SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY
28 TAC §19.1710

DIVISION 2. PREAUTHORIZATION EXEMPTIONS
28 TAC §§19.1730 - 19.1733

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §19.1710 and to add new 28 TAC Chapter 19, Subchapter R, Division 2, §§19.1730 - 19.1733, concerning requirements prior to issuing an adverse determination and preauthorization exemptions. These amended and new sections implement House Bill 3459, 87th Legislature, 2021.

EXPLANATION. The amendments to §19.1710 and addition of new Division 2, §§19.1730 - 19.1733 to Subchapter R are necessary to conform TDI's rules regarding utilization review with HB 3459. HB 3459 allows a health maintenance organization or insurer to grant, deny, or rescind an exemption from preauthorization requirements under certain conditions. Under the proposed rules, an issuer must provide notice of an initial exemption or denial of an exemption not later than October 1, 2022, based on an evaluation period of January 1, 2022, through June 30, 2022.

The proposed amended and new sections are described in the following paragraphs.

Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy.

Section 19.1710. Amended §19.1710 clarifies that a utilization review agent must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician licensed to practice in Texas. This section follows Insurance Code §4201.206, as amended by HB 3459, in which new language specifies that

an agent must provide to a health care provider an opportunity to discuss the health care service in question with a physician licensed to practice medicine "in this state." Physicians holding Texas Administrative Medicine Licenses under the Medical Practice Act and Texas Medical Board rule 22 TAC §172.17 meet this standard. TDI has historically interpreted this statute to include Texas Administrative Medicine Licenses, and TDI believes that recent changes to §4201.206 do not indicate that this long-standing position should change. The section is also amended to add a sentence stating, in accordance with Insurance Code §4201.206, that if the health care service was ordered, requested, or provided by a physician, the opportunity to discuss the health care service in question must be with a physician licensed to practice medicine in Texas and who has the same or similar specialty as the requesting physician.

Division 2. Preauthorization Exemptions. TDI proposes to add new Division 2, titled "Preauthorization Exemptions," to distinguish §§19.1730 - 19.1733 from existing rules in Subchapter R, which relate to utilization review and preauthorization procedures generally. After this Division's adoption, a new Division 1, with a heading clarifying that it addresses utilization review, will be administratively added for §§19.1701 - 19.1719.

Section 19.1730. New §19.1730 defines terms used in the new division: "adverse determination regarding a preauthorization exemption," "denial of preauthorization exemption," "evaluation," "evaluation period," "issuer," "particular health care service," "physician," "preauthorization," "preauthorization exemption," "provider," "random sample," "rescission of preauthorization exemption," and "treating physician or provider." The definitions clarify:

- the nature of an adverse determination regarding a preauthorization exemption, as compared with the meaning of adverse determination under §19.1703;

- the number of claims needed for granting or denying a preauthorization exemption;

- the threshold percentage of accepted claims needed for an issuer to grant, deny, or rescind a preauthorization exemption;

- the nature of an evaluation depending on whether the physician or provider currently has a preauthorization exemption in place;

- the time allowed for evaluation periods; and

- the scope of "health care services" to include prescription drugs.

Section 19.1731. New §19.1731 describes the initial preauthorization exemption process. Subsection (a) clarifies that for purposes of Division 2, a "physician" or "provider" should be identified using the National Provider Identifier under which a physician or provider makes preauthorization requests. Subsection (b) states that the issuer must review the outcomes of no fewer than 20 preauthorization requests for a particular health care service in a given evaluation period and determine whether the physician or provider qualifies for an exemption. The department specifically seeks comments on this minimum threshold for review and whether it should be modified. Subsection (c) provides the requirements for an issuer to rescind a preauthorization exemption that has already been granted to a physician or provider, which must be rescinded consistent with Insurance Code §4201.655. Subsection (d) clarifies that a treating physician rendering or referring services without a preauthorization exemption who relies on another physician's preauthorization exemption in violation of subsection (d) may be considered by the issuer as failing to substantially perform the health care service. In that situation, the issuer may reduce or deny payment for that service under Insurance Code §4201.659.

