Request for information to use in implementation of House Bill 3459 and stakeholder notice

Stakeholder meeting date: September 23, 2021

Time: 10:30 a.m. – 12 p.m.

Location: Online. Register on Zoom. After you register, you will get an email with instructions for joining the meeting and an option to add the meeting to your calendar.

Details:

The Texas Department of Insurance (TDI) is developing rules to implement House Bill 3459 from the 2021 regular legislative session.

HB 3459 amends Insurance Code Section 4201.206 to require that a physician participating in a peer-to-peer review on behalf of a health benefit plan issuer must be a Texas-licensed physician who has the same or similar specialty as the physician or provider requesting the service.

HB 3459 also adds Subchapter N to Chapter 4201. Subchapter N requires issuers to provide an exemption from any preauthorization requirement for a particular health care service if the issuer has approved, or would have approved, at least 90% of the preauthorization requests submitted by the physician or provider for that service.

To provide input
TDI is seeking input on implementation issues related to HB 3459.

Please provide your comments to LHLcomments@tdi.texas.gov by 5 p.m., Central time, September 20. TDI will host an online public stakeholder meeting on September 23 at 10:30 a.m. to discuss the comments received. TDI will publish the comments before the meeting on the TDI website.

Texas administrative medical licenses

1. Insurance Code Section 4201.206(a) requires that before an adverse determination is issued, the ordering health care provider be given the opportunity to discuss the treatment plan with a licensed physician. Please provide input on TDI's consideration of a rule providing that an Administrative Medical License could satisfy the requirements of Section 4201.206(a).

Preauthorization requests

2. Insurance Code Section 4201.653(a) exempts physicians and other health providers from preauthorization requirements for certain services if the HMO or health plan "has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service."

    a. When determining a provider's approval rate for preauthorization requests, should requests for a certain quantity (such as five days of inpatient care) be counted as a single request or multiple requests? What is the approval rate if, using the inpatient care example, three days were approved and two days were denied?

    b. How should approval rates be calculated for preauthorization requests for a treatment regimen (such as three-drug regimen) where some services within the request may be approved and others denied or approved with changes?

        i. Should each distinct service be counted as a separate request?

        ii. Should a preauthorization request for a drug be treated as the same particular health care service if the prescribed dosage or other dispensing details are different?

Preauthorization exemptions

3. Under Insurance Code Sections 4201.655(a)(2) and 4201.656(d), the issuer must make a determination by evaluating a random sample of at least five claims from the most recent six-month evaluation period. Please provide input on how an exemption should be considered when there are four or fewer claims for the particular health care service in the most recent six-month evaluation period.

4. Under Insurance Code Section 4201.653(d), a physician or provider is not required to request an exemption to qualify. Under Section 4201.653(c), an issuer may grant an exemption without evaluating whether the physician or provider qualifies. Please provide input on TDI's consideration of rules that would require physicians or providers to be automatically granted an exemption by an issuer at the end of the first six-month evaluation period, unless the insurer shows that the 90% threshold was not met during the evaluation period.

5. Please provide input on TDI's consideration of rules that would require issuers to provide notice of a denial of a preauthorization exemption to a physician or provider for a particular health care service rather than when the exemption is granted.
6. Under Insurance Code Section 4201.655, an issuer may rescind an exemption from preauthorization requirements only during January or June of each year. Under Section 6 of HB 3459, Subchapter N of Chapter 4201 applies only to a request for preauthorization of health care service made on or after January 1, 2022. Please provide input on TDI's consideration of rules that would require issuers to provide an initial notice of exemption or denial of exemption in June 2022, based on an evaluation of preauthorization requests that were submitted on or after January 1, 2022.

Rescinding preauthorization exemptions

7. Starting from the date notification is received, how much time should a physician or provider have to request an appeal of the issuer's determination to rescind the exemption?
8. Under Insurance Code Section 4201.655(a)(2), an issuer seeking to rescind an exemption from preauthorization must make a determination "on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted … during the most recent evaluation period." Under Insurance Code Section 4201.656(d), a physician or provider may request that the independent review organization (IRO) "consider another random sample of not less than five and no more than 20 claims submitted ... during the relevant evaluation period." Is additional guidance in rules needed to clarify how an issuer or IRO should determine how to select the random sample or the number of claims to consider?

Additional comments

9. Please provide any additional comments or points of clarification that the rule should address.