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

1. INTRODUCTION. The Texas Department of Insurance proposes new Subchapter S §§19.1801 – 19.1804 and 19.1810, in 28 TAC Chapter 19, Agents' Licensing, concerning Forms to Request Prior Authorization. Subchapter S will prescribe a prior authorization request form for health care services that will 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.

Background and Justification.

Senate Bill 1216, 83rd Legislature, Regular Session (2013) amended 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 the department and the issuer and its agents to make the form available in paper form and electronically on their websites. The proposed rule addresses these requirements.

SB 1216 also directed 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 the department, or established by the Centers for Medicare and Medicaid Services, and

to consider national standards or draft standards on electronic prior authorization of benefits.

In compliance with new Insurance Code §1217.005, the commissioner appointed an advisory committee composed as required by §1217.005(c). 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 was used to create the form in this rule proposal.

Description of Proposed Rule.

In addition to SB 1216, the 83rd Legislature (Regular Session) 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. Although this proposal addresses only the prior authorization request form for health care services mandated by SB 1216, some provisions of this rule will also apply to the prior authorization request form for prescription drug benefits when the rule adopting that form is added.

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 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, as 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.

2. FISCAL NOTE. Patricia Brewer, special advisor for policy development in the Life, Accident, and Health Section, has determined that for each year of the first five years the proposed new sections will be in effect, there will be no fiscal impact to state or local governments resulting from enforcement or administration of the rule. The proposal will have no measurable effect on local employment or on the local economy.

3. PUBLIC BENEFIT AND COST NOTE. Ms. Brewer has also determined that for each year of the first five years the proposed new sections are in effect, the rule's anticipated public benefits include reduced administrative time spent by physicians, hospitals, and other health care providers identifying and completing each issuer's prior authorization form or forms; easy provider access to the standard prior authorization form on the department's and the issuers' and agents' websites; and expedited delivery of health care services to consumers.

The costs to persons who must comply with the proposed sections, for each year of the first five years they would be in effect, result from the enactment of SB 1216, and not from the adoption, enforcement, or administration of the proposed sections. SB 1216 explicitly prohibits the department from declining to prescribe the form. The department is unable to determine the actual cost for issuers and providers to adopt and use the form when adopted, as those costs will vary based on each entity's administrative processes. However, as required by SB 1216, the department developed the proposed form with input from an advisory committee in which issuer representatives and health care provider and facility representatives, among others, participated. After extensively discussing the form's elements with the advisory committee, the department does not anticipate that issuers or their agents or providers and facilities will incur undue material costs due to the particular elements of the proposed form. The agency does not anticipate a difference in the cost of compliance between small and large businesses.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. In compliance with Government Code §2006.002(c), the department has determined that the proposed new sections that require issuers and their agents to use and accept the standard prior authorization request form and to make the form available in paper form and electronically on their respective websites will not have an adverse economic effect on small or micro businesses required to comply with the proposed rule. The proposal does not impose on businesses any requirements or costs other than those required by SB 1216. Costs to persons required to comply with the proposed new sections result from the enactment of SB 1216, and not from the adoption, enforcement, or administration of the proposal. Therefore, the department has determined that a regulatory flexibility analysis is not required because the proposal will not have an adverse impact on small or micro businesses. It is not possible both to provide flexibility for small or micro businesses and to comply with the Legislature's mandate in SB 1216 to create a single, standard prior authorization request form for Texas. Permitting small or micro businesses to refuse to accept the adopted form, and instead require providers to use a form specific to or created by individual small or micro businesses, would increase, rather than decrease, providers' confusion.

5. TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal. This proposal does not restrict or

limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. The department invites comments on the proposed rule. If you wish to comment on this proposal, your comments must be postmarked no later than 5:00 p.m., Central time, on September 22, 2014. Please send comments by mail to Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov. Please simultaneously submit an additional copy of the comments by mail to Patricia Brewer, Special Advisor for Policy Development, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to lhlcomments@tdi.texas.gov. You must submit any request for a public hearing separately to the Office of Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov before the close of the public comment period. If there is a hearing on this proposal, you may present written comment and public testimony at the hearing.

7. STATUTORY AUTHORITY. The department proposes the amendments to 28 TAC Chapter 19 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 the department 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 the department under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. All statutes cited below are in the Insurance Code unless otherwise noted. The following statutes are affected by this proposal:

Rule	Statute
§19.1801 (Applicability)	§1217.002
§19.1802 (Exception)	§1217.003

§19.1803 (Definitions)	§1217.001
§19.1804 (Severability)	§36.001
§19.1810 (Prior Authorization Request Form for Health Care Services, Required Acceptance, and Use)	§1217.004

9. TEXT.

SUBCHAPTER S. FORMS TO REQUEST PRIOR AUTHORIZATION

DIVISION I. Texas Standardized 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 in lieu of 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:

(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 Standardized 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 Standardized 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 department's 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) if requesting prior authorization for therapy, 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 of 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 of 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) 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 to process the request. Such a call is not a peer-to-peer discussion afforded by a utilization review agent before issuing an adverse determination required by 28 TAC §19.1710.

(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.

10. CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on August 8, 2014.

Sara Waitt
General Counsel
Texas Department of Insurance