Section 19.1732. New §19.1732(a) states that an issuer must provide notice to the physician or provider when granting a preauthorization exemption, and requires that an exemption be in place for at least six months before it can be rescinded. If an issuer subsequently receives a preauthorization request from the physician or provider for a service for which the physician or provider has been granted an exemption, the issuer

must provide notice in accordance with Insurance Code §4201.659(e). For denials of preauthorization exemptions, new §19.1732(b) states that an issuer must provide notice and list the reasons for a denial in accordance with Insurance Code §4201.655(c)(2). New §19.1732(c) provides a required timeframe for issuing notices of exemption or denial following the initial and subsequent evaluation periods and clarifies that such notices are required with respect to a particular health care service only if the physician or provider had submitted at least 20 preauthorization requests during the evaluation period. The department specifically seeks comments on this minimum duration for exemptions and the timeframe for issuing notices, and whether either should be modified. New §19.1732(d) describes the requirements of the notice that must be delivered to a physician or provider when rescinding a preauthorization exemption, the requirements for a physician or provider to appeal a rescission of preauthorization exemption, and notes an example form (LHL011) available on TDI's website.

Section 19.1733. New §19.1733(a) clarifies that Insurance Code §4201.305 does not apply to retrospective reviews conducted in accordance with Insurance Code §4201.659(b)(1). New §19.1733(b) provides that a physician or provider has at least 30 days to provide medical records or other documents for the issuer to conduct an evaluation. Medical records can be requested only during an evaluation period or within 90 days following the end of an evaluation period. If the physician or provider does not provide the necessary records for an issuer to make a determination, the issuer may determine that the claim would not have met the screening criteria. New §19.1733(c) states that a physician or provider may request an independent review of the retrospective review that resulted in the rescission of preauthorization exemption at any time before the rescission is effective. New §19.1733(d) provides that a physician or provider must submit to the issuer the form provided by the issuer under §19.1732(c) in order to request an independent review. Upon receipt, the issuer must submit the request for independent

review to TDI, consistent with proposed new 28 TAC §12.601 (which is included in a separate proposal) and 28 TAC §19.1717. New §19.1733(e) states that a physician or provider may request that the independent review organization review another random sample of claims. New §19.1733(f) states that an issuer must communicate the determination of a review by the independent review organization to the physician or provider within five days. New §19.1733(g) states that physicians and providers must continue to maintain medical records adequate to demonstrate that the exempted services they provide meet medical guidelines in order to retain a preauthorization exemption. Most, if not all, physicians and providers subject to this proposed rule already maintain records for a sufficient amount of time. *See, e.g.,* 22 TAC §76.4(a) (Texas Board of Chiropractic Examiners rule imposing a six-year records retention requirement); 22 TAC §165.1(b)(1) (Texas Medical Board rule imposing a six-year records retention requirement); and 22 TAC §§291.34(a), 291.75(a), and 291.94(a) (Texas State Pharmacy Board rules imposing a two-year records retention requirement). If there are no adequate records for an issuer to use during an evaluation, an exemption may be rescinded.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the proposed amendments and sections are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the amendments and sections, other than that imposed by the statute. Ms. Bowden made this determination because the proposed amendments and sections do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the amendments and sections.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments and sections are in effect, Ms. Bowden expects that administering the amendments and sections will have the public benefit of ensuring that TDI's rules conform to Insurance Code Chapter 4201, Subchapter N, and implement a cohesive preauthorization exemption process under that subchapter.

Ms. Bowden expects that the proposed amendments and sections will not impose an economic cost on persons required to comply with them. Any associated costs are due to statute or other current regulatory requirements.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments and sections will not have an adverse economic effect on small or micro businesses, or on rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a cost on regulated persons. Therefore, no additional rule repeals or amendments are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed sections are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will create a new regulation;

- will expand, limit, or repeal an existing regulation;

- will increase the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI 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. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on May 9, 2022. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The Commissioner will also consider written and oral comments on the proposal in a public hearing under Docket No. 2832 at 2:00 p.m. central time, on May 12, 2022, in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin Texas.

