilization review is in violation of Chapter 4201 or applicable rules. These steps include 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.

Proposed new §19.2016(g) provides that §19.2016 applies to specialty URAs.

Section 19.2017 addresses **Administrative Violations**. Proposed §19.2017(a)(3) is proposed to be amended to include subparagraphs (a)(3)(B) – (C) to authorize the Commissioner to issue a cease and desist order under the Insurance Code Chapter 83 or assess administrative penalties under the Insurance Code Chapter 84. Chapters 83 and 84 of the Insurance Code are referenced generally in existing

rules; proposed new §19.2017(a)(3)(B) – (C) specify the possible disciplinary actions that may be imposed under these chapters. Additionally, an amendment is proposed to §19.2017(a)(4) relating to the commission of fraudulent or deceptive acts in obtaining or using a URA certification, to include the commission of fraudulent or deceptive acts in obtaining or using a URA registration.

Proposed new §19.2017(b), relating to actions by the TDI-DWC for a URA's alleged violation of the Labor Code or TDI-DWC rules, provides that proposed new §19.2017 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 the Labor Code Title 5 or applicable TDI-DWC rules. Nothing in proposed new §19.2017 prohibits the joint enforcement actions of the Department and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

Proposed new §19.2017(c) provides that §19.2017 applies to specialty URAs.

In conjunction with this proposal, existing §19.2018, concerning criminal penalties, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register*.

Section 19.2019 addresses **Responsibility of Insurance Carriers Performing Utilization Review**. An amendment to the title of §19.2019 changes the word "companies" to the word "carriers." This change is necessary because the term "insurance company" in existing §19.2003(19) is proposed for deletion, but the definition

of "insurance carrier" in proposed redesignated §19.2003(17) incorporates the definition of "insurance company." Existing §19.2019(a) – (c) address requirements for insurance companies performing utilization review. Proposed new §19.2019(a) – (c) address requirements for insurance *carriers* performing utilization review.

Proposed new §19.2019(a) provides that an insurance carrier performing utilization review only for coverage for which it is the payor is subject to Subchapter U except for the *certification* requirements in §19.2004 of this title. This proposed provision is consistent with the Insurance Code §4201.058(a).

Proposed amendments to existing §19.2019(b) update the certification requirements for an insurer performing utilization review for an individual or entity for which it is not the payor. Such insurers will be required to have a valid certificate under Chapter 4201 of the Insurance Code and in accordance with §19.2004 of this title. This provision is consistent with the Insurance Code §4201.058(c).

Amendments are proposed to §19.2019(c) to update the registration requirements for an insurer that performs utilization review under Chapter 4201 of the Insurance Code only for coverage for which it is the payor. Such insurers will be required to have a valid registration pursuant to §19.2004 and to comply with the filing requirements under §19.2004. These proposed amendments are necessary for the Department to obtain additional information about insurers conducting utilization review for coverage for which they are the payor for purposes of monitoring and oversight. Under the proposed amendments to §19.2019(c), the insurer is not required to submit

an original application fee or renewal fee if the insurer only performs utilization review for workers' compensation coverage for which it is the payor.

Proposed new §19.2019(d) provides that §19.2019 applies to specialty URAs.

Section 19.2020 addresses **Specialty Utilization Review Agent**. Proposed new §19.2020(a) requires a specialty URA, in order to be certified or registered as a specialty URA, to submit to the Department the application and information required in §19.2004. Proposed §19.2020(b)(1) provides that a specialty URA is subject to the requirements of the Insurance Code Chapter 4201, except as specified in the proposed amendments. Proposed §19.2020(b)(2) provides that a specialty URA is subject to the requirements of Subchapter U, except as specified in the proposed amendments. These amendments are consistent with the 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.

Proposed §19.2020(c) specifies requirements relating to the specialty URA's utilization review plan, which provide consistency with the Insurance Code §4201.453, which provides that a specialty URA's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Proposed new §19.2020(d) addresses requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Proposed new §19.2020(d)(1) requires physicians, doctors, other health care providers, and personnel

employed by or under contract with a specialty URA to perform workers' compensation utilization review to be appropriately trained, qualified, and currently licensed in accordance with 28 TAC Chapter 180 (relating to Monitoring and Enforcement).

Proposed new §19.2020(d)(2) requires personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by the Texas Medical Board or be otherwise authorized to provide health care services in Texas. This requirement is based on an Advisory Committee recommendation and is necessary to ensure that all such personnel are appropriately trained and qualified to conduct specialty utilization review.

Proposed amendments to §19.2020(d)(3) clarify that physicians or doctors obtaining information under §19.2020 must be qualified in accordance with the Labor Code §§408.0043, 408.0044, and 408.0045, and nurses, physician assistants, or other health care providers must be qualified in accordance with 28 TAC Chapter 180. The proposed provision may not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

Proposed new §19.2020(e) requires the specialty URA to provide the name, number, type, Texas license number and qualifications of the personnel either employed by or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information. This requirement is necessary to enable the Department to monitor and to ensure that appropriate personnel are conducting utilization review, which should result in a higher quality of utilization review for the injured employee. The Department has

authority to require this information under the Insurance Code §4201.104, which requires the Commissioner to promulgate forms to be filed for a URA's initial certification and renewal certification. Additionally, the Insurance Code §4201.107 requires the URA to report to the Department any material changes to information disclosed in the application form.

Proposed new §19.2020(f) requires the specialty URA to: (i) develop and implement written procedures for determining if physicians, doctors, or other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced; and (ii) maintain documentation demonstrating that physicians, doctors, and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced. The requirements are necessary to create a written record that the URA can provide to the Department upon request to enable the Department to determine whether the physicians, doctors, or other health care providers are licensed, qualified, and appropriately trained or experienced. The requirements should ultimately result in a higher quality of utilization review for the injured employee. These requirements are consistent with the Insurance Code §4201.454.

Under the proposed amendments to subsection (g), 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 change is consistent with the Insurance Code §1305.351 and the Labor

Code §408.023(h). Additionally, an amendment is proposed to §19.2020(g) to provide that the directing physician, doctor, or other health care provider may be employed by or under contract to the URA. This proposed amendment is necessary to avoid any ambiguity or misunderstanding regarding the type of business relationship that the URA may have with the directing physician, doctor, or other health care provider.

Proposed new §19.2020(h)(1)(B) requires that a discussion under subsection (h) prior to the issuance of an adverse determination in prospective or concurrent utilization review include, at a minimum, the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision required under subsection (h)(1)(A), as deemed necessary by the URA and/or provider of record. This requirement is consistent with the Insurance Code §4201.456.

Proposed new §19.2020(h)(1)(C) provides that when the specialty URA provides the reasonable opportunity required under §19.2020(h)(1)(A), the specialty URA must include the specialty URA's 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 in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA.

Proposed new §19.2020(h)(1)(D) requires 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. Proposed new §19.2020(h)(1)(E) requires the specialty URA to submit the subsection(h)(1)(D) documentation to the Department or TDI-DWC upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department 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.

Proposed new §19.2020(h)(2)(A) requires a specialty URA, before issuing a retrospective review adverse determination, to provide the provider of record a reasonable opportunity to discuss the treatment provided to the injured employee with a health care provider of the same specialty as the URA. Proposed new §19.2020(h)(2)(B) requires a discussion to include, at a minimum, the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters

in addition to the clinical basis for the specialty URA's decision as deemed necessary by the URA and/or provider of record.

Proposed §19.2020(h)(2)(C) proposes new requirements that when the specialty URA provides the reasonable opportunity required under subsection (h)(2)(A), the specialty URA must include the specialty URA's phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. Under the proposed requirements, the specialty URA must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.2011, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than five working days prior to issuing a retrospective utilization review.

A new requirement is proposed in new §19.2020(h)(2)(D) to mandate that the specialty URA 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 date and time that the discussion, if any, took place, and the discussion outcome. The new requirement proposed in new §19.2020(h)(2)(E) requires that the specialty URA submit the §19.2020(h)(2)(D) documentation to the Department upon request. These proposed requirements are

necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department 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. Both of these requirements are necessary to ensure that the proper consumer protection is afforded to injured employees who are using specialty URAs for utilization review.

Amendments are proposed to §19.2020(i) to 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.

In conjunction with this proposal, existing §19.2021, concerning independent review organizations non-involvement with the URA process, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register*.

Proposed new §19.2021 addresses **Independent Review of Adverse Determinations**.

Proposed new §19.2021(a) addresses notifications of an adverse determination for life-threatening conditions.

Proposed new §19.2021(a)(1)(A)(i) and (ii) specify the time frames for the notification of an adverse determination: (i) for workers' compensation non-network coverage, the adverse determination notice must be provided within the time frames

specified by 28 TAC §134.600; (ii) for workers' compensation network coverage, the adverse determination notice must be provided within the time frames specified by the Insurance Code §1305.353 and 28 TAC §10.102.

Proposed §19.2021(a)(1)(B) adds a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)). This requirement is necessary to inform the injured employee of the process for independent review of the adverse determination in the event of life-threatening conditions. The provision of the copy of Form No. LHL009, will inform the injured employee of his or her additional options following an adverse determination and enable the injured employee to more quickly and efficiently request independent review.

Proposed new §19.2021(a)(1)(C) requires that the injured employee, injured employee's representative, or the injured employee's provider of record determine the existence of a life-threatening condition on the basis of the prudent layperson standard. This standard provides 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. 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 injured employee as long as the prudent layperson test is met. The Texas 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 is required to make the determination that the disease or condition is life-threatening. The Department 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 to allow only medical personnel to make the determination. Under this interpretation, an 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 the Department's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Proposed new §19.2021(a)(2) reiterates the statutory requirement that a party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA is entitled to review of the adverse determination by an IRO. This provision is necessary to implement the Insurance Code §4201.360.

Proposed new §19.2021(b) governs independent review involving life-threatening and non-life threatening conditions. Proposed new §19.2021(b)(1) addresses the request for independent review. Proposed new §19.2021(b)(1)(A) requires the URA to notify the Department within one working day from the date the request for an independent review is received. A "working day" is defined by §19.2003(47). The proposed requirement that the URA notify the Department 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 injured employees. The Department has determined that the proposed "working day" requirement will avoid impractical deadlines in situations such as when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Proposed §19.2021(b)(1)(B) requires the URA to provide the Department the completed Form No. LHL009 that is submitted to the URA by the party requesting independent review. This requirement should result in greater efficiency and less time for the URA and in quicker response time for the injured employee who is requesting the independent review. Proposed §19.2021(b)(1)(C) requires the URA to submit the completed Form No. LHL009 via the Department's Internet website.

Under proposed new §19.2021(b)(2), the Department will, within one working day of receipt of the complete request for independent review, randomly assign an IRO to conduct the independent review and notify the URA, payor, IRO, injured employee or 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 of the IRO assignment. This prompt assignment is necessary for both life-threatening and non-life threatening conditions because assigning IROs is a primary function of the Department.

Proposed new §19.2021(b)(3) 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.

Proposed new §19.2021(b)(4) references additional requirements for an independent review of an adverse determination for a workers' compensation network coverage review under the Insurance Code Chapter 1305, Department and TDI-DWC rules, including, but not limited to 28 TAC Chapter 10, Subchapter F, and Chapter 133, Subchapter D.

Proposed new §19.2021(c) provides that §19.2021 applies to a specialty URA.

2. FISCAL NOTE. Debra Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, has determined that for each year of the first five years the proposed amendments and new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, also has determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the enforcement and administration of the proposal, as well as potential costs for persons required to comply with the proposal. The Department, however, 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. Specifically, the anticipated public benefits of the proposed rules and amendments related to compliance with legislation include the establishment of a regulatory framework that supports the operation of a URA 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 the Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service; these amended rules will assist health care consumers by providing for review of claims that could otherwise be denied without such recourse.

Clarification of existing rules. Additionally, the anticipated public benefits of the proposed rules and amendments 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 upon which an URA is required to 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 enrollee or injured employee 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 rules and amendments 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, upon 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 incurring expenses for uncovered medical treatment.

Improved regulatory framework. The anticipated public benefits of the proposed rules and amendments relating to the improved regulatory framework for URAs are: (i) additional required notice elements in the Form No. LHL005 (Utilization Review Agent (URA) Application Form) that will result in the provision of additional information to the Department necessary to certify or register a URA; (ii) disclosure of screening criteria to be filed with the Department 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 accordance with applicable law; and (v) inclusion of written procedures to be filed with the Department 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 the Department and a more efficient utilization review process for health consumers.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL

Ms. Diaz-Lara anticipates that there will be probable costs to persons required to comply with several of the proposed amendments and new sections during each year of the first five years that the rule will be in effect.

The Department has identified three sections in Subchapters R and three 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 three requirements are in proposed §19.1711(c) and §19.2011(c), §19.1712(b) and §19.2012(b)(1)(B), and 19.1720(h)(2)(A) and §19.2020(h)(2)(A).

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 proposed requirements in §19.1711(c) and §19.2011(c), §19.1712(b) and §19.2012(b)(1)(B), and 19.1720(h)(2)(A) and §19.2020(h)(2)(A), which implement statutory provisions, are not the result of the proposed rules.

The Department has identified 21 requirements of the proposal that may result in compliance costs for entities subject to Subchapter R and/or Subchapter U including

proposed (i) §19.1704(d) and §19.2004(c); (ii) §19.1704(e) and §19.2004(d); (iii) §19.1705(d) and §19.2005(d); (iv) §19.1705(g) and §19.2005(g); (v) §19.1703(12) and §19.2003(11); (vi) §19.1706(c) and §19.2006(c); (vii) §19.1706(d) and §19.2006(d); (viii) §19.1710(b)(2) and §19.2010(b)(2); (ix) §19.1710(c) and §19.2010(c); (x) §19.1715(b) and §19.2015(b); (xi) §19.1711(b)(3) – (4) and §19.2011(b)(3) – (4); (xii) §19.1711(c)(3) – (4) and §19.2011(c)(3) – (4); (xiii) §19.1712(a) and §19.2012(a); (xiv) §19.1712(b) and §19.2012(b); (xv) §19.1714(a)(12) and §19.2014(a)(12); (xvi) §19.1721(a) and §19.2021(a); (xvii) §19.1719(b) and §19.2019(c); (xviii) §19.1720(c) and §19.2020(c); (xix) §19.1720(e) and §19.2020(e); (xx) §19.1720(h)(1)(D) – (E) and §19.2020(h)(1)(D) – (E); (xxi) §19.1720(h)(2)(D) – (E) and §19.2020(h)(2)(D) – (E). The Department has identified two requirements of the proposal that may result in compliance costs for entities subject only to Subchapter R including proposed §19.1719(a) and §19.1721(b)(3). The Department has identified two proposed requirements that may result in compliance costs for entities subject only to Subchapter U including proposed §19.2013(c) and §19.2016(b)(3). Any other costs to comply with proposed §19.1704 - §19.1724 and proposed §19.2004 - §19.2021 result from the legislative enactment of HB 4290 or are statutory requirements under Chapter 4201 of the Insurance Code and are not a result of the adoption, enforcement, or administration of the proposal.

Repetitive Cost Note Information

There are cost components and analyses that are utilized throughout this Cost Note numerous times. The Department is interested in avoiding unnecessary repetition

in lengthy Cost Notes. Therefore, for purposes of readability and brevity, the Department has included under this part of the Cost Note, the detail for these repetitive cost components and analyses. These cost components and analyses are referenced under the subheading "Repetitive Cost Note Information" in the Cost Note discussions of the individual proposed provisions that require additional compliance costs. The Cost Note has been prepared in accordance with the requirements in the Government Code §2001.024(a)(5), relating to the content of a rule notice, and Chapter 2006, relating to agency actions affecting small businesses.

Wages for a general operations manager in an insurance-related industry. The Department's analysis of the cost for a URA general operations manager to perform required compliance tasks is based on the following factors. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, according to the Texas Workforce Commission, Labor Market and Career Information Department, Occupation & Employment Statistics Estimate Delivery System (hereafter referred to as the Texas Workforce Commission OES Report), available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5242&occcode=11-1021&compare=2. 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.

Wages for an administrative assistant in an insurance-related industry. The Department's analysis of the cost for a URA administrative assistant to perform required

compliance tasks is based on the following factors. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, 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. 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.

Wages for a computer programmer in an insurance-related industry. The Department's analysis of computer programmer costs in this Cost Note is based on the following factors. Computer programmers working in an insurance related industry in Texas earn a median hourly wage of $34.93, 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=15-1021&compare=2. 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.

Printing costs. The Department's analysis of standard printing and paper costs in this Cost Note is based on the following factors. The Department estimates that the cost of printing could range from approximately $.06 to $.08 per page for printing and paper. The Department anticipates that the individual or entity required to comply with a

proposed provision will have the information necessary to determine its individual cost, including 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 and/or be slightly higher if in-house printing is not used.

Mailing costs. The Department's analysis of standard mailing costs in this Cost Note is based on the following factors. According to the United States 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 $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has determined that the cost of a standard business envelope is $0.016. Accordingly, for each additional mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28. The Department anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including 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 when Applicable.

Proposed §19.1704(d) and §19.2004(c): Form No. LHL005 Required Information. Proposed §19.1704(d) and §19.2004(c) set forth the information required in proposed Form No. LHL005 (Utilization Review Agent (URA) Application Form). Although some of the information is required by the Insurance Code §§4201.004, 4201.102, and 4201.104, and 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 proposed §19.1704(d) and §19.2004(c): (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 §19.1710 or §19.1712, or with §19.2010 or §19.2012, as applicable; (iv) written evidence that the applicant is doing business in Texas in accordance 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(c): 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.

The Department 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 upon initial application and initial drafting of requisite policies and procedures and subsequent costs every two years on renewal and policy and procedure updating. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1704(d) or §19.2004(c), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages; (ii) cost of administrative assistant wages; (iii) cost to print new policies, procedures, and additional paperwork; and (iv) cost to mail new documentation.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1704(d) or §19.2004(c), as applicable.

(i) Cost of general operations manager wages. The Department 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. Therefore, the Department estimates, based on the median hourly wage for general operations managers detailed under the subheading "Repetitive Cost Note Information," that the total initial cost will be approximately $269.60. Additionally, the procedures and policies required under proposed

§19.1704(d) or §19.2004(c), as applicable, are also required to be submitted upon renewal of the URA's certification or registration every two years, and therefore the URA's policies and procedures may require review and/or amendments biennially. The Department anticipates that the review and/or amendments will also require a general operations manager's time.

(ii) Cost of administrative assistant wages. The Department anticipates that a URA's administrative assistant will make copies of template letters for notification of determinations made in utilization review, obtaining written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, and obtaining a letter of good standing from the Texas Comptroller of Public Accounts. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that these required tasks will take approximately two hours. The Department therefore estimates that a URA could incur an average cost of administrative staff wages of approximately $37.20. This documentation is also required to be submitted upon renewal of the URA's certification or registration every two years and therefore the URA may incur similar costs biennially.

(iii) Cost to print new policies, procedures, and additional paperwork. The Department anticipates that a URA could incur a cost for 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

accordance with the Texas Business Organizations Code as specified in §19.1704(d) or §19.2004(c), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." This documentation has to be submitted upon renewal of the URA's certification or registration every two years and therefore the URA may incur similar costs biennially.

(iv) Cost to mail new documentation. The Department anticipates that a URA could incur a cost if the URA opts to transmit additional documentation by mail. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information."

Proposed §19.1704(e) and §19.2004(d): Correction of omissions or deficiencies and submission of a request for a waiver. Proposed §19.1704(e) and §19.2004(d) require an applicant to correct omissions or deficiencies in the URA application within 15 working days of the date of the Department's latest notice of such omissions or deficiencies. Under existing rules, an applicant has 30 days to correct omissions or deficiencies. Proposed §19.1704(e) and §19.2004(d) also allow the applicant to request in writing additional time to correct the omissions or deficiencies. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1704(e) or §19.2004(d), as applicable, could vary based upon cost of administrative assistant wages.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1704(e) or §19.2004(d), as applicable.

Cost of administrative assistant wages. The Department 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, the Department does not anticipate that the shorter time period will require any new staff. Alternatively, if an extension of time is requested in writing, the Department anticipates that a URA's administrative assistant will write and submit the request. The Department anticipates that writing and submitting the request could take approximately an hour. The Department therefore estimates, based on the median administrative assistant wage described under the subheading "Repetitive Cost Note Information," that a URA could incur an average one-time cost of administrative staff wages of $18.60 for submitting a written request for additional time. The Department does not anticipate that there will be any additional compliance costs for actually making or submitting the corrections as a result of proposed §19.1704(e) or §19.2004(d), as applicable, because such costs are required under existing rules.

Proposed §19.1705(d) and §19.2005(d): Development of screening criteria. Proposed §19.1705(d) and §19.2005(d) require URAs to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the 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. Currently, certified URAs conducting utilization review for health coverage under workers' compensation coverage and subject to §19.2005(d) 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 proposed §19.2005(d).

Although the proposed rules do not prescribe the specific review criteria and procedures to be used by the URA, the Department has determined that the total estimated cost for a URA to comply with proposed §19.1705(d) or §19.2005(d), as applicable, could vary based upon the following cost components: (i) cost to acquire some additional review criteria in order 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 the 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. The Department cannot, however, 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.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1705(d) or §19.2005(d), as applicable.

Proposed §19.1705(g) and §19.2005(g): Complaint System. Proposed §19.1705(g) requires a URA to develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, their representatives, or health care providers concerning the utilization review. Proposed §19.2005(g) requires a URA to 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. Under the 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 proposed §19.1705(g) and §19.2005(g), the written response must include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department. The Department anticipates that URAs may incur nominal costs associated with including the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department in the written response. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1705(g) or §19.2005(g) could vary based upon the cost of administrative assistant wages.

Though the Department has identified one factor attributable to the costs of compliance with proposed §19.1705(g) or §19.2005(g), as applicable, it is not possible

for the Department to estimate the total amount of cost attributable to compliance with these provisions because there are numerous factors affecting such a total that are not suitable to reliable quantification by the Department, including factors such as the number of complainant responses that will be required for each URA, or are minimal.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1705(d) or §19.2005(d), as applicable.

*Cost of administrative assistant wage*s. The Department anticipates that inclusion of the additional required information in each written response to complainants as specified in proposed §19.1705(g) and §19.2005(g) will likely require a one-time cost of approximately two hours of administrative staff time. The Department 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. The Department anticipates that an administrative assistant will include this additional information, *i.e.,* the Department's address; the Department's toll-free telephone number; and a statement explaining that a complainant is entitled to file a complaint with the Department. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that a URA could incur a one-time cost of approximately $37.20 for administrative staff wages.

Proposed §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c).

Proposed §19.1706(c) and §19.2006(c) prohibit the physician who reviews the appeal from having any disqualifying associations with the physician or doctor who issued the initial adverse determination or the enrollee or injured employee, as applicable, who is requesting the appeal. Being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not constitute a disqualifying association. Proposed §19.1703(12) and §19.2003(11) define "disqualifying association" as any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician or doctor, and the sections also contain a non-exhaustive list of examples of these associations.

Any URA subject to proposed §19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c), 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.

The Department has determined that the total estimated cost for a URA to comply with proposed §19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c), as applicable, could vary based upon 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.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed 19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c), as applicable.

Cost of general operations manager wages. The Department anticipates that a URA's general operations manager will determine whether a disqualifying association exists. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that 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 existing 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 such a physician and the number of physicians available.

Proposed §19.1706(d) and §19.2006(d): Documentation of information on physicians, doctors, and other health care providers. Proposed §19.1706(d) and §19.2006(d) 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 the Department upon filing an original

application or renewal application or upon providing updated information. While some of this information is required under existing rules, the following information is required as a result of both proposed §19.1706(d) and §19.2006(d): (i) name of personnel; and (ii) license number and state of licensure of personnel.

The Department anticipates that URAs may incur minimal costs associated with submitting to the Department the name, license number, and state of licensure of its personnel either employed by or under contract to perform utilization review in accordance with proposed §19.1706(d) or §19.2006(d), as applicable. 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. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1706(d) or §19.2006(d), as applicable, could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to mail new documentation.

Specialty URAs. Proposed §19.1706(d) or §19.2006(d) are not applicable to specialty URAs.

(i) Cost of administrative assistant wages. The Department anticipates that a URA will utilize an administrative assistant on a recurring basis for submitting the requisite information to the Department. The Department anticipates that a URA's administrative assistant will take approximately one hour to obtain the information, prepare it for mailing, and transmit it in accordance with the URA's mailing processes.

Therefore, the Department estimates that a URA could incur an average cost of administrative staff wages of $18.60 per submission of an individual's information.

(ii) Cost to print the information. The Department anticipates that a URA could incur a cost for printing the name, license number, and state of licensure for submission in accordance with §19.1706(d) or §19.2006(d), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department estimates that the additional information will require less than one additional page to print.

(iii) Cost to mail new documentation. The Department anticipates that a URA could incur a cost to submit the name, license number, and state of licensure to the Department in accordance with §19.1706(d) and §19.2006(d). The Department estimates that the requisite documentation will not exceed one page and will therefore result in a mailing cost of $0.28 per submission.

Proposed §19.1710(b)(2) and §19.2010(b)(2): Preauthorization numbers.

Proposed §19.1710(b)(2) and §19.2010(b)(2) require URAs to ensure that preauthorization numbers assigned by URAs, based on the type of service in the preauthorization request, comply with the data and format requirements contained in the standards adopted by the federal 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.

Any URA subject to proposed §19.1710(b)(2) or §19.2010(b)(2), as applicable, that has not already modified its automated system to align with the formats required under the standards adopted by the 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. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1710(b)(2) or §19.2010(b)(2), as applicable, could vary based on the cost of programming to modify the URA's automated system.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1710(b)(2) or §19.2010(b)(2), as applicable.

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. The Department anticipates that a URA could incur a one-time cost for programming necessary for this type of automation project. The Department estimates that an in-house programmer could require approximately 90 hours to complete this automation project. Therefore, the Department estimates that a URA could incur a one-time cost of approximately $3,143.70 for programming costs based on the median hourly wage for a computer programmer detailed under the subheading "Repetitive Cost Note Information."

Proposed §19.1710(c) and §19.2010(c): Notice of adverse determinations made in prospective and concurrent utilization review; Proposed §19.1715(b) and §19.2015(b): Notice of adverse determination for retrospective review. Proposed §19.1710(c) and §19.2010(c) set forth the notice elements that a URA is required to include in the written notification of a prospective or concurrent utilization review adverse determination. Proposed §19.1715(b) and §19.2015(b) set forth the notice elements that a URA is required to include in the written notification of a retrospective utilization review adverse determination. Although some of the information in proposed §19.1710(c) and §19.2010(c) and in proposed §19.1715(b) and §19.2015(b) is required as a result of existing rules and §4201.303 of the Insurance Code, the following information is required as a result of both proposed §19.1710(c) and §19.2010(c) and proposed §19.1715(b) and §19.2015(b): (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and state(s) of licensure of the physician or doctor that made the determination; (iii) a

description of the URA's appeal process; (iv) the date and time the URA offered the opportunity to discuss the adverse determination; and (v) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)).

Additionally, the following information is required in a written notification of a prospective or concurrent utilization review adverse determination issued by a URA conducting utilization review for health care provided under workers' compensation insurance coverage and subject to proposed §19.2010(c) and in the written notification of a retrospective review adverse determination that a URA conducting utilization review for health care provided under workers' compensation coverage and subject to proposed §19.2015(b): for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 (relating to Disability Management).

Although the Department 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 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 the Insurance Code §4201.403. However, it is not possible for the Department 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 the Department, including factors such as the number of written notifications of adverse determinations that are

sent and whether the inclusion of the copy of the Form No. LHL009 would actually result in a request for independent review that would not have otherwise been made.

The Department anticipates that under proposed §19.1710(c) or §19.2010(c), as applicable, and proposed §19.1715(b) or §19.2015(b), as applicable, 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.

The Department has determined that the total estimated cost for a URA to comply with the proposed requirements in §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable, could vary based upon 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; (iv) cost to print additional paperwork and the Form No. LHL009; and (v) cost to mail additional paperwork.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed 19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable.

(i) Cost of general operations manager wages. Because the proposed requirements will likely require development of a new template for the written notification required in proposed §19.1710(c) and §19.2010(c) and for the written notification required in proposed §19.1715(b) and §19.2015(b), the Department 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. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require, on average, approximately one to two hours of a general operations manager's time for the initial drafting to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and will likely require, on average, approximately another one to two hours of a general operations manager's time for the initial drafting to comply with proposed §19.1715(b) or §19.2015(b), as applicable. Therefore, a URA could incur a total initial cost of $67.40 to $134.80 to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and a separate initial cost of $67.40 to $134.80 to comply with proposed §19.1715(b) or §19.2015(b), as applicable. The Department does not anticipate that a general operation manager's time will be otherwise required for the URA to comply with proposed §19.1710(c) or §19.2010(c), as applicable, or with proposed §19.1715(b) or §19.2015(b), as applicable.

(ii) Cost of programming automated fields in the notice. Each notice of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable, and under proposed §19.1715(b) or §19.2015(b), as applicable, will not be identical, but there are certain automated fields that may be created in order to comply more efficiently with the notice requirements. The Department 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 under proposed §19.1710(c) or §19.2010(c), as applicable.

The Department also 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 under proposed §19.1715(b) or §19.2015(b), as applicable. The Department estimates that an in-house programmer could require approximately five to 10 hours to format the notice required under proposed §19.1710(c) or §19.2010(c), as applicable, and another five to 10 hours to format the notice required under proposed §19.1715(b) or §19.2015(b), as applicable. A computer programmer working in an insurance-related industry in Texas earns a median hourly wage of $34.93, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Therefore, the estimated average cost for a URA's in-house programmer time could range from $174.65 to $349.30 per year for compliance with proposed §19.1710(c) or §19.2010(c), as applicable, and an additional $174.65 to $349.30 per year for compliance with proposed §19.1715(b) or §19.2015(b), as applicable. The total annual amount will depend upon the number of hours that a particular URA needs the programmer based upon its unique preferences and existing information technology resources.

A URA's total cost for programming necessary to generate notices as necessary for compliance with proposed §19.1710(c) or §19.2010(c), as applicable, and with proposed §19.1715(b) or §19.2015(b), as applicable, will vary depending on the URA's computer systems and whether the URA uses an in-house or contract programmer. 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 under proposed §19.1710(c) or §19.2010(c), as applicable, and under proposed §19.1715(b) or §19.2015(b), as applicable, requires some additional information that is specific to the individual case, the Department anticipates that a URA will incur a recurring cost of administrative assistant wages to tailor each notification of adverse determination. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that approximately one to two hours will be required for an administrative assistant to tailor each written notification of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable. The Department also anticipates that another approximately one to two hours will be required for an administrative assistant to tailor each written notification of adverse determination under proposed §19.1715(b) or §19.2015(b), as applicable. Therefore, a URA could have recurring administrative assistant cost of $18.60 to §37.20 per written notification of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable, and the same amount per written notification of adverse determination under proposed §19.1715(b) or §19.2015(b), as applicable. 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 additional paperwork and the Form No. LHL009. The Department anticipates that as a result of proposed §19.1710(c) or §19.2010(c), as

applicable, and proposed §19.1715(b) or §19.2015(b), as applicable, a URA could incur a recurring cost for printing the additional required notice elements and a copy of the Form No. LHL009. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Form No. LHL009 contains four pages, but the additional pages necessary for the required notice elements may vary. Therefore, the Department is not able to estimate the required number of pages. In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary based on the number of written notifications of adverse determination issued by each URA.

(v) Cost to mail additional paperwork. The Department anticipates that a URA could incur a recurring cost to mail the additional required notice elements and the copy of Form No. LHL009 to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and with proposed §19.1715(b) or §19.2015(b), as applicable. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Form No. LHL009 contains four pages, but the additional pages necessary for the required notice elements may vary. Therefore, the Department is not able to estimate the required number of pages per notice. In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary

based on the number of written notifications of adverse determination issued by each URA.

Proposed §19.1711(b)(3) and (4) and §19.2011(b)(3) and (4): Documentation of Peer to Peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations. Proposed §19.1711(b)(3) and §19.2011(b)(3) 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. Further, proposed §19.1711(b)(4) and §19.2011(b)(4) require the URA to submit the documentation to the Department or TDI-DWC upon request, as applicable. The Department 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 such documentation to the Department upon request, as required under proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4). The Department has determined that the total estimated cost for a URA to comply with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable, could vary based upon the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to the Department upon request.

Specialty URAs. Proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) are not applicable to specialty URAs.

*(i) Cost of administrative assistant wage*s. The Department 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 the Department upon request in accordance with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that the URA could incur an estimated total cost of $74.40 per week. This estimate, however, could vary depending on how much time is required based upon the particular URA's number of adverse determinations and communications with providers of record. The Department 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 with the requirements of proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable. The Department also anticipates that a URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable. The Department anticipates that approximately five hours annually will be required of a URA's administrative assistant to submit such documentation. The Department, therefore, estimates that the URA could incur an estimated annual cost of $93.00. 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 Department or TDI-DWC requests for the required documentation.

(ii) *Cost to print the required documentation*. The Department anticipates that a URA could incur a cost for printing 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 the Department upon request. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's potential printing costs could vary based upon the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

(iii) *Cost to mail the documentation to the Department upon request*. The Department anticipates that a URA could incur costs to mail the documented communications to the Department upon request. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each submission to the Department of documented discussions with providers of record that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per submission. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost

Note Information," the total cost to the URA to transmit by mail the requisite documentation in accordance with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable, will vary depending on the business practices of the URA, the number of adverse determinations and, consequently, the amount of documentation that is required.

Proposed §19.1711(c)(3) – (4) and §19.2011(c)(3) – (4): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Retrospective Review Adverse Determinations.

Proposed §19.1711(c)(3) and §19.2011(c)(3) require the URA, prior to issuing a retrospective review adverse determination, to maintain certain specified documentation relating to the discussion opportunity provided to the provider of record. The requisite documentation must detail 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 the discussion, if any, took place; and the discussion outcome. Proposed §19.1711(c)(4) and §19.2011(c)(4) require the URA to submit the documentation required by proposed §19.1711(c)(3) and §19.2011(c)(3) to the Department, upon request, and, for URAs subject to §19.2011(c)(4), to TDI-DWC, upon request.

The Department anticipates that URAs may incur costs associated with maintaining the required documentation and submitting it upon request to the Department or TDI-DWC, as applicable. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1711(c)(3) – (4) or

§19.2011(c)(3) – (4), as applicable, could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation upon request.

Specialty URAs. Proposed §19.1711(c)(3) and (4) or §19.2011(c)(3) and (4) are not applicable to specialty URAs.

(i) Cost of administrative assistant wages. The Department anticipates that a URA will incur a weekly recurring cost of administrative assistant wages 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 date and time the discussion, if any, took place; and the discussion outcome, as required under proposed §19.1711(c)(3) or §19.2011(c)(3), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that approximately four hours per week will be required of a URA's administrative assistant to maintain the required documentation, for a recurring weekly fee of $74.40. This estimate, however, could vary depending on how much time is required based upon the particular URA's number of adverse determinations and communications with providers of record. The Department 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 with the requirements of proposed §19.1711(c)(3) or §19.2011(c)(3), as applicable. The

Department also anticipates that a URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with §19.1711(c)(4) or §19.2011(c)(4), as applicable. The Department anticipates that approximately five hours annually will be required of a URA's administrative assistant to submit such documentation, for an annual cost of $93.00. The total annual cost to the URA will vary, however, based on the number of peer-to-peer opportunities that are offered by the URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) Cost to print required documentation. The Department anticipates that a URA could incur a recurring cost for printing the required documentation. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of times the Department or TDI-DWC requests the required documentation.

(iii) Cost to mail required documentation upon request. The Department anticipates that a URA could incur a recurring cost to mail the required documentation. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note

Information," a URA's total annual cost will also vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of Department or TDI-DWC requests for the required documentation.

Proposed §19.1712(a) and §19.2012(a): Written procedures for appeals of prospective or concurrent review adverse determinations. Proposed §19.1712(a) and §19.2012(a) require a URA to maintain and make available a written description of appeal procedures involving an adverse determination that are used by the agent and prescribe the information that the written procedures must include. Although some of the information in §19.1712(a) is required under existing rules or is required by statute, the following new information is required as a result of proposed amendments to §19.1712(a): (i) a statement specifying the time frames 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; (iv) a provision that states that an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed by a letter within three working day of the initial telephonic or electronic notification.

Further, the following new information is also required as a result of proposed §19.1712(a): (i) a provision that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter, and such letter must include all of the requirements of proposed §19.1712(a)(2)(H); and (ii) a provision that

the appeal must be resolved as soon as practical, but, in accordance with the Insurance Code §4201.359, in no case later than 30 days after the date the URA receives the written appeal, as required in existing rules; or, as provided in the proposed amendment, the one-page appeal form from the appealing party.

Proposed §19.2012(a) requires a URA to maintain and make available a written description of appeal procedures involving an adverse determination that are 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 and subject to §19.2012(a): (i) a statement specifying the time frames for filing the appeal; for workers' compensation network coverage, the time frames may not be less than 30 days after the date of issuance of written notification of an adverse determination; (ii) a provision that if the health care provider sets forth in the written request for appeal good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review; (iii) a provision that appeal decisions must be made by a physician who has not previously reviewed the case in accordance with 28 TAC Chapter 180 (relating to Monitoring and Enforcement), the Insurance Code §1305.354 and 28 TAC §10.103; (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 §19.2012(a)(2)(e) – (f).

The Department 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. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1712(a) or §19.2012(a), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages; and (ii) cost of implementation of written procedures, including printing and mailing costs. For URAs subject to §19.2012, the cost of implementation will include the cost of determining whether there is good cause for a specialty reviewer and obtaining review by a specialty health care provider under §19.2012(a)(2)(B) if the URA does not have the applicable specialty reviewer on staff or under contract.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1712(a) or §19.2012(a), as applicable, with the following exceptions: (i) proposed §19.1712(a)(2)(D) or §19.2012(a)(2)(C) requiring that appeal decisions of prospective or concurrent adverse determinations be made by a physician who has not previously reviewed the case; and (ii) proposed §19.1712(a)(2)(E) 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 §19.2012(a)(2)(D) 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. The Department 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. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department 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, for a total initial fee of $269.60 to $674.00.

(ii) Cost of implementation of written procedures, including printing and mailing costs.

(a) Implementation. The Department anticipates that a URA's implementation of the proposed new procedures and requirements will also result in additional costs to the URA. Under proposed §19.1712(a), implementation of the following new procedures may require additional costs: (i) the 30-day time frame for filing the written or oral appeal; (ii) the requirement that appeal decisions must be made by a physician, doctor, or other health care provider who has not previously reviewed

the case; (iii) the requirement that, for an expedited appeal determination, a letter must be provided within three working day of the initial telephonic or electronic notification; (iv) the requirement that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that must contain certain specified elements of information, including a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) and procedures for filing a complaint; and (v) the requirement that the appeal be resolved as soon as practical, but in no case later than 30 days after the date the URA receives the written appeal or one-page appeal form from the appealing party.

Under proposed §19.2012(a), implementation of the following procedures may require additional costs (i) the time frame for filing the appeal; for workers' compensation network coverage, the time frame may not be less than 30 days after the date of issuance of written notification of an adverse determination; (ii) the requirement that if the health care provider sets forth in the written request for appeal good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review; (iii) the requirement that appeal decisions be made by a physician who has not previously reviewed the case; and (iv) the requirement that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that must contain certain specified

elements of information, including a copy of the Form No. LHL009 request for independent review and procedures for filing a complaint;

(b) Printing costs. Implementation of these written procedures may require printing costs for the additional letters or information required under proposed §19.1712(a) or §19.2012(a), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will vary based on the number of letters the URA is required to send under proposed §19.1712(a) or §19.2012(a), as applicable.

(c) Mailing costs. Implementation of these written procedures may also include a recurring cost to mail the required letters. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will vary based on the number of letters the URA is required to send under proposed §19.1712(a) or §19.2012(a), as applicable.

(d) Costs of implementing §19.2012(a)(2)(B). Implementation of §19.2012(a)(2)(B) may include recurring costs for (i) the URA to review the request to determine whether good cause exists for a specialty reviewer; and (ii) obtaining the specialty reviewer. The Department anticipates that a general operations manager

would review the written request for appeal by a specialty reviewer and would make the decision as to whether good cause exists for a specialty reviewer. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this review will likely require on average approximately 15 minutes of a general operations manager's time, for a total recurring fee of $16.85 per request. Additionally, if the URA determines that good cause exists for a specialty reviewer, the URA may need to obtain a specialty reviewer if the URA does not have the applicable specialty reviewer on staff or under contract. The Department estimates that the cost for the specialty reviewer to conduct the review will be comparable to the cost for a physician or doctor, but obtaining such a specialty reviewer may incur costs, which will vary depending on the URA's method of obtaining a specialty reviewer and the number of specialty reviewers available.

(e) Cost factors not quantifiable. It is not possible for the Department 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 the Department. 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.

Proposed §19.1712(b) and §19.2012(b): Written procedures for appeals of retrospective review adverse determinations. Proposed §19.1712(b) or §19.2012(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. The Department anticipates that URAs may incur costs associated with drafting this written description. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1712(b) or §19.2012(b), as applicable, could vary based upon the cost of general operations manager wages necessary for drafting the written description.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1712(b) or §19.2012(b), as applicable, with the following exception: proposed §19.1712(b)(4) or §19.2012(b)(1)(B), as applicable, 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, prior to issuance of a retrospective review 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 or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor respectively.

Cost of general operations manager wages necessary for drafting the written description. The Department 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. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note

Information." The Department anticipates that this drafting will likely require on average approximately 10 hours of a general operations manager's time for the drafting, for a total one-time cost of approximately $674.00.

Proposed §19.1714(a)(12) and §19.2014(a)(12): Retention of records. Proposed §19.1714(a)(12) and §19.2014(a)(12) 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.

The Department 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 Department has determined that the total estimated cost for a URA to comply with proposed §19.1714(a)(12) or §19.2014(a)(12), as applicable, could vary based upon the following cost component: cost of storing the required information for an additional two years.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1714(a)(12) or §19.2014(a)(12), as applicable.

Cost of storing the required information for an additional two years. Although the Department estimates that the cost of storing the required information for an additional two years is nominal, the Department has 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 proposed §19.1714(a)(12) or §19.2014(a)(12), as applicable, will result in significant additional costs or in an alteration of a URA's current record storage system. Each URA, however, that is required to comply with proposed §19.1714(a)(12) or §19.2014(a)(12) has the cost and other available information necessary to determine the URA's individual storage costs to comply. Therefore, each URA has the flexibility to determine the most economical means of complying with the §19.1714(a)(12) or §19.2014(a)(12) requirements.

Proposed §19.1721(a) and §19.2021(a): Notification of independent review of adverse determinations concerning life-threatening conditions. Proposed §19.1721(a)(1)(B) and §19.2021(a)(1)(B) require a URA, at the time of notification of an adverse determination concerning life-threatening conditions, to include a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) for requesting independent review with the notice of the independent review process.

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 Independent Review Organization (IRO)) with the notice of the independent review process. The inclusion of a copy of Form No. LHL009 may facilitate the submission of a request for review by an IRO, thereby increasing the

overall number of requests for review by an IRO. A URA is required to pay for an independent review under the Insurance Code §4201.403, if such review is conducted under Chapter 4201, Subchapter I, of the Insurance Code. Although the Department 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 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 the Insurance Code §4201.403.

It is not possible for the Department 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 by the Department. These factors include the number of written notifications of adverse determinations that are sent and whether the copy of the Form No. LHL009 would actually cause a request for independent review that would not have otherwise been made.

The Department has determined that the total estimated cost for a URA to comply with proposed §19.1721(a) or §19.2021(a), as applicable, could vary based upon the following cost components: (i) cost to print the independent review request form; (ii) cost to mail the independent review request form; and (iii) for URAs subject to §19.2021, cost of the potential increase in life-threatening cases based on the "prudent layperson" standard.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1721(a) or §19.2021(a), as applicable.

(i) *Cost to print independent review request form.* The Department anticipates that a URA could incur a cost for printing Form No. LHL009 to include with the notice of adverse determination, as required by §19.1721(a) or §19.2021(a), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Form No. LHL009 is four pages in length; therefore, the printing cost of the form could range from approximately $.24 to $.32 per form that is included with the notice of adverse determination. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's potential printing costs will also vary depending on the number of notifications of adverse determination that the URA is required to send.

(ii) *Cost to mail independent review request form.* The Department anticipates that URAs may incur costs associated with sending Form No. LHL009. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Because the URA is required to send a notice of adverse determination under existing rules and Form No. LHL009 is only four pages, the Department estimates that any additional mailing cost resulting from this rule proposal would be nominal. In addition to the cost variables identified in the Cost Note

discussion under the subheading "Repetitive Cost Note Information," a URA's potential mailing costs will also vary depending on the number of notifications of adverse determination that the URA is required to send.

(iii) *For URAs subject to §19.2021, potential cost of the increase in life-threatening cases based on the "prudent layperson" standard*. Under proposed §19.2021(a)(1)(C), the injured employee, injured employee's representative, or the injured employee's provider of record is required to 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.

Existing rules do not specify who has to make the determination on whether a case is life-threatening. However, the addition of the "prudent layperson" standard to determine the existence of a life-threatening condition by the injured employee, injured employee's representative, or the injured employee's provider could increase the number of life-threatening cases, and thereby increase the number of requests for independent review for such cases. However, it is not possible for the Department to estimate the amount of costs that a URA would incur as a result of such increases because the factors involved are not reliably quantifiable by the Department. 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 Insurers Only

Proposed §19.1719(b) and §19.2019(c): Responsibility of Insurers to Comply with Registration Filing Requirements. Proposed §19.1719(b) specifies that when an insurer performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the insurer must have a valid registration pursuant to §19.1704 (relating to Certification or Registration of Utilization Review Agents) and must comply with all filing requirements under §19.1704. Proposed §19.2019(c) requires an insurance carrier performing utilization review under Chapter 4201 of the Insurance Code only for coverage for which it is the payor, to have a valid registration pursuant to §19.2004, and comply with all filing requirements under §19.2004. However, an insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health or workers' compensation coverage for which it is the payor.

The Department anticipates that proposed §19.1719(b) or §19.2019(c) could result in costs to comply for insurers that are performing utilization review for health coverage for which it is the payor. The Department anticipates that insurers may incur costs associated with preparing the application for registration and renewal of registration required under §19.1704 or §19.2004, as applicable, printing the application, and submitting it to the Department. These estimated costs will likely be one-time costs upon initial application for registration and initial drafting of requisite policies and subsequent costs every two years on renewal of registration. The Department has determined that the total estimated cost for an insurer to comply with proposed §19.1719(b) or §19.2019(c), as applicable, could vary based upon the

following cost components: (i) cost of general operations manager wages necessary for drafting policies and procedures; (ii) cost of administrative assistant wages for submitting the application for registration or renewal of registration; (iii) cost to print the application required under proposed §19.1704 or §19.2004, as applicable; and (iv) cost to mail the application required under proposed §19.1704 or §19.2004, as applicable.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1719(b) or §19.2019(c), as applicable.

(i) Cost of general operations manager wages necessary for drafting policies and procedures. The Department anticipates that, because the proposed provisions will likely require development of new policies and procedures to meet the application requirements under §19.1704 or §19.2004, as applicable, an insurer's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures for completion of Form No. LHL005 (Utilization Review Agent (URA) Application Form). A general operations manager working for an insurer in Texas earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately eight to ten hours of a general operations manager's time for the initial drafting. Therefore, the URA's total initial cost would range from $539.20 to $674.00. Additionally, Form No. LHL005 must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer's policies and procedures may require review and/or amendments biennially.

The Department anticipates that the review and/or amendments could also require a general operations manager's time.

(ii) Cost of administrative assistant wages for submitting the insurer's application for registration or renewal of registration. The Department anticipates that an insurer's administrative assistant will complete and submit the application Form No. LHL005 for original registration or renewal of registration. An administrative assistant working for an insurer in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that these activities will take approximately two hours. The Department therefore estimates that an insurer could incur an average cost of administrative staff wages of $37.20. Form No. LHL005 must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer may incur similar costs biennially.

(iii) Cost to print the application required under §19.1704 or §19.2004. The Department anticipates that an insurer could incur a cost for printing the application Form No. LHL005 as required under §19.1704 or §19.2004, as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." This application must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer may incur similar costs biennially.

(iv) Cost to mail the application required under §19.1704 or §19.2004. The Department anticipates that an insurer will incur a cost when the insurer mails the application Form No. LHL005 for registration or renewal of registration by mail. For

each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," an insurer's total cost to mail the application will vary depending on the number of pages and the business practices of the insurer. Form No. LHL005 must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer may incur similar costs biennially.

C. Estimated Costs to Specialty URAs Only

Proposed §19.1720(c) and §19.2020(c): Utilization Review Plan. Proposed §19.1720(c) and §19.2020(c) 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 accordance 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).

The Department anticipates that proposed §19.1720(c) or §19.2020(c), as applicable, could result in costs to comply for specialty URAs. The Department estimates that the total cost for a specialty URA to comply with §19.1720(c) or §19.2020(c), as applicable, could vary based upon the following cost component: cost of general operations manager to develop written procedures.

Cost of general operations manager wages to develop written procedures. The Department anticipates that, because the proposed provisions will likely require development of new policies and procedures to meet the requirements under §19.1720(c) or §19.2020(c), as applicable, an insurer's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures. A general operations manager working for an insurer in Texas earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this development of written procedures will likely require on average approximately eight to ten hours of a general operations manager's time for the initial drafting. Therefore, the URA's total initial cost would range from $539.20 to $674.00.

Proposed §19.1720(e) and §19.2020(e): Documentation of physicians, doctors and other health care providers. Proposed §19.1720(e) and §19.2020(e) require the specialty URA to provide to the Department 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.

The Department anticipates that specialty URAs may incur costs associated with submitting the name, number, type, license number and state of licensure, and qualifications of its personnel either employed by or under contract to perform utilization review in accordance with proposed §19.1720(e) or §19.2020(e), as applicable. These estimated costs will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1720(e) or §19.2020(e), as applicable, could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to mail new documentation.

(i) Cost of administrative assistant wages. The Department anticipates that a specialty URA's administrative assistant will likely submit to the Department on a recurring basis the name, number, type, license number and state of licensure, and qualifications of its personnel. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The administrative assistant will need to obtain the information, prepare it for mailing, and transmit it in accordance with the URA's mailing processes. The Department anticipates that these tasks will take approximately one hour. The Department therefore estimates that a URA could incur an average cost of administrative staff wages of $18.60 per submission. The annual costs will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review.

(ii) Cost to print the information. The Department anticipates that a specialty URA could incur a cost for printing the name, number, type, license number and state of licensure, and qualifications for submission in accordance with §19.1720(e) or §19.2020(e). The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's annual costs will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review.

(iii) Cost to mail new documentation. The Department anticipates that a specialty URA could incur a cost to submit the name, number, type, license number and state of licensure, and qualifications to the Department in accordance with §19.1720(e) and §19.2020(e). For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a specialty URA's total cost to transmit documentation by mail will vary depending on the number of pages and the business practices of the specialty URA. The annual costs for submission of documentation will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review.

Proposed §19.1720(h)(1)(D) – (E) and §19.2020(h)(1)(D) – (E): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations.

Proposed new §19.1720(h)(1)(D) and §19.2020(h)(1)(D) 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, proposed new §19.1720(h)(1)(E) and §19.2020(h)(1)(E) require the specialty URA to submit the documentation to the Department or TDI-DWC upon request, as applicable. Under the 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.

The Department anticipates that a specialty URA may incur ongoing weekly costs associated with recording 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 and submitting such documentation to the Department upon request as required under proposed new §19.1720(h)(1)(D) – (E) or proposed new §19.2020(h)(1)(D) – (E), as applicable. The Department has determined

that the total estimated cost for a specialty URA to comply with proposed new §19.1720(h)(1)(D) – (E) or proposed new §19.2020(h)(1)(D) – (E), as applicable, could vary based upon the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to the Department upon request.

*(i) Cost of administrative assistant wage*s. The Department anticipates that a specialty 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 the Department upon request in accordance with proposed new §19.1720(h)(1)(D) – (E) or proposed new §19.2020(h)(1)(D) – (E), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that the specialty URA could incur an estimated total cost of $74.40 per week. This estimate, however, could vary depending on how much time is required based upon the particular specialty URA's number of adverse determinations and communications with providers of record. The Department anticipates that each specialty 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 specialty URA is aware that will impact the specialty URA's total cost to comply with the requirements of proposed new §19.1720(h)(1)(D) – (E) or proposed new §19.2020(h)(1)(D) – (E), as applicable. The Department also anticipates that a specialty URA will incur a recurring cost of

administrative assistant wages to submit the required documentation upon request, in compliance with proposed new §19.1720(h)(1)(E) or proposed new §19.2020(h)(1)(E), as applicable. The Department anticipates that approximately five hours annually will be required of a specialty URA's administrative assistant to submit such documentation. The Department, therefore, estimates that the specialty URA could incur an estimated annual cost of $93.00. The total annual cost to the specialty URA will vary based on the number of peer-to-peer opportunities that are offered by the specialty URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) *Cost to print the required documentation*. The Department anticipates that a specialty URA could incur a cost for printing the required documentation of 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, to submit to the Department upon request. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a specialty URA's potential printing costs could vary based upon the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

(iii) *Cost to mail the documentation to the Department upon request*. The Department anticipates that a specialty URA could incur costs to mail the documented communications to the Department upon request. For each individual mailing that does

not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each submission to the Department of documented discussions with providers of record that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per submission. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," the total cost to the specialty URA to transmit by mail the requisite documentation in accordance with proposed new §19.1720(h)(1)(E) or proposed new §19.2020(h)(1)(E), as applicable, will vary depending on the business practices of the specialty URA, the number of adverse determinations and, consequently, the amount of documentation that is required.

Proposed §19.1720(h)(2)(D) – (E) and §19.2020(h)(2)(D) – (E): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Retrospective Review Adverse Determinations.

Proposed new §19.1720(h)(2)(D) and §19.2020(h)(2)(D) 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. Proposed new §19.1720(h)(2)(E) and §19.2020(h)(2)(E) require the specialty URA to submit the documentation to the Department or TDI-DWC upon request, as applicable.

The Department anticipates that a specialty URA may incur ongoing weekly costs associated with recording 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 and submitting such documentation to the Department upon request as required under proposed new §19.1720(h)(2)(D) – (E) or proposed new §19.2020(h)(2)(D) – (E), as applicable. The Department has determined that the total estimated cost for a specialty URA to comply with proposed new §19.1720(h)(2)(D) – (E) or proposed new §19.2020(h)(2)(D) – (E), as applicable, could vary based upon the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to the Department upon request.

*(i) Cost of administrative assistant wage*s. The Department anticipates that a specialty 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 the Department upon request in accordance with proposed new §19.1720(h)(2)(D) – (E) or proposed new §19.2020(h)(1)(D) – (E), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that the specialty URA could incur an estimated total cost of $74.40 per week. This estimate, however, could vary depending on how much time is required based upon the particular specialty URA's number of adverse determinations and communications with

providers of record. The Department anticipates that each specialty 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 specialty URA is aware that will impact the specialty URA's total cost to comply with the requirements of proposed new §19.1720(h)(2)(D) – (E) or proposed new §19.2020(h)(2)(D) – (E), as applicable. The Department also anticipates that a specialty URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with proposed new §19.1720(h)(2)(E) or proposed new §19.2020(h)(2)(E), as applicable. The Department anticipates that approximately five hours annually will be required of a specialty URA's administrative assistant to submit such documentation. The Department, therefore, estimates that the specialty URA could incur an estimated annual cost of $93.00. The total annual cost to the specialty URA will vary based on the number of peer-to-peer opportunities that are offered by the specialty URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) *Cost to print the required documentation*. The Department anticipates that a specialty URA could incur a cost for printing the required documentation of 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, to submit to the Department upon request. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a

specialty URA's potential printing costs could vary based upon the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

(iii) *Cost to mail the documentation to the Department upon request*. The Department anticipates that a specialty URA could incur costs to mail the documented communications to the Department upon request. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each submission to the Department of documented discussions with providers of record that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per submission. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," the total cost to the specialty URA to transmit by mail the requisite documentation in accordance with proposed new §19.1720(h)(2)(E) or proposed new §19.2020(h)(2)(E), as applicable, will vary depending on the business practices of the specialty URA, the number of adverse determinations and, consequently, the amount of documentation that is required.

II. Estimated Costs for Entities Subject to Additional Subchapter R Requirements that have not been Previously Discussed.

The following provisions may result in compliance costs for URAs and HMO URAs, to comply with Subchapter R:

A. Estimated Costs to URAs, including HMO and insurer URAs, and specialty URAs

Proposed §19.1721(b)(3): Information required to be provided to the assigned independent review organization. Proposed §19.1721(b)(3) requires the URA, after receiving a request for independent review, to provide the assigned IRO copies of documentation. Although some of the documentation is required under existing rules, the following information is required as a result of proposed §19.1721(b)(3): (i) any documents used by the URA in making the determinations to be reviewed by the IRO; (ii) the written notification described by §19.1710 (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review), and §19.1715 (relating to Notice of Determination Made in Retrospective Review); and (iii) any documentation and written information submitted to the health benefit plan in support of the appeal.

The Department has determined that the total estimated cost for a URA to comply with proposed §19.1721(b)(3) could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to mail new documentation.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1721(b)(3).

(i) Cost of administrative assistant wages. The Department anticipates that a URA's administrative assistant will need to assemble, print and submit to the Department on a recurring basis the additional documentation required by proposed

§19.1721(b)(3). An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that the requisite tasks will take approximately one to 10 hours, depending on the amount of documentation required. The Department therefore estimates that a URA could incur an average cost of administrative staff wages of $18.60 to §186.00 per assigned independent review. The annual costs will vary depending on how many independent reviews are assigned.

(ii) Cost to print the information. The Department anticipates that a URA could incur a cost for printing the additional documentation required by proposed §19.1721(b)(3). The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's annual costs will vary depending on how many independent reviews are assigned.

(iii) Cost to mail new documentation. The Department anticipates that a URA could incur a cost to submit the additional documentation required by proposed §19.1721(b)(3). For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total cost to mail the documentation will vary

depending on the number of pages and the business practices of the URA. The annual costs for submission of documentation will vary depending on how many independent reviews are assigned.

B. Estimated Costs to HMOs Only

Proposed §19.1719(a): Responsibility of HMOs to Comply with Registration Filing Requirements. Proposed §19.1719(a)(3) specifies that when an HMO performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the HMO must have a valid registration pursuant to §19.1704 (relating to Certification or Registration of Utilization Review Agents) of Chapter 4201, Subchapter C of the Insurance Code and must comply with all filing requirements under §19.1704. However, an HMO is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health coverage for which it is the payor.

The Department anticipates that proposed §19.1719(a) could result in costs to comply for HMOs that are performing utilization review for health coverage for which it is the payor. The Department anticipates that HMOs may incur costs associated with preparing the application for registration required under §19.1704, printing the application, and submitting it to the Department. These estimated costs will likely be one-time costs upon initial application for registration and initial drafting of requisite policies and similar subsequent costs every two years on renewal of registration. The Department has determined that the total estimated cost for an HMO to comply with proposed §19.1719(a) could vary based upon the following cost components: (i) cost

of general operations manager wages necessary for drafting and updating policies and procedures; (ii) cost of administrative assistant wages for submitting the application for registration or renewal of registration; (iii) cost to print the HMO application for registration or renewal of registration; and (iv) cost to mail the application.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1719(a).

(i) Cost of general operations manager wages necessary for drafting and updating policies and procedures. The Department anticipates that, because the proposed provisions will likely require development of new policies and procedures to meet the application requirements under proposed §19.1719(a), an HMO's general operations manager will do most if not all of the drafting and basic review of these new policies and procedures for completion of Form No. LHL005 (Utilization Review Agent (URA) Application Form). A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately eight to 10 hours of a general operations manager's time for the initial drafting, for a total initial cost ranging from $539.20 to $674.00. Additionally, Form No. LHL005 must be submitted upon renewal of the HMO's registration every two years, and therefore the HMO's policies and procedures may require review and/or amendments biennially. The Department anticipates that the review and/or amendments could also require a general operations

manager's time; the amount of time will vary based on how many changes, if any, are needed to the policies and procedures.

(ii) Cost of administrative assistant wages for submitting the HMO application for registration or renewal of registration. The Department anticipates that an HMO's administrative assistant will complete and submit the application Form No. LHL005 for original registration or renewal of registration. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that these form completion and submission tasks will take approximately two hours. The Department therefore estimates that an HMO could incur an average cost of administrative staff wages of $37.20. Form No. LHL005 must also be submitted upon renewal of the HMO's registration every two years and therefore the HMO may incur similar costs biennially.

(iii) Cost to print the HMO application for registration or renewal of registration. The Department anticipates that an HMO could incur a cost for printing the application Form No. LHL005 to comply with proposed §19.1719(a). The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." This application must be submitted upon renewal of the HMO's registration every two years and therefore the HMO may incur similar costs biennially.

(iv) Cost to mail the HMO application. The Department anticipates that an HMO will incur a cost when the HMO submits the application Form No. LHL005 for

registration or renewal of registration by mail. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each page of the application that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28. However, the total cost to the HMO to mail the application will vary depending on the number of pages and the business practices of the HMO. Form No. LHL005 must be submitted upon renewal of the HMO's registration every two years, and therefore the HMO may incur similar costs biennially.

III. Estimated Costs for Entities Subject to Additional Subchapter U Requirements that have not been Previously Discussed.

The following proposed provision may result in compliance costs for URAs to comply with Subchapter U:

Costs to URAs, including insurer URAs and specialty URAs

Proposed §19.2013(c): Requirement for a written description of procedures for responding to requests for drugs, post-stabilization care and pain management medication under certain circumstances. Proposed §19.2013(c) 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.

The Department has determined that the total estimated one-time cost for a URA to comply with proposed §19.2013(c) could vary based upon the following cost components: (i) cost of general operations manager wages; (ii) cost to print the written description of procedures; (iii) cost to mail the written description of procedures; and (iv) cost to implement the written description of procedures.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.2013(c).

(i) Cost of general operations manager wages. The Department 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. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately 10 hours of a general operations manager's time for a total one-time cost of $674.00.

(ii) Cost to print the written description of procedures. The Department anticipates that a URA could incur a cost for printing the new written description of procedures. The cost of printing could range from approximately $.06 to $.08 per page

for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information."

(iii) Cost to mail the written description of procedures. The Department anticipates that a URA could incur a cost to transmit the written description of procedures by mail, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total cost to mail the written description of procedures will vary depending on the number of pages and the business practices of the URA.

(iv) Cost to implement the written description of procedures. A URA may incur costs to implement the written procedures. However, it is not possible for the Department to estimate the amount of such costs because the relevant factors are not suitable to reliable quantification by the Department. 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.

Proposed §19.2016(b)(3): Summary report. Amendments to proposed §19.2016(b)(3) require additional information to be included in the summary report that the URA must submit to the Department 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 of the notification and appeal process; and (ii) the subject matter of any complaint filed with the URA with required categorization as: (a) administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider); (b) qualifications of URA's personnel; or (c) appeal/complaint process (e.g., treating physician unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal not provided).

The Department anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with submitting the summary report information. The Department has determined that the total estimated cost for a URA to comply with proposed §19.2016(b)(3), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages; and (ii) costs for programming necessary to collect the additional required information.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.2016(b)(3).

(i) Cost of general operations manager wages. The Department 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. A

general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department 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, for a total annual fee of $67.40 to $134.80.

(ii) Costs for programming necessary to collect the additional required information. The Department also anticipates that a URA could incur a one-time cost for programming necessary to collect the additional required information. The Department estimates that an in-house programmer could require approximately five to 10 hours to set up a process to automatically collect the information required under proposed §19.2016(b)(3). A computer programmer working in an insurance-related industry in Texas earns a median hourly wage of $34.93, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Therefore, the estimated average one-time cost for a URA's in-house programmer time could range from $174.65 to $349.30 for compliance with proposed §19.2016(b)(3).

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

Analysis of Economic Impact

In accordance with the Government Code §2006.002(c), the Department has determined that there are several proposed amendments and new sections that may

have an adverse economic impact on URAs, including HMO URAs, insurer URAs, and specialty URAs, that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules.

Economic Impact on URAs, including HMO and insurer URAs; and specialty URAs when applicable.

The Department was unable to obtain information relating to the number of URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has identified 181 certified and 16 registered URAs in the state, including HMO URAs, insurer URAs, and specialty URAs. Of those 181 certified URAs, currently 72 URAs are certified for workers' compensation. Of those 16 registered URAs, currently 4 are registered for workers' compensation.

Economic Impact on HMO URAs and Specialty URAs

The Department has determined that §19.1719(a) may have an adverse economic impact on HMO and specialty URAs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules.

The Department was unable to obtain information relating to the number of HMO URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has identified 19 certified or registered HMO URAs in the state. The Department estimates 1 – 2 of these HMO URAs qualify as a small or micro business.

Economic Impact on Insurer URAs and Specialty URAs

The Department has determined that proposed §19.1719(b) and §19.2019(c) may have an adverse economic impact on insurer URAs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules.

The Department was unable to obtain information relating to the number of insurer URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has identified 17 certified or registered insurer URAs in the state. The Department estimates 1 – 2 of these insurer URAs qualify as a small or micro business.

Economic Impact on Specialty URAs only

The Department has determined that the following sections may have an adverse economic impact on specialty URAs only that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules: (i) proposed §19.1720(c) and §19.2020(c); (ii) proposed §19.1720(e) and (f) and §19.2020(e) and (f); and (iii) proposed §19.1720(h)(1)(C) – (E) and (h)(2)(C) – (E) and proposed §19.2020(h)(1)(C) – (E) and (h)(2)(C) – (E).

The Department was unable to obtain information relating to the number of specialty URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has 20 specialty URAs in the state, all of which are certified.

Regulatory Flexibility Analysis

As previously indicated, the Department has identified 21 provisions of the proposal that may result in compliance costs for entities subject to Subchapter R and/or Subchapter U, including proposed (i) §19.1704(d) and §19.2004(c); (ii) §19.1704(e) and §19.2004(d); (iii) §19.1705(d) and §19.2005(d); (iv) §19.1705(g) and §19.2005(g); (v) §19.1703(12) and §19.2003(11); (vi) §19.1706(c) and §19.2006(c); (vii) §19.1706(d) and §19.2006(d); (viii) §19.1710(b)(2) and §19.2010(b)(2); (ix) §19.1710(c) and §19.2010(c); (x) §19.1715(b) and §19.2015(b); (xi) §19.1711(b)(3) – (4) and §19.2011(b)(3) – (4); (xii) §19.1711(c)(3) – (4) and §19.2011(c)(3) – (4); (xiii) §19.1712(a) and §19.2012(a); (xiv) §19.1712(b) and §19.2012(b); (xv) §19.1714(a)(12) and §19.2014(a)(12); (xvi) §19.1721(a) and §19.2021(a); (xvii) §19.1719(b) and §19.2019(c); (xviii) §19.1720(c) and §19.2020(c); (xix) §19.1720(e) and §19.2020(e); (xx) §19.1720(h)(1)(D) – (E) and §19.2020(h)(1)(D) – (E); (xxi) §19.1720(h)(2)(D) – (E) and §19.2020(h)(2)(D) – (E); two provisions of the proposal that may result in compliance costs for entities subject only to Subchapter R, including proposed §19.1719(a) and §19.1721(b)(3) and two provisions of the proposal that may result in compliance costs for entities subject only to Subchapter U, including proposed §19.2013(c) and §19.2016(b)(3).

The cost of compliance with these proposed requirements will not vary between large businesses and small or micro-businesses; therefore, the Department'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.

Pursuant to the Government Code §2006.002(c), for each of these proposed requirements, the Department has 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 the 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 and/or Subchapter U

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

Proposed §19.1704(d) and §19.2004(c): Form No. LHL005 Required Information.

The Department considered, as a regulatory alternative, exempting small and micro business URAs from the non-statutory requirements under proposed §19.1704(d) and §19.2004(c).

