SUBCHAPTER S. FORMS TO REQUEST PRIOR AUTHORIZATION
28 TAC §§19.1801 - 19.1804 and 19.1810

1. INTRODUCTION. The Texas Department of Insurance adopts new Subchapter S §§19.1801 - 19.1804 and 19.1810, in 28 TAC Chapter 19, Agents' Licensing, concerning Forms to Request Prior Authorization. TDI adopts the new sections with changes to the proposed text published in the August 22, 2014, issue of the *Texas Register* (39 *TexReg* 6372).

In response to one comment, TDI has revised the text of §19.1803 as proposed by adding the words "unless the context clearly indicates otherwise" to the end of the first sentence of the section. In response to another comment, TDI has deleted the lead-in language in §19.1810(a)(12) as proposed to allow a broader range of information to be reported in Sections V and VI of the Texas Standard Prior Authorization Request Form for Health Care Services (prior authorization form). In response to a third comment, TDI has revised §19.1810(a)(16) as proposed to clarify that a phone call can only be considered a peer-to-peer discussion required by 28 TAC §19.1710 if it is a discussion between peers that includes, at a minimum, the clinical basis for the utilization review agent's (URA's) decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. In order to conform the rule to the statute's language, in three places the word "standard" has replaced "standardized."

2. REASONED JUSTIFICATION. The new sections are necessary to implement SB 1216 and SB 644, 83rd Legislature, Regular Session (2013), by prescribing a prior authorization request form for health care services that must be accepted and used by health benefit plan issuers, and the agents of health benefit plan issuers that manage or administer issuers' health care services benefits, when a provider or facility submits the form to request prior authorization of a health care service for which an issuer's plan requires prior authorization.

SB 1216 amends Insurance Code Title 8, Subtitle A, to add Chapter 1217 to require the commissioner of insurance to prescribe by rule a single, standard form for requesting prior authorization of health care services. SB 1216 also requires an issuer and its agents to accept and use the form for all prior authorizations of health care services for which the issuer's plan requires prior authorization, and it requires TDI and the issuer and its agents to make the form available in paper form and electronically on their websites. The adopted rule addresses these requirements.

SB 1216 also directs the commissioner to develop the form with input from an advisory committee and to consider prior authorization forms now used widely in Texas, used by TDI, or established by the Centers for Medicare and Medicaid Services, and to consider national standards or draft standards on electronic prior authorization of health care services.

In compliance with Insurance Code §1217.005, the commissioner appointed an advisory committee composed of physicians, health care providers other than physicians, hospitals, health benefit plan issuers, and the Texas Health and Human

Services Commission. Agency staff met with the advisory committee on April 22, 2014; May 14, 2014; and June 10, 2014; and consulted the committee by email to get the committee's input, which staff used to create the prior authorization form.

In addition to SB 1216, the 83rd Legislature, Regular Session (2013) passed SB 644, which directs the commissioner to prescribe by rule a single, standard form for requesting prior authorization of prescription drug benefits.

Because the prior authorization rules implementing SB 1216 and SB 644 are closely linked, both rules will be included in Subchapter S.

3. HOW THE SECTION WILL FUNCTION. Division 1, §§19.1801 - 19.1804, includes sections common to both rules. Section 19.1801 lists the health benefit plans, coverages, and programs to which the subchapter applies. Section 19.1802 lists the health benefit plans, coverages, and policies excepted from the rules. Section 19.1803 defines terms also defined in SB 1216 or SB 644 or used in the prescribed forms. Section 19.1804 is a severability provision.

Division 2, §19.1810, is specific to SB 1216. Section 19.1810(a) adopts the prior authorization form by reference and lists several ways to find and get the form. Subsection (a) also contains a description of the form sufficiently specific to provide the substantive detail about the form prescribed by 28 TAC §1.203(b)(2). Section 19.1810(b) states that issuers are required to accept and use the form when submitted by a provider seeking prior authorization of a health care service for which the issuer requires prior authorization. This subsection also lists purposes for which the form may

not be used. Section 19.1810(c) states the rule's effective date. Section 19.1810(d) directs both the health benefit plan issuer and the agent of a health benefit plan issuer that manages or administers the issuer's health care services benefits to make the form available both on paper and on its website.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Section 19.1801 and §19.1803.

Comment: A commenter asked that TDI confirm that issuers are not required to accept or use the prior authorization form for a request for preauthorization of a prescription drug, as defined in the proposed rule.

Agency Response: In response to the commenter's request, TDI confirms that issuers are not required to accept or use the prior authorization form for a request for prior authorization of a prescription drug. The definitions of a health care service contained in SB 1216 and the adopted rule state that the term does not include a prescription drug as defined in Occupations Code §551.003.

Section 19.1803.

Comment: A commenter recommends that TDI amend §19.1803 to state that the words and terms, when used in the subchapter, have the defined meanings "unless the context clearly indicates otherwise."

Agency response: TDI agrees with the commenter and has added the suggested language.

Section 19.1810 and prior authorization form.

Comment: A commenter requests that the prior authorization form include a required field for the service provider's Tax Identification Number (TIN) in addition to the provider's National Provider Identification (NPI). The commenter states that the information is needed because a provider may be affiliated or employed through multiple provider groups or practices, each with its own TIN. The commenter states that both the NPI and TIN are needed for accurate and timely claim payments, adding that the absence of both identifiers can create claims processing errors, resultant problems for a provider's account receivables, and misreporting of income to the IRS for tax purposes.

Another commenter also says that the treating provider's TIN should be required on the form, particularly when the requesting provider is the treating provider.

Agency response: TDI disagrees with the commenters and declines to require the service provider or facility TIN because it is outside the scope of SB 1216 and this rule. SB 1216 directs the commissioner to prescribe a standard form for requesting authorization of a health care service before the service is provided. The commenter's stated reasons for this change relate to accurate and timely claim payment, income reporting to IRS, and problems for a provider's accounts receivable. TDI notes that the commenter will have knowledge of these identifiers before paying a claim because the provider's NPI and TIN are required on the CMS 1500 (02/12) claim form and in the HIPAA standard format for filing electronic claims.

The Advisory Committee for the Standard Form for Requesting Prior Authorization of Health Care Services (Advisory Committee) discussed the potential form field addressed in the commenter's request at length. Physicians and health care providers voiced strong opposition, stating that requiring them to call service providers and obtain and report the service providers' TINs would be burdensome and costly. Physicians and providers further stated that, unlike NPIs, TINs are not publicly available and issuers should be responsible for contacting the service provider for this information.

Section 19.1810(a)(16).

Comment: A commenter notes that the proposed rules require that the prior authorization form include a place to list a direct phone number for the requesting provider or facility the issuer can call to ask for additional or missing information to process the request. The commenter states that such a call would not be a peer-to-peer discussion required by 28 TAC §19.1710 before issuance of an adverse determination. The commenter requests clarification that the issuer is not required to make a telephone call asking for additional or missing information in addition to or before the required peer-to-peer call.

Agency response: TDI does not agree with the assertion made by the commenter, because the clarification requested by the commenter is not consistent with 28 TAC §19.1707.

The prior authorization form's instructions page makes clear that entry of a direct phone number is optional for the requesting provider or facility and that the issuer can use the number, if provided, to request missing information. However, TDI does not agree that an issuer is not required to make a telephone call asking for additional or missing information in addition to or before the required peer-to-peer call. A reviewing entity, whether an issuer or utilization review agent, must comply with the requirements of the URA statute and rules, and 28 TAC §19.1707 states that a reviewer must request all relevant and updated information and medical records to complete the review. TDI expects a reviewer to request the additional or missing information needed to complete a review, though the request may be made by fax, telephone, or other available methods.

Section 19.1810(b).

Comment: A commenter supports this provision which states that that the prior authorization form may not be used by a provider or facility for the purposes listed in this subsection, but believes that issuers should not be prohibited from accepting the prior authorization form for other purposes if they choose to do so for administrative purposes.

Agency response: TDI disagrees with the suggestion in the comment and declines to make a change. The rule's instructions to providers are in keeping with the scope of the statute and are intended to prevent confusion in the proper use of the prior authorization request form.

Section 19.1810(b)(1) and prior authorization form's instructions page.

Comment: A commenter objects to a statement on the prior authorization form's instructions page which states that "Some issuers may require more information or additional forms to process your request." The commenter believes that TDI's intent in including this information was to place providers on notice that state government programs may require additional information or an entirely different type of form (such as an affidavit in the Medicaid program) for processing of the request. The commenter proposed that TDI amend the sentence by adding "such as state government programs" after "Some issuers."

The commenter also contends that the statement quoted above could be misconstrued as authorizing issuers to circumvent the law by requiring providers to submit information that is already included on the standard form. The commenter requested that TDI add language stating that if prior authorization is requested using the standard form, the issuer may not require the requesting provider or facility to submit any other form for prior authorization purposes that duplicates information found on the standard form.

Agency response: TDI disagrees with the comment and declines to add the suggested language. SB 1216 requires the commissioner to adopt a standard form for requesting prior authorization, but does not prohibit an issuer or a reviewer from asking for additional information needed to process the request.

TDI also declines to add the suggested language prohibiting an issuer from requiring a provider or facility to submit any other form for prior authorization purposes that duplicates information found on the prior authorization form. The prior authorization form requires information that identifies the patient, the requesting provider, and the requested service. Basic identifying information would be necessary on any additional forms a provider or facility submits. TDI will monitor the use of the prior authorization form and initiate future rulemaking as necessary.

Section 19.1810(a)(16) and prior authorization form's instructions page.

Comment: A commenter notes that the prior authorization form's instructions page allows requesting providers to enter their phone number if they wish to be contacted directly about missing information and states that such a call would not constitute a peer-to-peer discussion afforded by a utilization review agent (URA) before making an adverse determination. The commenter believes that limiting these calls to requests for missing information is too restrictive and fails to acknowledge certain circumstances under which a peer-to-peer discussion may actually occur during the call. The commenter states that allowing this phone call to be considered a peer-to-peer discussion may streamline the utilization review process and may promote patient access to timely, medically necessary services.

Agency response: TDI agrees with the comment and has revised the text of the rule as proposed to clarify this issue. TDI believes that calls to requesting physicians and providers for missing information needed to process a prior authorization request are

rarely, if ever, made by a physician's or provider's peer. However, TDI has amended the language on the prior authorization form's instructions page and in adopted §19.1810(a)(16) to clarify that a phone call can only be considered a peer-to-peer discussion required by 28 TAC §19.1710 if it is a discussion between peers that includes, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

Section 19.1810(b)(2) and "Intended Uses" section of the prior authorization form's instructions page.

Comment: A commenter objects to the statement in the rule and on the prior authorization form's instructions page that the prior authorization form may not be used by a provider or facility to request a referral to an out-of-network physician, facility, or other health care provider, stating that the language is overly broad, inflexible, and could create unnecessary confusion regarding the appropriate use of the standard prior authorization form. The commenter says that representatives of some health benefit plans who served on the advisory committee state they do not need any other information and currently do not require a separate form for requesting out-of-network referrals. The commenter requests that TDI amend the rule and the prior authorization form's instructions page to advise providers that some issuers require a separate form for out-of-network referrals and to check the issuer's policy regarding these types of requests.

Agency response: TDI disagrees with the comment and declines to make a change. SB 1216 requires the commissioner to prescribe a standard form for requesting prior authorization of health care services. However, the bill does not contemplate that the prior authorization form would also serve as a request for referral to an out-of-network health care provider. TDI does not agree that instructions limiting use of the prior authorization form to requests for prior authorization of health care services is confusing. To the contrary, TDI believes the commenter's suggested nonstandard use of the prior authorization form would create confusion about the appropriate use of the prior authorization form.

TDI notes that unlike certain other issuers, commercial issuers have two business days to approve a prior authorization request after receiving all needed information, but up to five days to approve a referral to an out-of-network provider. The non-standard use of the prior authorization form at the discretion of an issuer would be potentially misleading to providers and enrollees who may not understand that a timely approval of a service does not necessarily include approval to treat with an out-of-network provider, resulting in higher out-of-pocket costs for care received out-of-network.

Section 19.1810(d).

Comment: A commenter notes that the section requires a health benefit plan issuer and an issuer's agent that manages or administers health benefit to make the prior authorization form available on paper and electronically on their respective websites.

The commenter requests clarification that the website requirement does not apply to both the plan issuer and its agent if the agent is performing the issuer's utilization review activities.

Agency response: TDI disagrees with the comment and declines to make a change. Insurance Code §1217.004(a)(3) states that the prior authorization form must be available on paper and electronically on the websites of TDI, issuers, and agents of issuers that manage or administer health care services benefits.

Prior authorization form.

Comment: A commenter requests that TDI consider adding further specification for ECT, rTMS, and psychological/neuropsychological testing in Section V for Mental Health/Substance Abuse.

Agency response: TDI agrees with the comment and has revised the rule text as proposed. The elements needed to request prior authorization of ECT, rTMS, and psychological/neuropsychological testing are included in Sections V and VI of the form. The prior authorization form was designed with input from the Advisory Committee to accommodate prior authorization requests for all types of health care services while keeping the prior authorization form as short as possible to comply with stakeholder expectations. TDI has deleted the lead-in language in proposed §19.1810(a)(12) to allow a broader range of information that can be reported in this section of the form.

Prior authorization form, Section IV.

Comment: A commenter recommends that TDI reorder the table columns in Section V of the prior authorization form by moving the "Start Date" and "End Date" columns from the middle of the table to the far right of the table to be more readily identifiable, facilitate date entry, and better align with standard provider workflow.

Agency response: TDI disagrees with the suggestion and declines to make the requested change. Section V is captioned "*Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code).*" At the request of Advisory Committee members, the columns relating to requested services are grouped together, followed by the columns relating to the supporting diagnosis. The "Start Date" and "End Date" relate to the start and end date of the requested services and are grouped accordingly. TDI believes that placing the start and end date columns after the columns relating to supporting diagnoses would be illogical and potentially confusing to providers and their staff.

Prior authorization form's instructions page.

Comment: A commenter recommends that TDI add language on the prior authorization form's instructions page directing providers to retain the fax confirmation page as documentation of receipt of the request if the prior authorization form is submitted by fax.

Agency response: TDI disagrees with the comment and declines to make a change. While TDI agrees that it is a good business practice for physicians and providers to

retain fax confirmations, a change to the prior authorization form's instructions page is not necessary. TDI understands that retention of fax confirmations is a standard business practice and believes that physicians and providers are accustomed to retaining documentation when submitting medical records, prior authorization requests, and other documents that contain protected health information.

5. NAMES OF THOSE COMMENTING.

For with changes: Superior HealthPlan, the Texas Association of Health Plans, and the Texas Medical Association.

6. STATUTORY AUTHORITY. TDI adopts §§19.1801 - 19.1804 and 19.1810 under Insurance Code §§1217.001, 1217.002, 1217.003, 1217.004, 1217.006, and 36.001. Section 1217.001 provides definitions for Insurance Code Chapter 1217. Section 1217.002 states applicability of Insurance Code Chapter 1217. Section 1217.003 states exceptions to the applicability of Insurance Code Chapter 1217. Section 1217.004 requires the commissioner to adopt a rule to prescribe a single, standard form for requesting prior authorization of health care services; to require an issuer to use the form for all prior authorizations of health care services for which the issuer's plan requires prior authorization; and to require TDI and the issuer to make the form available in paper form and electronically on their websites. Section 1217.006 states that nothing in Subchapter 1217 may be construed to authorize the commissioner to decline to prescribe the form required by §1217.004. Section 36.001 provides that the

commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of Texas.

7. TEXT.

SUBCHAPTER S. FORMS TO REQUEST PRIOR AUTHORIZATION

DIVISION I. Texas Standard Prior Authorization Request Forms.

§19.1801. Applicability.

(a) Applicable health benefit plans. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement holding a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation holding a certificate of authority under Chapter 844.

(b) Other applicable coverages and programs.

(1) This subchapter applies to group health coverage made available by a school district under Education Code §22.004.

(2) This subchapter applies to:

(A) a basic coverage plan under Chapter 1551;

(B) a basic plan under Chapter 1575;

(C) a primary care coverage plan under Chapter 1579; and

(D) basic coverage under Chapter 1601.

(3) This subchapter applies to coverage under the child health program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code.

(4) This subchapter applies to a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

§19.1802. Exception. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) only for wages or payments to replace wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by §1882, Social Security Act (42 U.S.C. §1395ss);

(3) medical payment insurance coverage provided under a motor vehicle insurance policy;

(4) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by §1217.002; or

(5) a workers' compensation insurance policy.

§19.1803. Definitions. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

(1) CDT--Current Dental Terminology code set maintained by the American Dental Association.

(2) CPT--Current Procedural Terminology code set maintained by the American Medical Association.

(3) Department--Texas Department of Insurance.

(4) Form--In Division 2 of this subchapter, the Texas Standard Prior Authorization Request Form for Health Care Services.

(5) HCPCS--Healthcare Common Procedure Coding System.

(6) Health benefit plan--

(A) a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document offered by a health benefit plan issuer.

(B) Health benefit plan also includes:

(i) group health coverage made available by a school district in accord with Education Code §22.004;

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

(iii) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code;

(iv) a basic coverage plan under Chapter 1551;

(v) a basic plan under Chapter 1575;

(vi) a primary care coverage plan under Chapter 1579; and

(vii) basic coverage under Chapter 1601.

(7) Health benefit plan issuer--An entity authorized under the Texas Insurance Code or another insurance law of this state that delivers or issues for delivery a health benefit plan or other coverage described in Insurance Code §1217.002.

(8) Health care service--A service to diagnose, prevent, alleviate, cure, or heal a human illness or injury, which is provided by a physician or other health care provider. The term includes medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices, and durable medical equipment. The term does not include prescription drugs as defined by Occupations Code §551.003.

(9) Issuer--A health benefit plan issuer and the agent of a health benefit plan issuer that manages or administers the issuer's health care services or prescription drug benefits.

(10) NPI number--A provider's or facility's National Provider Identifier.

(11) Prescription drug--Has the meaning assigned by Occupations Code §551.003.

§19.1804. Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter

that can be given effect without the invalid provision or application, and to this end, the provisions of this subchapter are severable.

DIVISION II. Texas Standard Prior Authorization Request Form for Health Care Services.

§19.1810. Prior Authorization Request Form for Health Care Services, Required Acceptance, and Use.

(a) Form requirements. The commissioner adopts by reference the Prior Authorization Request Form for Health Care Services, to be accepted and used by an issuer in compliance with subsection (b) of this section. The form and its instruction sheet are posted on the TDI website at www.tdi.texas.gov/forms/form10.html; or the form and its instruction sheet can be requested by mail from the Texas Department of Insurance, Rate and Form Review Office, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104. The form must be reproduced without changes. The form provides space for the following information:

(1) the plan issuer's name, telephone number, and facsimile (fax) number;

(2) the date the request is submitted;

(3) the type of review, whether:

(A) nonurgent, or

(B) urgent.

An urgent review should only be requested for a patient with a life-threatening condition or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. A provider or facility may also request an urgent review to authorize treatment of an acute injury or illness if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health;

(4) the type of request (whether an initial request or an extension, renewal, or amendment of a previous authorization);

(5) the patient's name, date of birth, sex, contact telephone number, and identifying insurance information;

(6) the requesting provider's or facility's name, NPI number, specialty, telephone and fax numbers, contact person's name and telephone number, and the requesting provider's signature and date, if required (if a signature is required, a signature stamp may not be used);

(7) the service provider's or facility's name, NPI number, specialty, and telephone and fax numbers;

(8) the primary care provider's name and telephone and fax numbers, if the patient's plan requires the patient to have a primary care provider and that provider is not the requesting provider;

(9) the planned services or procedures and the associated CPT, CDT, or HCPCS codes, and the planned start and end dates of the services or procedures;

(10) the diagnosis description, ICD version number (if more than one version is allowed by the U.S. Department of Health and Human Services), and ICD code;

(11) identification of the treatment location (inpatient, outpatient, provider office, observation, home, day surgery, or other specified location);

(12) information about the duration and frequency of treatment sessions for physical, occupational, or speech therapy, cardiac rehabilitation, mental health, or substance abuse;

(13) if requesting prior authorization for home health care, information about the requested number of home health visits and their duration and frequency, and an indication whether a physician's signed order or a nursing assessment is attached;

(14) if requesting prior authorization for durable medical equipment, an indication whether a physician's signed order is attached, a description of requested equipment or supplies with associated HCPCS codes, duration, and, if the patient is a Medicaid beneficiary, an indication whether a Title 19 Certification is attached;

(15) a place for the requester to include a brief narrative of medical necessity or other clinical documentation. A requesting provider or facility may also attach a narrative of medical necessity and supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.); and

(16) if a requesting provider wants to be called directly about missing information, a place to list a direct telephone number for the requesting provider or facility the issuer can call to ask for additional or missing information if needed to

process the request. The phone call can only be considered a peer-to-peer discussion required by 28 TAC §19.1710 if it is a discussion between peers that includes, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(b) Acceptance and use of the form.

(1) If a provider or facility submits the form to request prior authorization of a health care service for which the issuer's plan requires prior authorization, the issuer must accept and use the form for that purpose. An issuer may also have on its website another electronic process a provider or facility may use to request prior authorization of a health care service.

(2) This form may not be used by a provider or facility:

(A) to request an appeal;

(B) to confirm eligibility;

(C) to verify coverage;

(D) to ask whether a service requires prior authorization;

(E) to request prior authorization of a prescription drug; or

(F) to request a referral to an out of network physician facility or other health care provider.

(c) Effective date. An issuer must accept a request for prior authorization of health care services made by a provider or facility using the form on or after September 1, 2015.

(d) Availability of the form.

(1) A health benefit plan issuer must make the form available on paper and electronically on its website.

(2) A health benefit plan issuer's agent that manages or administers health care services benefits must make the form available on paper and electronically on its website.

8. CERTIFICATION. This agency certifies that legal counsel has reviewed the amended section and found it to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on December 1, 2014.

Sara Waitt, General Counsel
Texas Department of Insurance

The commissioner adopts new §§19.1801 - 19.1804 and 19.1810.

Julia Rathgeber, Commissioner
Texas Department of Insurance