SUBCHAPTER R. UTLIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY
28 TAC §19.1710 and §§19.1730 - 19.1733

STATUTORY AUTHORITY. TDI proposes amendments to §19.1710 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the Commissioner to adopt rules to implement Insurance Code Chapter 4201, concerning utilization review and independent review.

Insurance Code §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 this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §19.1710 implement Insurance Code §4201.206, as amended by HB 3459.

TEXT.

§19.1710. Requirements Prior to Issuing an Adverse Determination.

In any instance in which the URA is questioning the medical necessity, the appropriateness, or the experimental or investigational nature of the health care services prior to the issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician licensed to practice medicine in Texas. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. If the health care service was ordered, requested, or provided, or is to be provided, by a physician, then the opportunity must be

with a physician licensed to practice medicine in Texas and who has the same or similar specialty as the physician.

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

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

DIVISION 2. PREAUTHORIZATION EXEMPTIONS.

STATUTORY AUTHORITY. TDI proposes new Division 2, §§19.1730 - 19.1733, under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the Commissioner to adopt rules to implement Insurance Code Chapter 4201, concerning utilization review and independent review.

Insurance Code §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 this state.

CROSS-REFERENCE TO STATUTE. Proposed new §§19.1730 - 19.1733 implement Insurance Code Chapter 4201, Subchapter N.

§19.1730. Definitions.

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

(1) Adverse determination regarding a preauthorization exemption--A decision by an issuer that one or more claims reviewed as part of an evaluation, with respect to a particular health care service for which the physician or provider has a preauthorization exemption, did not meet the issuer's screening criteria, and leads to an issuer's decision to rescind a preauthorization exemption. An adverse determination regarding a preauthorization exemption is not an adverse determination as defined under §19.1703 of this title (relating to Definitions).

(2) Denial of preauthorization exemption--A determination that a physician or provider does not qualify for a preauthorization exemption based on the issuer conducting an evaluation of preauthorization requests and demonstrating that the physician or provider received full and final approval for fewer than 90% of the preauthorization requests made for a particular health care service during the most recent evaluation period.

(3) Evaluation--

(A) with respect to a particular health care service for which a physician or provider does not have a preauthorization exemption, a review of the outcomes of preauthorization requests submitted by the physician or provider during the most recent evaluation period to determine the percentage of requests that were approved, which is conducted for the purpose of evaluating whether to grant or deny a preauthorization exemption; or

(B) with respect to a particular health care service for which a physician or provider has a preauthorization exemption, a review of a random sample of claims to determine the percentage of claims that would have been approved, based on the issuer's applicable medical necessity criteria at the time the service was provided, as applied under a retrospective review of claims submitted by the physician or provider during the most recent evaluation period, which is conducted for the purpose of

evaluating whether to continue or rescind a preauthorization exemption and consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption;

(4) Evaluation period--The six-month period preceding an evaluation. The evaluation periods are as follows:

(A) for an initial determination of a preauthorization exemption grant or denial, the evaluation period is the six-month period that begins on January 1, 2022, or the subsequent six-month periods of July 1 - December 31 and January 1 - June 30 that follow each year;

(B) after a denial or rescission of a preauthorization exemption for a particular health care service, the subsequent six-month evaluation period begins on the first day following the end of the evaluation period that formed the basis of the denial or rescission; and

(C) for a notification of a preauthorization exemption rescission as provided in Insurance Code §4201.655(a), the evaluation period is the six-month period an issuer determines or the subsequent six-month periods that follow, but there may not be more than two months between an evaluation period ending and the provision of notice under §19.1732 of this title (relating to Notice of Preauthorization Exemption Grants, Denials, or Rescissions).