The Department has determined, however, this exemption would not accomplish the objectives of proposed §19.1704(d) and §19.2004(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state, for the following reasons: (a) the exemption is inconsistent with legislative intent; (b) the exemption could result in some consumers receiving fewer health care services; and (c) the requirement will have a minimal economic impact. Additionally, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1704(d) and §19.2004(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic

impact on these small and micro businesses that will have to comply with these requirements.

(a) Exemption is inconsistent with legislative intent.

The Senate Committee on State Affairs Bill Analysis for HB 4290 specifies the legislative intent of HB 4290. According to this analysis, the legislative intent of HB 4290 is to ensure that carriers have consistent standards for what is considered experimental and investigational. TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Substituted), C.S.H.B. 4290, 81st Leg., R.S. (May 12, 2009). Exempting small or micro business URAs from the non-statutory requirements of proposed §19.1704(b) and §19.2004(c), however, would not allow the Department 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.

(b) Exemption could result in some consumers receiving less health care services.

Requiring all URAs to follow the submission of information requirements under proposed §19.1704(d) and §19.2004(c) for a certification or registration and for renewal of a certification or registration as a URA is important and necessary to protect the health and economic welfare of consumers. Absent these requirements, the Department's ability to oversee URAs would be diminished, and this diminished oversight could potentially 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 proposed §19.1704(d)(1)(A), an applicant is required to 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 is also required in proposed §19.1704(d)(1)(A) to submit the availability of personnel to handle consumer complaints. Proposed §19.1704(d)(2)(H) requires applicants and URAs to submit 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 in 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 the Department for a certification or registration or for renewal of a certification or registration under proposed §19.1704(d) or §19.2004(c) as a URA promotes confidence in the URA's decisions. For example, under proposed §19.1704(d)(1)(B), 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 the

Department pursuant to proposed §19.1704(d) and §19.2004(c) could be subject to a lesser quality of review. Further, under proposed §19.1704(d)(2), a URA must submit written policies to the Department 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 proposed §19.1704(d) or §19.2004(c) eliminates the possibility that the Department would have to create a dual tracking system for certifications, registrations, and renewals based on URA business size. Therefore, the Department determined that requiring uniform applicant information and qualifications for certification or registration and renewal of certification or registration under proposed §19.1704(d) and §19.2004(c) is necessary to protect the health and economic welfare of Texas consumers.

(c) The requirement will have a minimal economic impact. While compliance with the proposed application requirements in §19.1704(d) and §19.2004(c) may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact for the following reasons. The Department 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 are currently required to submit. This similarity will reduce the amount of time and effort needed to prepare and submit the new application, especially for renewal applications.

Additionally, it is anticipated that any additional costs will be minimal because the URA will already have some of the information available that the Department requires under proposed §19.1704(d). For example, under proposed §19.1704(d)(6)(A) and proposed §19.2004(c)(5)(A), applicants must submit written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code. This evidence may include a letter from the Texas 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 they would be subject at the time of formation to existing Texas statutory business formation requirements and fees.

Department's determination. Therefore, based on the prior discussion of the potential substantial adverse impact on Texas consumers, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1704(d) and §19.2004(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that no alternative methods can

accomplish the objectives of proposed §19.1704(d) or §19.2004(c) and protect the health and economic welfare of Texas consumers.

Proposed §19.1704(e) and §19.2004(d): Correction of omissions or deficiencies and submission of a request for a waiver. The Department considered the following regulatory alternatives for those proposed amendments to §19.1704(e) and §19.2004(d) 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 are required to submit to the Department for a waiver under proposed §19.1704(e) and §19.2004(d); and (iii) permitting small and micro business URAs to apply for a waiver electronically. However, the Department has determined that such options would not accomplish the objectives of proposed §19.1704(e) and §19.2004(d) 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.

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

Additionally, there is a cost saving mechanism proposed as part of §19.1704(e) and §19.2004(d) that is available to small and micro business URAs. If a small or micro-business URA is unable to comply with the time limits prescribed in §19.1704(e) and §19.2004(d) for correction of errors or deficiencies in the application, the proposed rule enables such a URA to apply for a waiver of the time limits. The Department has 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 are required to submit to the Department for a waiver under proposed §19.1704(e) and §19.2004(d).

The Department considered reducing the information that a URA is required to submit to the Department 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, therefore, the Department 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 the Department is nominal.

(iii) Permitting small and micro business URAs to apply for a waiver electronically.

The Department considered alternatives that could assist small or micro-business URAs in obtaining waivers, such as allowing small or micro-business URAs to seek waivers through electronic applications. However, the Department concluded that such 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 Chief Clerk procedures and not to add additional expense to the state in creating new electronic processes. 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 cost on the Department for minimal savings to small or micro-business URAs.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1704(e) and §19.2004(d) are nominal, and the adverse impact that would result for Texas consumers of small and micro business URAs far outweighs any economic impact on small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods of accomplishing the objectives of proposed §19.1704(e) or §19.2004(d) protect the health and economic welfare of Texas consumers.

Proposed §19.1705(d) and §19.2005(d): Development of screening criteria.

The Department considered the following regulatory alternatives for those proposed amendments to §19.1705(d) and §19.2005(d) that are not statutory

requirements: exempting small and micro business URAs from the requirements under proposed §19.1705(d) and §19.2005(d).

The Department has determined that this option would not accomplish the objectives of proposed §19.1705(d) and §19.2005(d) 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) set the parameters for screening criteria, which will provide for more uniform and evidence-based utilization review for enrollees and injured employees; (b) promote valid and sound decisions when credible and scientific guidelines are utilized; (c) promote confidence in the URA's decisions because the URA can support and substantiate its decisions; and (d) 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 the Department 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 therefore would receive potentially lower quality health

care than those utilizing the larger URAs that are required to comply with the screening criteria requirements.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1705(d) and §19.2005(d) are nominal, and the adverse impact that would result for Texas consumers of small and micro business URAs far outweighs any economic impact on small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods of accomplishing the objectives of proposed §19.1705(d) or §19.2005(d) that would protect the health and economic welfare of Texas consumers, as required under the Government Code §2006.002(c-1).

Proposed §19.1705(g) and §19.2005(g): Complaint System.

The Department considered the following regulatory alternative to the proposed amendments to §19.1705(g) and §19.2005(g): exempting small and micro business URAs from the requirement to include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department in the written response.

The Department, however, determined that such an exemption would not accomplish the objectives of proposed §19.1705(g) and §19.2005(g) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (a) the information is useful and should be available to all enrollees or injured employees whose health care has been subject to utilization review; and (b) any

adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers.

(a) The information is useful and should be available to all enrollees or injured employees whose health care has been subject to utilization review. Providing the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department 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 the Department 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 the Department in monitoring URAs and ensuring utilization review decisions are being made in accordance with the Insurance Code Chapter 4201 and Department rules.

(b) 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(g) and §19.2005(g) may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact for the following reasons. The Department anticipates that only a minimal amount of additional time and work will be required to include the minimal

additional information, *i.e.*, the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department, because under the Insurance Code §4201.204, the complaints procedure must already include a written response to the complainant by the URA within 30 calendar days.

Department's determination. The Department has determined that the costs for small and micro businesses to comply with proposed §19.1705(g) and §19.2005(g) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods to accomplish the objectives of proposed §19.1705(g) or §19.2005(g) that would also protect the health and economic welfare of Texas consumers, as required under the Government Code §2006.002(c-1).

Proposed §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c): Disqualifying associations.

The Department considered the following regulatory alternative to proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c): exempting small and micro business URAs from the requirements under proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c).

The Department has determined, however, that this exemption would not accomplish the objectives of proposed new §19.1703(12) and §19.1706(c) and

§19.2003(11) and §19.2006(c) 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 proposed new prohibition is to prevent the physician who reviews the appeal from being improperly influenced by a relationship that he or she has with the physician or doctor who issued the initial adverse determination or 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 the Department 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.

Department's determination. The Department has determined that the costs for small and micro businesses to comply with proposed new §19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined based on the preceding analysis that no alternative methods can accomplish the objectives of

proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c) that would also protect the health and economic welfare of Texas consumers, as required under the Government Code §2006.002(c-1).

Proposed §19.1706(d) and §19.2006(d): Documentation of information on physicians, doctors, and other health care providers. The Department considered the following regulatory alternative for those proposed amendments to §19.1706(d) and §19.2006(d) that are not statutory requirements: exempting small and micro business URAs from the requirement to provide the name, license number, and state of licensure of personnel to the Department under proposed §19.1706(d) and §19.2006(d).

Exempting small and micro business URAs from the proposed requirement to provide the name, license number, and state of licensure of personnel.

The Department, however, has determined that such an exemption would not accomplish the objectives of proposed §19.1706(d) and §19.2006(d) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption could result in some consumers receiving a lesser quality of utilization review; and (b) the requirement will have a minimal economic impact.

(a) 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 under proposed §19.1706(d) and §19.2006(d) provides the Department 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 the Department's ability to monitor whether proper

personnel are performing utilization review, and therefore could foster a situation in which a URA could more easily utilize unqualified personnel. The use of unqualified personnel for utilization review could, in turn, result in a lesser quality of utilization review for those consumers who utilize the small or micro business URAs. 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.

(b) The requirement will have a minimal economic impact. While compliance with the proposed requirements in §19.1706(d) and §19.2006(d) may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact since URAs are already required to *collect* such information when credentialing their personnel.

Department's determination. The Department has determined that the costs for small and micro businesses to comply with proposed §19.1706(d) and §19.2006(d) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods to accomplish the

objectives of proposed §19.1706(d) or §19.2006(d) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1710(b)(2) and §19.2010(b)(2): Preauthorization numbers.

The Department considered the following regulatory alternative to the proposed amendments to §19.1710(b)(2) and §19.2010(b)(2): exempting small and micro business URAs from the requirements under proposed §19.1710(b)(2) and §19.2010(b)(2).

However, the Department has determined that such exemption would not accomplish the objectives of proposed §19.1710(b)(2) and §19.2010(b)(2) 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 the Department 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.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1710(b)(2) and §19.2010(b)(2) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that no alternative methods can accomplish the objectives of proposed §19.1710(b)(2) and §19.2010(b)(2) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1710(c) and §19.2010(c): Notice of adverse determinations made in prospective and concurrent utilization review; Proposed §19.1715(b) and §19.2015(b): Notice of adverse determination for retrospective review.

The Department considered the following regulatory alternative for those proposed amendments to §§19.1710(c), 19.2010(c), 19.1715(b), and 19.2015(b) that are not statutory requirements: exempting small and micro business URAs from the requirement to provide the additional requisite information under proposed §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §§19.1710(c), 19.2010(c), 19.1715(b), and 19.2015(b), and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) 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 (b) any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers.

(a) 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. The Department has determined that these additional notice elements are necessary for the enrollee or injured employee when receiving notice of the adverse determination. The first additional notice element is important for the enrollee or injured employee to understand what evidence or documentation can be submitted to possibly obtain a different determination. Additional information on the physician or doctor who made the adverse determination is for the enrollee's or injured employee's reference. Information on the date and time the URA offered the opportunity to discuss the adverse determination is also useful, because the enrollee or injured employee may not have been aware of when this opportunity was offered to the provider of record. Information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the enrollee or injured employee of his or her additional options following an adverse determination. For injured employees receiving notice of an adverse determination under §19.2010(c) or §19.2015(c), a description of the source of the screening criteria or guidelines will also inform the 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 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.

(b) Any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers. The Department anticipates that the required compliance will have a minimal adverse economic impact since URAs are already required under existing rules and under §4201.303 of the Insurance Code to mail a notice of adverse determination, and §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable only require additional notice elements.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable, are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1710(c) or §19.2010(c) and §19.1715(b) or §19.2015(b), that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1711(b)(3) and (4) and §19.2011(b)(3) and (4), and §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4): Documentation of Peer-to-Peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations and Prior to Issuing Retrospective Review Adverse Determinations.

Because of the similarity in the requirements 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, the Department, considered for the proposed amendments to §19.1711(b)(3) and (4) and §19.2011(b)(3) and (4) and for the proposed amendments to §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), the following regulatory alternative: exempting small and micro business URAs from some or all of the proposed documentation, maintenance, and response requirements.

The Department has determined, however, that such 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: (a) the total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement; and (b) the costs to comply with the proposed requirements are nominal.

(a) The total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement. The Insurance Code §4201.206 requires a URA to provide a peer-to-peer discussion opportunity prior to issuing an adverse determination. Under the 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 the Department or TDI-DWC to monitor each URA's compliance with the §4201.206 statutory requirement. If the Department is unable to monitor a small or micro business 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 URA. Such enrollees or injured employees could be potentially deprived of a favorable determination for needed health care.

(b) The cost to comply with the proposed requirements are nominal. While compliance with the proposed requirements in §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) and in proposed §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Under the proposed requirements, the URA is required to put in writing the actions that are required under the 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 upon request. The Department 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 URAs, including small or micro business URAs.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) and with proposed §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods to accomplish the objectives of proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) and proposed §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1712(a) and §19.2012(a): Written procedures for appeals of prospective or concurrent review adverse determinations.

The Department considered exempting small and micro business URAs from the requirements to develop and implement additional written procedures under proposed §19.1712(a) and §19.2012(a).

The Department, however, has determined that such an exemption would not accomplish the objectives of proposed §19.1712(a) and §19.2012(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 time frames 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 written requirement to ensure peer-to-peer discussions are necessary to implement the Insurance Code §4201.206. 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 Independent Review Organization (IRO)), and procedures for filing a complaint in accordance with the Insurance Code §4201.204. All of these required procedures and information are essential to fully inform consumers and ensure that consumers are able to receiving necessary health care. If small or micro business URAs were exempt from proposed §19.1712(a) or §19.2012(a), 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.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro

business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that no alternative method can accomplish the objectives of proposed §19.1712(a) or §19.2012(a) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1712(b) and §19.2012(b): Written procedures for appeals of retrospective review adverse determinations.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the proposed §19.1712(b) and §19.2012(b) requirements.

The Department has determined, however, that such 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: (a) the exemption would result in inconsistent URA written appeal procedures; and (b) the requirement will have a minimal adverse economic impact.

(a) 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 under §19.1712(b)(1) that appeal procedures be in accordance 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. The requirement under §19.1712(b)(2) and §19.2012(b) that the appeal must comply with §19.1715 and

§19.2015, respectively, is important in order 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. The written requirement to ensure peer-to-peer discussions under §19.1712(b)(3) and §19.2012(b)(1)(B) implements the Insurance Code §4201.206. Under §19.2015(b)(2) and (3), additional references to the Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133 are necessary to incorporate other statutes and rules that govern the appeal process.

The Department 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.

(b) The requirement will have a minimal adverse economic impact. The Department 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, the Department

has determined that any additional cost to incorporate into the written procedures the requirement in proposed §19.1712(b)(3) or §19.2012(b)(1)(B), as applicable, will be minimal. The only costs incurred will be to draft the written procedures; the underlying requirements should already be implemented pursuant to the Insurance Code Chapter 1305 and §4201.206, 28 TAC Chapter 10; Chapter 21, Subchapter T; and Chapter 133; and §19.1715 and §19.2015.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1712(b) or §19.2012(b) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined based on the preceding reasons that there are no alternative methods that can accomplish the objectives of proposed §19.1712(b) or §19.2012(b) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1714(a)(12) and §19.2014(a)(12): Retention of records.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirement to store the required information for four years under proposed §19.1714(a)(12) and §19.2014(a)(12).

The Department has determined, however, that this exemption would not accomplish the objectives of proposed §19.1714(a)(12) and §19.2014(a)(12) 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.

As previously discussed in the Introduction, the proposed amendment to change the storage period from two years to four years allows sufficient time for the Department to examine the information. The Department 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 the Department has the opportunity to review such information. Because this information is generated and obtained by a URA in the course of utilization review, it is valuable for the Department's monitoring purposes to ensure that enrollees or injured employees are afforded utilization review that is conducted in accordance with the Texas Insurance Code and applicable rules. If the URA is not required to store records for a long enough time period to ensure the Department's access to the information, it renders the Department's examinations less effective, possibly resulting in a lesser quality of utilization review for enrollees or injured employees.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1714(a)(12) or §19.2014(a)(12) and would also protect the health and economic welfare of Texas consumers.

Proposed §19.1721(a) and §19.2021(a): Notification of independent review of adverse determinations concerning life-threatening conditions.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirements to include a copy of Form No. LHL009 under proposed §19.1721(a) and §19.2021(a) and to use the "prudent layperson" standard under proposed §19.2021(a).

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.1721(a) and §19.2021(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (a) the exemption would result in some enrollees and injured employees not receiving a copy of Form No. LHL009; (b) the exemption could result in inconsistent standards between §19.1721 and §19.2021 regarding the "prudent layperson" standard; and (c) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in some enrollees and injured employees not receiving a copy of Form No. LHL009. Including a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (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, pursuant to the Insurance Code §4201.360. In the event of such a life threatening condition, it is important that all enrollees and injured employees, including those who utilize small and micro business URAs, receive a copy of the request-for-IRO-review form as provided in proposed

§19.1721(a) and §19.2021(a). The receipt of the form could significantly 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.

(b) The exemption could result in inconsistent standards for enrollees under §19.1721 and injured employees under §19.2021 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. Proposed §19.2021(a) incorporates 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 §19.1721 or §19.2021 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 proposed §19.2021 "prudent layperson" standard for

injured employees would result in significant disparate consumer protections for these injured employees compared to those injured employees who utilize large URAs.

(c) The requirement will have a minimal adverse economic impact. The Department anticipates that the required compliance will have a minimal adverse economic impact. The URA is already required under the Insurance Code §4201.301 to send a notice of adverse determination, so the addition of a copy of the IRO form will incur 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 under proposed §19.2021(a), it is possible that in many cases this standard was already being used. However, for those small and micro business URAs that are not currently utilizing the "prudent layperson" standard, the Department is of the opinion that not requiring these small and micro businesses to use the standard will not result in cost savings so significant that the benefit of these potential cost savings outweigh the need for patients utilizing these URAs to be deprived of immediate appeal to an IRO in the event of a life threatening condition on the basis of this standard.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1721(a) or §19.2021(a) are likely to be nominal, but in the event that the "prudent layperson" standard, does result in additional costs, the potential adverse health and economic welfare impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that

there are no alternative methods can accomplish the objectives of proposed §19.1721(a) or §19.2021(a) and protect the health and economic welfare of Texas consumers.

B. Estimated Costs to Insurers Only.

Proposed §19.1719(b) and §19.2019(c): Responsibility of Insurers to Comply with Registration Filing Requirements. The Department considered the following regulatory alternative: exempting small and micro business insurer URAs from the requirements under proposed §19.1719(b) or §19.2019(c) to have a valid registration and to comply with all the filing requirements under §19.1704 or §19.2004, respectively.

The Department has determined, however, that this exemption would not accomplish the objectives of proposed §19.1719(b) or §19.2019(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption would result in the Department's inability to monitor certain insurer URAs; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in the Department's inability to monitor certain insurer URAs. The registration and filing requirements under proposed §19.1719(b) or §19.2019(c) provide the Department with information on insurer URAs that are conducting utilization review only for coverage for which they are the payors. This information allows the Department to monitor such insurer URAs. Exempting small or micro business insurer URAs from the requirements under proposed §19.1719(b) or §19.2019(c) would prevent the Department from even knowing whether these insurer

URAs are conducting utilization review. Enrollees and injured employees could then be subject to utilization review that is not monitored by the Department.

(b) The requirement will have a minimal adverse economic impact. While compliance with the proposed application requirements in §19.1719(b) or §19.2019(c) may have an adverse economic impact on small or micro business insurer URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Although the insurer URA will incur costs to register and comply with filing requirements, an insurer URA is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health or workers' compensation coverage for which it is the payor.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1719(b) or §19.2019(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1719(b) or §19.2019(c) and would also protect the health and economic welfare of Texas consumers.

C. Estimated Costs to Specialty URAs Only.

Proposed §19.1720(c) and §19.2020(c): Utilization Review Plan.

The Department considered the following regulatory alternative: exempting small and micro business specialty URAs from the requirements under proposed §19.1720(c) and §19.2020(c) to develop written procedures.

The Department has determined that this exemption would not accomplish the objectives of proposed §19.1720(c) and §19.2020(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because 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 under proposed §19.1720(c) and §19.2020(c) is intended to ensure that the existing §19.1720(c) and §19.2020(c) requirements are implemented. Without the requirement that the procedures be in writing, it is impossible for the procedures to be made available to consumers for informational purposes or to the Department for regulatory purposes. Therefore, it is important for the enrollees and injured employees of small and micro business URAs to have the same consumer protections that will accrue to the enrollees and injured employees of large URAs as a result of these proposed requirements. Exempting small or micro business specialty URAs from the requirement 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. Enrollees and injured employees utilizing small or

micro business specialty URAs are entitled to the same quality of utilization review as enrollees and injured employees of large URAs.

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

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1720(c) and §19.2020(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1720(c) and §19.2020(c) and would also protect the health and economic welfare of Texas consumers

Proposed §19.1720(e) and §19.2020(e): Documentation of physicians, doctors and other health care providers.

The Department considered the following regulatory alternative for those proposed amendments to §19.1720(e) and §19.2020(e) that are not statutory requirements: exempting small and micro business specialty URAs from the proposed requirement to provide the name, number, type, license number, and state of licensure of personnel to the Department under proposed §19.1720(e) and §19.2020(e).

The Department has determined that this exemption would not accomplish the objectives of proposed §19.1720(e) and §19.2020(e) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption could result in some consumers receiving a lesser quality of utilization review; and (b) the requirement will have a minimal economic impact.

(a) The exemption could result in some consumers receiving a lesser quality of utilization review. The requirement to provide the name, number, type, license number, and state of licensure of personnel under proposed §19.1720(e) and §19.2020(e) provides the Department 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 prevent the Department from monitoring whether proper personnel are performing utilization review and use of unqualified personnel for utilization review could, in turn, result in a lesser quality of utilization review for those consumers who utilize the small or micro business URAs. But all consumers are entitled to utilization review by qualified personnel, including those enrollees and injured employees using small and micro business URAs.

(b) The requirement will have a minimal economic impact. While compliance with the proposed requirements in §19.1720(e) and §19.2020(e) may have an adverse economic impact on small or micro business specialty URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact since specialty URAs are already required to *collect* such information when credentialing their personnel.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1720(e) and §19.2020(e) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1720(e) and §19.2020(e) and protect the health and economic welfare of Texas consumers.

Proposed §19.1720(h)(1)(D) – (E) and §19.2020(h)(1)(D) – (E), and §19.1720(h)(2)(D) – (E) and §19.2020(h)(2)(D) – (E): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations and Prior to Issuing Retrospective Review Adverse Determinations. Because of the similarity in the requirements in the potential compliance costs for small and micro business specialty URAs, and in the potential impact on the health and economic welfare of enrollees and injured employees, the Department, pursuant to the Government Code §2006.002(c), considered for the proposed amendments to §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and for the proposed amendments to §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), the following regulatory alternative: exempting small and micro business specialty URAs from some or all of the proposed documentation, maintenance, and response requirements.

The Department has determined that such a total or partial 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: (a) the total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement; and (b) the costs to comply with the proposed requirements are nominal.

(a) The total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement. Under the 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 the Department or TDI-DWC to monitor each specialty URA's compliance with the §4201.456 statutory requirement. If the Department 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. Such enrollees or injured employees could be potentially deprived of a favorable determination for needed health care.

(b) The cost to comply with the proposed requirements are nominal. While compliance with the proposed requirements in §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and proposed new §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), may have an adverse economic impact on small or micro business specialty URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Under the proposed requirements, the specialty URA is required to put in writing the actions that are required under the Insurance Code §4201.456 to maintain this written documentation, and to provide it upon request. The Department 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.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed new §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and with proposed new §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), are nominal, and the adverse impact that would 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. Thus, the Department has

determined that there are no alternative methods that can accomplish the objectives of proposed new §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and proposed new §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), and protect the health and economic welfare of Texas consumers.

II. Estimated Costs for Entities Subject to Additional Subchapter R Requirements that have not been Previously Discussed.

A. Estimated Costs to URAs, including HMO and insurer URAs and specialty URAs.

Proposed §19.1721(b)(3): Information required to be provided to the assigned independent review organization.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirements under proposed §19.1721(b)(3) to provide the assigned IRO copies of the additional requisite documentation.

The Department has determined that this exemption would not accomplish the objectives of proposed §19.1721(b)(3) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption would result in the IRO not receiving as much information; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in the IRO not receiving as much information. The Department has determined that the additional documentation requirements are necessary to ensure that the IRO has sufficient information to conduct a thorough and accurate independent review. The purpose of the IRO independent

review is to review a URA adverse determination relating to health care requested by the enrollee who received the adverse determination. The independent review process provides the enrollee an opportunity for the request to be reviewed by an IRO, which could possibly overturn the adverse determination at issue. Exempting small or micro business URAs from providing any copies of the documents required in proposed §19.1721(b)(3) may result in the IRO making an incorrect determination or, at least, a different determination than it would have made with complete information. This additional required information is intended to provide the IRO with important information needed for a thorough and accurate independent review. Therefore, an enrollee using a URA that is not subject to these requirements will be more likely to receive an IRO determination that is based on insufficient information. Potentially, this lack of sufficient information could adversely affect the independent review decision, potentially resulting in lack of access to medically necessary and appropriate health care for an enrollee using a small or micro business URA. Enrollees are entitled to medically necessary and appropriate health care regardless of the size of the URA being used by the enrollee.

(b) The requirement will have a minimal adverse economic impact. The cost that will be incurred by the small and micro business URAs as a result of these requirements are primarily administrative assistant wages, copying and mailing costs. As detailed in the Public Benefit/Cost Note part of this proposal, the Department anticipates that these costs will be nominal. The URA is already required under existing §19.1721 to provide documentation to the IRO. Proposed §19.1721(b)(3) adds only a few additional required documents, which the URA can submit along with the existing

required documentation. However, if in some instances, the cost is higher than the Department anticipates, the Department is of the opinion that the consumer protection afforded to the enrollees of these small or micro business URAs is of greater importance than any potential adverse economic impact on the small or micro business URA.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1721(b)(3) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1721(b)(3) and protect the health and economic welfare of Texas consumers.

B. Estimated Costs to HMOs Only.

Proposed §19.1719(a): Responsibility of HMOs to Comply with Registration Filing Requirements.

The Department considered the following regulatory alternative: exempting small and micro business HMO URAs from the requirements under proposed §19.1719(a) to have a valid registration and to comply with all the filing requirements under §19.1704.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.1719(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a)

the exemption would result in the Department's inability to monitor certain HMO URAs; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in the Department's inability to monitor certain HMO URAs. The registration and filing requirements under proposed §19.1719(a) provide the Department with information on HMO URAs that are conducting utilization review only for coverage for which they are the payors. This information allows the Department to monitor such HMO URAs. Exempting small or micro business HMO URAs from the requirements under proposed §19.1719(a) would prevent the Department from even knowing whether these HMO URAs are conducting utilization review. Enrollees could then be subject to utilization review that is not monitored by the Department.

(b) The requirement will have a minimal adverse economic impact. While compliance with the proposed application requirements in §19.1719(a) may have an adverse economic impact on small or micro business HMO URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Although the HMO URA will incur costs to register and comply with filing requirements, an HMO URA is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health compensation coverage for which it is the payor.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1719(a) are nominal, and the adverse impact that would result for Texas consumers of these small

and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1719(a) and protect the health and economic welfare of Texas consumers.

III. Estimated Costs for Entities Subject to Additional Subchapter U Requirements That Have Not Been Previously Discussed.

Costs to URAs, including insurer URAs and specialty URAs.

Proposed §19.2013(c): Requirement for a written description of procedures for responding to requests for drugs, post-stabilization care and pain management medication under certain circumstances.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirements under proposed §19.2013(c) to provide a written description setting forth the requisite procedures.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.2013(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) these procedures are important to ensure access to injured employees to certain drugs and post-stabilization care and pain management medication; and (b) these procedures complement existing rules.

(a) These procedures are important to ensure access to injured employees to certain drugs and post-stabilization care and pain management medication.

The requirement under proposed §19.2013(c) 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.

(b) 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 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. The Department has determined that injured employees who use small or micro business URAs are entitled to the same consumer protective health and economic welfare benefits that are provided in these requirements to injured employees who utilize large URAs. The Department has therefore determined that these requirements which 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.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of

proposed §19.2013(c) and protect the health and economic welfare of Texas consumers.

Proposed §19.2016(b)(3): Summary report.

The Department considered the following regulatory alternative to the proposed amendments to §19.2016(b)(3): exempting small and micro business URAs from the requirements to provide the additional information in the summary report.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.2016(b)(3) 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 the Department to monitor how many appeals result in a favorable outcome to the injured employee. If these statistics indicate an unusually high number of appeals resulting in favor of the original utilization review determination, the Department may follow-up with the URA to determine whether the appeals procedures are compliant with the Insurance Code and applicable rules. This 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 the Department 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 to §19.2016(b)(3), small and micro business URAs would not be subject to the same level of monitoring by the Department. This lack of information from small and micro business URAs could result in the Department's inability to properly monitor and enforce the provisions of the Insurance Code 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.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.2016(b)(3) and protect the health and economic welfare of Texas consumers.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence

of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 6, 2011 to Gene C. Jarmon, General Counsel and Chief Clerk, 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, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, 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 amendments and new sections in a public hearing under Docket No. 2727 scheduled for September 13, 2011, at 9:30 am 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.

7. STATUTORY AUTHORITY. The amendments and new sections to both Subchapters R and U are proposed pursuant to the 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 the Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority). Additionally, the Subchapter U amendments and new sections are also proposed pursuant to the 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), 402.061 (Adoption of Rules), and 402.072 (Sanctions); 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); 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 accordance with applicable law.

The 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 the 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 addresses 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 and 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 time frames 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 the 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 must 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 Chapter 2001, Government Code. Under §4201.603, the Commissioner of Insurance may impose remedies and penalties for violations of Chapter 4201 which include 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.

The Insurance Code §38.001 provides, in relevant part, that the Department 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 the Department considers necessary for the public good or for the proper discharge of the Department's duties.

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

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

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

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

The 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.

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

The 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.

The 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."

The 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 the Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

The 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 the 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.

The 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 the Labor Code Title 5.

The 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.

The Labor Code §402.072(a) provides that the TDI-DWC may impose sanctions against any person regulated by the TDI-DWC.

The Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who perform health care services under the 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. The Labor Code §408.0043(b) requires that a person described by the 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.

The Labor Code §408.0044 pertains to dentists who perform dental services under the Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. The 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.

The Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under the 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. The 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.

The 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 such 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.

The 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.

The 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.

The Labor Code §408.0231(g) requires the Commissioner of Workers' Compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers, including standards for peer review and imposition of sanctions against 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 of Workers' Compensation.

The Labor Code §413.011 requires the Commissioner of Workers' Compensation by rule to establish medical policies and guidelines relating to necessary treatment for

injuries and designed to ensure the quality of medical care and to achieve effective medical cost control.

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

The 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.

The 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.

The 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) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations.

The 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.

The 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.

The 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.

The 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.

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

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§19.1701	Insurance Code Chapter 4201
§19.1702	Insurance Code Chapter 4201, Subchapter B; Insurance Code §4201.051
§19.1703	Insurance Code §§843.002(14), 1305.004(13) - (14), 4201.002(4) – (8), (10), and (16), 4201.153, 4201.451, and Chapter 4151; Labor Code §§401.011(17), 401.011(20), and 413.014(a);

	Government Code §662.003(a) and Chapter 552
§19.1704	Insurance Code Chapter 4201, Subchapter C; Insurance Code §§4201.004, 4201.057(e), 4201.058(c), 4201.103, and 4201.104
§19.1705	Insurance Code Chapter 4201, Subchapter D; Insurance Code §§1369.056, 4201.151, 4201.153, 4201.204, 4201.251, 4201.452, 4201.453, and 4201.556
§19.1706	Insurance Code §§1352.004, 4201.152, 4201.252, 4201.253, and 4201.452 – 4201.454
§19.1707	Insurance Code §§4201.155, 4201.201, and 4201.452
§19.1708	Insurance Code §§4201.203, 4201.205, 4201.207, and 4201.452
§19.1709	Insurance Code §4201.202 and §4201.452
§19.1710	Insurance Code §§1352.006, 4201.301 – 4201.304, 4201.452, and 4201.552
§19.1711	Insurance Code §§4201.002(13), 4201.206, 4201.452, and 4201.456
§19.1712	Insurance Code §§1352.006, 4201.002(13), 4201.204, 4201.206, 4201.303(a)(3), 4201.352 – 4201.360, and 4201.452
§19.1713	Insurance Code §4201.004 and §4201.452
§19.1714	Insurance Code §§4201.452 and 4201.551 – 4201.558
§19.1715	Insurance Code §§1352.006, 4201.203, 4201.301, 4201.303, 4201.305, and 4201.452
§19.1716	Insurance Code §§38.001, 4201.107, 4201.204, 4201.452, and

	4201.601
§19.1717	Insurance Code §§4201.452 and 4201.601 – 4201.603
§19.1719	Insurance Code §§4201.053, 4201.057, 4201.058, 4201.452, and Chapter 257
§19.1720	Insurance Code §§4201.002(13), 4201.104, 4201.107, 4201.356(b), and 4201.452 – 4201.457
§19.1721	Insurance Code §§4201.002, 4201.304, 4201.352, 4201.360, 4201.401 – 4201.403, and 4201.452; Government Code §662.003(a)
§19.1723	Insurance Code §§843.308, 1301.135, and 4201.304
§19.1724	Insurance Code §843.347 and §1301.133
§19.2001	Insurance Code Chapters 1305 and 4201; Labor Code Title 5
§19.2002	Insurance Code §4201.051 and §4201.054(a) and (c); Labor Code Title 5
§19.2003	Insurance Code §§1305.002, 1305.004, 4201.002, 4201.153, 4201.451; Insurance Code Chapters 4151 and 4201; Labor Code §401.011 and §413.014(a); Government Code §662.003(a) and Chapter 552
§19.2004	Insurance Code §§4201.004, 4201.058(c), 4201.101, 4201.103, 4201.104, 4201.204; Insurance Code Chapter 1305; Insurance Code Chapter 4201, Subchapter C and Subchapter H; Labor Code Chapter 504

§19.2005	Insurance Code Chapter 4201, Subchapter D; Insurance Code §§4201.151, 4201.153, 4201.204, 4201.251, 4201.452, 4201.453, and 4201.556; Labor Code Title 5, §§401.011(22-a), 408.0043, 408.0044, and 408.0045
§19.2006	Insurance Code §§1305.351, 4201.152, 4201.252, 4201.253, and 4201.452 – 4201.454; Labor Code §408.0231(g) and §408.023(h)
§19.2007	Insurance Code §§4201.054(c), 4201.201, and 4201.452
§19.2008	Insurance Code §§4201.203, 4201.205, 4201.207, and 4201.452
§19.2009	Insurance Code §4201.202 and §4201.452
§19.2010	Insurance Code Chapter 4201, Subchapter G; Insurance Code §§1305.353, 4201.002, 4201.206, 4201.301 – 303, 4201.452, and 4201.552
§19.2011	Insurance Code §4201.206 and §4201.452
§19.2012	Insurance Code §§1305.003, 1305.354, 4201.002, 4201.054, 4201.204, 4201.206, 4201.303(a)(1) and (a)(3), 4201.352 – 4201.360, and 4201.452; Labor Code §413.014
§19.2013	Insurance Code §§1305.004(a)(13), 4201.004 and 4201.452
§19.2014	Insurance Code §4201.452 and §§4201.551 – 4201.558; Government Code Chapter 552
§19.2015	Insurance Code §§1305.003(b), 4201.054, 4201.301, 4201.303, 4201.305, and 4201.452
§19.2016	Insurance Code §§38.001, 4201.107, 4201.108, 4201.204 and

	4201.452; Labor Code §§402.00128, 413.052, 413.0511, and 413.0512
§19.2017	Insurance Code §§4201.452 and 4201.601 – 4201.603; Labor Code Chapter 415
§19.2019	Insurance Code Chapter 4201, Subchapter C; Insurance Code §4201.058 and §4201.452
§19.2020	Insurance Code §§1305.351, 4201.002, 4201.104, 4201.107, 4201.054, and 4201.452 – 4201.457; Labor Code §§408.0043, 408.0044, 408.0045, and 408.023(h)
§19.2021	Insurance Code §§1305.003(b), 1305.353, 4201.002, 4201.054, 4201.304, 4201.352, 4201.360, and 4201.452; Government Code §662.003(a)

9. TEXT.

SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY [~~REVIEW AGENTS~~]
28 TAC §§19.1701 – 19.1717, 19.1719 – 19.1721, 19.1723, and 19.1724

§19.1701. General Provisions.

(a) Statutory Basis [~~basis~~]. This subchapter implements the provisions of the Insurance Code Chapter 4201 which was amended by Acts 2009, 81st Legislature, Chapter 1330, which was effective September 1, 2009, but applies only to a health

benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010[~~, Article 21.58A, which was added by Acts 1991, 72nd Legislature, Chapter 242, §11.03(a), which was effective September 1, 1991, but applies only to utilization reviews conducted on or after June 1, 1992~~].

(b) Severability. If [~~Where any terms or sections of this subchapter are determined by~~] 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 [~~to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining terms and provisions of this subchapter shall remain in~~] 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 [~~these rules~~] is to:

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

(2) assure that utilization review agents adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and utilization review agents;

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

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

(d) Workers' Compensation Utilization Review. For utilization review performed under workers' compensation insurance coverage, the provisions of Subchapter U of this chapter (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage) apply in lieu of the provisions in this subchapter.

§19.1702. Limitations on Applicability.

(a) Except as provided in the Insurance Code Chapter 4201, this subchapter applies to utilization review performed under a health benefit plan or a health insurance policy. [~~noted in §19.1719 of this title (relating to Responsibility of HMOs and Insurers Performing Utilization Review under the Insurance Code Article 21.58A, §14(g) and (h)), all utilization review agents performing utilization reviews of services provided or proposed to be provided to an individual within the state on or after June 1, 1992, regardless of where the utilization review activities are physically based, must comply with this subchapter. All regulations in this subchapter shall relate to persons or entities subject to this subchapter.~~]

[~~(b) Insurers and HMOs are not required to obtain a certificate of registration, but must comply with §19.1719 of this title.~~]

(b) [~~(c)~~] This subchapter does not apply to [~~a utilization review agent or other person which conducts only the functions of categories of utilization review listed in paragraphs (1) - (3) of this subsection:~~]

[~~(1)~~] a person that [~~who~~] provides information to enrollees, their representatives, or their physicians, doctors, or other health care providers about scope of coverage or benefits [~~provided under a health insurance policy or health benefit plan~~] and that [~~who~~] does not determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. [~~whether particular health care services provided or to be provided to an enrollee are medically necessary or appropriate;~~]

[~~(2) a person, as defined in §19.1703 of this title (relating to Definitions), performing utilization review who is employed by, or under contract to, a certified utilization review agency;~~]

[~~(3) a utilization review agency which conducts only the categories of utilization review listed in subparagraphs (A) - (E) of this paragraph:~~]

[~~(A) reviews performed pursuant to any contract with the federal government for utilization review of patients eligible for services under Title XVIII or XIX of the Social Security Act (42 United States Code §§1395 et seq. or §§1396 et seq.);~~]

[~~(B) reviews performed for the Texas Medicaid Program, except reviews performed by a health maintenance organization that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code; the Chronically Ill and Disabled Children's Services Program created pursuant to Chapter 35, Health and Safety Code, any program administered under Title 2, the Human Resources Code, any program of~~

~~the Texas Department of Mental Health and Mental Retardation, or any program of the Texas Department of Criminal Justice;~~]

[~~(C) reviews of health care services provided to patients under the authority of the Texas Workers' Compensation Act (Texas Civil Statutes, §8308-1.01 et seq.);~~]

[~~(D) reviews of health care services provided under a policy or contract of automobile insurance promulgated by the department under the Insurance Code, Subchapter A, Chapter 5 or issued pursuant to the Insurance Code, Article 1.14; or~~]

[~~(E) reviews that apply to the terms and benefits of the employee welfare benefit plans as defined in §3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).~~]

§19.1703. Definitions. The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

[~~(1) Act--Insurance Code Article 21.58A, entitled "Health Care Utilization Review Agents."~~]

[~~(2) Administrative Procedure Act--Government Code, Chapter 2001.~~]

(1) [~~(3)~~] Administrator--A person holding a certificate of authority under the Insurance Code Chapter 4151 [~~Article 21.07-6~~].

(2) [~~(4)~~] Adverse determination--A determination by a utilization review agent made on behalf of any payor that the health care services provided [~~furnished~~] or

proposed to be provided [~~furnished~~] to an enrollee [~~a patient~~] are not medically necessary or [~~not~~] appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the lack of prospective or concurrent utilization review.

(3) [~~(5)~~] Appeal [~~process~~]--The utilization review agent's formal process in [~~by~~] which an enrollee, an individual acting on behalf of the enrollee, or the provider of record may request reconsideration of an [~~a utilization review agent offers a mechanism to address~~] adverse determination [~~determinations~~].

(4) [~~(6)~~] Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a utilization review agent in the State of Texas. A certificate is not issued to an insurance carrier or health maintenance organization that is registered as a utilization review agent under §19.1704 of this subchapter (relating to Certification or Registration of Utilization Review Agents). [~~A certificate of registration granted by the commissioner to a utilization review agent.~~]

(5) [~~(7)~~] Commissioner--The commissioner of insurance.

(6) [~~(8)~~] Complaint--An oral or written expression of dissatisfaction with a utilization review agent concerning the utilization review agent's process in conducting a utilization review. The term "complaint" does not include: [~~A complaint is not~~]

(A) an expression of dissatisfaction with a specific adverse determination; 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 [~~enrollee~~].

(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) [~~(9)~~] Declination--A response to a request for verification in which an HMO or preferred provider benefit plan [~~carrier~~] 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.

[~~(10) Department--Texas Department of Insurance.~~]

(9) [~~(11)~~] Dental plan--An insurance policy or health benefit plan, including a policy written by a company subject to the Insurance Code Chapters 842 and 843 [~~Chapter 20~~], that provides coverage for expenses for dental services.

(10) [~~(12)~~] Dentist--A licensed doctor of dentistry, holding either a D.D.S. or a D.M.D. degree.

(11) Department--Texas Department of Insurance.

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

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and 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 the physician's or doctor's practice;

(D) personal or family relationships; or

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

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

(14) [~~(13)~~] Emergency care--Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the enrollee's [~~patient's~~] health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

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

(15) [~~(14)~~] Enrollee--An individual [~~A person~~] covered by a health insurance policy or health benefit plan. This term includes an individual [~~a person~~] who is covered as an eligible dependent of another individual [~~person~~].

(16) Experimental or investigational--A 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.

(17) [~~(15)~~] Health benefit plan--A plan of benefits, other than a health insurance policy, that:

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

(B) is offered or provided by a public or private [~~any~~] organization[~~, public or private, other than health insurance~~].

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

(19) [~~(16)~~] Health care provider-- A [~~Any~~] person, corporation, facility, or institution that is:

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

(B) [~~that is~~] eligible for independent reimbursement for those health care services.

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

(21) [~~(17)~~] Health insurance policy--An insurance policy, including a policy written by a corporation [~~company~~] subject to the Insurance Code Chapter 842 [~~20,~~] that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

[~~(18) Inquiry--A request for information or assistance from a utilization review agent.~~]

(22) Health maintenance organization or HMO--A health maintenance organization as defined in the Insurance Code §843.002.

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

(24) Legal Holiday--A national holiday as defined in the Government Code §662.003(a).

(25) [~~(19)~~] Life-threatening--A disease or condition from [~~for~~] which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(26) 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 enrollee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(27) Medical records--The entire history of diagnosis and treatment, including but not limited to medical, mental health records as allowed by law, dental, and other health care records from all disciplines rendering care to an enrollee.

(28) [~~(20)~~] Mental health medical record summary--A summary of process or progress notes relevant to understanding the enrollee's [~~patient's~~] need for treatment of a mental or emotional condition or disorder such as:

(A) identifying information; and

(B) a treatment plan that includes:

(i) diagnosis;

(ii) treatment intervention;

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

(iv) discharge plan.

(29) [~~(21)~~] Mental health therapist--Any of the following individuals [~~persons~~] 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 [~~a person~~] licensed by the Texas Medical [~~State~~] Board [~~of Medical Examiners~~] to practice medicine in this state;

(B) an individual [~~a person~~] licensed as a psychologist by the Texas State Board of Examiners of Psychologists;

(C) an individual [~~a person~~] licensed as a psychological associate by the Texas State Board of Examiners of Psychologists;

(D) an individual [~~a person~~] licensed as a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(E) an individual [~~a person~~] licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(F) an individual [~~a person~~] licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

[~~(G) a person licensed as a chemical dependency counselor by the Texas Commission on Alcohol and Drug Abuse;~~]

(G) [~~(H)~~] an individual [~~a person~~] licensed as an advanced clinical practitioner by the Texas State Board of Social Worker Examiners;

(H) [~~(I)~~] an individual [~~a person~~] licensed as a master social worker by the Texas State Board of Social Worker Examiners;

(I) [~~(J)~~] an individual [~~a person~~] licensed as a social worker by the Texas State Board of Social Worker Examiners;

(J) [~~(K)~~] an individual [~~a person~~] licensed as a physician assistant by the Texas Medical [~~State~~] Board [~~of Physician Assistant Examiners~~];

(K) [~~(L)~~] an individual [~~a person~~] licensed as a registered professional nurse by the Texas Board of Nursing [~~Nurse Examiners~~];

(L) [~~(M)~~] an individual [~~a person~~] licensed as a vocational nurse by the Texas Board of Nursing; or [~~Vocational Nurse Examiners~~];

(M) [~~(N)~~] any other individual [~~person~~] 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.

(30) [~~(22)~~] Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current [~~revision of the~~] Diagnostic and Statistical Manual of Mental Disorders.

(31) [~~(23)~~] Nurse--A registered or professional nurse, a licensed vocational nurse, or a licensed practical nurse.

[~~(24) Open records law -- Government Code Chapter 552.~~]

[~~(25) Patient -- An enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance plan.~~]

(32) [~~(26)~~] Payor--[~~An~~]

(A) an insurer that writes [~~writing~~] health insurance policies;

(B) a [~~any~~] preferred provider organization, health maintenance organization, or self-insurance plan; or

(C) any other person or entity that [~~which~~] provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to an

individual [~~persons~~] treated by a health care provider in this state under a [~~pursuant to any~~] policy, plan, or contract.

(33) Peer Review--An administrative review performed at the insurance carrier's request. For purposes of this subchapter, the term does not include a review performed by an independent review organization under the Insurance Code Chapter 4202.

(34) [~~(27)~~] Person--An individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(35) [~~(28)~~] Physician--A licensed doctor of medicine or a licensed doctor of osteopathy.

(36) [~~(29)~~] Preauthorization--A form of prospective utilization review by a payor or its utilization review agent of [~~determination by an HMO or preferred provider carrier that medical care or~~] health care services proposed to be provided to an enrollee [~~are medically necessary and appropriate~~].

(37) [~~(30)~~] Preferred Provider--

(A) with regard to a preferred provider benefit plan [~~carrier~~], a preferred provider as defined by the Insurance Code Chapter 1301 [~~Article 3.70-3C, §1(10) (Preferred Provider Benefit Plans) or Article 3.70-3C, §1(1) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(B) with regard to an HMO:[~~,~~]

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

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

(38) [~~(31)~~] Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care[~~, treatment, and~~] services rendered or requested on behalf of [~~to~~] the enrollee or the physician, doctor or other health care provider that has rendered or has been requested [~~is requesting or proposing~~] to provide the health care[~~, treatment and~~] services to the enrollee. [~~and~~] This definition includes any health care facility where health care services are [~~when treatment is~~] rendered on an inpatient or outpatient basis.

(39) Registration--The process for a licensed insurance carrier or health maintenance organization to register with the department to perform utilization review solely for its own insureds or enrollees.

(40) [~~(32)~~] Retrospective utilization review--A form of utilization review for [~~system in which review of the medical necessity and appropriateness of~~] health care services that have been provided to an enrollee [~~is performed for the first time subsequent to the completion of such health care services~~]. Retrospective utilization review does not include [~~subsequent~~] review of services for which prospective or concurrent utilization reviews [~~for medical necessity and appropriateness~~] were previously conducted or should have been previously conducted.

(41) [~~(33)~~] 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.

(42) [~~(34)~~] Screening criteria--The written policies, decision rules, medical protocols, or guides used by the utilization review agent as part of the utilization review process (e.g., appropriateness evaluation protocol (AEP) and intensity of service, severity of illness, discharge, and appropriateness screens (ISD-A)).

(43) [~~(35)~~] Single health care service plan--A single health care service plan as defined by the Insurance Code §843.002(26) [~~Section 843.002(26)~~].

(44) Specialty utilization review agent--A utilization review agent that conducts utilization review for a specialty health care service under the Insurance Code Chapter 4201 including, but not limited to, dental services, chiropractic services, behavioral health services, vision services, or physical therapy services.

(45) [~~(36)~~] Utilization review--A system for prospective, [~~or~~] 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 [~~being provided or proposed to be provided to an individual within the state~~]. Utilization review does [~~shall~~] not include elective requests for clarification of coverage.

(46) [~~(37)~~] Utilization review agent--An entity that conducts utilization review[~~,~~] for:

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

(B) a payor;[,] or

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

(47) [(38)] Utilization review plan--The screening criteria and utilization review procedures of a utilization review agent.

(48) [(39)] Verification--A guarantee by an HMO or preferred provider benefit plan [carrier] that the HMO or preferred provider benefit plan [carrier] will pay for proposed medical care or health care services if the services are rendered within the required time frame [timeframe] to the enrollee [patient] 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 [carrier] to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §19.1724(d) of this subchapter [title] (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

(49) [(40)] Working day--Any day, Monday – Friday, other than a national holiday as defined by the Government Code §662.003(a) and the Friday after Thanksgiving Day, December 24 and December 26. Use in this subchapter of the term "day," rather than "working day," means a calendar day. [A weekday, excluding New

~~Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.~~]

§19.1704. Certification or Registration of Utilization Review Agents.

(a) Applicability of Certification or Registration Requirements. A person acting as or holding itself out as a utilization review agent must be certified or registered under the Insurance Code Chapter 4201 and this subchapter and must comply with all requirements in this section.

(1) Pursuant to §19.1719(a)(2) and (b)(3) of this subchapter (relating to Responsibility of HMOs and Insurers Performing Utilization Review), if an HMO or insurer, respectively, performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such HMO or insurer must have a valid certificate pursuant to the Insurance Code §4201.101 and this section.

(2) Pursuant to §19.1719(a)(3) and (b)(4) of this subchapter, if an HMO or insurer, respectively, performs utilization review only for coverage for which it is the payor, the HMO or insurer must have a valid registration pursuant to this section.

(b) Application Form. The commissioner adopts by reference Form No. LHL005 (Utilization Review Agent (URA) Application) to be used for application for a certification or registration and for renewal of a certification or registration as a utilization review agent in this state.

(c) Application Filing Requirements.

(1) Application for certification.

(A) [~~(a)~~] An application for certification of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in subsection (b) of this section.

(B) The application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19) of this chapter (relating to Amount of Fees).

(2) Application for registration.

(A) An application for registration of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in subsection (b) of this section.

(B) The original application fee requirement specified by §19.802(b)(19) of this chapter does not apply to an applicant for registration.

(3) Where to Obtain and File the Application Form. Form No. LHL005 may be obtained from and must be filed with the department [~~Texas Department of Insurance~~] at the following address: Texas Department of Insurance, Health and Workers' Compensation Network Certification & QA (HWCN) Division, Mail Code 103-6A, [~~108-6A,~~] P.O. Box 149104, Austin, Texas 78714-9104.

[~~(b) The application must be submitted on a form which can be obtained from the Utilization Review Section, Mail Code 108-6A, Texas Department of Insurance, 333 Guadalupe, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(d) Required Information. Form No. LHL005 (Utilization Review Agent (URA) Application Form) requires

[~~(c) The attachments to the application form require~~] the following information:

(1) a summary description of the utilization review plan, which must include the matters listed in subparagraphs (A) and (B) of this paragraph and otherwise comply with[~~. The utilization review plan must meet~~] the requirements of §19.1705 of this subchapter [~~title~~] (relating to General Standards of Utilization Review):

(A) an adequate summary description of screening criteria and review procedures to be used to determine medical necessity or [~~and~~] appropriateness, or the experimental or investigational nature, of health care; and

(B) a certification, signed by an authorized representative of the applicant [~~company~~] that screening criteria and review procedures to be applied in review determination are established with input from appropriate health care providers and approved by physicians;

(2) utilization review plan written policies that evidence compliance with:

(A) §19.1705 of this subchapter;

(B) §19.1706 of this subchapter (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.1707 of this subchapter (relating to Prohibition of Certain Activities and Procedures Related to Health Care Providers and Enrollees);

(D) §19.1708 of this subchapter (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers);

(E) §19.1709 of this subchapter (relating to On-Site Review by the Utilization Review Agent);

(F) §19.1710 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review);

(G) §19.1711 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination);

(H) §19.1712 of this subchapter (relating to Appeal of Adverse Determination);

(I) §19.1713 of this subchapter (relating to Utilization Review Agent's Telephone Access);

(J) §19.1714 of this subchapter (relating to Confidentiality);

(K) §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review);

(L) §19.1716 of this subchapter (relating to Regulatory Requirements Subsequent to Certification or Registration);

(M) §19.1720 of this subchapter (relating to Specialty Utilization Review Agent), if applicable;

(N) §19.1721 of this subchapter (relating to Independent Review of Adverse Determinations);

(O) §19.1723 of this subchapter (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans), if applicable; and

(P) §19.1724 of this subchapter (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans) if applicable;

(3) copies of template letters for notification of determinations made in utilization review that comply with §19.1710 and §19.1712 of this subchapter;

(4) organizational information:

(A) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state;

(B) a chart showing the internal organizational structure of the applicant's executives, officers, and directors and title of position held by each; and

(C) letter of good standing from the Texas Comptroller of Public Accounts;

(5) the name and biographical affidavit and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under §1.503 of this title (relating to Application of Fingerprint Requirement) and §1.504 of this title (relating to Fingerprint Requirement); and

~~[(2) copies of procedures established for appeal of an adverse determination. These procedures must comply with the provisions of §19.1712 of this title (relating to Adverse Determinations of Utilization Review Agents);]~~

~~[(3) copies of procedures established for handling oral or written complaints by enrollees, patients, or health care providers. These procedures must comply with §19.1716 of this title (relating to Complaints and Information);]~~

[~~(4) copies of policies and procedures which ensure that all applicable state and federal laws to protect the confidentiality of medical records are followed. These procedures must comply with §19.1714 of this title (relating to Confidentiality);~~]

(6) [~~(5)~~] a certification signed by an authorized representative of the company that the utilization review agent will comply with the provisions of Chapter 4201 of the Insurance Code. [~~the Act;~~]

[~~(6) a description of the categories of persons and names of the personnel employed or contracted to perform utilization review;~~]

[~~(7) a description of the hours of operation within the State of Texas and how the utilization review agent may be contacted during weekends and holidays. This description must be in compliance with §19.1713 of this title (relating to Utilization Review Agent's Telephone Access);~~]

[~~(8) representative samples of all materials provided by the utilization review agent/applicant to inform its clients, enrollees or providers of the requirements of the utilization review plan. Samples shall include language for notification of an adverse determination made in a utilization review;~~]

[~~(9) a description of the basis by which the utilization review agent compensates its employees or agents to ensure compliance with paragraph (10) of this subsection;~~]

[~~(10) a certification signed by an authorized representative that the utilization review agent shall not permit or provide compensation or anything of value to its employees or agents, condition employment or its employee or agent evaluations, or~~

~~set its employee or agent performance standards, based on the amount or volume of adverse determinations, reductions or limitations on lengths of stay, benefits, services, or charges or on the number or frequency of telephone calls or other contacts with health care providers or patients, which are inconsistent with the provisions of this subchapter;~~]

[~~(11) the organizational information, documents and all amendments, including:~~]

[~~(A) the bylaws, rules and regulations, or any similar document regulating the conduct of the internal affairs of the applicant with a notarized certification bearing the original signature of an officer or authorized representative of the applicant that they are true, accurate, and complete copies of the originals;~~]

[~~(B) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;~~]

[~~(C) a chart showing the internal organizational structure of the applicant's management and administrative staff; and~~]

[~~(D) a chart showing contractual arrangements of the utilization review agent.~~]

[~~(12) the name and biographical information for each director, officer and executive of the applicant.~~]

[~~(d) The utilization review agent shall report any material changes in the information in the application or renewal form referred to in this section, not later than the 30th day after the date on which the change takes effect. Material changes include,~~

~~but are not limited to, new personnel hired who are officers and directors who perform utilization review; changes in the organizational structure; changes in contractual relationships and changes in the utilization review plan.~~]

(e) Original Application Requirements and Process. Paragraphs [~~The application process is described in paragraphs~~] (1) - (4) [~~(6)~~] of this subsection specify the requirements and process for entities that are applying for a certification or registration.

(1) Within [~~The department shall have~~] 60 days after receipt of a complete [~~an~~] application, the department will [~~to~~] process the application and [~~to~~] certify or register the entity or deny certification or registration [~~it~~]. The department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered. The department will [~~shall~~] give the applicant written notice of any omissions or deficiencies noted as a result of the review conducted pursuant to this paragraph.

(2) The applicant must correct the omissions or deficiencies in the application within 15 working [~~30~~] days of the date of the department's latest notice of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(3) The applicant may waive any of the time limits described in this subsection, except the requirement in paragraph (2) of this subsection. However, before the end of the 15 working days specified in paragraph (2) of this subsection, the [~~The~~] applicant may request in writing additional time to correct the noted omissions or deficiencies in the application. The request for the additional time must be approved by

the department in writing for the requested extension to be effective [~~waive the time limit in paragraph (2) of this subsection, only with the consent of the department~~].

(4) The department will [~~shall~~] maintain a charter [~~an application~~] file which must [~~shall~~] contain the approved application documents, notices of omissions or deficiencies, and requests for additional time and responses from the applicant [~~and any written materials generated by any person that was considered by the department in evaluating the application~~].

(f) Renewal Requirements. Paragraphs (1) - (4) of this subsection specify the requirements for entities that are renewing a certification or registration.

(1) Two-year renewal. A utilization review agent must apply for renewal of certification or registration [~~the certificate of registration~~] every two years from the date of certification or registration by submitting Form No. LHL005 (Utilization Review Agent (URA) Application Form). For an application for renewal of a certification, a utilization review agent must also submit a renewal fee in the amount specified by §19.802(b)(19) of this chapter. [~~A renewal form must be used for this purpose. The renewal fee must be submitted with the renewal form. The renewal form can be obtained from the address listed in subsection (b) of this section. The completed renewal form, a summary of the current screening criteria, a statement signed by an authorized representative of the company certifying that all information previously submitted is true and correct and all changes have been previously filed to the application certified by the department, and the renewal fee must be submitted to the department at the address listed in subsection (a) of this section.~~]

(2) Continued operation during department review. If a utilization review agent has filed the required information specified in this subsection and the fee as applicable for certification renewal with the department on or before the expiration of the certification or registration, the [~~A~~] utilization review agent may continue to operate under its certification or registration [~~certificate of registration if the information and the fee have been filed for renewal and timely received by the department,~~] until the renewal certification or registration is finally denied or issued by the department. [~~If the required information and fee is not received prior to the deadline for renewal of the certificate of registration the certificate of registration will automatically expire and the utilization review agent must complete and submit a new application form and a new fee with all required information.~~]

(3) Expiration for 90 days or less. If the certification or registration has been expired for 90 days or less, the utilization review agent may renew the certification or registration by filing a completed renewal application, fee as applicable for certification renewal, and the required information described in this subsection. The utilization review agent may not operate from the time the certification or registration has expired until the time the department has issued a renewal certification or registration.

(4) Expiration for longer than 90 days. If a utilization review agent's certification or registration has been expired for longer than 90 days, the utilization review agent 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 accordance with this section. Subsection (e) of this section applies to applications made under this paragraph.

(g) Contesting a Denial of an Application or Renewal.

If an application for an original or renewal certification or registration is [~~initially~~] denied under this section, the applicant [~~or registrant~~] may contest [~~appeal~~] such denial under [~~the terms of~~] the provisions of Chapter 1, Subchapter A of this title (relating to Rules of Practice and Procedure) and the Government Code[~~,~~] Chapter 2001. The contesting party is entitled to a hearing [~~A hearing of such appeal shall be conducted~~] within 45 days of the date the petition for such hearing is filed with the commissioner. A decision by the commissioner must [~~shall~~] be rendered within 60 days of the date of the hearing.

[~~(h) An applicant for a certificate of registration as a utilization review agent must provide evidence that the applicant:~~]

[~~(1) has available the services of physicians, nurses, physician's assistants, or other health care providers qualified to provide the service requested by the provider to carry out its utilization review activities in a timely manner;~~]

[~~(2) meets any applicable provisions of this chapter and regulations relating to the qualifications of the utilization review agents or the performance of utilization review;~~]

~~(3) has policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws;~~]

[~~(4) makes itself accessible to patients and providers 40 working hours a week during normal business hours in this state in each time zone in which it operates.~~]

[~~(i) Utilization review agents that have received their certificate of registration prior to the adoption of these rules, must file with the department all changes to their original application as set forth in subsections (c) and (d) of this section by March 1, 1998.~~]

§19.1705. General Standards of Utilization Review.

(a) Review of Utilization Review Plan. The utilization review plan[~~, including reconsideration and appeal requirements,~~] must [~~shall~~] be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, [~~appropriate~~] doctors, or other health care providers. [~~, including practicing health care providers that are both primary and specialty physicians, and approved by a physician. The utilization review plan shall include the following components:~~]

[~~(1) a description of the elements of review which the utilization review agent provides such as:~~]

[~~(A) prospective review:~~]

[~~(i) hospital admission;~~]

[~~(ii) procedures (such as surgical and non-surgical procedures);~~]

[~~(iii) courses of outpatient treatment;~~]

[~~(B) second surgical opinion;~~]

[~~(C) discharge planning;~~]

[~~(D) concurrent review;~~]

[~~(E) readmission review; and~~]

[~~(F) continued stay authorization;~~]

[~~(2) written procedures for:~~]

[~~(A) identification of individuals with special circumstances who may require flexibility in the application of screening criteria through utilization review decisions. Special circumstances includes, but is not limited to, a person who has a disability, acute condition, or life-threatening illness;~~]

[~~(B) notification of the utilization review agent's determinations provided to the enrollee, a person acting on behalf of the enrollee, or the enrollee's provider of record as addressed in §19.1710 of this title (relating to Notice of Determinations Made by Utilization Review Agents);~~]

[~~(C) appeal of an adverse determination and a copy of any forms used during the appeal process, as required by §19.1711 and §19.1712 of this title (relating to Requirements Prior to Adverse Determination and Appeal of Adverse Determinations of Utilization Review Agents);~~]

[~~(D) receiving or redirecting a toll-free normal business hour and after-hour calls, either in person or by recording, and assurance that a toll-free number will be maintained 40 hours per week during normal business hours as addressed in §19.1713 of this title (relating to Utilization Review Agent's Telephone Access);~~]

[~~(E) review including:~~]

[~~(i) any form used during the review process;~~]

[~~(ii) time frames that shall be met during the review;~~]

[~~(F) handling of oral or written complaints by enrollees, patients, or health care providers as addressed in §19.1716(a) of this title (relating to Complaints and Information);~~

[~~(G) determining if physicians or other health care providers utilized by the utilization review agent are licensed, qualified, and appropriately trained;~~]

[~~(H) assuring that patient-specific information obtained during the process of utilization review, as addressed in §19.1714 of this title (relating to Confidentiality), will be:~~]

[~~(i) kept confidential in accordance with applicable federal and state laws;~~]

[~~(ii) used solely for the purposes of utilization review, quality assurance, discharge planning, and catastrophic case management;~~]

[~~(iii) shared with only those agencies (such as the claims administrator) who have authority to receive such information; and~~]

[~~(iv) in the case of summary data, such data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients;~~]

~~[(I) providing prior written notice to a physician or health care provider when publishing data, including quality review studies or performance tracking data which identifies a particular physician or health care provider;]~~

~~[(3) screening criteria. Each utilization review agent shall utilize written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from the physicians, including practicing physicians, dentists, and other health care providers. Utilization review decisions shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norm when justified on a case-by-case basis. Screening criteria must be used to determine only whether to approve the requested treatment. Denials must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity. Such written screening criteria and review procedures shall be available for review and inspection to determine appropriateness and compliance as deemed necessary by the commissioner or his or her designated representative and copying as necessary for the commissioner to carry out his or her lawful duties under the Insurance Code, provided, however, that any information obtained or acquired under the authority of this chapter and the Act, is confidential and privileged and not subject to the open~~

~~records law or subpoena except to the extent necessary for the commissioner to enforce this chapter and the Act;~~]

(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) Performance Tracking Data. The utilization review plan must provide prior written notice to a physician, doctor, or other health care provider and an opportunity to correct reports prior to publishing data that identifies the particular physician, doctor, or other health care provider, including quality review studies or performance tracking data.

(d) Screening Criteria. Each utilization review agent is required to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the 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 utilization review agent must utilize generally accepted standards of medical practice recognized in the medical community.

(e) Referral and Determination of Adverse Determinations. Adverse determinations must be referred to and may only be determined by an appropriate physician or doctor to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

(f) Delegation of Review. A utilization review agent, including a specialty utilization review agent, may delegate the review to qualified personnel in

[~~(4) delegation of review. Provide circumstances, if any, under which the utilization review agent may delegate the review to~~] a hospital utilization review program or a qualified health care provider. Such delegation does [~~shall~~] not relieve the utilization review agent of full responsibility for compliance with this subchapter and Chapter 4201 of the Insurance Code [~~the Act,~~] including the conduct of those to whom utilization review has been delegated.

(g) Complaint System. The utilization review agent is required to develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, their representatives, or health care providers concerning the utilization review and is required to maintain records of such 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 the department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the department.

(h) Pursuant to the Insurance Code §1369.056, the refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of this subchapter if:

(1) the drug is not included in a drug formulary used by the group health benefit plan; and

(2) the enrollee's physician has determined that the drug is medically necessary.

(i) Applicability to Specialty Utilization Review Agents. This section also applies to a specialty utilization review agent, except for subsection (a) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1706. Requirements and Prohibitions Relating to Personnel.

(a) Qualification Requirements.

(1) Physicians, doctors, and other health care providers [~~Personnel~~] employed by or under contract with the utilization review agent to perform utilization review must [~~shall~~] be appropriately trained, [~~and~~] qualified, and [~~if applicable,~~] currently licensed.

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

(3) Personnel who obtain information regarding an enrollee's [~~a patient's~~] specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, [~~dentist~~] or other health care provider, either orally or in writing, and who are not physicians or doctors [~~dentists~~], must [~~shall~~] be nurses, physician [~~physicians~~] assistants, or other health care providers qualified to provide the service

requested [~~by the provider~~]. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(b) Prohibitions. A utilization review agent may not permit or provide compensation or anything [~~any thing~~] of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards, based on:

(1) the amount or volume of adverse determinations; [~~,~~]

(2) reductions or limitations on lengths of stay, benefits, services, or charges; or

(3) [~~on~~] the number or frequency of telephone calls or other contacts with health care providers or enrollees [~~patients~~], which are inconsistent with the provisions of this subchapter.

(c) Disqualifying associations. The physician who reviews the appeal must not have any disqualifying associations with the physician or doctor who issued the initial adverse determination or the enrollee who is requesting the appeal. For purposes of this subsection, being employed by or under contract with the same utilization review agent as the physician or doctor who issued the initial adverse determination does not in itself constitute a disqualifying association.

(d) [~~(c)~~] Information Required to be Filed with the Department. The utilization review agent is required to provide the name, number, type, license number and state of licensure, and [~~minimum qualification or~~] qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an

original application or renewal application or upon providing updated information [~~commissioner~~].

(e) Written Procedures and Maintenance of Records.

(1) Utilization review agents are [~~shall be~~] required to develop and implement [~~adopt~~] written procedures [~~used~~] to determine if physicians, doctors, and [~~or~~] other health care providers used [~~utilized~~] by the utilization review agent are licensed, qualified, and appropriately trained or experienced [~~, and must maintain records on such~~].

(2) The utilization review agent must maintain documentation that demonstrates that physicians, doctors and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced in accordance with subsection (a) of this section.

(f) Training Related to Acquired Brain Injury Treatment. A utilization review agent is required to provide adequate training to personnel responsible for pre-certification, certification, and recertification of services or treatment relating to acquired brain injury in accordance with the Insurance Code §1352.004. The purpose of the training is to prevent denial of coverage in violation of the Insurance Code §1352.003 and to avoid confusion of medical benefits with mental health benefits.

(g) [~~(d)~~] Physician Direction Requirement. Utilization review conducted by a utilization review agent must [~~shall~~] be under the direction of a physician currently licensed to practice medicine by a state licensing agency in the United States. Such physician may be employed by or under contract with [~~to~~] the utilization review agent.

(h) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (a), (d), (e), and (g) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

[~~(e) Utilization review dental plans shall be reviewed by a dentist currently licensed by a state licensing agency in the United States.~~]

§19.1707. Prohibition [~~Prohibitions~~] of Certain Activities and Procedures Related to Health Care Providers and Enrollees [~~of Utilization Review Agents~~].

(a) A utilization review agent may not engage in unnecessary or unreasonably repetitive contacts with the health care provider or enrollee [~~patient~~] and must [~~shall~~] base the frequency of contacts or reviews on the severity or complexity of the enrollee's [~~patient's~~] condition or on necessary treatment and discharge planning activity.

(b) A utilization review agent may [~~shall~~] not set or impose any notice or other review procedures contrary to the requirements of the health insurance policy or health benefit plan.

(c) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1708. Utilization Review Agent Contact with and Receipt of Information from Health Care Providers.

(a) A health care provider may designate one or more individuals as the initial contact or contacts for utilization review agents seeking routine information or data. The [~~In no event shall the~~] designation of such an individual or individuals may not in any circumstance relieve the [~~preclude a~~] utilization review agent or medical advisor of the obligation to contact [~~from contacting~~] a health care provider or others in the health care provider's [~~his or her~~] employ where a review might otherwise be unreasonably delayed or where the designated individual is unable to provide the necessary information or data requested by the utilization review agent.

(b) Unless precluded or modified by contract, a utilization review agent must [~~shall~~] reimburse health care providers for the reasonable costs for providing medical information in writing, including copying and transmitting any requested enrollee [~~patient~~] records or other documents relevant to the utilization review. A health care provider's charge for providing medical information to a utilization review agent must be in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation) [~~shall not exceed the cost of copying set by rules of the Texas Workers Compensation Commission for records~~] and may not include any costs that are otherwise recouped as a part of the charge for health care.

(c) When conducting routine utilization review, the utilization review agent must request all relevant and updated medical records in order to complete the review [~~shall collect only the information necessary to certify the admission, procedure, or treatment and length of stay~~]. This information may include identifying information about the [~~patient and~~] enrollee;[~~,~~] the benefit plan or 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 enrollee [~~patient~~] and the medical history of the enrollee [~~patient~~] relevant to the diagnoses; the enrollee's [~~patient's~~] prognosis; and the [~~treatment~~] plan of treatment prescribed by the [~~treating health care~~] provider of record, along with the provider of record's [~~provider's~~] justification for the [~~treatment~~] plan of treatment. [~~Second opinion information may also be required when applicable, sufficient to support benefit plan requirements. 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.~~] The required information should be obtained from the appropriate source, since no one source will have all of this information.

(1) Utilization review agents may request [~~shall not routinely require hospitals and physicians to supply~~] numerically codified diagnoses or procedures to be considered for certification only if[~~. Utilization review agents may ask for such coding, since if it is known,~~] its inclusion in the data collected increases the effectiveness of the communication.

(2) Utilization review agents must [~~shall~~] not routinely request copies of all medical records on enrollees [~~all patients~~] reviewed. During utilization [~~prospective and concurrent~~] review, copies of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate, or whether it is experimental or investigational [~~certifying the medical necessity or~~

~~appropriateness of the admission or extension of stay~~]. In those cases, only the necessary or pertinent sections of the record should be required.

(d) Information in addition to that described in this section may be requested by the utilization review agent or voluntarily submitted by the [~~health care~~] provider of record, when there is significant lack of agreement between the utilization review agent and [~~health care~~] provider of record regarding the appropriateness of health care [~~certification~~] during the review or appeal process. "Significant lack of agreement" means that the utilization review agent:

(1) has tentatively determined[~~, through its professional staff,~~] that a service cannot be approved [~~certified~~];

(2) has referred the case to a physician or doctor for review; and

(3) has had a discussion with [~~talked to~~] or attempted to have a discussion with [~~talk to~~] the [~~health care~~] provider of record in order to obtain [~~for~~] further information.

(e) The utilization review agent should share among its various divisions all clinical and demographic information on individual enrollees [~~patients among its various divisions (e.g., certification, discharge planning, case management)~~] to avoid duplicate requests for information from enrollees, physicians, doctors, and [~~or~~] other health care providers.

(f) Notwithstanding any other provision of this section [~~chapter~~], a utilization review agent may not require as a condition of treatment approval, or for any other reason, the observation of a psychotherapy session or the submission or review of a

mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's [~~a patient'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 utilization review agent from:

(1) requiring submission of an enrollee's [~~a patient's~~] mental health medical record summary or

(2) requiring submission of medical records or [~~and/or~~] process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

(g) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1709. On-Site Review by the Utilization Review Agent.

(a) Observing or Participating in Patient's Care. Unless approved for an individual enrollee [~~patient~~] by the provider of record or allowed [~~modified~~] by contract, a utilization review agent is [~~shall be~~] prohibited from observing, participating in, or otherwise being present during an enrollee's [~~a patient's~~] examination, treatment, procedure, or therapy. In no event may [~~shall~~] this prohibition [~~section otherwise~~] be construed to limit or deny contact with an enrollee [~~a patient~~] for purposes of conducting utilization review unless otherwise specifically prohibited by law.

(b) Identification of Utilization Review Agents. Utilization review agents' staff must [~~shall~~] identify themselves by name and by the name of their organization and must[~~, for on-site reviews, should~~] carry picture identification and the utilization review agent [~~company~~] identification card with the certificate number assigned by the department [~~Texas Department of Insurance~~].

(c) On-site Review at a Health Care Facility. For on-site review conducted at a health care facility, utilization [~~Utilization~~] review agents:

(1) must ensure [~~should assure~~] that their on-site review staff:

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

(B) wear appropriate health care facility [~~hospital~~] supplied identification tags while on the health care facility premises; and[~~.~~]

(2) [~~Utilization review agents~~] are required to [~~shall~~] 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 [~~hospital~~] administrative procedures will [~~shall~~] be followed by on-site review staff in order [~~so as~~] to not disrupt health care facility [~~hospital~~] operations or enrollee [~~patient~~] care. Such procedures, however, should not obstruct or limit the ability of the utilization review agent to efficiently conduct the necessary review on behalf of the enrollee's [~~patient's~~] health benefit plan.

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1710. Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~].

(a) Notice of Favorable or Adverse Determinations. A utilization review agent is required to [~~shall~~] notify, in accordance with this section as applicable, the enrollee, or an individual [~~a person~~] acting on behalf of the enrollee, and [~~or~~] the enrollee's provider of record of a favorable or adverse determination made in a prospective or concurrent utilization review.

(b) Favorable Determinations.

(1) Except in the case of notification of adverse determinations which are addressed in subsection (c) [~~(d)~~] of this section, the written notification required by this subsection [~~section~~] must be mailed or electronically [~~otherwise~~] transmitted no [~~not~~] later than two working days after the date of the request for utilization review and all medical information necessary to substantiate the need for the treatment or service recommended is received by the agent.

(2) A utilization review agent must ensure that preauthorization numbers assigned by the utilization review agent comply with the data and format requirements contained in the standards adopted by the federal 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.

(c) Adverse Determinations.

(1) Required notice elements. In all instances of a prospective or concurrent utilization review adverse determination, written notification [~~Notification~~] of the adverse determination by the utilization review agent must include:

(A) [~~(1)~~] the principal reasons for the adverse determination;

(B) [~~(2)~~] the clinical basis for the adverse determination;

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

(D) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(E) the professional specialty and state(s) of licensure of the physician or doctor that made the adverse determination;

(F) [~~(4)~~] a description of the procedure for the utilization review agent's complaint system as required by §19.1705 of this subchapter (relating to General Standards of Utilization Review); [~~and appeal process; and~~]

[~~(5) the independent review notification and the form prescribed by the commissioner.~~]

(G) a description of the utilization review agent's appeal process, as required by §19.1712 of this subchapter (relating to Appeal of Adverse Determination);

(H) the date and time the utilization review agent offered the opportunity to discuss the adverse determination and the date and time the discussion, if any, took place, as required in §19.1711 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination) or §19.1720 of this subchapter (relating to Specialty Utilization Review Agent); and

(I) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization), which is available at www.tdi.state.tx.us/forms. Such notice must include instruction that:

(i) Form No. LHL009 (Request for a Review by an Independent Review Organization) must be completed by the enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the carrier or utilization review agent that made the adverse determination to begin the independent review process; and

(ii) the release of medical information to the independent review organization, which is included as part of the independent review request form prescribed by the commissioner, must be signed by the enrollee or the enrollee's legal guardian.

(2) Independent review in the event of life-threatening condition. In accordance with §19.1712(a)(3) of this subchapter, the description of the utilization

review agent's appeal process required by paragraph (1)(G) of this subsection must include a statement that in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate review of the adverse determination by an independent review organization and is not required to comply with procedures for an internal review of the adverse determination by a utilization review.

(3) Release of medical information. The release of medical information to the independent review organization included in the request for review by an independent review organization required by paragraph (1)(I) of this subsection must be signed by the enrollee or the enrollee's legal guardian.

(4) [~~(d)~~] Required time frames. Unless §19.1723 of this subchapter (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) applies, the time frames for notification of the [~~The~~] adverse determination are [~~notification must be provided~~]:

(A) [~~(1)~~] with respect to an enrollee who is hospitalized at the time of the adverse determination, within one working day by telephone or electronic transmission to the provider of record [~~in the case of a patient who is hospitalized at the time of the adverse determination, to be~~] followed by a letter within three working days notifying the enrollee [~~patient~~] and the provider of record of the [~~an~~] adverse determination [~~within three working days~~];

(B) [~~(2)~~] with respect to an enrollee who is not hospitalized at the time of the adverse determination, within three working days of the request in writing to

the provider of record and the enrollee [~~patient if the patient is not hospitalized at the time of the adverse determination~~]; or

(C) [~~(3)~~] with respect to a denial of post-stabilization care subsequent to emergency treatment as requested by a provider of record, within the time appropriate to the circumstances relating to the delivery of the services to the enrollee and the enrollee's condition, [~~of the patient,~~] but not later than [~~in no case to exceed~~] one hour from the time of request by telephone or electronic transmission to the provider of record, to be followed by a written notification within three working days of the telephone or electronic transmission [~~notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or health care provider~~].

[~~(e) For life-threatening conditions, notification of adverse determination by the utilization review agent must be provided within the time frames addressed in subsection (d) of this section. At the time of notification of the adverse determination, the utilization review agent shall provide to the enrollee or person acting on behalf of the enrollee, and the enrollee's provider of record, the independent review notification and the form prescribed by the commissioner.~~]

(d) Determination Concerning an Acquired Brain Injury. In addition to the notification required by subsections (b) and (c) of this section, a utilization review agent is required to 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 utilization review agent 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 pursuant to coverage under a small employer health benefit plan.

(e) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter.

§19.1711. Requirements Prior to Issuing Adverse Determination.

(a) Reasonable Opportunity. For purposes of this section, "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or no less than five working days prior to issuing a retrospective utilization review adverse determination.

(b) Requirements Prior to Issuing Prospective or Concurrent Utilization Review Adverse Determinations.

(1) Subject to the notice requirements of §19.1710 of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~]), in any instance in which [~~where~~] the utilization review agent 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 utilization review agent must afford the provider of record [~~the health care provider who ordered the services shall be afforded~~] a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision [~~patient and the clinical basis for the utilization review agent's decision with a physician or, in the case of a dental plan with a dentist, prior to issuance of an adverse determination~~].

(2) When the utilization review agent provides the reasonable opportunity required under subsection (b)(1) of this section, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination.

(3) The utilization review agent must maintain documentation that details [~~shall have written procedures describing how~~] the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome [~~is afforded~~].

(4) The utilization review agent must submit the documentation required by paragraph (3) of this subsection to the department upon request.

(c) Requirements Prior to Issuing Retrospective Review Adverse Determinations.

(1) Subject to the notice requirements of §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services provided, prior to the issuance of an adverse determination, the utilization review agent is required to afford the provider of record a reasonable opportunity to discuss the treatment provided to the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(2) When the utilization review agent provides the reasonable opportunity required under paragraph (c)(1) of this subsection, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination. The utilization review agent must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(3) The utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(4) The utilization review agent is required to submit the documentation required by paragraph (3) of this subsection to the department upon request.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (b) and (c) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1712. Appeal of Adverse Determination [~~of Utilization Review Agents~~].

(a) Appeal of Prospective or Concurrent Adverse Determinations.

(1) A utilization review agent must [~~shall~~] maintain and make available a written description of appeal procedures involving an adverse determination that are used by the agent.

(2) [~~(b)~~] Each utilization review agent is required to comply with its written procedures for appeals. In accordance with the Insurance Code Chapter 4201, Subchapter H (relating to Appeal of Adverse Determination), the [~~The~~] written procedures for appeals must [~~shall~~] be reasonable and must [~~shall~~] include the information specified in this paragraph [~~following~~]:

[~~(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination orally or in writing;~~]

[~~(2) a provision that within five working days from receipt of the appeal the utilization review agent shall send to the appealing party a letter acknowledging the date of the utilization review agent's receipt of the appeal and include a reasonable list of documents needed to be submitted by the appealing party to the utilization review agent~~

~~for the appeal. Such letter must also include provisions listed in subsections (b) and (c) of this section. When the utilization review agent receives an oral appeal of adverse determination, the utilization review agent shall send a one-page appeal form to the appealing party;~~]

(A) a statement specifying the time frames for filing the written or oral appeal, which may not be less than 30 days after the date of issuance of written notification of an adverse determination;

(B) a provision 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;

(C) a provision that an appeal acknowledgement letter:

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

(ii) must acknowledge the date the utilization review agent received the appeal;

(iii) must include a list of relevant documents that must be submitted by the appealing party to the utilization review agent; and

(iv) must include a one-page appeal form to be filled out by the appealing party when the utilization review agent receives an oral appeal of an adverse determination;

(D) [~~(3)~~] a provision that appeal decisions must [~~shall~~] be made by a physician who has not previously reviewed the case;

(E) a provision that in any instance in which the utilization review agent 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 utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.1711(a) of this subchapter (relating to Requirements Prior to Issuing Adverse Determination), 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 utilization review agent's decision;

(F) a provision that [~~, or dentist, as appropriate, provided that,~~] if the appeal is denied and within 10 working days from such 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 [~~shall~~] be reviewed by a health care provider in the same or similar specialty that [~~as~~] typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination, and such specialty review must [~~shall~~] 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;

(G) [~~(4)~~] a provision that, in addition to the written appeal, a method for expedited appeals [~~appeal procedure~~] for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized enrollees is available [~~patients~~]. The provision must state that such [~~Such~~] procedure must [~~shall~~] include a review by a health care provider who has not previously reviewed the case

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. The provision must state that an expedited [~~The time in which such~~] appeal must be completed [~~shall be~~] based on the [~~medical or dental~~] 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. The provision must also state 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;

(H) [~~(5)~~] a provision that after the utilization review agent has sought review of the appeal of the adverse determination, the utilization review agent must [~~shall~~] issue a response letter to the enrollee or [~~patient,~~] an individual [~~a person~~] acting on behalf of the enrollee [~~patient,~~] and [~~or~~] the [~~patient's physician or health care~~] provider of record explaining the resolution of the appeal. The provision must state that such [~~Such~~] letter must [~~shall~~] include:

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

(ii) [~~(B)~~] the medical or clinical basis for such decision, including screening criteria;

[~~(C) the specialization of any physician or other provider consulted; and~~]

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

(iv) the professional specialty and state or states of licensure of the physician who made the determination;

(v) [~~(D)~~] notice of the appealing party's right to seek review of the denied appeal [~~denial~~] by an independent review organization in accordance with §19.1721 of this subchapter (relating to Independent Review of Adverse Determinations), [~~and~~] the procedures for obtaining that review, and Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)); and[~~.~~]

(vi) procedures for filing a complaint in accordance with the Insurance Code §4201.204 and as described in §19.1705(g) of this subchapter (relating to General Standards of Utilization Review);

(I) a provision that the appeal must be resolved [~~(6) written notification to the appealing party of the determination of the appeal,~~] as soon as practical, but, in accordance with the Insurance Code §4201.359, in no case later than 30 days after the date the utilization review agent receives the written appeal or the one-page appeal form from the appealing party referenced under subparagraph (C) of this paragraph; and[~~.~~].

(3) [~~(c)~~] In a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

(b) Appeal of Retrospective Review Adverse Determinations. A utilization review agent is required to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with the requirements in paragraphs (1) – (3) of this subsection.

(1) The appeal procedures must be in accordance with the requirements in Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims).

(2) An appeal of an adverse determination relating to retrospective utilization review must comply with §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review).

(3) In any instance in which the utilization review agent 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 utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.1711(a) of this subchapter, to discuss the plan of treatment for the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(c) Appeals Concerning an Acquired Brain Injury. In addition to the requirements in subsections (a) and (b) of this section, a utilization review agent is required to 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 utilization review agent 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 pursuant to coverage under a small employer health benefit plan.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (a)(2)(D) and (E) and (b)(3) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1713. Utilization Review Agent's Telephone Access.

(a) A utilization review agent is required to [~~shall~~] have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both time zones in Texas, [~~if applicable,~~] to discuss enrollees' [~~patients'~~] care and to respond [~~allow response~~] to telephone review requests.

(b) A utilization review agent must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours and must [~~shall~~] respond to such calls not later than two working days of the later of the date on which the call was received or the date on which the details necessary to respond were [~~have been~~] received from the caller.

(c) A utilization review agent must provide a written description to the commissioner setting forth the procedures that the utilization review agent will

implement [~~to be used~~] when responding to post-stabilization care subsequent to emergency treatment as requested by a treating physician, doctor, or other health care provider of record. Such procedure must comply with the Insurance Code §4201.004.

(d) This section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1723 of this subchapter (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and §19.1724 of this subchapter (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

(e) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1714. Confidentiality.

(a) Confidentiality Requirements.

(1) A utilization review agent is required to [~~shall~~] preserve the confidentiality of individual medical records to the extent required by law.

(2) [~~(b)~~] A utilization review agent may not disclose or publish individual medical records, personal information, or other confidential information about an enrollee [~~a patient~~] obtained in the performance of utilization review without the prior written consent of the enrollee [~~patient~~] or as otherwise required by law. Personal information includes, [~~shall include~~] at a minimum, name, address, phone number, social security number, and financial information. If such authorization is submitted by

anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must:

(A) [~~(1)~~] be dated; and

(B) [~~(2)~~] contain the signature of the individual whose [~~who is the subject of the~~] personal or confidential information is being requested. The signature must have been obtained one year or less prior to the date the disclosure is sought or the authorization is invalid.

(3) [~~(c)~~] A utilization review agent may provide confidential information to a third party under contract or affiliated with the utilization review agent for the sole purpose of performing or assisting with utilization review. Information provided to third parties must [~~shall~~] remain confidential.

(4) [~~(d)~~] If an individual submits a written request to the utilization review agent for access to recorded personal information about the individual, the utilization review agent must [~~shall~~] within 10 working [~~business~~] days from the date such request is received:

(A) [~~(1)~~] inform the individual submitting the request of the nature and substance of the recorded personal information in writing; and

(B) [~~(2)~~] permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, at the discretion of the individual, unless the recorded personal information is in coded form, in which case an accurate translation in plain language must [~~shall~~] be provided in writing.

(5) [~~(e)~~] A utilization review agent's charges for providing a copy of recorded personal information to individuals may [~~shall~~] not exceed ten cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(6) [~~(f)~~] The utilization review agent may not publish data that [~~which~~] identifies a particular physician, doctor, or other health care provider, including any quality review studies or performance tracking data without prior written notice to the subject physician, doctor, or other [~~involved~~] health care provider. This prohibition does not apply to internal systems or reports used by the utilization review agent.

(7) [~~(g)~~] When the utilization review agent determines that documents [~~Documents~~] in the custody of the utilization review agent that contain confidential enrollee [~~patient~~] information or physician, doctor, or other health care provider financial data are no longer needed, the documents must [~~shall~~] be destroyed by a method that results in the [~~which induces~~] complete destruction of the information [~~when the agent determines the information is no longer needed~~].

(8) [~~(h)~~] All enrollee [~~patient~~], physician, doctor, and other health care provider data must [~~shall~~] be maintained by the utilization review agent in a confidential manner that [~~which~~] prevents unauthorized disclosure to third parties. Nothing in this section may [~~article shall~~] be construed to allow a utilization review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of enrollee [~~patient~~] records.

(9) [~~(i)~~] To assure confidentiality, a utilization review agent must, when contacting a physician's, doctor's [~~office~~] or other health care provider's office [~~hospital~~], provide its certification number, the caller's name, and professional qualifications [~~to the provider's named utilization review representative in the health care provider's office~~].

(10) [~~(j)~~] Upon request by the physician, doctor, or other health care provider, the utilization review agent must [~~shall~~] present written documentation that it is acting as an agent of the payor for the relevant enrollee [~~patient~~].

[~~(k) The utilization review agent's procedures shall specify that specific information exchanged for the purpose of conducting reviews will be considered confidential, be used by the private review agent solely for the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such information, such as the claim administrator. The utilization review agent's process shall specify that procedures are in place to assure confidentiality and that the utilization review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual patients or providers need not be considered confidential.~~]

(11) [~~(l)~~] Medical records and enrollee [~~patient~~] specific information must [~~shall~~] be maintained by the utilization review agent in a secure area with access limited to essential personnel only.

(12) [~~(m)~~] A utilization review agent is required to retain information [~~Information~~] generated and obtained by a [~~the~~] utilization review agent [~~agents~~] in the

course of utilization review [~~shall be retained~~] for at least four [~~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~~].

(13) [~~(n)~~] Notwithstanding the provisions in paragraphs (1) – (12) of this subsection and subsection (b) [~~subsections (a) – (m)~~] of this section, the utilization review agent is required to [~~shall~~] provide to the department [~~commissioner~~] on request individual medical records or other confidential information for determination of compliance with this subchapter. The information is confidential and privileged and is not subject to the [~~open records law,~~] Government Code[~~,~~] Chapter 552 (Public Information), or to subpoena, except to the extent necessary to enable the commissioner to enforce this subchapter.

(b) Written Procedures on Confidentiality. The utilization review agent must specify in writing the procedures that the utilization review agent will implement pertaining to confidentiality of information received from the enrollee, the enrollee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for the purpose of conducting utilization review. These procedures must specify that specific information received from the enrollee, the enrollee's representative, and/or 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 the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such

information, such as the claim administrator. These procedures must also specify that the utilization review agent has procedures in place to assure confidentiality and that the utilization review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual enrollees, physicians, doctors, or other health care providers need not be considered confidential.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1715. Notice of Determination Made in Retrospective Review [~~of Medical Necessity~~].

(a) Required Notice. A utilization review agent is required to notify the enrollee, or an individual acting on behalf of the enrollee, and the enrollee's provider of record of a determination made in a retrospective review of medical necessity or appropriateness, or the experimental or investigational nature, of care. [~~When a retrospective review of the medical necessity and appropriateness of health care service is made under a health insurance policy or plan:~~]

[~~(1) such retrospective review shall be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers; and~~]

[~~(2) the payor's system for such retrospective review of medical necessity and appropriateness shall be under the direction of a physician.~~]

(b) Required Procedures. The utilization review agent is required to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the time frames for the notice of adverse determination. These procedures must comply with the Insurance Code §4201.305 and the requirements specified in paragraphs (1) – (3) of this subsection.

(1) The notice of an adverse determination required by subsection (a) of this section must be in writing and be sent to the provider of record(s), including the health care provider who rendered service, and the enrollee or the individual acting on behalf of the enrollee.

(2) The notice of an adverse determination required by subsection (a) of this section must include:

(A) the principal reasons for the adverse determination;

(B) the clinical basis for the adverse determination;

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

(D) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(E) the professional specialty and state(s) of licensure of the physician or doctor that made the determination;

(F) a description of the procedure for the utilization review agent's complaint system as required by §19.1705 of this subchapter (relating to General Standards of Utilization Review);

(G) a description of the utilization review agent's appeal process, as required by §19.1712 of this subchapter (relating to Appeal of Adverse Determination);

(H) the date and time the utilization review agent offered the opportunity to discuss the adverse determination, and the date and time that the discussion, if any, occurred, as required in §19.1711 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination) or §19.1720(h) of this subchapter (relating to Specialty Utilization Review Agent); and

(I) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)). Such notice must include instruction that:

(i) The independent review request Form No. LHL009 must be completed by the enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the utilization review agent to begin the independent review process.

(ii) The release of medical information to the independent review organization, which is included as part of the independent review request Form No. LHL009, must be signed by the enrollee or the enrollee's legal guardian.

[~~(b) When an adverse determination is made under a health insurance policy or plan based on a retrospective review of the medical necessity and appropriateness of the allocation of health care resources and services, the payor shall afford the health care providers the opportunity to appeal the determination in the same manner afforded the enrollee, with the enrollee's consent to act on his or her behalf, but in no event shall health care providers be precluded from appeal if the enrollee is not reasonably available or competent to consent. Such appeal shall not be construed to imply or confer on such health care providers any contract rights with respect to the enrollee's health insurance policy or plan that the health care provider does not otherwise have.~~]

(3) [~~(c)~~] When a retrospective review of the medical necessity or [~~and~~] appropriateness, or the experimental or investigational nature, of health care service is made in relation to health coverage, [~~under a health insurance policy or health benefit plan,~~] the utilization review agent 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 [~~a patient's~~] mental or emotional condition or disorder [~~may not be required~~]. 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:

(A) [~~(1)~~] requiring submission of an enrollee's [~~a patient's~~] mental health medical record summary; or

(B) [~~(2)~~] requiring submission of medical records and/or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

(c) Determination Concerning an Acquired Brain Injury. In addition to the notification required by subsection (a) of this section, a utilization review agent is required to 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 utilization review agent 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 pursuant to coverage under a small employer health benefit plan.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter.

§19.1716. Regulatory Requirements Subsequent to Certification or Registration [~~Complaints and Information~~].

(a) Reporting of Material Changes. The utilization review agent is required to report any material changes in the information in the application or renewal Form No. LHL005 (Utilization Review Agent (URA) Application Form) last filed with the

department by the utilization review agent, not later than the 30th day after the date on which the change takes effect. [~~Utilization review agent's complaint system. A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review and shall maintain records of such complaints for three years from the time the complaints are filed. The complaint procedure shall include a written response to the complainant by the agent within 30 days.~~]

(b) Summary Report ~~Review Agent's Reporting~~ to the Department [~~Utilization review agent's reporting requirements to the department~~].

(1) By March 1, of each year, the utilization review agent must [~~shall~~] submit to the department [~~commissioner or his or her delegated representative,~~] a summary report of information related to complaints, adverse determinations, appeals of adverse determinations, and any other related information requested by the department in accordance with the Insurance Code §38.001. [~~all complaints at such times and in such form as the commissioner may require and shall permit the commissioner to examine the complaints and all relevant documents at any time.~~]

(2) The summary report must be provided in the form required by the commissioner, and the utilization review agent must permit the commissioner or the commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the department.

(3) The summary report is required to cover [~~covers~~] reviews performed by the utilization review agent during the preceding calendar year and must include [~~includes~~]:

(A) [~~(1)~~] the total number of written notices of adverse determinations;

(B) [~~(2)~~] a listing of appeals of adverse determinations, by the medical condition that is the source of the dispute using primary ICD-9 (physical diagnosis) or DSM-IV (mental health diagnosis) code, 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;

(C) [~~(3)~~] the classification of appellant (i.e., health care provider, enrollee, patient, etc.);

[~~(4) the subject matter of the appeal of the adverse determination. Appeal of adverse determinations shall be categorized as follows:~~]

[~~(A) benefit denial or limitation (e.g., treatment not pre-authorized, treatment not medically necessary, hospital stay not medically necessary, referral to specialty physician not provided);~~]

[~~(B) timely determinations (e.g., utilization review agent not responding to requests in a timely manner, appropriate personnel not available by telephone);~~]

[~~(C) screening criteria;~~]

(D) [~~(5)~~] 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;

(E) [~~(6)~~] the subject matter of any [~~the~~] complaint filed with the utilization review agent. Complaints must [~~shall~~] be categorized as follows:

(i) [~~(A)~~] administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider);

(ii) [~~(B)~~] qualifications of utilization review agent's personnel; or

(iii) [~~(C)~~] appeal/complaint process (e.g., treating physician unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal not provided).

(c) Complaints to the Department [~~department~~]. Complaints filed with the department against a utilization review agent must be processed in accordance with the department's established procedures for investigation and resolution of complaints. [~~Within a reasonable time period, upon receipt of a written complaint alleging a violation of this subchapter or the Act, by a utilization review agent, from an enrollee's health care provider, a person acting on behalf of the enrollee, or the enrollee, the commissioner or his or her delegated representative shall investigate the complaint, notify the utilization review agent of the complaint, require response by the utilization review agent~~

~~addressing the complaint within 10 days of receipt of the complaint, and furnish a written response to the complainant and the utilization review agent named. The response will not identify in any manner, the patient or patients, without written consent. This response must include the following:~~]

[~~(1) a statement of the original complaint;~~]

[~~(2) a copy of any written response by the utilization review agent. The written response should not contain privileged medical records. If it is necessary to refer to medical records, they shall be separately forwarded with the response and clearly marked as privileged medical records;~~]

[~~(3) a statement of the findings of the commissioner or his or her delegated representative and an explanation of the basis of such findings;~~]

[~~(4) corrective actions, if any, on the part of the utilization review agent which the commissioner or his or her designated representative finds appropriate and whether the utilization review agent has voluntarily agreed to take such action;~~]

[~~(5) a time frame in which any corrective actions should be completed.~~]

(d) Department Inquiries. Pursuant to the Insurance Code §38.001, the department may address inquiries to a utilization review agent related to any matter connected with utilization review agent transactions that the department considers necessary for the public good or for the proper discharge of the department's duties. In accordance with the Insurance Code §38.001, a utilization review agent that receives an inquiry from the department pursuant to the Insurance Code §38.001 is required to respond to the inquiry in writing not later than the 10th day after the date the inquiry is

received. [~~Evidence of corrective action. The utilization review agent will provide evidence of corrective action within the specified time frame to the commissioner or his or her representative.~~]

[~~(e) Authority of the department to make inquiries. In addition to the authority of the commissioner to respond to complaints described in subsection (b) of this section, the department is authorized to address inquiries to any utilization review agent in relation to the agents' business condition or any matter connected with its transactions which the department may deem necessary for the public good or for a proper discharge of its duties. It shall be the duty of the agent to promptly answer such inquiries in writing.~~]

[~~(f) Lists of utilization review agents. The commissioner shall maintain and update monthly a list of utilization review agents issued certificates and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.~~]

(e) [~~(g)~~] On-site Review [~~review~~] by the [~~Texas~~] Department [~~of Insurance~~].

(1) Provisions for scheduled and unscheduled on-site reviews.

(A) The department may [~~commissioner or the commissioner's designated representative is authorized to~~] make a complete on-site review of the operations of each utilization review agent at the principal place of business for such agent, as often as is deemed necessary. Such review may be scheduled or unscheduled.

(B) An on-site review will only be conducted during working days and normal business hours.

(C) The utilization review agent must make available all records relating to its operation during such scheduled and unscheduled on-site review.

(2) Scheduled on-site reviews. Utilization review agents will be notified of any [~~the~~] scheduled on-site review [~~visit~~] by letter, which will specify, at a minimum, the identity of the department's [~~commissioner's~~] designated representative and the expected arrival date and time.

(3) Unscheduled on-site reviews. At a minimum, notice of an unscheduled on-site review of a utilization review agent will be in writing and be presented by the department's designated representative upon arrival. [~~The utilization review agent must make available during such on-site visits all records relating to its operation.~~]

[~~(4) The commissioner or the designated representative may perform periodic telephone audits of utilization review agents authorized to conduct business in this state, to determine if the agents are reasonably accessible.~~]

(f) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1717. Administrative Violations.

(a) In accordance with the Insurance Code §4201.601, if [~~If~~] the department [~~commissioner, through the commissioner's designated representative,~~] believes that any individual [~~person~~] or entity conducting utilization review pursuant to this subchapter [~~article~~] is in violation of Chapter 4201 of the Insurance Code [~~the Act~~] or applicable rules or any other provision of the Insurance Code or rules [~~regulations~~], the department [~~commissioner's designated representative~~] shall notify the utilization review agent, health maintenance organization, or insurer of the alleged violation and may compel the production of any and all documents or other information as necessary to determine whether or not such violation has occurred [~~taken place~~].

(b) The department [~~commissioner's designated representative~~] may initiate the proceedings under this section.

(c) Proceedings under this subchapter are a contested case for the purpose of the Government Code[~~,~~] Chapter 2001.

(d) If the commissioner determines that the utilization review agent, health maintenance organization, insurer, or other [~~person or~~] entity or individual conducting utilization review pursuant to this subchapter has violated or is violating [~~any provision of~~] Chapter 4201 of the Insurance Code, any other provision of the Insurance Code, or department rules, [~~this Act~~], the commissioner may:

(1) impose sanctions under the Insurance Code Chapter 82 [~~, Article 1.10, §7~~];

(2) issue a cease and desist order under the Insurance Code Chapter 83 [~~, Article 1.10A~~]; or

(3) assess administrative penalties under the Insurance Code Chapter 84 [~~, Article 1.10E~~].

[~~(e) If the utilization review agent has violated or is violating any provisions of the Insurance Code other than the Act, or applicable rules of the department, sanctions may be imposed under the Insurance Code, Article 1.10 or 1.10A.~~]

(e) [~~(f)~~] The commission of fraudulent or deceptive acts or omissions in obtaining, attempting to obtain, or use of certification or registration as a utilization review agent is [~~shall be~~] a violation of Chapter 4201 of the Insurance Code [~~the Act~~].

(f) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1719. Responsibility of HMOs and Insurers Performing Utilization Review [~~under the Insurance Code, Article 21.58A, §14(g) and (h)~~].

(a) HMOs Performing Utilization Review [~~HMOs performing utilization review~~].

(1) An HMO [~~HMOs~~] performing utilization review under the Insurance Code Chapter 4201 is subject to this subchapter, except, pursuant to the Insurance Code §4201.057, an HMO performing utilization review under the Insurance Code Chapter 4201 is not subject to the certification requirements in §19.1704 of this subchapter (relating to Certification or Registration of Utilization Review Agents), if the HMO performs utilization review only for coverage for which it is the payor[~~, Article 21.58A, §14(g) shall be subject to §19.1701 of this title (relating to General Provisions),~~

~~§19.1702 of this title (relating to Limitations on Applicability), §19.1703 of this title (relating to Definitions), §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents), §19.1705 of this title (relating to General Standards of Utilization Review), §19.1706 of this title (relating to Personnel), §19.1707 of this title (relating to Prohibitions of Certain Activities of Utilization Review Agents), §19.1708 of this title (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers), §19.1709 of this title (relating to On-Site Review by the Utilization Review Agent), §19.1710 of this title (relating to Notice of Determinations Made by Utilization Review Agents), §19.1711 of this title (relating to Requirements Prior to Adverse Determination), §19.1712 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents), §19.1713 of this title (relating to Utilization Review Agent's Telephone Access), §19.1714 of this title (relating to Confidentiality), §19.1715 of this title (relating to Retrospective Review of Medical Necessity), §19.1716 of this title (relating to Complaints and Information), §19.1717 of this title (relating to Administrative Violations), §19.1720 of this title (relating to Specialty Utilization Review Agent), and §19.1721 of this title (relating to Independent Review of Adverse Determinations) with respect to their operations under the provisions of the Act, §14(g)~~].

(2) Notwithstanding paragraph (1) of this subsection, when an HMO [~~When a health maintenance organization~~] performs utilization review for an individual [~~a person~~] or entity subject to this subchapter [~~other than one~~] for which it is not the payor, such HMO must have [~~health maintenance organization shall be required to obtain~~] a

valid certificate under Chapter 4201 of the Insurance Code and in accordance with §19.1704 of this subchapter [~~the Act, §3, and comply with all the provisions of the Act~~].

(3) Notwithstanding paragraph (1) of this subsection, when an HMO performs [~~Health maintenance organizations performing~~] utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the HMO must have a valid registration pursuant to §19.1704 of this subchapter and must comply with all filing requirements under §19.1704 of this subchapter. However, an HMO is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health coverage for which it is the payor [~~the Act, §14(g) must register with the department and submit written documentation demonstrating compliance with all filing requirements defined in §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents) and the name, address, contact name and phone number of the health maintenance organization~~].

(4) An HMO [~~A health maintenance organization~~], including an HMO [~~a health maintenance organization~~] that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under the [~~Chapter 32,~~] Human Resources Code Chapter 32, is subject to the Insurance Code Chapter 4201 and this subchapter [~~article~~].

(5) An HMO [~~Health maintenance organizations~~] must submit to assessment of maintenance taxes under the Insurance Code Chapter 258 [~~Article~~

~~20A.33~~], to cover the costs of administering compliance of HMOs [~~health maintenance organizations~~] under Chapter 4201 of the Insurance Code [~~the Act~~].

(b) Insurers Performing Utilization Review [~~performing utilization review~~].

(1) An insurer performing utilization review under the Insurance Code Chapter 4201 is subject to this subchapter, except, pursuant to the Insurance Code §4201.058, an insurer performing utilization review under the Insurance Code Chapter 4201 is not subject to the certification requirements in §19.1704 of this subchapter, if the insurer performs utilization review only for coverage for which it is the payor.

(2) [~~(1)~~] Pursuant to the Insurance Code §4201.058, an [~~An~~] insurer that delivers or issues for delivery a health insurance policy in Texas and that performs utilization review [~~is subject to the Insurance Code, Article 21.58A and such insurer~~] is [~~shall be~~] subject to assessment of maintenance tax under the Insurance Code Chapter 257 to cover the costs of administering compliance of insurers.

[~~(2) Insurers performing utilization review under the Insurance Code, Article 21.58A, §14(g) will be subject to §19.1701 of this title (relating to General Provisions), §19.1702 of this title (relating to Limitations on Applicability), §19.1703 of this title (relating to Definitions), §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents), §19.1705 of this title (relating to General Standards of Utilization Review), §19.1706 of this title (relating to Personnel), §19.1707 of this title (relating to Prohibitions of Certain Activities of Utilization Review Agents), §19.1708 of this title (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers), §19.1709 of this title (relating to On-Site Review by the~~

~~Utilization Review Agent), §19.1710 of this title (relating to Notice of Determinations Made by Utilization Review Agents), §19.1711 of this title (relating to Requirements Prior to Adverse Determination), §19.1712 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents), §19.1713 of this title (relating to Utilization Review Agent's Telephone Access), §19.1714 of this title (relating to Confidentiality), §19.1715 of this title (relating to Retrospective Review of Medical Necessity), §19.1716 of this title (relating to Complaint and Information), §19.1717 of this title (relating to Administrative Violations), §19.1720 of this title (relating to Specialty Utilization Review Agent), and §19.1721 of this title (relating to Independent Review of Adverse Determinations) with respect to their operations under the provisions of the Act, §14(h).~~]

(3) Notwithstanding paragraph (1) of this subsection, when an insurer performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such insurer must have a valid certificate as required by the Insurance Code §4201.101 and in accordance with §19.1704 of this subchapter.

(4) [~~(3)~~] Notwithstanding paragraph (1) of this subsection, when [~~When~~] an insurer performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the insurer must have a valid registration pursuant to §19.1704 of this subchapter and comply with all filing requirements under §19.1704 of this subchapter. However, the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health coverage for which it is the payor. [~~for a person or entity subject to this subchapter other~~

~~than one for which it is the payor, such insurer shall be required to obtain a certificate under the Act, §3, and comply with all the provisions of the Act.~~]

[~~(4) Insurers performing utilization review under the Act, §14(h) must register with the department and submit written documentation demonstrating compliance with all the filing requirements defined in §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents) and the name, address, contact name and phone number of the insurer.~~]

(c) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1720. Specialty Utilization Review Agent.

(a) Application. In order to be certified or registered as a specialty utilization review agent, an applicant must submit to the department the application and information required in §19.1704 of this subchapter (relating to Certification or Registration of Utilization Review Agents).

(b) Statutory and Rule Requirements.

(1) In accordance with the Insurance Code §4201.452, a specialty utilization review agent [~~A utilization review agent that solely performs specialty review under the Insurance Code, Article 21.58A, §14(j)~~] is subject to the requirements of [~~Act, except for~~] the Insurance Code Chapter 4201[~~, Article 21.58A, §4, (c), (h) or (k) or~~

~~§6(b)(3) of the Act.~~], except that the specialty utilization review agent is not subject to the following sections:

(A) §4201.151 (Utilization Review Plan);

(B) §4201.152 (Utilization Review Under Direction of Physician);

(C) §4201.206 (Opportunity to Discuss Treatment Before Adverse Determination);

(D) §4201.252 (Personnel); and

(E) §4201.356 (Decision by Physician Required; Specialty Review).

(2) A specialty utilization review agent [~~that does not solely perform specialty review,~~] is [~~not~~] subject to the requirements of this subchapter, except for the following provisions: [~~of this section or the Insurance Code, Article 21.58A, §14(j).~~]

[~~(b) A utilization review agent that performs specialty review under the Insurance Code, Article 21.58A, §14(j) is subject to this subchapter, except: §19.1704(c)(1)(B); (c)(6); (j)(1)~~]

(A) §19.1705(a) of this subchapter [~~title (relating to Certification of Utilization Review Agents); §19.1705 of this title~~] (relating to General Standards of Utilization Review); [~~and~~]

(B) §19.1706(a), (d), (e), and (g) of this subchapter [~~title~~] (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.1711(b) and (c) [~~§19.1711)~~] of this subchapter [~~title~~] (relating to Requirements Prior to Issuing Adverse Determination); and

(D) §19.1712(a)(2)(D) and (E) and (b)(3) [~~§19.1712(b)(3)~~] of this subchapter [~~title~~] (relating to Appeal of Adverse Determination [~~of Utilization Review Agents~~]).

(c) Utilization Review Plan. A specialty utilization review agent is required to have its [~~must submit by attachment to the application assurance that the~~] utilization review plan, including [~~reconsideration and~~] appeal requirements, [~~shall be~~] reviewed by a health care provider of the appropriate specialty, and the plan must be implemented [~~conducted~~] in accordance with standards developed with input from a health care provider of the appropriate specialty. The specialty utilization review agent must have written procedures to ensure that these requirements are implemented.

[~~(d) A specialty utilization review agent must submit by attachment to the application a description of the categories of personnel who perform utilization review, such as physicians, dentists, nurses, physicians assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States, except that this provision does not require those qualifications from personnel who perform solely clerical or administrative tasks.~~]

[~~(e) An applicant for a certificate of registration as a specialty utilization review agent must provide evidence that the applicant has available the services of physicians, dentists, nurses, physician's assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to~~

~~provide the specialty health care service by a state licensing agency in the United States to carry out its utilization review activities in a timely manner.~~]

(d) [~~(f)~~] Requirements of Employed or Contracted Physicians, Doctors, Other Health Care Providers, and Personnel.

(1) Physicians, doctors, other health care providers, and personnel [~~Personnel~~] employed by or under contract with the specialty utilization review agent to perform utilization review must [~~shall~~] be appropriately trained, [~~and~~] qualified, and[~~, if applicable,~~] currently licensed.

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

(3) Personnel who obtain information regarding an enrollee's [~~a patient's~~] specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, [~~dentist~~] or health care provider, either orally or in writing, and who are not physicians or doctors [~~dentists~~], must [~~shall~~] be nurses, physician [~~physician's~~] assistants, or [~~other~~] health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(e) Information Required to be Filed with the Department. The specialty utilization review agent is required to provide the name, number, type, license number, and state of licensure and qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information.

(f) Written Procedures and Maintenance of Records.

(1) Specialty utilization review agents are required to develop and implement written procedures for determining if physicians, doctors or other health care providers used by the utilization review agent are licensed, qualified, and appropriately trained or experienced.

(2) The specialty utilization review agent must maintain documentation that demonstrates that physicians, doctors and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced, in accordance with subsection (d) of this section.

(g) Utilization Review by a Specialty Utilization Review Agent. Utilization review conducted by a specialty utilization review agent must [~~shall~~] be [~~conducted~~] under the direction of a physician, doctor, or health care provider of the same specialty, and the physician, doctor, or health care provider must [~~shall~~] be currently licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. Such physician, doctor, or health care provider may be employed by or under contract to the specialty utilization review agent.

(h) Reasonable Opportunity for Discussion.

(1) Prospective and concurrent utilization review.

(A) Subject to the notice requirements of §19.1710 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review) and §19.1712 of this subchapter [~~title (relating to Appeal of Adverse Determination)~~], in any instance in which [~~where~~] the specialty utilization review agent questions the medical necessity or appropriateness, or the experimental or investigational nature, of health care services, the health care provider of record [~~who ordered the services~~] must [~~shall~~], prior to the issuance of an adverse determination, be afforded a reasonable opportunity, as defined in §19.1711(a) of this subchapter, to discuss the plan of treatment for the patient and the clinical basis for the decision of the utilization review agent with a health care provider of the same specialty as the utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under paragraph (1)(A) of this subsection, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity

to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent must submit the documentation required by subparagraph (D) of this paragraph to the department upon request.

(2) Retrospective utilization review.

(A) Subject to the notice requirements of §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the specialty utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services provided, prior to the issuance of an adverse determination, the specialty utilization review agent must provide the provider of record a reasonable opportunity, as defined in §19.1711(a) of this subchapter, to discuss the treatment provided to the enrollee with a health care provider of the same specialty as the specialty utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under paragraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination. The specialty utilization review agent

must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent is required to submit the documentation required by subparagraph (D) of this paragraph to the department upon request.

(i) Appeal. The decision in any appeal of an adverse determination by a specialty utilization review agent [~~An appeal decision~~] must [~~shall~~] be made by a physician or other health care provider who has not previously reviewed the case and who is of [~~in~~] the same [~~or a similar~~] specialty as the specialty utilization review agent that made the adverse determination. [~~typically manages the medical, dental or specialty condition, procedure, or treatment which is the subject of the adverse determination under review. The specialty review must be completed within 15 working days of receipt of the request.~~]

§19.1721. Independent Review of Adverse Determinations.

(a) Life-threatening Conditions.

(1) Notification for life-threatening conditions.

(A) For life-threatening conditions, notification of adverse determination by the utilization review agent must be provided within the time frames specified [~~addressed~~] in §19.1710(c)(4) [~~§19.1710(d)~~] of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~]).

(B) At the time of notification of the adverse determination, the utilization review agent must [~~shall~~] provide to the enrollee[~~,~~] or individual [~~person~~] acting on behalf of the enrollee, and to the enrollee's provider of record, the notice of the independent review process [~~notification~~] and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) [~~the form prescribed by the commissioner~~] for requesting [~~accessing~~] independent review. Such notice must [~~notification shall~~] describe how to obtain independent review of such determination and how the department assigns a request for review to an independent review organization[~~, and include the form requesting enrollee information~~].

(C) [~~(b)~~] The enrollee, individual [~~person~~] acting on behalf of the enrollee, or the enrollee's provider of record is required to [~~shall~~] 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 [~~his or her~~] disease or condition is a life-threatening condition.

(2) [~~(c)~~] Appeal of adverse determination involving life-threatening condition. Any [~~A utilization review agent shall permit any~~] party who receives an adverse determination involving a life-threatening condition(s) or whose [~~has completed~~

~~the internal appeals process as defined in Insurance Code, Article 21.58A, §6 and such~~] appeal of an adverse determination is denied [~~resulted in a denial~~] by the utilization review agent[~~, health maintenance organization or insurer,~~] may [~~to~~] seek review of that determination or denial by an independent review organization assigned [~~to the appeal~~] in accordance with the Insurance Code Chapter 4202. [~~,Article 21.58C as follows:~~]

[~~(1) the utilization review agent shall provide a notification prescribed by the commissioner to the enrollee or the person acting on behalf of the enrollee and the enrollee's provider of record, on how to appeal the denial of an internal appeal to an independent review organization. The notification shall describe how to obtain independent review of such determination and how the department assigns a request for review to an independent review organization, and include the form requesting enrollee information;~~]

[~~(2) the utilization review agent shall provide the notification and the form prescribed by the commissioner to the enrollee or the person acting on behalf of the enrollee and the enrollee's provider of record at the time of denial of the appeal;~~]

[~~(3) the form prescribed by the commissioner shall be completed by the enrollee, person acting on behalf of the enrollee or the enrollee's provider of record and returned to the utilization review agent to begin the independent review process. The form prescribed by the commissioner authorizing release of medical information to the independent review organization must be signed by the enrollee or the enrollee's legal guardian.~~]

(b) [~~(d)~~] Independent Review Involving Life-Threatening and Non-Life Threatening Conditions.

(1) Request for independent review.

(A) The utilization review agent is required to [~~shall~~] notify the department within one working day from the date the request [~~upon receipt of the request~~] for an independent review is received.

(B) [~~(e)~~] The utilization review agent must [~~shall~~] provide [~~information~~] to the department the completed Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) submitted to the utilization review agent by the party requesting independent review [~~contained in the form prescribed by the commissioner to the department~~].

(C) The [~~notification and information~~] ~~contained in~~ Form No. LHL009 must [~~shall~~] be submitted to the department via the department's Internet website [~~modem or, in the event that modem is unavailable, through facsimile~~].

[~~(f) The utilization review agent may access the department on working days, between 7:00 a.m. and 6:00 p.m. Central time, Monday through Friday, to obtain assignment of an independent review organization.~~]

(2) [~~(g)~~] Assignment of independent review organization. The department will [~~shall~~], within one working day of receipt of the complete request for independent review, randomly assign an independent review organization to conduct the independent review and notify the utilization review agent, payor, [~~and~~] the independent review organization, [~~of the assignment. The department shall send notification to~~] the

enrollee or individual [~~person~~] acting on behalf of the enrollee, [~~and~~] the enrollee's provider of record, and any other providers listed by the utilization review agent as having records relevant to the review of the assignment [~~no later than one working day after the assignment has been made~~].

(3) [~~(h)~~] Information required to be provided to the assigned independent review organization. Not later than the third working day after the date that the utilization review agent receives a request for independent review, the utilization review agent must [~~shall~~] provide to the assigned independent review organization a copy of:

(A) [~~(1)~~] any medical records of the enrollee in the possession of the utilization review agent or health benefit plan that are relevant to the review;

(B) [~~(2)~~] any documents used by the utilization review agent or the health benefit plan in making the determinations to be reviewed by the independent review organization;

(C) [~~(3)~~] the written notification described by §19.1710 of this subchapter, §19.1712 of this subchapter (relating to Appeal of Adverse Determination), and §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review) [~~§19.1712(b)(6) of this title (relating to Appeal of Adverse Determination of Utilization Review Agents)~~];

(D) [~~(4)~~] any documentation and written information submitted to the utilization review agent or health benefit plan in support of the appeal; and

(E) [~~(5)~~] a list containing the name, address, and phone number of each physician, doctor, or other health care provider who has provided care to the enrollee and who may have medical records relevant to the review [~~appeal~~].

(4) [~~(i)~~] Payor and utilization review agent compliance. The payor and utilization review agent must [~~shall~~] comply with the independent review organization's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of health care items and services for an enrollee.

(5) Costs of independent review.

(A) [~~(j)~~] The utilization review agent is required to [~~shall~~] pay for the independent review.

(B) [~~(k)~~] The utilization review agent may recover costs associated with the independent review from the payor.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1723. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) An HMO or preferred provider benefit plan [~~carrier~~] that requires preauthorization as a condition of payment to a preferred provider must [~~shall~~] 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 [~~carrier~~] identifies in accordance with subsection (b) of this section.

(b) An HMO or preferred provider benefit plan [~~carrier~~] that uses a preauthorization process for medical care and health care services must [~~shall~~] provide to each contracted preferred provider, not later than the 10th working [~~business~~] 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.

(c) If the proposed medical care or health care services involve inpatient care, the HMO or preferred provider benefit plan must [~~carrier shall~~] review the request and, if approved, issue a length of stay for the admission into a health care facility based on the recommendation of the enrollee's [~~patient's~~] preferred provider and the HMO or preferred provider benefit plan's [~~carrier's~~] written medically accepted screening criteria and review procedures.

(d) On receipt of a preauthorization request from a preferred provider for proposed services that require preauthorization, the HMO or preferred provider benefit plan must [~~carrier shall~~] issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. An HMO or preferred provider benefit plan must [~~carrier shall~~] respond to request for preauthorization within the following time periods.

(1) For services not included under paragraphs (2) and (3) of this subsection, the 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 [~~carrier~~]. 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 such personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider benefit plan must [~~carrier shall~~] 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 such 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 subchapter [~~title~~] (relating to Definitions), the HMO or preferred provider benefit plan must [~~carrier shall~~] 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 [~~patient~~], 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 such personnel. In such circumstances, the determination must [~~shall~~] be provided to the treating physician, doctor, or other health care provider. If the HMO or preferred provider benefit plan [~~carrier~~] 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 [~~carrier shall~~] provide to the enrollee or individual [~~person~~] acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1721(a)(1)(A) and (B) [~~§19.1721(c)~~] of this subchapter [~~title~~] (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may request a preauthorization determination [~~inquire~~] via telephone from [~~as to~~] the HMO or preferred provider benefit plan [~~carrier's preauthorization determination~~]. An HMO or preferred provider benefit plan must [~~carrier shall~~] have appropriate personnel as described in §19.1706 of this subchapter [~~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 [~~central time~~] Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon Central Time [~~central time~~] on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan [~~carrier~~] must have a telephone system capable of accepting or recording incoming

requests [~~inquiries~~] after 6:00 p.m. Central Time [~~central time~~] Monday through Friday and after noon Central Time [~~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 [~~carrier~~] providing a preauthorization determination under subsection (d) of this section must [~~shall~~], 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 that is exempt from subsection (e), as described in this subsection, must [~~shall~~]:

(1) have appropriate personnel as described in §19.1706 of this subchapter [~~title (relating to Personnel)~~] 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 [~~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 [~~inquiries~~] after 5:00 p.m. Central Time [~~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 [~~business~~] 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 [~~carrier~~] has preauthorized medical care or health care services, the HMO or preferred provider benefit plan [~~carrier~~] 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 [~~carrier~~] issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1710(c)(1) [~~§19.1710(c)~~] of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~]) must [~~shall~~] be provided to the enrollee, an individual [~~a person~~] acting on behalf of the enrollee, or the enrollee's provider of record. An enrollee may appeal any adverse determination in accordance with §19.1712 of this subchapter [~~title~~] (relating to Appeal of Adverse Determination [~~of Utilization Review Agents~~]).

(i) This section applies to an agent or other person with whom an HMO or preferred provider benefit plan [~~carrier~~] 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 [~~carrier's~~] responsibility to comply with all statutory and regulatory requirements.

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

(k) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1724. Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The provisions of this section apply to:

(1) HMOs;

(2) preferred provider benefit plans [~~carriers~~];

(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 [~~carrier~~]:

(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 [~~carrier~~], 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 [~~carrier's~~] network.

(b) An HMO or preferred provider benefit plan [~~carrier~~] 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 [~~internet~~], as agreed to by the preferred provider and the HMO or preferred provider benefit plan [~~carrier~~], provided that such agreement may not limit the preferred provider's option to request a verification by telephone call.

(c) An HMO or preferred provider benefit plan [~~carrier~~] is required to [~~shall~~] have appropriate personnel reasonably available at a toll-free telephone number to accept telephone requests for verification and to provide determinations of previously requested verifications between 6:00 a.m. and 6:00 p.m. Central Time [~~central time~~] Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon Central Time [~~central time~~] on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan [~~carrier~~] must have a telephone system capable of accepting or recording incoming requests [~~inquiries~~] after 6:00 p.m. Central Time [~~central time~~] Monday through Friday and after noon Central Time [~~central time~~] on Saturday, Sunday, and legal holidays. The HMO or preferred provider benefit plan [~~carrier~~] must acknowledge each of those 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; [~~and~~]

(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) 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 (c) of this section with respect to those services. Instead, such exempt HMO must [~~An HMO that is exempt from subsection (c) of this section, as described in this subsection, shall~~]:

(1) have appropriate personnel reasonably available at a toll-free telephone number to accept telephone requests for verification and to provide determinations of previously requested verifications between 8:00 a.m. and 5:00 p.m. Central Time [~~central time~~] Monday through Friday on each day that is not a legal holiday and;

(2) have a telephone system capable of accepting or recording incoming requests [~~inquiries~~] after 5:00 p.m. Central Time [~~central time~~] Monday through Friday and all day on Saturday, Sunday, and legal holidays. The HMO must acknowledge each of those calls not later than the next working [~~business~~] day after the call is received.

(e) Any request for verification must [~~shall~~] contain the following information:

(1) enrollee [~~patient~~] name;

(2) enrollee [~~patient~~] ID number, if included on an identification card issued by the HMO or preferred provider benefit plan [~~carrier~~];

(3) enrollee [~~patient~~] date of birth;

(4) name of enrollee or subscriber, if included on an identification card issued by the HMO or preferred provider benefit plan [~~carrier~~];

(5) enrollee [~~patient~~] relationship to enrollee or subscriber;

(6) presumptive diagnosis, if known; [~~,~~] otherwise presenting symptoms;

(7) description of proposed procedure(s) or procedure code(s);

(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 [~~carrier~~];

(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.

(f) 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).

(g) If necessary to verify proposed medical care or health care services, an HMO or preferred provider benefit plan [~~carrier~~] may, within one day of receipt of the 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 [~~carrier~~] may make only one request for additional information from the requesting preferred provider under this section.

(h) A request for information under subsection (g) 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.

(i) On receipt of a request for verification from a preferred provider, the HMO or preferred provider benefit plan must [~~carrier shall~~] issue a verification or declination. An HMO or preferred provider benefit plan must [~~carrier shall~~] 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 [~~carrier shall~~] 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 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 subsections (c) and (d) of this section, the determination must be provided within five days from the beginning of the next time period requiring such 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 [~~carrier~~] 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 24 hours from the beginning of the next time period requiring such 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 [~~carrier~~] 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 such personnel.

(j) If the request involves services for which preauthorization is required, the HMO or preferred provider benefit plan is required to implement [~~carrier shall follow~~] the procedures set forth in §19.1723 of this subchapter [~~title~~] (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and respond regarding the preauthorization request in compliance with that section.

(k) 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 [~~carrier~~]. If the verification or declination is delivered via telephone call, the HMO or preferred provider benefit plan must [~~carrier shall~~], 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 [~~shall~~] not be less than 30 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 [~~carrier~~] 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 [~~pursuant to Title 28 Texas Administrative Code §19.1724~~].

(l) An HMO or preferred provider benefit plan [~~carrier~~] that issues a verification may not deny or otherwise reduce payment to the preferred provider for those medical care or health care services if provided on or before the expiration date for the verification, which may [~~shall~~] not be less than 30 days, unless the preferred provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the medical or health care services as verified.

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

(n) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE
28 TAC §§19.2001 – 19.2017 and 19.2019 - 19.2021

§19.2001. General Provisions.

(a) Statutory basis. This subchapter implements the provisions of the Insurance Code Chapter 4201, which was amended by Acts 2009, 81st Legislature, Chapter 1330, which was effective September 1, 2009; the Insurance Code Chapter 1305 as of the effective date of the rule, and the Labor Code Title 5 as of the effective date of the rule [~~, Article 21.58A.~~]

(b) Severability. If [~~Where any terms or sections of this subchapter are determined by~~] 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 [~~to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining terms and provisions of this subchapter shall remain in~~] 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 [~~these rules~~] is to:

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

(2) assure that utilization review agents adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and utilization review agents;

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

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

(d) Health Care Utilization Review. For utilization review performed under a health benefit plan or health insurance policy, the provisions of Subchapter R of this chapter (relating to Utilization Reviews for Health Care Provided under a Health Benefit Plan or Health Insurance Policy) apply in lieu of the provisions in this subchapter.

§19.2002. Limitations on Applicability.

(a) Except as provided in the Insurance Code Chapter 4201, this subchapter applies to utilization review performed under workers' compensation insurance coverage. This subchapter does not affect the authority of the TDI-DWC [~~Texas Workers' Compensation Commission~~] to exercise the powers granted to it [~~that commission~~] under [~~Title 5,~~] the Labor Code Title 5 and the Insurance Code Chapter 4201. This subchapter applies to utilization review as set forth in the Insurance Code Chapters 1305 and 4201 and the Labor Code Title 5.

(b) Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must comply with this subchapter, the Labor Code Title 5, and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement). If there is a conflict between this chapter and rules adopted by the Commissioner of Workers' Compensation, the rules adopted by the Commissioner of Workers' Compensation prevail.

(c) This subchapter does not apply to [~~a utilization review agent or other person which conducts only the functions of categories of utilization review listed in paragraphs (1) – (3) of this section:~~]

[~~(1)~~] a person that only [~~who~~] provides information to injured employees, their representatives, or their physicians, doctors, or other [~~and/or~~] health care providers about scope of coverage or benefits provided for under workers' compensation

insurance coverage but that [~~and who~~] does not determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. [~~whether particular health care provided or to be provided to an injured employee is medically reasonable and necessary;~~]

[~~(2) a doctor, as defined in §19.2003 of this title (relating to Definitions), or any other individual licensed to provide health care, performing utilization review who is an employee of, or a contractor to, a certified utilization review agent;~~]

[~~(3) a utilization review agency which conducts only the categories of utilization review listed in subparagraphs (A) - (D) of this paragraph:~~]

[~~(A) reviews performed pursuant to any contract with the federal government for utilization review of patients eligible for services under Title XVIII or XIX of the Social Security Act (42 United States Code §§1395 et seq. or §§1396 et seq.);~~]

[~~(B) reviews performed for the Texas Medicaid Program, except reviews performed by a health maintenance organization that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code, the Chronically Ill and Disabled Children's Services Program created pursuant to Chapter 35, Health and Safety Code, any program administered under Title 2, the Human Resources Code, any program of the Texas Department of Mental Health and Mental Retardation, or any program of the Texas Department of Criminal Justice;~~]

[~~(C) reviews of health care services provided under a policy or contract of automobile insurance promulgated by the department under the Insurance Code, Subchapter A, Chapter 5 or issued pursuant to the Insurance Code Article 1.14; or~~]

[~~(D) reviews that apply to the terms and benefits of the employee welfare benefit plans as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).~~]

§19.2003. Definitions. The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

[~~(1) Act--Insurance Code Article 21.58A, entitled "Health Care Utilization Review Agents."~~]

[~~(2) Active practice -- A minimum of 20 hours per week in the examination, diagnosis and/or treatment of patients.~~]

[~~(3) Administrative Procedure Act--Government Code, Chapter 2001.~~]

(1) Administrator--A person holding a certificate of authority under the Insurance Code Chapter 4151.

(2) [~~(4)~~] Adverse determination--A determination by a utilization review agent made on behalf of any payor that the health care services provided [~~furnished~~] or proposed to be provided [~~furnished~~] to an injured employee are [~~is~~] not medically [~~reasonable and~~] necessary or appropriate. The term does not include a denial of health care services due to the lack of 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.

(3) [~~(5)~~] Appeal [~~process~~]--The utilization review agent's formal process in which an injured employee, an injured employee's representative, or the 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 the Labor Code Title 5 and applicable rules for workers' compensation. [~~The processes outlined in the Texas Workers' Compensation Act, including, but not limited to Texas Labor Code §413.031, Chapter 134, Subchapter G of this Title (relating Prospective and Concurrent Review of Health Care), and Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance carriers).~~]

(4) [~~(6)~~] Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a utilization review agent in the State of Texas. A certificate is not issued to an insurance carrier that is registered as a utilization review agent under §19.2004 of this subchapter (relating to Certification or Registration of Utilization Review Agents). [~~A certificate of registration granted by the commissioner to a utilization review agent.~~]

(5) [~~(7)~~] Commissioner--The commissioner of insurance [~~Commissioner of Insurance~~]

(6) [~~(8)~~] Compensable injury--An injury that arises out of and in the course and scope of employment for which compensation is payable under the Texas Workers' Compensation Act.

(7) [~~(9)~~] Complaint--An oral or written expression of dissatisfaction with a utilization review agent concerning the utilization review agent's process in conducting a utilization review. The term "complaint" does not include: [~~A complaint is not~~]

(A) an expression of dissatisfaction with a specific adverse determination; 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.

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

[~~(10) Department--Texas Department of Insurance.~~]

(9) [~~(11)~~] Dentist--A licensed doctor of dentistry, holding either a D.D.S. or a D.M.D. degree.

(10) Department--Texas Department of Insurance.

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

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and 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 the physician's or doctor's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Labor Code or applicable TDI-DWC rules, the Insurance Code, or applicable department rules, or any other association with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the reviewing physician or doctor from rendering an unbiased opinion.

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

(13) Experimental or investigational--A 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.

(14) [~~(13)~~] Health care--Includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term does not include vocational rehabilitation. The term includes:

(A) medical, surgical, chiropractic, podiatric, optometric, dental, nursing, and physical therapy services provided by or at the direction of a doctor;

(B) physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a doctor;

(C) psychological services prescribed by a doctor;

(D) the services of a hospital or other health care facility;

(E) a prescription drug, medicine, or other remedy; and

(F) a medical or surgical supply, appliance, brace, artificial member, or prosthetic or orthotic device [~~prosthesis~~], including the fitting of, change or repair to, or training in the use of the appliance, brace, member, or device [~~prosthesis~~].

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

(16) [~~(15)~~] Health care provider--A [~~Any~~] person, corporation, facility, or institution that is:

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

(B) [~~that is~~] eligible for independent reimbursement for those health care services.

[~~(16) Injured employee--An employee with a compensable injury under the Texas Workers' Compensation Act.~~]

[~~(17) Inquiry—A request for information or assistance from a utilization review agent.~~]

(17) [~~(18)~~] Insurance carrier or insurer--

(A) a person authorized and admitted by the Texas Department of Insurance to do the business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance [~~an insurance company~~];

(B) a certified self-insurer for workers' compensation insurance; [~~or~~]

(C) a certified self-insurance group under the Labor Code Chapter 407A; or

(D) [~~(C)~~] a governmental entity that self-insures, either individually or collectively.

[~~(19) Insurance company--A person authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance.~~]

(18) Legal holiday--A national holiday as defined in the Government Code §662.003(a).

(19) [~~(20)~~] Life-threatening--A disease or condition resulting from a compensable injury, from [~~for~~] which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(20) [~~(21)~~] Medical benefit--Payment for health care reasonably required by the nature of a compensable injury and intended to:

(A) cure or relieve the effects naturally resulting from the compensable injury, including reasonable expenses incurred by the injured employee

for necessary treatment to cure and relieve the injured employee from the effects of an occupational disease before and after the injured employee knew or should have known the nature of the disability and its relationship to the employment;

(B) promote recovery; or

(C) enhance the ability of the injured employee to return to or retain employment.

(21) 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.

(22) Medical records--The entire history of diagnosis and treatment for a compensable injury, including but not limited to medical, mental health records as allowed by law, dental, and other health care records from all disciplines rendering care to an injured employee.

(23) 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 such as:

(A) identifying information; and

(B) a treatment plan that includes:

(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.

(24) 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 by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a psychological associate by the Texas State Board of Examiners of Psychologists;

(D) an individual licensed as a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

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

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

(G) an individual licensed as an advanced clinical practitioner by the Texas State Board of Social Worker Examiners;

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

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

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

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

(L) an individual licensed as a vocational nurse by the Texas Board of Nursing; or

(M) 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.

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

(26) [~~(23)~~] Nurse--A professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse.

[~~(24) Open records law--Government Code Chapter 552.~~]

(27) 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 in this state under a policy, plan, or contract.

(28) Peer review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

(29) [~~(25)~~] Person--An individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(30) [~~(26)~~] Physician--A licensed doctor of medicine or a licensed doctor of osteopathy.

(31) [~~(27)~~] Preauthorization--A form of prospective utilization review by a payor or its utilization review agent of health care services proposed to be provided to an injured employee. [~~The process requesting approval to provide a specific treatment or service prior to rendering the treatment or service as defined and delineated in Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care).~~]

(32) 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 injured employee, or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to the injured employee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(33) Registration--The process for an insurance carrier to register with the department to perform utilization review solely for its own insureds or injured employees.

(34) [~~(28)~~] 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. [~~The process of reviewing health care which has been provided to injured employees under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary.~~]

(35) [~~(29)~~] Screening criteria--The written policies, decision rules, medical protocols, or guidelines [~~TWCC fee and treatment guidelines, and TWCC rules and advisories~~] used by the utilization review agent as part of the utilization review process (e.g., appropriateness evaluation protocol (AEP) and intensity of service, severity of illness, discharge, and appropriateness screens (ISD-A)). [~~The TWCC Treatment Guidelines are tools that identify recommended treatment parameters and typical courses of intervention, whose purpose is to clarify those services that are reasonable and medically necessary. The guidelines are not to be used as fixed treatment protocols by either the health care provider or insurance carrier and shall not be viewed as prescriptive or the sole basis for approval or denial of proposed services. There may be injured employees who will require more or less treatment than is recommended in the guidelines. Treatment falling outside the parameters of the guidelines will be~~

~~subject to more careful scrutiny and may require additional documentation of special circumstances to justify the need for treatment. Each guideline includes specific ground rules which establish the use of the guideline.~~]

(36) Specialty utilization review agent-- A utilization review agent that conducts utilization review for a specialty health care service under the Insurance Code Chapter 4201 including, but not limited to, dental services, chiropractic services, behavioral health services, vision services, or physical therapy services.

(37) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(38) ~~(30)~~] Texas Workers' Compensation Act--The [~~Texas~~] Labor Code Title 5, Subtitle A.

(39) [~~(31)~~] Treating doctor--The doctor primarily responsible for treating the injured employee's compensable injury as defined in the [~~Texas~~] Labor Code, §401.011(42).

[~~(32) TWCC--Texas Workers' Compensation Commission.~~]

(40) [~~(33)~~] Utilization review--A system for prospective, [~~preauthorization and~~] 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. [~~, or both preauthorization and retrospective review or both concurrent and retrospective review, to determine if health care proposed to be provided, being provided, or which has been provided to an injured employee is medically reasonable and necessary.~~] Utilization

review does [~~shall~~] not include elective requests for clarification of coverage [~~or prepayment guarantee~~].

(41) [~~(34)~~] Utilization review agent--An entity that conducts utilization review for: [~~insurance carrier, the carrier's agent(s), and/or any entity contracted or subcontracted to provide utilization review.~~]

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

(B) a payor; or

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

(42) [~~(35)~~] Utilization review plan--The screening criteria and utilization review procedures of a utilization review agent.

(43) Workers' compensation health care network--An organization that is:

(A) formed as a health care provider network to provide or arrange to provide health care services to injured employees;

(B) required to be certified in accordance with the Insurance Code Chapter 1305, this chapter, and other rules of the commissioner as applicable; and

(C) established by, or operating under contract with, an insurance carrier.

(44) Workers' compensation insurance coverage--As defined in the Labor Code §401.011.

(45) Workers' compensation network coverage--Healthcare provided pursuant to a workers' compensation health care network.

(46) Workers' compensation non-network coverage--Health care delivered pursuant to the Labor Code Title 5, excluding health care provided pursuant to the Insurance Code Chapter 1305.

(47) [~~(36)~~] Working day-- Any day, Monday – Friday, other than a national holiday as defined by the Government Code §662.003(a) and the Friday after Thanksgiving Day, December 24, and December 26. Use in this subchapter of the term "day," rather than "working day," means a calendar day. [~~A weekday, excluding a legal holiday.~~]

[~~(37) Workers' compensation insurance coverage:~~]

[~~(A) an approved insurance policy, pursuant to Article 5.56 of the Insurance Code, to secure the payment of compensation under the Texas Workers' Compensation Act;~~]

[~~(B) coverage to secure the payment of compensation through self-insurance as provided by the Texas Workers' Compensation Act; or~~]

[~~(C) coverage provided by a governmental entity to secure the payment of compensation under the Texas Workers' Compensation Act.~~]

[~~(38) Concurrent review--A review of on-going health care for an extension of treatment beyond previously approved health care in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).~~]

§19.2004. Certification or Registration of Utilization Review Agents.

(a) Applicability of Certification or Registration Requirements. A person acting as or holding itself out as a utilization review agent must be certified or registered under the Insurance Code Chapter 4201 and this subchapter and must comply with all requirements in this section.

(1) Pursuant to §19.2019(b) of this subchapter (relating to Responsibility of Insurance Carriers Performing Utilization Review), if an insurance carrier performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such insurance carrier must have a valid certificate pursuant to the Insurance Code §4201.101 and this section.

(2) Pursuant to §19.2019(c) of this subchapter, if an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must have a valid registration pursuant to this section.

[~~(a) An application for certification of a utilization review agent must be filed with the Texas Department of Insurance at the following address: HMO Compliance/URA/IRO Section, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104.~~]

(b) Application Filing Requirements.

(1) Application for certification.

(A) An application for certification of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is

adopted by reference in §19.1704(b) of this chapter (relating to Certification or Registration of Utilization Review Agents).

(B) The application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19) of this chapter (relating to Amount of Fees).

(2) Application for registration.

(A) An application for registration of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in §19.1704(b) of this chapter.

(B) The original application fee requirement specified by §19.802(b)(19) of this chapter does not apply to an applicant for registration.

(3) Where to obtain and file the application Form. Form No. LHL005 may be obtained from and must be filed with the department at the following address: Texas Department of Insurance, Health and Workers' Compensation Network Certification & QA (HWCN) Division, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

[~~(b) The application must be submitted on a form which can be obtained from the HMO Compliance/URA/IOR Section, Mail Code 103-6A, Texas Department of Insurance, 333 Guadalupe, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(c) Required Information. Form No. LHL005 (Utilization Review Agent (URA) Application Form) requires [~~The attachments to the application form require~~] the following information:

(1) a summary description of the utilization review plan, which must include the matters listed in subparagraphs (A) and (B) of this paragraph and otherwise comply with[. The utilization review plan must meet] the requirements of §19.2005 of this subchapter [title] (relating to General Standards of Utilization Review):[;]

(A) an adequate summary description of screening criteria and review procedures to be used to determine health care is medically [reasonable and] necessary or appropriate, or experimental or investigational in nature; and

(B) a certification, signed by an authorized representative of the applicant [company], that screening criteria and review procedures to be applied in review determination are established with input from appropriate health care providers and approved by physicians;

(2) utilization review plan written policies that evidence compliance with:

(A) §19.2005 of this subchapter;

(B) §19.2006 of this subchapter (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.2007 of this subchapter (relating to Prohibition of Certain Activities and Procedures Related to Health Care Providers and Injured Employees);

(D) §19.2008 of this subchapter (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers);

(E) §19.2009 of this subchapter (relating to On-Site Review by the Utilization Review Agent);

(F) §19.2010 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review);

(G) §19.2011 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination);

(H) §19.2012 of this subchapter (relating to Appeal of Adverse Determination);

(I) §19.2013 of this subchapter (relating to Utilization Review Agent's Telephone Access);

(J) §19.2014 of this subchapter (relating to Confidentiality);

(K) §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review);

(L) §19.2016 of this subchapter (relating to Regulatory Requirements Subsequent to Certification or Registration);

(M) §19.2020 of this subchapter (relating to Specialty Utilization Review Agent), if applicable;

(N) §19.2021 of this subchapter (relating to Independent Review of Adverse Determinations); and

(O) the Labor Code §504.055, regarding expedited provision of medical benefits for first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment;

(3) utilization review plan written policies which attest that peer reviews will comply with the Texas Workers' Compensation Act and rules adopted pursuant to

the Texas Workers' Compensation Act including, but not limited to, Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills); Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care); Chapter 137 of this title (relating to Disability Management); and Chapter 180, Subchapter B of this title (relating to Medical Benefit Regulation);

(4) copies of template letters for notification of determinations made in utilization review that comply with §19.2010 and §19.2012 of this subchapter;

(5) organizational information:

(A) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state;

(B) a chart showing the internal organizational structure of the applicant's executives, officers, and directors and title of position held by each; and

(C) a letter of good standing from the Texas Comptroller of Public Accounts;

(6) the name and biographical affidavit and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under §1.503 of this title (relating to Application of Fingerprint Requirement) and §1.504 of this title (relating to Fingerprint Requirement); and

[~~(2) copies of procedures established for informing appropriate parties of the process for appeal of an adverse determination to TWCC. These procedures must~~

~~comply with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers);~~]

[~~(3) copies of procedures established for handling oral or written complaints by injured employees, their representatives or health care providers. These procedures must comply with §19.2016 of this title (relating to Complaints and Information);~~]

[~~(4) copies of policies and procedures which ensure that all applicable state and federal laws to protect the confidentiality of medical records are followed. These procedures must comply with §19.2014 of this title (relating to Confidentiality);~~]

(7) [~~(5)~~] a certification signed by an authorized representative of the company that the utilization review agent will comply with the provisions of the Insurance Code Chapter 1305, the Insurance Code Chapter 4201 [~~Act~~], the Texas Workers' Compensation Act and department and TDI-DWC rules. [~~TWCC Rules;~~]

[~~(6) a description of the categories of persons and names of the personnel employed or contracted to perform utilization review;~~]

[~~(7) a description of the hours of operation within the State of Texas and how the utilization review agent may be contacted during weekends and holidays. This description must be in compliance with §19.2013 of this title (relating to Utilization Review Agent's Telephone Access);~~]

[~~(8) representative samples of all materials provided by the utilization review agent/applicant to inform its clients, injured employees, their representatives or~~

~~providers of the requirements of the utilization review plan. Samples shall include language for notification of an adverse determination made in a utilization review;~~]

[~~(9) a description of the basis by which the utilization review agent compensates its employees or agents to ensure compliance with paragraph (10) of this subsection;~~]

[~~(10) a certification signed by an authorized representative of the company that the utilization review agent shall not permit or provide compensation or anything of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards based on: the amount or volume of adverse determinations; reductions or limitations on lengths of stay; duration of treatment; medical benefits; services; or charges; or on the number or frequency of telephone calls or other contacts with health care providers or injured employees, which are inconsistent with the provisions of this subchapter;~~]

[~~(11) the organizational information, documents and all amendments, including:~~]

[~~(A) the bylaws, rules or any similar document regulating the conduct of the internal affairs of the applicant with a notarized certification bearing the original signature of an officer or authorized representative of the applicant that they are true, accurate, and complete copies of the originals;~~]

[~~(B) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;~~]

[~~(C) a chart showing the internal organizational structure of the applicant's management and administrative staff; and~~]

[~~(D) a chart showing contractual arrangements of the utilization review agent related to utilization review.~~]

[~~(12) the name and biographical information for each director, officer and executive of the applicant.~~]

[~~(d) The utilization review agent shall report any material changes in the information in the application or renewal form referred to in this section, not later than the 30th day after the date on which the change takes effect. Material changes include, but are not limited to, new personnel hired as directors, officers, or executives, changes in the organizational structure, changes in contractual relationships, changes in the utilization review plan, and changes in methods of compensation to utilization review agents or their employees.~~]

(d) [~~(e)~~] Original Application Requirements and Process. Paragraphs [~~The application process is described in paragraphs~~] (1) - (4) of this subsection specify the requirements and process for entities that are applying for a certification or registration.

(1) Within [~~The department shall have~~] 60 days after receipt of a complete [~~an~~] application, the department will [~~to~~] process the application and [~~to~~] certify or register the entity or deny certification or registration [~~it~~]. The department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered. The department will [~~shall~~] give the applicant written notice of any omissions or deficiencies noted as a result of the review conducted pursuant to this paragraph.

(2) The applicant must correct the omissions or deficiencies in the application within 15 working [~~30~~] days of the date of the department's latest notice of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(3) The applicant may waive any of the time limits described in this subsection, except the requirement in paragraph (2) of this subsection. However, before the end of the 15 working days specified in paragraph (2) of this subsection, the [~~The~~] applicant may request in writing additional time to correct the noted omissions or deficiencies in the application. The request for the additional time must be approved by the department in writing for the requested extension to be effective. [~~waive the time limit in paragraph (2) of this subsection, only with the consent of the department.~~]

(4) The department will [~~shall~~] maintain a charter [~~an application~~] file which must [~~shall~~] contain the approved application documents, notices of omissions or deficiencies, and requests for additional time and responses from the applicant [~~and any written materials generated by any person that was considered by the department in evaluating the application~~].

(e) Renewal Requirements. Paragraphs (1) - (4) of this subsection specify the requirements for entities that are renewing a certification or registration.

[~~(f) An applicant for a certificate of registration as a utilization review agent must provide evidence that the applicant:~~]

[~~(1) has available the services of doctors, nurses, physician's assistants, or other health care providers qualified to provide the service requested by the provider to carry out its utilization review activities in a timely manner;~~]

[~~(2) meets any applicable provisions of this subchapter and regulations relating to the qualifications of the utilization review agents or the performance of utilization review;~~]

[~~(3) has policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws;~~]

[~~(4) makes itself accessible to injured employees, their representatives and health care providers 40 working hours a week during normal business hours in this state in each time zone in which it operates.~~]

(1) [~~(g)~~] Two-year renewal. A utilization review agent must apply for renewal of certification or registration [~~the certificate of registration~~] every two years from the date of certification or registration by submitting Form No. LHL005 (Utilization Review Agent (URA) Application Form). For an application for renewal of a certification, a utilization review agent must also submit a renewal fee in the amount specified by §19.802(b)(19) of this chapter. [~~A renewal form must be used for this purpose. The renewal fee must be submitted with the renewal form. The renewal form can be obtained from the address listed in subsection (b) of this section. The completed renewal form, a summary of the current screening criteria, a statement signed by an authorized representative of the company certifying that all information previously submitted is true and correct and all changes have been previously filed to the~~

~~application certified by the department, and the renewal fee must be submitted to the department at the address listed in subsection (a) of this section.~~]

(2) Continued operation during department review. If a utilization review agent has filed the required information specified in this subsection and submitted the fee as applicable for certification renewal with the department on or before the expiration of the certification or registration, the [~~A~~] utilization review agent may continue to operate under its certification or registration [~~certificate of registration, if the information and the fee have been filed for renewal and timely received by the department,~~] until the renewal certification or registration is finally denied or issued by the department. [~~If the required information and fee are not received prior to the deadline for renewal of the certificate of registration, the certificate of registration will automatically expire and the utilization review agent must complete and submit a new application form and a new fee with all required information.~~]

(3) Expiration for 90 days or less. If the certification or registration has been expired for 90 days or less, the utilization review agent may renew the certification or registration by filing a completed renewal application, submitting the fee as applicable for certification renewal, and providing the required information described in this subsection. The utilization review agent may not operate from the time the certification or registration has expired until the time the department has issued a renewal certification or registration.

(4) Expiration for longer than 90 days. If a utilization review agent's certification or registration has been expired for longer than 90 days, the utilization

review agent 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 accordance with this section. Subsection (d) of this section applies to applications made under this paragraph.

(f) [~~(h)~~] Contesting a Denial of an Application or Renewal. If an application for an original or renewal certification or registration is [~~initially~~] denied under this section, the applicant [~~or registrant~~] may contest [~~appeal~~] such denial under [~~the terms of~~] the provisions of Chapter 1, Subchapter A of this title (relating to Rules of Practice and Procedure) and the Government Code Chapter 2001. The contesting party is entitled to a hearing [~~A hearing of such appeal shall be conducted~~] within 45 days of the date the petition for such hearing is filed with the commissioner. A decision by the commissioner must [~~shall~~] be rendered within 60 days of the date of the hearing.

[~~(i) A utilization review agent providing utilization review on the effective date of this subchapter must abide by the provisions of this subchapter effective upon its adoption, and must file with the department its original application within 180 days of the effective date of this subchapter. Utilization review agents that have received their certificate of registration prior to the adoption of these rules, and are performing workers' compensation utilization review as defined in §19.2003 of this title (relating to Definitions), must file with the department all changes to their original application as set forth in subsections (c) and (d) of this section within 180 days of the effective date of this subchapter.~~]

[~~(j) A utilization review agent will be required to make a single application and fee payment for one certification to cover all lines of utilization review business.~~]

§19.2005. General Standards of Utilization Review.

(a) Review of Utilization Review Plan. The utilization review plan must [~~shall~~] be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other [~~appropriate~~] health care providers, including practicing health care providers. [~~doctors engaged in an active practice that are both primary and specialty doctors, and approved by a physician. The utilization review plan shall include the following components:~~]

[~~(1) a description of the elements of review which the utilization review agent provides, including:~~]

[~~(A) prospective and concurrent review in accordance with Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care);~~]

[~~(B) the elements of review in the TWCC guidelines contained in Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care);~~]

[~~(C) The elements of review contained in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).~~]

[~~(2) written procedures for:~~]

[~~(A) identification of individuals with special circumstances who may require flexibility in the application of screening criteria through utilization review decisions. Special circumstances include, but are not limited to, a person who has a disability, acute condition, or life-threatening illness. Disability shall not be construed to mean an injured employee who is off work or receiving income benefits;~~]

[~~(B) notification of the utilization review agent's determinations provided in accordance with Chapter 134, Subchapter G of this title and as addressed in §19.2010(b) of this title (relating to Notice of Determinations Made by Utilization Review Agents, Excluding Retrospective Review);~~]

[~~(C) informing appropriate parties of the process for appeal of an adverse determination to TWCC, as required by §19.2011 and §19.2012 of this title (relating to Requirements Prior to Adverse Determination and Appeal of Adverse Determinations of Utilization Review Agents);~~]

[~~(D) receiving or redirecting a toll-free normal business hour and after-hour calls, either in person or by recording, and assurance that a toll-free number will be maintained 40 hours per week during normal business hours as addressed in §19.2013 of this title (relating to Utilization Review Agent's Telephone Access);~~]

[~~(E) review including:~~]

[~~(i) any form used during the review process;~~]

[~~(ii) time frames that shall be met during the review;~~]

[~~(F) handling of oral or written complaints by injured employees, their representatives or health care providers as addressed in §19.2016(a) of this title (relating to Complaints and Reporting Requirements);~~]

[~~(G) determining if doctors or other health care providers utilized by the utilization review agent are licensed, qualified and appropriately trained, including written procedures for ensuring that doctors that perform utilization review for the utilization review agent are either on TWCC's list of approved doctors or, if licensed in another state, will perform utilization review under the direction of a doctor licensed in Texas who is on TWCC's list of approved doctors, in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement);~~]

[~~(H) assuring that injured employee specific information obtained during the process of utilization review, as addressed in §19.2014 of this title (relating to Confidentiality), will be:~~]

[~~(i) kept confidential in accordance with applicable federal and state laws;~~]

[~~(ii) used solely for the purposes of utilization review, quality assurance and case management;~~]

[~~(iii) shared with only those agencies who have authority to receive such information; and~~]

[~~(iv) in the case of summary data, not considered confidential if it does not provide sufficient information to allow identification of individual injured employees;~~]

[~~(I) providing prior written notice to a doctor or health care provider when publishing data, including quality review studies or performance tracking data which identifies a particular doctor, or health care provider;~~]

[~~(3) screening criteria. Each utilization review agent shall utilize written medically acceptable screening criteria as defined in §19.2003 of this title (relating to Definitions) and review procedures which are established and periodically evaluated and updated, at a minimum, upon certification renewal with appropriate involvement from the doctors, including doctors engaged in an active practice, and other health care providers. Utilization review decisions shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norm when justified on a case-by-case basis. Screening criteria must be used to determine only whether to approve the requested treatment. Denials must be referred to an appropriate doctor or other health care provider to determine whether health care is medically reasonable and necessary. Such written screening criteria and review procedures shall be available for review and inspection to determine appropriateness and compliance as deemed necessary by the commissioner, his or her designated representative, or TWCC and copying as necessary for the commissioner and/or TWCC to carry out the lawful duties under the Insurance Code, and the Texas Labor Code, provided, however, that any information obtained or acquired under the authority of this~~

~~subchapter and the Act, is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this subchapter and the Act, and for TWCC to enforce the Texas Workers' Compensation Act.~~]

(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) Performance Tracking Data. The utilization review plan must provide prior written notice to a physician, doctor or health care provider and an opportunity to correct reports prior to publishing data that identifies the particular physician, doctor, or health care provider, including quality review studies or performance tracking data.

(d) Screening Criteria. Each utilization review agent is required to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the 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 utilization review agent must utilize generally accepted standards of medical practice recognized in the medical community. For workers' compensation network coverage, screening criteria must comply with the Insurance Code Chapter 1305 and §10.101 of this title (relating to General Standards for

Utilization Review and Retrospective Review); and, for workers' compensation non-network coverage, screening criteria must comply with the Labor Code §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).

(e) Referral and Determination of Adverse Determinations. Adverse determinations must be referred to and may only be determined by a physician or doctor with appropriate credentials in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement). Physicians and doctors performing utilization review must also be in compliance with the Labor Code §§408.0043, 408.0044, and 408.0045.

(f) Delegation of Review. A utilization review agent, including a specialty utilization review agent, [~~(4) delegation of review. Provide circumstances, if any, under which the utilization review agent~~] may delegate the review to qualified personnel in a [~~the~~] hospital utilization review program or a qualified health care provider. [~~or health care facility where the health care is to be provided.~~] Such delegation does [~~shall~~] not relieve the utilization review agent of full responsibility for compliance with this subchapter, Chapter 4201 of the Insurance Code [~~the Act~~], and the Texas Workers' Compensation Act, including the conduct of those to whom utilization review has been delegated.

(g) Complaint System. The utilization review agent is required to 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 and is required to maintain records of such 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 the department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the department.

(h) Applicability to Specialty Utilization Review Agents. This section also applies to a specialty utilization review agent except for subsection (a) of this section. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2006. Requirements and Prohibitions Relating to Personnel.

(a) Qualification Requirements.

(1) Physicians, doctors, and other health care providers [~~Personnel~~] employed by or under contract with the utilization review agent to perform utilization review must [~~shall~~] be appropriately trained, [~~and~~] qualified, and[~~, if applicable,~~] currently licensed.

(2) 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. 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 in accordance with the Labor Code §§408.0043,

408.0044, and 408.0045. Physicians, doctors and other health care providers conducting utilization review must have the appropriate credentials in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement). [~~Doctors that perform utilization review for the utilization review agent must be on TWCC's list of approved doctors in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement), or comply with subsection (d) of this section.~~]

(3) Personnel who obtain information regarding an injured employee's specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, or other health care provider, either orally or in writing, and who are not physicians or doctors, must [~~shall~~] be nurses, physician [~~physicians~~] assistants, or other health care providers qualified to provide the service requested by the provider. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(b) Prohibitions. A utilization review agent may not permit or provide compensation or anything [~~any thing~~] of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards, based on:

(1) the amount or volume of adverse determinations;

(2) reductions or limitations on lengths of stay, [~~duration of treatment, medical~~] benefits, services, or charges; or

(3) the number or frequency of telephone calls or other contacts with health care providers or injured employees, which are inconsistent with the provisions of this subchapter or the Insurance Code Chapter 4201.

(c) Disqualifying Associations. The physician who reviews the appeal must not have any disqualifying associations with the physician or doctor who issued the initial adverse determination or the injured employee who is requesting the appeal. For purposes of this subsection, being employed by or under contract with the same utilization review agent as the physician or doctor who issued the initial adverse determination does not in itself constitute a disqualifying association.

(d) [~~(c)~~] Information Required to be Filed with the Department. The utilization review agent is required to provide the name, number, type, Texas license number, and [~~minimum qualification or~~] qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information [~~commissioner.~~]

(e) Written Procedures and Maintenance of Records.

(1) Utilization review agents are [~~shall be~~] required to develop and implement [~~adopt~~] written procedures [~~used~~] to determine if physicians, doctors, and [~~or~~] other health care providers used [~~utilized~~] by the utilization review agent are licensed, qualified, and appropriately trained or experienced [~~, and must maintain records on such~~].

(2) The utilization review agent must maintain documentation that demonstrates that physicians, doctors, and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced in accordance with subsection (a) of this section.

(f)[~~(d)~~] Physician Direction Requirement. Utilization [~~A utilization~~] review [~~agent that uses doctors to perform reviews of health care services provided under a workers' compensation policy may use doctors licensed by another state to perform the reviews, but the reviews~~] conducted by a utilization review agent must be [~~performed~~] under the direction of a physician [~~doctor~~] currently licensed to practice medicine in Texas [~~in this state who is on TWCC's approved doctor list, in accordance with Chapter 180 of this title~~]. Such physician [~~doctor~~] may be employed by or under contract to the utilization review agent.

[~~(e) Utilization review of dental health care shall be reviewed by a dentist currently licensed by a state licensing agency in the United States prior to issuance of an adverse determination.~~]

(g) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (a), (d), (e) and (f) of this section. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2007. Prohibition [~~Prohibitions~~] of Certain Activities and Procedures Related to Health Care Providers and Injured Employees [~~of Utilization Review Agents~~].

(a) A utilization review agent may not engage in unnecessary or unreasonably repetitive contacts with the health care provider or injured employee and must [~~shall~~] base the frequency of contacts or reviews on the severity or complexity of the injured employee's condition or on the need for medical documentation to support the necessity of the [~~necessary~~] treatment requested or rendered [~~and return to work planning activity~~].

(b) A utilization review agent may [~~shall~~] not set or impose any notice or other review procedures contrary to the requirements of the Insurance Code, Labor Code Title 5, department rules, and TDI-DWC rules [~~this subchapter, the Texas Workers' Compensation Act, and the TWCC rules~~].

(c) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2008. Utilization Review Agent Contact with and Receipt of Information from Health Care Providers.

(a) A health care provider may designate one or more individuals as the initial contact or contacts for utilization review agents seeking routine information or data. The [~~In no event shall the~~] designation of such an individual or individuals may not in any circumstance relieve the [~~preclude a~~] utilization review agent or medical advisor of the obligation to contact [~~from contacting~~] a health care provider or others in the health care provider's [~~his or her~~] employ where a review might otherwise be unreasonably delayed

or where the designated individual is unable to provide the necessary information or data requested by the utilization review agent.

(b) Unless precluded or modified by contract, a utilization review agent [~~the workers' compensation insurance carrier~~] must [~~shall~~] reimburse health care providers for the reasonable costs for [~~of~~] providing [~~written~~] medical information in writing, including copying and transmitting any requested injured employee records or other documents relevant to the utilization review [~~pursuant to Chapter 133, Subchapter B of this title (relating to Required Reports)~~]. A health care provider's charge for providing medical information to a utilization review agent must be in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation) [~~shall not exceed the cost of copying records set by rules of the Texas Workers' Compensation Commission~~] and may not include any costs that [~~are otherwise specified in TWCC rules and/or guidelines as not reimbursed separately or~~] are recouped as a part of the charge for health care.

(c) When conducting utilization review, the utilization review agent must request all relevant and updated medical records in order [~~shall require only the information necessary~~] to complete the review. 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 [~~plan~~] prescribed by

the [~~treating health care~~] provider of record, along with the provider of record's [~~provider's~~] justification for the plan of treatment [~~plan~~]. [~~It must include the medical information to substantiate the medical necessity for the specific treatment in review. These items shall only be requested when relevant to the utilization review in question, and be requested as appropriate from the health care provider or health care facility.~~] The required information should be obtained from the appropriate source, since no one source will have all of this information.

(1) Utilization review agents may request [~~shall not routinely require hospitals and doctors to supply~~] numerically codified diagnoses or procedures to be considered for certification only if[~~. Utilization review agents may ask for such coding, since if it is known,~~] its inclusion in the data collected increases the effectiveness of the communication.

(2) Utilization review agents must [~~shall~~] not routinely request copies of all medical records on [~~all~~] injured employees reviewed. During utilization review, copies of medical records should only be required when a difficulty develops in determining whether the health care is medically [~~reasonable and~~] necessary or appropriate, or experimental or investigational in nature. In those cases, only the necessary or pertinent sections of the record should be required.

(d) Information in addition to that described in this section may be requested by the utilization review agent or voluntarily submitted by the [~~health care~~] provider of record when there is significant lack of agreement between the utilization review agent and [~~health care~~] provider of record regarding the appropriateness of health care during

the review or appeal process. "Significant lack of agreement" means that the utilization review agent:

(1) has tentatively determined[~~, through its professional staff,~~] that a service cannot be approved [~~authorized to be provided or reimbursed~~];

(2) has referred the case to a physician, [~~an appropriate~~] doctor, or other health care provider for review; and

(3) has had a discussion with [~~talked to~~] or attempted to have a discussion with [~~talk to~~] the [~~health care~~] provider of record in order to obtain [~~for~~] further information.

(e) The utilization review agent must [~~shall~~] share among its various divisions all [~~pertinent~~] clinical and demographic information on individual injured employees [~~among its various divisions (e.g., preauthorization, return to work planning, case management)~~] to avoid duplicate requests for information from injured employees, physicians, doctors, and [~~or~~] other health care providers.

(f) Notwithstanding any other provision of this section [~~subchapter~~], a utilization review agent may not require as a condition of treatment approval, or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes 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 utilization review agent from:

(1) requiring submission of an injured employee's mental health medical record summary; or

(2) 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.

(g) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2009. On-Site Review by the Utilization Review Agent.

(a) Observing or Participating in Patient's Care. Unless approved by an injured employee and the treating doctor or allowed [~~modified~~] by contract, a utilization review agent is [~~shall be~~] prohibited from observing, participating in, recording, or otherwise being present during an injured employee's examination, treatment, procedure, or therapy. In no event may [~~shall~~] this prohibition [~~section otherwise~~] be construed to limit or deny contact with an injured employee or the health care provider for purposes of conducting utilization review unless otherwise specifically prohibited by law.

(b) Identification of Utilization Review Agents. Utilization review agents' staff must [~~shall~~] identify themselves by name and by the name of their organization and must [~~, for on-site reviews, should~~] carry picture identification and the utilization review agent [~~company~~] identification card with the certification or registration number assigned by the department [~~Texas Department of Insurance~~].

(c) On-site Review at a Health Care Facility. For on-site review conducted at a health care facility, utilization [~~Utilization~~] review agents:

(1) must ensure [~~should assure~~] that their on-site review staff:

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

(B) wear appropriate health care facility [~~hospital~~] supplied identification tags while on the health care facility premises; and[~~.~~]

(2) [~~Utilization review agents~~] are required to [~~shall~~] 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 [~~hospital~~] administrative procedures will [~~shall~~] be followed by on-site review staff in order [~~so as~~] to not disrupt health care facility [~~hospital~~] operations or injured employee [~~patient~~] care. Such procedures, however, should not obstruct or limit the ability of the utilization review agent to efficiently conduct the necessary review.

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2010. Notice of Determinations Made in Prospective and Concurrent Utilization Review [~~by Utilization Review Agents, Excluding Retrospective Review~~].

(a) Notice of Favorable or Adverse Determinations. A utilization review agent is required to provide notice, [~~shall notify~~] in accordance with this section as applicable, of a determination made in a prospective or concurrent utilization review to the following individuals: [~~the injured employee, their representative and the treating doctor or the treating doctor's designated representative (e.g., referred health care providers or health care facilities) of a determination made in a utilization review.~~]

(1) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided to the individuals specified by §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

(2) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided to the individuals specified by the Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

(b) Favorable Determinations.

(1) Except in the case of adverse determinations which are addressed in subsection (c) of this section, the written notification required by this subsection must be mailed or electronically transmitted within the following time frames:

(A) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided within the time frames specified by §134.600 of this title.

(B) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided within the time frames specified by the Insurance Code §1305.353 and §10.102 of this title.

(2) A utilization review agent must ensure that preauthorization numbers assigned by the utilization review agent comply with the data and format requirements contained in the standards adopted by the federal 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. [~~The notification and time frames for notification required by this section must be made in accordance with TWCC rules contained in Chapter 134, Subchapter G of this title (relating Prospective and Concurrent Review of Health Care).~~]

(c) Adverse Determinations.

(1) Required Notice Elements.

(A) In all instances of a prospective or concurrent utilization review adverse determination, written notification [~~Notification~~] of the adverse determination by the utilization review agent must include:

(i) [~~(1)~~] the principal reasons for the adverse determination;

(ii) [~~(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;~~]

(iii) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(iv) [~~(4)~~] a description of the procedure for filing a complaint with the department; [~~the complaint process to the Department and appeal process to TWCC, and~~]

[~~(5) plain language notifying the employee of the right to timely request reconsideration of the health care denied in accordance with Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care).~~]

(v) the professional specialty and Texas license number of the physician or doctor that made the adverse determination. Decisions must be made by physicians or doctors in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement);

(vi) a description of the procedure for the utilization review agent's complaint system as required by §19.2005 of this subchapter (relating to General Standards of Utilization Review);

(vii) a description of the utilization review agent's appeal process, as required by §19.2012 of this subchapter (relating to Appeal of Adverse Determination) or §19.2020(h) of this subchapter (relating to Specialty Utilization Review Agent);

(viii) the date and time the utilization review agent offered the opportunity to discuss the adverse determination, and the date and time that the

discussion, if any, took place, as required in §19.2011 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination); and

(ix) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), which is available at www.tdi.state.tx.us/forms. Such notice must include statements that:

(I) Form No. LHL009 must be completed by the injured employee, the injured employee's representative, or the injured employee's provider of record and be returned to the insurance carrier or utilization review agent that made the adverse determination to begin the independent review process;

(II) a request of 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 by Independent Review Organizations); and

(III) a request of 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).

(B) Workers' compensation network coverage. In addition to the requirements in subparagraph (A) of this paragraph, the written notification of the adverse determination by the utilization review agent must also include, for workers'

compensation network coverage, a description of or the source of the screening criteria that were utilized in making the determination.

(C) Workers' compensation non-network coverage. In addition to the requirements in subparagraph (A) of this paragraph, the written notification of the adverse determination by the utilization review agent must also include, for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 of this title (relating to Disability Management) in making the determination.

(2) Independent review in the event of life-threatening condition. In accordance with §19.2012(a)(3) of this subchapter, the description of the utilization review agent's appeal process required by paragraph (1)(A)(vii) of this subsection must include 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 to an independent review organization and is not required to comply with procedures for an internal review of the adverse determination by the utilization review agent.

(3) Required time frames. The time frames for notification of the adverse determination are:

(A) Workers' compensation non-network coverage. The adverse determination notification for workers' compensation non-network coverage must be provided within the time frames specified by §134.600 of this title.

(B) Workers' compensation network coverage. The adverse determination notification for workers' compensation network coverage must be provided within the time frames specified by the Insurance Code §1305.353 and §10.102 of this title.

(4) Other requirements for non-network workers' compensation coverage. In addition to the requirements of paragraph (1) of this subsection, the notice of adverse determination for non-network workers' compensation coverage must also comply with the requirements of §134.600 of this title.

(5) Peer review reports. This notice may constitute a peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter.

§19.2011. Requirements Prior to Issuing Adverse Determination.

(a) Reasonable Opportunity. For purposes of this section, "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or no less than five working days prior to issuing a retrospective utilization review adverse determination.

(b) Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations.

(1) Subject to the notice requirements of §19.2010 of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents, Excluding Retrospective Review~~]), in any instance in which [~~where~~] the utilization review agent is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision. [~~whether the health care is medically reasonable and necessary, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the injured employee and the clinical basis for the utilization review agent's decision with the appropriate doctor or health care provider performing the review, prior to issuance of an adverse determination.~~]

(2) When the utilization review agent provides the reasonable opportunity required under paragraph (1) of this subsection, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination.

(3) The utilization review agent must maintain documentation that details [~~shall have written procedures describing how~~] the discussion opportunity provided to

the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome [~~is afforded~~].

(4) The utilization review agent must submit the documentation required by paragraph (3) of this subsection to the department or TDI-DWC upon request.

(c) Requirements Prior to Issuing Retrospective Review Adverse Determinations.

(1) Subject to the notice requirements of §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the utilization review agent is questioning the medical necessity or appropriateness of the health care services provided, prior to the issuance of an adverse determination, the utilization review agent is required to afford the provider of record a reasonable opportunity to discuss the treatment provided to the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(2) When the utilization review agent provides the reasonable opportunity required under subsection (c)(1) of this section, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination. The utilization review agent must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(3) The utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(4) The utilization review agent is required to submit the documentation required by paragraph (3) of this subsection to the department or TDI-DWC upon request.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (b) and (c) of this section. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2012. Appeal of Adverse Determination.

(a) Appeal of Prospective or Concurrent Adverse Determinations.

(1) A utilization review agent must maintain and make available a written description of the appeal procedures involving an adverse determination that are used by the agent.

(2) Each utilization review agent is required to comply with its written procedures for appeals. In accordance with the Insurance Code Chapter 4201, Subchapter H (relating to Appeal of Adverse Determination), the written procedures for

appeals must be reasonable and must include the information specified in this paragraph:

(A) time frames for filing the appeal:

(i) Workers' compensation network coverage. A statement specifying the time frames for filing the oral or written appeal in accordance with the Insurance Code §1305.354, which may not be less than 30 days after the date of issuance of written notification of an adverse determination; and

(ii) Workers' compensation non-network coverage. A statement specifying that the time frames for filing the oral or written appeal of the adverse determination must comply 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);

(B) a provision that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination by making an oral or written request; if the health care provider sets forth in the request good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review;

(C) a provision that appeal decisions must be made by a physician who has not previously reviewed the case in accordance with 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);

(D) a provision that subject to the notice requirements of §19.2010 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review), in any instance in which the utilization review agent is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.2011(a) of this subchapter (relating to Requirements Prior to Issuing Adverse Determination), to discuss the plan of treatment for the injured employee with a physician. The provision must state that the discussion must include, at a minimum, the clinical basis for the utilization review agent's decision;

(E) a provision that after the utilization review agent has sought review of the appeal of the adverse determination, the utilization review agent must issue a response letter explaining the resolution to the appeal to the following individuals:

(i) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided to the individuals specified by §134.600 of this title.

(ii) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided to the individuals specified by the Insurance Code §1305.353 and §10.102 of this title (relating

to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements);

(F) the provision required in subparagraph (E) of this paragraph must also require that such letter include:

(i) for both workers' compensation network coverage and for workers' compensation non-network coverage:

(I) a statement of the specific medical or dental reasons for the resolution;

(II) the medical or clinical basis for such decision, including screening criteria;

(III) the professional specialty and Texas license number of the physician who made the determination;

(IV) notice of the appealing party's right to seek review of the denied appeal by an independent review organization in accordance with §19.2021 of this subchapter (relating to Independent Review of Adverse Determinations), the procedures for obtaining that review, and Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)); and

(V) procedures for filing a complaint in accordance with the Insurance Code §4201.204 as described in §19.2005(g) of this subchapter (relating to General Standards of Utilization Review);

(ii) for workers' compensation network coverage, a description of 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

(iii) for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 of this title (relating to Disability Management) in making a determination;

(G) time frames required for written notifications to the appealing party of the determination of the appeal:

(i) Workers' Compensation Network Coverage. A provision that the appeal must be resolved in accordance with §10.103 of this title;

(ii) Workers' Compensation Non-Network Coverage. A provision that the appeal must be resolved in accordance with §134.600 of this title.

(3) In a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review by an independent review organization of the adverse determination and is not required to comply with procedures for an internal review of the adverse determination by the utilization review agent.

(4) This subsection applies to a specialty utilization review agent except for paragraph (2)(C) and (D) of this subsection. A specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

(b) Appeal of Retrospective Review Adverse Determinations.

(1) Workers' compensation network and non-network coverage. A utilization review agent is required to maintain and make available a written description of appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with the requirements in subparagraphs (A) and (B) of this paragraph.

(A) An appeal of an adverse determination relating to retrospective utilization review must comply with §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review).

(B) In any instance in which the utilization review agent is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.2011(a) of this subchapter, to discuss the plan of treatment for the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(2) Workers' compensation network coverage. For workers' compensation network coverage, appeal procedures must comply with the requirements in the Insurance Code Chapter 1305, Chapter 10 of this title (relating to Workers' Compensation Health Care Networks), and Chapter 133 of this title (relating to General Medical Provisions).

(3) Workers' compensation non-network coverage. For workers' compensation non-network coverage, the appeal procedures must comply with the requirements of Chapter 133 of this title.

(4) Applicability to specialty utilization review agents. This subsection, except for paragraph (1)(B), of this subsection applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter.

§19.2013. Utilization Review Agent's Telephone Access.

(a) A utilization review agent is required to [~~shall~~] have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both time zones in Texas, [~~if applicable,~~] to discuss an injured employee's care and to respond [~~allow response~~] to telephone review requests.

(b) A utilization review agent must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours and must [~~shall~~] respond to such calls not later than two working days of the later of the date on which the call was received or the date on which the details necessary to respond were [~~have been~~] received from the caller.

(c) A utilization review agent must provide a written description to the commissioner setting forth the procedures that the utilization review agent 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.

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2014. Confidentiality.

(a) Confidentiality Requirements.

(1) A utilization review agent is required to [~~shall~~] preserve the confidentiality of individual medical records to the extent required by law.

(2) [~~(b)~~] A utilization review agent may not disclose or publish individual medical records, personal information, or other confidential information about an injured employee obtained in the performance of utilization review without the prior written consent of the injured employee or as otherwise required by law. Personal information includes, [~~shall include~~] at a minimum, name, address, phone number, social security number, and financial information. If such authorization is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must:

(A) [~~(1)~~] be dated; and

(B) [~~(2)~~] contain the signature of the individual whose [~~who is the subject of the~~] personal or confidential information is being requested. The signature must have been obtained one year or less prior to the date the disclosure is sought or the authorization is invalid.

(3) [~~(c)~~] A utilization review agent may provide confidential information to a third party under contract or affiliated with the utilization review agent for the sole purpose of performing or assisting with utilization review. Information provided to third parties must [~~shall~~] remain confidential.

(4) [~~(d)~~] If an individual submits a written request to the utilization review agent for access to recorded personal information about the individual, the utilization review agent must [~~shall~~] within 10 working [~~business~~] days from the date such request is received:

(A) [~~(1)~~] inform the individual submitting the request of the nature and substance of the recorded personal information in writing; and

(B) [~~(2)~~] permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, at the discretion of the individual, unless the recorded personal information is in coded form, in which case an accurate translation in plain language must [~~shall~~] be provided in writing.

(5) [~~(e)~~] A utilization review agent's charges for providing a copy of recorded personal information to individuals may [~~shall~~] not exceed ten cents per page

and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(6) [~~(f)~~] The utilization review agent may not publish data that [~~which~~] identifies a particular physician, doctor, or other health care provider, including any quality review studies or performance tracking data without prior written notice to the subject physician, doctor, or other [~~involved~~] health care provider. This prohibition does not apply to internal systems or reports used by the utilization review agent.

(7) [~~(g)~~] When the utilization review agent determines that documents [~~Documents~~] in the custody of the utilization review agent that contain confidential injured employee information or physician, doctor, or other health care provider financial data are no longer needed, the documents must [~~shall~~] be destroyed by a method that results in the [~~which induces~~] complete destruction of the information [~~when the agent determines the information is no longer needed~~].

(8) [~~(h)~~] All injured employee, physician, doctor, and other health care provider data must [~~shall~~] be maintained by the utilization review agent in a confidential manner that [~~which~~] prevents unauthorized disclosure to third parties. Nothing in this section may [~~article shall~~] be construed to allow a utilization review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of injured employee records and the confidentiality provisions of the Texas Workers' Compensation Act.

(9) [~~(i)~~] To assure confidentiality, a utilization review agent must, when contacting a physician's, doctor's, [~~office~~] or other health care provider's office [~~hospital~~],

provide its certification number, the caller's name, and professional qualifications [~~to the provider's named utilization review representative in the health care provider's office~~].

(10) [~~(j)~~] Upon request by the physician, doctor, or other health care provider, the utilization review agent must [~~shall~~] present written documentation that it is acting as an agent of the insurance carrier for the relevant injured employee.

[~~(k) The utilization review agent's procedures shall specify that specific information exchanged for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such information. The utilization review agent's process shall specify that procedures are in place to assure confidentiality and that the utilization review agent agrees to abide by the confidentiality provisions of the Texas Workers' Compensation Act and any other federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual injured employees or health care providers need not be considered confidential.~~]

(11) [~~(l)~~] Medical records and injured employee specific information must [~~shall~~] be maintained by the utilization review agent in a secure area with access limited to essential personnel only.

(12) [~~(m)~~] A utilization review agent is required to retain information [~~Information~~] generated and obtained by a [~~the~~] utilization review agent [~~agents~~] in the

course of utilization review [~~shall be retained~~] for at least four [~~two~~] years [~~from the date of the final decision in the utilization review~~].

(13) [~~(n)~~] Notwithstanding the provisions in paragraphs (1) – (12) of this subsection and subsection (b) [~~subsections (a) - (m)~~] of this section, the utilization review agent is required to [~~shall~~] provide to the department or TDI-DWC [~~commissioner and/or the Texas Workers' Compensation Commission~~] on request individual medical records or other confidential information for determination of compliance with this subchapter. The information is confidential and privileged and is not subject to the [~~open records law,~~] Government Code[~~,~~] Chapter 552 (Public Information), or to subpoena, except to the extent necessary to enable the commissioner to enforce this subchapter.

(b) Written Procedures on Confidentiality. The utilization review agent must specify in writing the procedures that the utilization review agent will implement pertaining to confidentiality of information received from the injured employee, the injured employee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the utilization review agent and third parties for the purpose of conducting utilization review. These procedures must specify that specific information received from the injured employee, the injured employee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the utilization review agent and third parties for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for the purposes of utilization review, and shared by the utilization review

agent with only those third parties who have authority to receive such information, such as the claim administrator. These procedures must also specify that the utilization review agent has procedures in place to assure confidentiality, and that the utilization review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual injured employees, physicians, doctors, or other health care providers need not be considered confidential.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2015. Notice of Determination Made in Retrospective Review.

(a) Required Notice. A utilization review agent is required to provide notice of a determination made in a retrospective review to the following individuals:

(1) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided to the individuals specified by §133.240 of this title (relating to Medical Payment and Denials).

(2) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided to the individuals specified by §133.240 of this title and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

(b) Required Procedures. The utilization review agent is required to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the time frames for the notice of adverse determination. These procedures must comply with the Insurance Code §4201.305 and the requirements specified in paragraphs (1) – (3) of this subsection.

(1) The notice of adverse determination required by subsection (a) of this section must be in writing and provided within the timeframes specified by:

(A) department rules in Chapter 10 of this title (relating to Workers' Compensation Health Care Networks) and TDI-DWC rules in Chapter 133 of this title (relating to General Medical Provisions) for workers' compensation network coverage; or

(B) TDI-DWC rules in Chapter 133 of this title for workers' compensation non-network coverage.

(2) The notice of an adverse determination required by subsection (a) of this section must include:

(A) the principal reasons for the adverse determination;

(B) the clinical basis for the adverse determination;

(C) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(D) for workers' compensation network coverage, a description or the source of the screening criteria that were utilized in making the determination;

(E) for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 of this title (relating to Disability Management) in making a determination;

(F) the professional specialty and Texas license number of the physician or doctor that made the determination;

(G) a description of the procedure for the utilization review agent's complaint system as required by §19.2005(g) of this subchapter (relating to General Standards of Utilization Review);

(H) a description of the utilization review agent's appeal process, as required by §19.2012 of this subchapter (relating to Appeal of Adverse Determination);

(I) the date and time the utilization review agent offered the opportunity to discuss the adverse determination, and the date and time the discussion, if any, took place, as required in §19.2011 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination) or §19.2020(h) of this subchapter (relating to Specialty Utilization Review Agent);

(J) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)). Such notice must include instructions that:

(i) the independent review request Form No. LHL009 must be completed by the injured employee, the injured employee's representative, or the

injured employee's provider of record and be returned to the utilization review agent to begin the independent review process;

(ii) a request of independent review of an adverse determination made under workers' compensation non-network coverage must be timely filed by the requestor in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations); and

(iii) a request of independent review of an adverse determination made under workers' compensation network coverage must be timely filed by the requestor in accordance with §10.104 of this title (relating to Independent Review of Adverse Determination).

(3) Peer review reports. The notice of determination required under this section may constitute a peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter.

§19.2016. Regulatory Requirements Subsequent to Certification or Registration [~~Complaints and Reporting Requirements~~].

(a) Reporting of Material Changes. The utilization review agent is required to report any material changes in the information in the application or renewal Form No.

LHL005 (Utilization Review Agent (URA) Application Form) last filed with the department by the utilization review agent, not later than the 30th day after the date on which the change takes effect. [~~Utilization review agent's complaint system. A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers, concerning the utilization review process, and shall maintain records of such complaints for three years from the time the complaints are filed. The complaint procedure shall include a written response to the complainant by the agent within 30 days of the agent's receipt of the complaint.~~]

(b) Summary Report to the Department. [~~Utilization review agent's complaint reporting requirements to the department~~].

(1) By March 1, of each year, the utilization review agent must [~~shall~~] submit to the department [~~commissioner or his or her delegated representative~~] a summary report of information related to complaints, adverse determinations, appeals of adverse determinations, and any other related information requested by the department in accordance with the Insurance Code §38.001. [~~all complaints involving workers' compensation at such times and in such form as the commissioner may require, and shall permit the commissioner to examine the complaints and all relevant documents at any time. To be disclosed in the report is the subject matter of the complaint categorized as follows:~~]

[~~(1) administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider);~~]

[~~(2) qualifications of utilization review agent's personnel;~~]

[~~(3) complaint process (e.g., treating doctor has not been afforded the opportunity to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal to TWCC not provided).~~]

(2) The summary report must be provided in the form required by the commissioner, and the utilization review agent must permit the commissioner or the commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the department.

(3) [~~(c) Utilization review agent's adverse determination reporting requirements to the department.~~] The summary report is required to cover [~~also covers~~] reviews performed by the utilization review agent during the preceding calendar year and includes:

(A) [~~(1)~~] the total number of written notices of adverse determinations;

(B) [~~(2)~~] a listing of adverse determinations for preauthorization, by the medical condition and treatment using primary ICD-9 (physical diagnosis) or DSM-IV (mental health diagnosis) code, 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; [~~and~~]

(C) [~~(3)~~] the classification of party requesting review (i.e., health care provider, injured employee, their representative, etc.);[~~.~~]

(D) 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; and

(E) the subject matter of any complaint filed with the utilization review agent. Complaints must be categorized as follows:

(i) administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider);

(ii) qualifications of utilization review agent's personnel; or

(iii) appeal/complaint process (e.g., treating physician unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal not provided).

(c) Complaints to the Department. Complaints filed with the department against a utilization review agent must be processed in accordance with the department's established procedures for investigation and resolution of complaints.

(d) Department Inquiries. Pursuant to the Insurance Code §38.001, the department may address inquiries to a utilization review agent related to any matter

connected with utilization review agent transactions that the department considers necessary for the public good or for the proper discharge of the department's duties. In accordance with the Insurance Code §38.001, a utilization review agent that receives an inquiry from the department pursuant to the Insurance Code §38.001 is required to respond to the inquiry in writing not later than the 10th day after the date the inquiry is received. [~~Complaints to the department. Within a reasonable time period, upon receipt of a written complaint alleging a violation of this subchapter or the Act, by a utilization review agent, from an injured employee, their representative or health care provider, the commissioner or his or her delegated representative shall investigate the complaint, notify the utilization review agent of the complaint, require response by the utilization review agent addressing the complaint within 10 days of receipt of the complaint, and furnish a written response to the complainant and the utilization review agent named. This response must include the following:~~]

[~~(1) a statement of the original complaint;~~]

[~~(2) a statement of the findings of the commissioner or his or her delegated representative and an explanation of the basis of such findings;~~]

[~~(3) corrective actions, if any, on the part of the utilization review agent which the commissioner or his or her designated representative finds appropriate and whether the utilization review agent has voluntarily agreed to take such action; and~~]

[~~(4) a time frame in which any corrective actions should be completed.~~]

(e) 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 utilization review agents or personnel employed by or under contract with utilization review agents to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules. [~~Evidence of corrective action. The utilization review agent will provide evidence of corrective action within the specified time frame to the commissioner or his or her representative.~~]

[~~(f) Authority of the department to make inquiries. In addition to the authority of the commissioner to respond to complaints described in subsection (b) of this section, the department is authorized to address inquiries to any utilization review agent in relation to the agents' business condition or any matter connected with its transactions which the department may deem necessary for the public good or for a proper discharge of its duties. It shall be the duty of the agent to promptly answer such inquiries in writing.~~]

[~~(g) Lists of utilization review agents. The commissioner shall maintain and update monthly a list of utilization review agents issued certificates and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.~~]

(f) [~~(h)~~] On-site Review [~~review~~] by the [~~Texas~~] Department [~~of Insurance~~].

(1) Provisions for scheduled and unscheduled on-site reviews.

(A) The department may [~~commissioner or the commissioner's designated representative is authorized to~~] make a complete on-site review of the operations of each utilization review agent at the principal place of business for such

agent, as often as is deemed necessary. Such review may be scheduled or unscheduled.

(B) An on-site review will only be conducted during working days and normal business hours.

(C) The utilization review agent must make available all records relating to its operation during such scheduled and unscheduled on-site reviews.

(2) Scheduled on-site reviews. Utilization review agents will be notified of any [~~the~~] scheduled on-site review [~~visit~~] by letter, which will specify, at a minimum, the identity of the department's [~~commissioner's~~] designated representative and the expected arrival date and time.

(3) Unscheduled on-site reviews. At a minimum, notice of an on-site review of a utilization review agent will be in writing and be presented by the department's designated representative upon arrival. [~~The utilization review agent must make available during such on-site visits all records relating to its operation.~~]

[~~(4) The commissioner or the designated representative may perform periodic telephone audits of utilization review agents authorized to conduct business in this state, to determine if the agents are reasonably accessible.~~]

(g) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2017. Administrative Violations.

(a) Actions by the Department. In accordance with the Insurance Code §4201.601, if [~~If~~] the department [~~commissioner, through the commissioner's designated representative,~~] believes that any individual [~~person~~] or entity conducting utilization review pursuant to this subchapter [~~article~~] is in violation of Chapter 4201 of the Insurance Code [~~the Act~~] or applicable rules or any other provision of the Insurance Code or rules [~~regulations~~], the department [~~commissioner's designated representative~~] shall notify the utilization review agent or insurance carrier of the alleged violation and may compel the production of any and all documents or other information as necessary to determine whether or not such violation has occurred [~~taken place~~].

(1) [~~(b)~~] The department [~~commissioner's designated representative~~] may initiate the proceedings under this section.

(2) [~~(c)~~] Proceedings under this subchapter are a contested case for the purpose of the Government Code Chapter 2001.

(3) [~~(d)~~] If the commissioner determines that the utilization review agent, insurance carrier, or other [~~person or~~] entity or individual conducting utilization review pursuant to this subchapter has violated or is violating any provision of Chapter 4201 of the Insurance Code [~~the Act~~], the Insurance Code, or department rules [~~this subchapter~~], the commissioner may:

(A) impose sanctions under the Insurance Code[~~,~~] Chapter [~~Chapters~~] 82;[~~,~~]

(B) issue a cease and desist order under the Insurance Code Chapter 83; or

(C) assess administrative penalties under the Insurance Code Chapter [~~and~~] 84.

(4) [~~(e)~~] The commission of fraudulent or deceptive acts or omissions in obtaining, attempting to obtain, or use of certification or registration as a utilization review agent is [~~shall be~~] a violation of Chapter 4201 of the Insurance Code and the Labor Code [~~the Act~~].

(b) Actions by TDI-DWC. 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 utilization review agents or personnel employed by or under contract with utilization review agents to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules. Nothing in this section prohibits joint enforcement actions by the department and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2019. Responsibility of Insurance Carriers [~~Companies~~] Performing Utilization Review [**~~under the Insurance Code, Article 21.58A, §14(g) and (h)~~**].

(a) An insurance carrier that performs utilization review under the Texas Workers' Compensation Act is subject to this subchapter, except, pursuant to the

Insurance Code §4201.058, an insurance carrier that performs utilization review under the Texas Workers' Compensation Act is not subject to the certification requirements in §19.2004 of this subchapter (relating to Certification of Utilization Review Agents), if it performs utilization review only for coverage for which it is the payor [~~An insurance company licensed by the department and performing utilization review under the Insurance Code, Article 21.58A, §14(h) will be subject to §19.2001 of this title (relating to General Provisions), §19.2002 of this title (relating to Limitations on Applicability), §19.2003 of this title (relating to Definitions), §19.2004(c)(1) - (10) and (d) of this title (relating to Certification of Utilization Review Agents), §19.2005 of this title (relating to General Standards of Utilization Review), §19.2006 of this title (relating to Personnel), §19.2007 of this title (relating to Prohibitions of Certain Activities of Utilization Review Agents), §19.2008 of this title (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers), §19.2009 of this title (relating to On-Site Review by the Utilization Review Agent), §19.2010 of this title (relating to Notice of Determinations Made by Utilization Review Agents, Excluding Retrospective Review), §19.2011 of this title (relating to Requirements Prior to Adverse Determination), §19.2012 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents), §19.2013 of this title (relating to Utilization Review Agent's Telephone Access), §19.2014 of this title (relating to Confidentiality), §19.2015 of this title (relating to Retrospective Review of Medical Necessity), §19.2016 of this title (relating to Complaint and Reporting Requirements), §19.2017 of this title (relating to Administrative

~~Violations), and §19.2020 of this title (relating to Specialty Utilization Review Agent) with respect to their operations under the provisions of the Act, §14(h)~~].

(b) Notwithstanding subsection (a) of this section, when [~~When~~] an insurance carrier that [~~company~~] performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such insurance carrier must have a valid certificate as required by the Insurance Code §4201.101 and in accordance with §19.2004 of this subchapter [~~under the Texas Workers' Compensation Act or TWCC rules for an insurance carrier, an employer, or a utilization review agent other than the insurance company itself, such insurance company shall be required to obtain a certificate under this subchapter and comply with all the provisions of this subchapter~~].

(c) Notwithstanding subsection (a) of this section, an insurance carrier [~~Insurance companies~~] performing utilization review under Chapter 4201 of the Insurance Code [~~§14(h) of the Act~~] only for coverage for which it is the payor must have a valid registration pursuant to §19.2004 of this subchapter and comply with all filing requirements under §19.2004 of this subchapter. However, the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for workers' compensation coverage for which it is the payor [~~must register with the department and submit written documentation demonstrating compliance with all the filing requirements defined in §19.2004(c)(1) - (10) and (d) of this title (relating to Certification of Utilization Review Agents) and the name, address, contact name and phone number of the insurance company~~].

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2020. Specialty Utilization Review Agent.

(a) Application. In order to be certified or registered as a specialty utilization review agent, an applicant must submit to the department the application and information required in §19.2004 of this subchapter (relating to Certification or Registration of Utilization Review Agents).

(b) Statutory and Rule Requirements.

(1) In accordance with the Insurance Code §4201.452, a specialty utilization review agent [~~(a) A utilization review agent that solely performs specialty review under the Insurance Code, Article 21.58A, §14(j)~~] is [~~not~~] subject to the requirements of the Insurance Code Chapter 4201, except that the specialty utilization review agent is not subject to the following sections: [~~, Article 21.58A, §4(b), (c), (h) or (k) or §6(b)(3) of the Act. A utilization review agent that does not solely perform specialty review, is not subject to the provisions of this section or the Insurance Code, Article 21.58A, §14(j).~~]

(A) §4201.151 (Utilization Review Plan);

(B) §4201.152 (Utilization Review Under Direction of Physician);

(C) §4201.206 (Opportunity to Discuss Treatment Before Adverse Determination);

(D) §4201.252 (Personnel); and

(E) §4201.356 (Decision by Physician Required; Specialty Review).

(2) [~~(b)~~] A specialty utilization review agent [~~that performs specialty review under the Insurance Code, Article 21.58A, §14(j)~~] is subject to the requirements of this subchapter, except for the following provisions: [~~§19.2004(c)(1)(B) and (c)(6) of this title (relating to Certification of Utilization Review Agents); the first sentence of §19.2005 of this title (relating to General Standards of Utilization Review); §19.2006(a), (d), (e) of this title (relating to Personnel); §19.2011 of this title (relating to Requirements Prior to Adverse Determination) and §19.2012 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents).~~]

(A) §19.2005(a) of this subchapter (relating to General Standards of Utilization Review);

(B) §19.2006(a), (d), (e), and (f) of this subchapter (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.2011(b) and (c) of this subchapter (relating to Requirements Prior to Issuing Adverse Determination); and

(D) §19.2012(a)(2)(D) and (b)(1)(B) of this subchapter (relating to Appeal of Adverse Determination).

(c) Utilization Review Plan. A specialty utilization review agent is required to have its [~~must submit, by attachment to the application, assurance that the~~] utilization review plan [~~shall be~~] reviewed by a physician, doctor, or other health care provider of

the appropriate specialty, and the plan must be implemented [~~and conducted~~] in accordance with standards developed with input from a physician, doctor, or other health care provider of the appropriate specialty. The specialty utilization review agent must have written procedures to ensure that these requirements are implemented.

(d) 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 utilization review agent to perform workers' compensation utilization review must be appropriately trained, qualified, and currently licensed in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement).

(2) Personnel conducting utilization review must hold an unrestricted license or an administrative license issued by the Texas Medical Board in Texas or be otherwise authorized to provide health care services in Texas. [~~A specialty utilization review agent must submit by attachment to the application a description of the categories of personnel who perform utilization review, such as doctors, nurses, physicians assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States, except that this provision does not require those qualifications from personnel who perform solely clerical or administrative tasks.~~]

[~~(e) An applicant for a certificate of registration as a specialty utilization review agent must provide evidence that the applicant has available the services of doctors, nurses, physician's assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care by a state licensing agency in the United States to carry out its utilization review activities in a timely manner.~~]

[~~(f) Personnel employed by or under contract with the specialty utilization review agent to perform utilization review shall be appropriately trained and qualified and, if applicable, currently licensed. Doctors that perform utilization review for the specialty utilization review agent must be on TWCC's list of approved doctors in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement).~~]

(3) Personnel who obtain information regarding an injured employee's specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, or health care provider, either orally or in writing, and who are not physicians or doctors qualified in accordance with the Labor Code §§408.0043, 408.0044, and 408.0045 to provide the requested service, must [~~shall~~] be nurses, physician [~~physician's~~] assistants, or other health care providers qualified in accordance with Chapter 180 of this title to provide the requested service [~~of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care by a state licensing agency in the United States~~]. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(e) Information Required to be Filed with the Department. The specialty utilization review agent is required to provide the name, number, type, Texas license number and qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information.

(f) Written Procedures and Maintenance of Records.

(1) Specialty utilization review agents are required to develop and implement written procedures for determining if physicians, doctors, or other health care providers used by the specialty utilization review agent are licensed, qualified, and appropriately trained or experienced.

(2) The specialty utilization review agent must maintain documentation that demonstrates that physicians, doctors, and other health care providers that are utilized to perform utilization review are licensed, qualified, and appropriately trained or experienced, in accordance with subsection (d) of this section.

(g) Utilization Review by a Specialty Utilization Review Agent. Utilization review conducted by a specialty utilization review agent must [~~shall~~] 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 [~~shall~~] be currently licensed [~~or otherwise authorized~~] to provide the specialty health care service in Texas [~~by a state licensing agency in the United States~~]. Such physician, doctor, or other health care provider may be employed by or under contract to the utilization review agent.

(h) Reasonable Opportunity for Discussion.

(1) Prospective or concurrent utilization review.

(A) Subject to the notice requirements of §19.2010 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review) and §19.2012 of this subchapter [~~title~~], in any instance in which [~~where~~] the specialty utilization review agent questions whether the health care is medically [~~reasonable and~~] necessary or appropriate, the health care provider that [~~who~~] ordered the services must [~~shall~~], prior to the issuance of an adverse determination, be afforded a reasonable opportunity, as defined in §19.2011(a) of this subchapter, to discuss the plan of treatment for the patient and the clinical basis for the decision of the utilization review agent with a health care provider of the same specialty as the utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under subparagraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity

to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent must submit the documentation required by subparagraph (D) of this paragraph to the department or TDI-DWC upon request.

(2) Retrospective utilization review.

(A) Subject to the notice requirements of §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the specialty utilization review agent is questioning the medical necessity or appropriateness of the health care services provided, prior to the issuance of an adverse determination, the specialty utilization review agent must provide the provider of record a reasonable opportunity, as defined in §19.2011(a) of this subchapter, to discuss the treatment provided to the injured employee with a health care provider of the same specialty as the utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under subparagraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination. The specialty utilization review agent

must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent is required to submit the documentation required by subparagraph (D) of this paragraph to the department or TDI-DWC upon request.

(i) Appeal. The decision in an appeal of any adverse determination by [~~Appeals from an adverse determination by~~] a specialty utilization review agent must [~~shall~~] 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 utilization review agent that made the adverse determination. [~~governed by the Texas Workers' Compensation Act and the applicable rules and procedures of the TWCC including but not limited to Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care) and Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)~~].

§19.2021. Independent Review of Adverse Determinations.

(a) Life-threatening Conditions.

(1) Notification for life-threatening conditions.

(A) For life-threatening conditions, notification of adverse determination by the utilization review agent must be provided within the time frames specified in clauses (i) and (ii) of this subparagraph.

(i) Workers' compensation non-network coverage. The adverse determination notification for workers' compensation non-network coverage must be provided within the time frames specified by §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

(ii) Workers' compensation network coverage. The adverse determination notification for workers' compensation network coverage must be provided within the time frames specified by the Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

(B) At the time of notification of the adverse determination, the utilization review agent must provide the notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) for requesting independent review as required by §19.2010 and §19.2015 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review and Notice of Determination Made in Retrospective Review, respectively). Such notice must describe how to obtain independent review of such determination and how the department assigns a request for review to an independent review organization.

(C) The injured employee, injured employee's representative, or the injured employee's provider of record is required to 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.

(2) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition(s) or whose appeal of an adverse determination involving a life-threatening condition(s) is denied by the utilization review agent may seek review of the adverse determination by an independent review organization assigned in accordance with the 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.

(1) Request for independent review.

(A) The utilization review agent is required to notify the department within one working day from the date of the request for an independent review is received.

(B) The utilization review agent must provide to the department the completed Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) submitted to the utilization review agent by the party requesting independent review.

(C) The Form No. LHL009 must be submitted to the department via the department's Internet website.

(2) Assignment of independent review organization The department will, within one working day of receipt of the complete request for independent review, randomly assign an independent review organization to conduct the independent review and notify the utilization review agent, payor, the independent review organization, injured employee or the injured employee's representative, injured employee's provider of record and any other providers listed by the utilization review agent as having records relevant to the review of the assignment.

(3) 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).

(4) Workers' compensation network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation network coverage review are governed by the Insurance Code Chapter 1305, department 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.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).