(5) Issuer--A health maintenance organization or insurer that is subject to Insurance Code Chapter 4201, Subchapter N, including a URA or a person who contracts with an issuer to issue a preauthorization determination, or performs the functions described in this division.

(6) Particular health care service--A health care service, including a prescription drug, that is subject to preauthorization as listed on the issuer's website

under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans).

(7) Physician--Has the meaning assigned by Insurance Code §843.002, concerning Definitions.

(8) Preauthorization--Has the meaning assigned in Insurance Code §4201.651, concerning Definitions. "Preauthorization" under this division does not include concurrent utilization review.

(9) Preauthorization exemption--A privilege obtained under this division in which a physician or provider is not subject to a preauthorization requirement that otherwise applies with respect to a particular health care service. The preauthorization exemption applies both to care rendered by a treating physician or provider and to care ordered by a physician or provider who is acting in his or her capacity as a treating physician or provider.

(10) Provider--Has the meaning assigned by Insurance Code §843.002, concerning Definitions.

(11) Random sample--A collection of at least five but no more than 20 claims for a particular health care service, selected without method or conscious decision, for the purpose of evaluating a physician's or provider's continued eligibility for a preauthorization exemption.

(12) Rescission of preauthorization exemption--An adverse determination regarding a preauthorization exemption based on an evaluation of claims by an individual licensed to practice medicine in this state in which the issuer would have fully approved fewer than 90% of claims for a particular health care service.

(13) Treating physician or provider--The physician or other provider who is primarily responsible for a patient's health care for an illness or injury. A "treating

physician or provider" includes a rendering physician or provider or a referring physician or provider.

§19.1731. Preauthorization Exemption.

(a) For the purposes of this division, a physician or provider should be identified using the National Provider Identifier under which a physician or provider makes preauthorization requests.

(b) With respect to a particular health care service for which a physician or provider does not have a preauthorization exemption, an issuer must conduct an evaluation of all preauthorization requests submitted by the physician or provider during the most recent evaluation period that were finalized prior to the evaluation and may not include a request that is pending appeal at the time the data is analyzed. The evaluation must be based on no fewer than 20 preauthorization requests.

(c) With respect to a particular health care service for which a physician or provider has a preauthorization exemption, an issuer may conduct an evaluation to determine whether to rescind a preauthorization exemption consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption. In order to determine whether to rescind an exemption, the issuer must conduct a retrospective review of a random sample of at least five and no more than 20 claims submitted during the most recent evaluation period.

(d) Other than care ordered by a treating physician or provider that has a preauthorization exemption that is then rendered by a physician or provider that does not have an exemption, a treating physician may not rely on another physician's preauthorization exemption. If a treating physician does not have a preauthorization exemption and relies on another physician's preauthorization exemption in violation of this subsection, an issuer may consider that treating physician as failing to substantially

perform the health care service under Insurance Code §4201.659, concerning Effect of Preauthorization Exemption, and may reduce or deny payment for that service on that basis.

§19.1732. Notice of Preauthorization Exemption Grants, Denials, or Rescissions.

(a) When granting a preauthorization exemption, an issuer must provide notice to the physician or provider, consistent with Insurance Code §4201.659(d), concerning Effect of Preauthorization Exemption. The exemption begins on the date the notice is issued and must be in place for at least six months before it may be rescinded. If an issuer subsequently receives a preauthorization request from the physician or provider for a particular health care service for which an exemption has been granted, the issuer must provide a notice consistent with Insurance Code §4201.659(e).

(b) When denying a preauthorization exemption, an issuer must provide notice to the physician or provider that demonstrates that the physician or provider does not meet the criteria for a preauthorization exemption, consistent with Insurance Code §4201.655(c)(2), concerning Denial or Rescission of Preauthorization Exemption.

(c) For the initial evaluation period of January 1 through June 30, 2022, an issuer must provide notice granting or denying a preauthorization exemption no later than October 1, 2022. For subsequent evaluation periods during which a physician or provider does not have a preauthorization exemption, an issuer must provide notice to the physician or provider granting or denying a preauthorization exemption no later than two months following the day after the end of the evaluation period. Notice need only be provided for a particular health care service if the issuer was able to complete an evaluation of at least 20 preauthorization requests, as provided in §19.1731(b) of this title (relating to Preauthorization Exemption).

(d) When rescinding a preauthorization exemption, an issuer must provide notice to the physician or provider, consistent with Insurance Code §4201.655(a)(3). The notice must include the following (a sample form LHL011 is available on TDI's website):

(1) an identification of the health care service for which a preauthorization exemption is being rescinded and the date the rescission is effective, consistent with Insurance Code §4201.654, concerning Duration of Preauthorization Exemption;

(2) a plain language explanation of how the physician or provider may appeal and seek an independent review of the determination, the date the notice is issued, and the company's address and contact information for returning the form to request an appeal;

(3) the sample information used to make the determination, including:

(A) identification of each claim included in the random sample, and if retrospective review was conducted for additional claims that were not included in the random sample, separate identification of such claims;

(B) the issuer's determination of whether each claim met the issuer's screening criteria; and

(C) for any claim determined to not have met the issuer's screening criteria:

(i) the principal reasons for the determination that the claim did not meet the issuer's screening criteria;

(ii) the clinical basis for the determination that the claim did not meet the issuer's screening criteria;

(iii) a description of the sources of the screening criteria that were used as guidelines in making the determination; and

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

(4) a space to be filled out by the physician or provider that includes:

(A) the name, address, contact information, and identification number of the physician or provider requesting an independent review;

(B) an indication of whether the physician or provider is requesting that the independent review organization review the same random sample or a different random sample of claims, if available; and

(C) the date the appeal is being requested; and

(5) an instruction for the physician or provider to return the form to the issuer before the date the rescission becomes effective.

§19.1733. Retrospective Reviews and Appeals of Preauthorization Exemption Rescissions.

(a) For a retrospective review that is conducted under Insurance Code §4201.659(b)(1), concerning Effect of Preauthorization Exemption, to determine whether the physician or provider still qualifies for an exemption, Insurance Code §4201.305, concerning Notice of Adverse Determination for Retrospective Utilization Review, does not apply.

(b) An issuer that is conducting an evaluation to determine whether a physician or provider still qualifies for a preauthorization exemption may request medical records or other documents, consistent with §19.1707 of this title (relating to URA contact with and Receipt of Information from Health Care Providers), and must provide at least 30 days for a physician or provider to provide the records. Medical records should be requested for no more than 20 claims for a particular health care service and may be requested only during an evaluation period or within 90 days following the end of an evaluation period. If the physician or provider fails to provide the records necessary for the issuer to make a

determination, the issuer may determine that the claim would not have met the screening criteria.

(c) After receiving a notice of rescission, a physician or provider may request an independent review of the adverse determination regarding a preauthorization exemption at any time before the rescission becomes effective.

(d) In order to request an independent review of a rescission of a preauthorization exemption, a physician or provider must submit the form provided by the issuer under §19.1732(c) of this title (relating to Notice of Preauthorization Exemption Grants, Denials, or Rescissions). Upon receipt, the issuer must submit the request for independent review to the department, consistent with §12.601 of this title (relating to Preauthorization Exemptions), and §19.1717(c) of this title (relating to Independent Review of Adverse Determinations).

(e) If the notice of rescission of preauthorization exemption identified that retrospective review was conducted for additional claims that were not included in the random sample, the physician or provider, when requesting an independent review, may request that the independent review organization review another random sample of claims.

(f) An issuer must communicate the determination of a review by an independent review organization under §12.601 of this title to the physician or provider within five days.

(g) In order to retain a preauthorization exemption, a physician or provider must continue to maintain medical records adequate to demonstrate that health care services meet medical guidelines. In the absence of adequate records during an evaluation or appeal, an exemption may be rescinded.

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

Issued in Austin, Texas, on March 25, 2022.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance