Subchapter K. Continuing Education, Adjuster Prelicensing Education Programs, and Certification Courses
28 TAC §19.1006 and §19.1028

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

Division 1. Utilization Reviews
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Subchapter S. Forms to Request Prior Authorization

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Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage
28 TAC §§19.2005, 19.2006, 19.2009, and 19.2010

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC:

- Section 19.1006 and §19.1028, concerning licensee continuing education courses and requirements for adjuster licensing, and annuity certification courses;

- Sections 19.1702, 19.1705, 19.1706, 19.1709, and 19.1710, concerning utilization review;

- Sections 19.1730 - 19.1733, concerning preauthorization exemptions;

- Section 19.1801 and §19.1803, concerning prior authorization request forms; and

- Sections 19.2005, 19.2006, 19.2009, and 19.2010, concerning utilization review and utilization review agents under workers' compensation insurance coverage.

TDI also proposes new §19.1734, concerning preauthorization exemptions. The proposed amendments and new section implement House Bills 2221 and 3812, 89th Legislature, 2025, and Senate Bill 815, 89th Legislature, 2025. The proposed amendments also implement House Bill 4611, 88th Legislature, 2023; Senate Bill 1296, 84th Legislature, 2015; and Senate Bill 1216, 83rd Legislature, 2013.

EXPLANATION. HB 2221 reorganized Insurance Code provisions related to rebating and unlawful inducements by repealing certain provisions in Insurance Code Chapter 541 and enacting similar provisions in new Insurance Code Chapter 1702. To conform to HB 2221, the proposal amends §19.1006 and §19.1028, which reference Insurance Code Chapter 541. The amendments revise provisions that reference Insurance Code Chapter 541 to also reference Insurance Code Chapter 1702.

SB 815 prohibits a utilization review agent (URA) from using an automated decision system to make an adverse determination. To implement this provision, the proposal amends §19.1705(d) and §19.2005(d) to reference new Insurance Code §4201.156. SB 815 also modifies the required contents of adverse determination notices. To implement these changes, the proposal amends §19.1709(c) and §19.2009(b) to conform to Insurance Code §4201.303.

SB 1216 created Insurance Code §1217.004(b), which requires issuers to exchange prior authorization requests electronically with a physician or provider who initiates a request electronically. This requirement applies "not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted." Recent federal rules adopted 45 CFR §156.223, which requires qualified health plans to maintain electronic systems for prior authorization that meet federal standards. By establishing national electronic prior authorization standards and requiring commercial health plans to use those standards, the federal rules trigger the implementation of

Insurance Code §1217.004(b). The proposal amends §19.1702 to reference Insurance Code Chapter 1217 and amends §19.1705 to add new subsection (g) to implement §1217.004 no later than January 1, 2027. This proposed date aligns with the deadline provided in the federal rules at 45 CFR §156.223.

HB 3812 amended Insurance Code §4201.152 to specify that a physician who directs utilization review may not hold a license to practice administrative medicine. To implement this provision, the proposal amends requirements related to URA personnel in §19.1706 (for health plans) and §19.2006 (for workers' compensation) to reference Insurance Code Chapter 4201.

HB 3812 also amended provisions in Insurance Code Chapter 4201, Subchapter N, related to preauthorization exemptions. To implement these changes, the proposal amends §§19.1730 - 19.1733. The amendments:

- add a definition for "affiliate" and revise the definitions of "adverse determination regarding a preauthorization exemption" and "evaluation";

- modify the definition of "evaluation period" by raising the period from six months to one year;

- require evaluations to include preauthorization requests submitted to either an issuer or its affiliate, and to include requests regardless of whether the request was made in connection with a plan subject to Insurance Code Chapter 4201, Subchapter N;

- clarify the requirements for review of fewer than five claims;

- update the evaluation time periods;

- add requirements addressing notice of a denial of a preauthorization exemption; and

- permit a physician or provider to appeal an exemption denial to an independent review organization (IRO).

Consistent with new Insurance Code §4201.660, the proposal adds new §19.1734 to specify data submission requirements for issuers to report annual data and provides that the reports are public information subject to disclosure under the Public Information Act, Government Code Chapter 552. In a separate rulemaking also published in this issue of the *Texas Register*, TDI proposes to amend 28 TAC §12.601 to address the independent review process related to denials of preauthorization exemptions.

HB 4611 reorganized Medicaid provisions in the Government Code by repealing Chapter 533 and adding new Chapter 540. To conform to these bills, the proposal amends §19.1801 and §19.1803 to remove outdated references to Government Code Chapter 533 and replace them with references to Government Code Chapter 540.

SB 1296 made nonsubstantive changes and corrections, including redesignating Insurance Code Chapter 1369, Subchapter F--as added by Senate Bill 644, 83rd Legislature, 2013--as Insurance Code Chapter 1369, Subchapter G. To conform to this change, the rule amends §19.1803(7) to correct a code reference.

Unrelated to specific legislation, the proposal also makes some minor changes to utilization review provisions. Screening criteria requirements in §19.1705 are amended to clarify that screening criteria must not be more restrictive than the Insurance Code's coverage standards. To increase transparency for recipients of adverse determination notices, the notice requirements in §19.1709 are amended to require inclusion of either the name or national provider identifier of the physician or provider who made the adverse determination. To address questions that have arisen from URAs, §19.1710 and §19.2010 are amended to clarify expectations when it is not feasible to provide a "reasonable opportunity" for the physician or provider to discuss the treatment plan before an adverse determination.

Descriptions of the proposed new and amended sections follow.

Subchapter K.

Section 19.1006. An amendment to §19.1006 adds new subparagraph (D) to subsection (a)(8) regarding topics that are approved for continuing education courses for licensees. Subsequent subparagraphs are redesignated to reflect addition of the new subparagraph. This addition references Insurance Code Chapter 1702, which was added under HB 2221. HB 2221 also repealed Insurance Code §§541.056 - 541.058, and it created similar provisions within new Chapter 1702. The reference to Chapter 541 in current §19.1006(a)(8)(A) is retained, as there are other provisions in Chapter 541 that are not repealed and thus continue to apply. Subsection (a)(8)(E), as redesignated, is amended to correct the title of a statutory citation.

Section 19.1028. An amendment to §19.1028 adds paragraph (3) to subsection (g) regarding subjects that must be included in an annuity certification course outline. This addition references Insurance Code Chapter 1702, which was added by HB 2221. The reference to Insurance Code §§541.051 - 541.061 in current §19.1028(g)(2) is retained, as there are some provisions that continue to apply. Existing paragraphs within subsection (g) that follow new paragraph (3) are redesignated to reflect addition of the new paragraph. Amendments to the section also change "shall" to "must" each place where the word appears in subsections (c) - (e); change "subchapter" to "title" in subsections (b), (c)(1), (d), and (f); and remove superfluous uses of the word "the" in subsection (g)(1), (2), and (5), for consistency with agency rule drafting style.

Subchapter R, Division 1.

Section 19.1702. Subsection (b) of §19.1702 is amended to add a reference to Insurance Code Chapter 1217. This addition clarifies that Chapter 1217, regarding the standard request form for prior authorization of health care services, applies to Subchapter R. In

addition, an amendment adds the title of Insurance Code Chapter 4201 to subsection (a), for consistency with agency rule drafting style.

Section 19.1705. Subsections (b) and (c) of §19.1705 are amended to add titles to the Insurance Code citations to conform to agency style and enhance readability.

Amendments to subsection (c) also specify that screening criteria must not be more restrictive than the coverage standards in Title 8, Subtitle E, of the Insurance Code. In recent years, legislation has added coverage standards that constrain or interact with health plan screening criteria. This change is necessary to remind utilization review agents that screening criteria must comply with Texas requirements.

To implement SB 815, subsection (d) is amended to reference new Insurance Code §4201.156. Current subsection (d) requires a referral to a physician or other health care provider with appropriate credentials to make adverse determinations. The added reference clarifies that these determinations must be consistent with the prohibition in §4201.156, effective January 1, 2026, against using automated decision systems to make an adverse determination.

Subsection (g) is added to implement Insurance Code §1217.004, as added by SB 1216. It requires an issuer to maintain an electronic prior authorization system that meets national standards, no later than January 1, 2027. The Insurance Code requires plans to make electronic prior authorization available "not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted." In February 2024, the Centers for Medicare and Medicaid Services (CMS) adopted 45 CFR §156.223, requiring qualified health plans to use application programming interfaces (APIs) to make various types of information and transactions available electronically, including a "HIPAA-compliant prior authorization request and response." The federal rule applies for plan years beginning on or after January 1, 2027. While a corresponding

requirement exists for prior authorization of prescription drug benefits in Insurance Code §1369.304, TDI is not implementing that requirement at this time, because the federal rule at 45 CFR §156.223 currently excludes prescription drugs. TDI will monitor future federal rulemaking related to electronic prior authorization standards, including 91 FR 19890, and will consider broadening subsection (g) at adoption to implement Insurance Code §1369.304, if appropriate.

Section 19.1706. To implement the personnel provisions in HB 3812 and other legislation that has specified physician licensure requirements, subsection (a) is amended to reference Insurance Code Chapter 4201, and new subsection (f) is added to require utilization review to be conducted under the direction of a licensed physician, consistent with Insurance Code §4201.152, which requires that the physician does not hold a license to practice administrative medicine. This aligns with a corresponding provision in §19.2006. Nonsubstantive amendments are made in subsections (a)(1) and (e) to correct legal citations and add title references to conform to agency style.

Section 19.1709. To implement SB 815, the elements required in an adverse determination notice under subsection (c)(3) are amended to align with Insurance Code §4201.303(a), which requires both a description and the source of the screening criteria and review procedures used in the determination. To increase transparency to recipients of adverse determination notices, subsection (c)(4) is amended to require URAs to include either the name or the National Provider Identifier of the physician, doctor, or other health care provider that made the adverse determination.

Nonsubstantive amendments are made in subsections (b), (e), and (f) to add titles to Insurance Code references to conform to agency style, change "C.F.R." to "CFR" in

subsection (e)(2), and to make "time frame" or "time frames" one word in subsections (e)(3), (e)(4), and (f)(1).

Section 19.1710. The existing provisions in §19.1710 are designated as subsection (a). Also, to reflect plain language and align with the definition of "reasonable opportunity" in §19.1703, the phrase "prior to the issuance of" is replaced with "before issuing."

New subsection (b) is added to clarify a URA's responsibility when the timeframe for issuing a determination prevents the opportunity from satisfying the "reasonable opportunity" definition in §19.1703. A reasonable opportunity is defined as one working day (during normal business hours). However, under Insurance Code §§843.348, 1301.135, and 4201.304, there are some circumstances when the timeframe for issuing an adverse determination may be shorter--such as 24 hours for an individual who is an inpatient in a facility or one hour for poststabilization care after emergency treatment. New subsection (b) clarifies that a URA must act in good faith to provide a reasonable opportunity for a peer-to-peer discussion before issuing an adverse determination. However, if there are fewer than 12 hours available during normal business hours between the time a request is received and the time a determination must be issued, the URA must issue the determination within the required timeframe.

Subchapter R, Division 2.

Section 19.1730. The proposed amendments add the defined term "affiliate" to align with Insurance Code §4201.651, renumber subsequent definitions to reflect addition of the new defined term, renumber internal paragraph references to reflect the renumbered definitions, and amend certain definitions to conform to changes made by HB 3812.

The definition of "adverse determination regarding a preauthorization exemption" is amended to broaden the term to include adverse determinations in connection with a

denial of a preauthorization exemption, in addition to a rescission. The definition of "eligible preauthorization request" is amended to include preauthorization requests submitted to an issuer or an affiliate of the issuer, regardless of whether the request was made in connection with a policy or plan subject to Insurance Code Chapter 4201, Subchapter N. The definition of "evaluation" is amended to reference the evaluation threshold of five eligible preauthorization requests and specify that all preauthorization requests submitted to the issuer or its affiliate must be included. The definition of "evaluation period" is amended to permit an issuer to determine the evaluation period for a determination issued on or after September 1, 2025, as long as the end of the evaluation period is not more than 12 months from the last day of the previous evaluation period. References to a six-month evaluation period are updated to a 12-month period.

To simplify the contents of the definition, the requirement limiting the amount of time between the evaluation period ending and the provision of the notice is removed from §19.1730(6)(C) and a similar provision is added to §19.1732(d). Conforming changes are made to paragraph cross-reference citations to reflect this change.

Section 19.1731. Subsection (b) of §19.1731 is amended to clarify that the evaluation requirement applies to all eligible preauthorization requests submitted to the issuer or its affiliate. References to when requests are finalized are removed to avoid duplication with the definition of "eligible preauthorization request." Subsection (c) is amended to clarify the number of claims that must be reviewed to rescind an exemption, depending on whether there are at least five claims available for review. A conforming change is made to a cross-reference citation to reflect the renumbering of definitions in §19.1730.

Section 19.1732. Subsection (a) of §19.1732 is amended to remove the requirement for an exemption to be in place at least six months, since HB 3812 provides a longer timeframe.

Subsection (b) is amended to require denial and rescission notices to comply with §19.1732 and specify that sample forms are available on TDI's website at www.tdi.texas.gov/forms. Language in subsection (b) concerning denial notice requirements is removed because more detailed requirements are proposed in new subsection (e).

Subsection (c) is amended to remove the initial evaluation period and notice deadline, which has now passed, and to update a cross-reference citation to reflect the renumbering of definitions in §19.1730.

Subsection (d) is amended to require that a notice of rescission be provided no later than three months following the day after the end of the evaluation period. This provision replaces the two-month-notice requirement previously contained in §19.1730(6)(C), as redesignated. Since HB 3812 modified Insurance Code §4201.655(a)(1) to allow a rescission to occur only in January (instead of January or June), this additional month will give issuers more time to evaluate and process proposed rescissions. Subsection (d) is also amended to remove the reference to a sample form, which is now provided in subsection (b), and to remove a duplicative issue date requirement from paragraph (2). To correct grammar and readability, a nonsubstantive change is made to subsection (d)(3)(C). In addition, a reference to the title of Insurance Code §4201.655 is added to the subsection.

Current subsection (e) is redesignated as subsection (f), and new subsection (e) is added to specify the requirements for notifying a physician or provider that their request for a preauthorization exemption is denied. The new notice requirements, which include information about the preauthorization requests that were evaluated and how to request

an independent review of the denial, are consistent with Insurance Code §4201.656(a), as amended by HB 3812.

Section 19.1733. The title of §19.1733 is amended to conform with HB 3812 by replacing "retrospective" with "utilization" and adding a reference to denials of preauthorization exemptions.

Subsection (b) is amended to update a cross-reference citation to reflect the renumbering of definitions in §19.1730.

Subsection (c) is amended to clarify that the subsection applies when a physician or provider receives a notice of rescission or denial and clarifies the deadlines for a physician or provider to request an independent review of a denial or a rescission of a preauthorization exemption.

Subsection (d) is amended to broadly reference "an adverse determination regarding a preauthorization exemption," thereby including both rescissions and denials, and to expand a reference to a rescission to add "or denial," to align with Insurance Code §4201.656(a) as amended by HB 3812. A reference to §19.1732 is corrected to remove a reference to subsection (c), since the forms to request an independent review are addressed in subsections (b), (d), and (e). In the context of a denial of a preauthorization exemption, the physician or provider would have already had the opportunity to appeal to an IRO for each adverse determination included in the evaluation. Subsection (d) is also amended to clarify that an adverse determination that was previously appealed to and upheld by an IRO is not eligible for a subsequent independent review. To conform to agency style, subsection (d) is amended to add the title of an Insurance Code citation.

New subsection (f) is added to explain the scope of the IRO's review for a denial of a preauthorization exemption, with reference to 28 TAC §12.601(f). Section 12.601(f) is a new provision proposed in a separate rulemaking, also published in this issue of the *Texas*

Register, that permits an IRO, in some circumstances, to review a random sample of adverse determinations to determine whether a denial of a preauthorization exemption should be overturned. To ensure that it is feasible for an IRO to meet the deadline provided in Insurance Code §4201.656(c), subsection (f) permits an IRO to review a random sample of at least five but not more than 20 adverse determinations. Subsection (f) also clarifies that an IRO's determination of an adverse determination reviewed in connection with a preauthorization denial does not impact the status of the original preauthorization request. TDI also proposes to amend §12.601 to provide additional detail regarding how IRO determinations related to denials must be calculated. Current subsection (f) and subsequent subsections are redesignated to reflect the addition of new subsection (f).

Section 19.1734. New §19.1734 is added to specify reporting requirements, consistent with Insurance Code §4201.660, as added by HB 3812. Subsection (a) specifies an annual due date of March 1, and a requirement to use the form on TDI's website. Subsection (b) specifies the contents of the report, including the issuer's name, National Association of Insurance Commissioners (NAIC) number, and contact information; name and NAIC number of each affiliate of the issuer; the number of lives covered by the issuer and each affiliate within each line of business; the number of particular health care services requiring preauthorization; the number of in-network physicians and providers; and the number of in-network physicians and providers receiving at least one preauthorization exemption.

Data on the number of preauthorization requests under each line of business will provide context for policymakers on the volume of data being added by inclusion of affiliates and lines of business that are not subject to Insurance Code Chapter 4201,

Subchapter N. Data must be reported for each line of business in which the issuer or affiliate offers health coverage that includes a preauthorization requirement.

Lines of business include insurance products subject to Insurance Code Chapter 4201, Subchapter N, including major medical and vision; HMO products subject to Insurance Code Chapter 4201, Subchapter N, including major medical, vision, and dental; insurance and HMO products *not* subject to Insurance Code Chapter 4201, Subchapter N, including major medical, vision, and dental; Medicaid managed care; the Children's Health Insurance Program (CHIP); Medicare Advantage; and administrative services only, including services in connection with major medical, vision, and dental.

Paragraph (6) of subsection (b) specifies the data that must be submitted concerning exemptions for each particular health care service, including the number of new evaluations conducted and how many were granted versus denied; the number of exemptions in place that were previously granted, how many were evaluated, and how many were rescinded; and the number of appeals that were requested for denials or rescissions, and how many denials and rescissions were upheld or overturned on appeal.

Subchapter S.

Section 19.1801. To implement HB 4611, which reorganized Medicaid provisions in the Government Code, §19.1801 is amended to remove the outdated reference to Government Code Chapter 533. The section is amended to simply reference Insurance Code Chapter 1217 and Chapter 1369, Subchapter G, rather than restating the statutory applicability provisions.

Section 19.1803. Paragraph (6)(B)(iii) of §19.1803 is amended to reference Government Code Chapter 540, instead of Chapter 533, which was repealed and replaced by HB 4611. Paragraph (7) is amended to replace a reference to Insurance Code §1369.252 with a

reference to Insurance Code §1369.302 because the section was redesignated in 2015 by SB 1296. To conform to agency style, paragraphs (6) - (8) are amended to add titles to statutory citations.

Subchapter U.

Section 19.2005. To implement SB 815, subsection (d) is amended to reference new Insurance Code §4201.156. Nonsubstantive amendments are made in subsections (c) - (e) to add titles to statutory citations to conform to agency style.

Section 19.2006. To implement the personnel provisions in HB 3812 and other legislation that has specified physician licensure requirements, subsection (a) is amended to reference Insurance Code Chapter 4201. Nonsubstantive amendments to subsection (a) are made to add or correct titles to statutory citations to conform to agency style and to correct an outdated rule citation.

Subsection (e) is amended to add a reference to Insurance Code §4201.152.

Section 19.2009. To implement SB 815, the elements required in an adverse determination notice under subsection (b)(7) and (8) are amended to align with Insurance Code §4201.303(a), which requires both a description of and the source of the screening criteria and review procedures used in the determination. To conform to agency style, a nonsubstantive amendment was made to a federal code citation in subsection (a)(4) and a title was added to a code reference in subsection (b)(8).

Section 19.2010. The existing provisions in §19.2010 are designated as subsection (a). To reflect plain language and align with the definition of "reasonable opportunity" in §19.2003, the phrase "prior to the issuance of" is replaced with "before issuing."

New subsection (b) is added to clarify a URA's responsibility when the timeframe for issuing a determination prevents the opportunity from satisfying the "reasonable opportunity" definition in §19.2003. A reasonable opportunity is defined as one working day (during normal business hours). However, under Insurance Code §4201.304, there are some circumstances when the timeframe for issuing an adverse determination may be shorter, such as one hour for poststabilization care after emergency treatment. New subsection (b) clarifies that a URA must act in good faith to provide a reasonable opportunity for a peer-to-peer discussion before issuing an adverse determination. However, if there are fewer than 12 hours available during normal business hours between the time a request is received and the time a determination must be issued, the URA must issue the determination within the required timeframe.

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 sections as proposed are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering them, other than that imposed by statute. Ms. Bowden made this determination because the sections as proposed do not add to or decrease state revenues or expenditures and because local and state government entities are only involved in enforcing or complying with the proposed amendments when acting in the capacity of a workers' compensation insurance carrier. Those entities will be affected in the same way as an insurance carrier and will realize the same benefits from the proposed amendments.

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 sections as proposed are in effect, Ms. Bowden expects that administering and enforcing them will have the public benefits of ensuring that TDI's rules conform to Insurance Code Chapters 1217 and 4201 and do not reference repealed statutes. The proposed amendments will also have the benefit of ensuring that screening criteria used for utilization review is no less restrictive than the coverage standards addressed in Insurance Code Title 8, Subtitle E.

Ms. Bowden expects that the sections as proposed will not increase the cost of compliance with Insurance Code Chapters 1217 or 4201 because the amendments do not impose requirements beyond those in statute. Health benefit plans are required to process electronic prior authorization requests under Insurance Code Chapter 1217 and grant preauthorization exemptions and report data under Insurance Code Chapter 4201, Subchapter N. Under Insurance Code §4201.152, utilization review must be conducted under the direction of a physician licensed to practice medicine in Texas. The physician may not hold a license to practice administrative medicine. Utilization review agents are also required to update adverse determination notices to comply with SB 815. As a result, the cost associated with developing electronic prior authorization systems, updating evaluation processes and reporting data for preauthorization exemptions, hiring utilization review directors without administrative medical licenses, and updating adverse determination notices does not result from enforcement or administration of the sections as proposed.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the sections as proposed 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 possible cost on regulated persons. However, even if the proposal did impose a cost on regulated persons, no additional rule amendments are required under Government Code §2001.0045 because the sections as proposed are necessary to implement legislation. The proposed rule implements Insurance Code Chapter 1702 and §§4201.002, 4201.152, 4201.156, 4201.303, 4201.651, 4201.653, 4201.655, 4201.656, 4201.658, 4201.659, and 4201.660, as added or amended by HB 2221, HB 3812, and SB 815, and Insurance Code §1217.004, as added by SB 1216.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the sections as proposed 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 not increase or decrease 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 June 17, 2026. Consistent with Government Code §2001.0024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. 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 of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2866. This proposal will be part of a rule hearing docket that will begin at 1:00 p.m., central time, on June 15, 2025. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.029. Visit www.tdi.texas.gov/alert/event/index.html for more information on the proposed rule, hearing, and comment submission.

Subchapter K. Continuing Education, Adjuster Prelicensing Education Programs, and Certification Courses
28 TAC §19.1006

STATUTORY AUTHORITY. TDI proposes amendments to §19.1006 and §19.1028 under Insurance Code §§4004.103, 4004.104, 4004.203, and 36.001.

Insurance Code §4004.103 provides that the commissioner may adopt rules establishing other requirements for continuing education program providers.

Insurance Code §4004.104 authorizes TDI to establish the scope and type of continuing education requirements for each type of licensee.

Insurance Code §4004.203 provides that the commissioner by rule adopt criteria for continuing education programs used to satisfy the requirements of Insurance Code §4004.202.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. Amendments to §19.1006 and §19.1028 implement Insurance Code Chapters 1702 and 4004, and HB 2221.

TEXT.

§19.1006. Course Criteria.

(a) To be certified as a continuing education course, the course content must include topics that contribute substantive knowledge relating to the business of insurance and expand the competence of the licensee. Ethics and consumer protection course credit, described in paragraph (8) of this subsection, applies equally to all license types.

TDI will not approve a course if it does not relate specifically to the business of insurance. Given that restriction, approved topics include, but are not limited to, the following:

(1) actuarial mathematics, statistics, and probability;

(2) assigned risk;

(3) claims adjusting;

(4) courses leading to and maintaining insurance designations;

(5) employee benefit plans;

(6) errors and omissions;

(7) estate planning/taxation;

(8) ethics and consumer protection, only if the course also provides instruction consistent with one or more of the following topics:

(A) Insurance Code Chapter 541, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices;

(B) Insurance Code Chapter 547, concerning False Advertising by Unauthorized Insurers;

(C) Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices;

(D) Insurance Code Chapter 1702, concerning Regulation of Certain Trade Practices;

(E) [~~(D)~~] Business and Commerce Code Chapter 17, Subchapter E, concerning Deceptive Trade Practices and Consumer Protection [~~Act~~];

(F) [~~(E)~~] analogous laws as specified by TDI, including:

(i) Insurance Code Chapter 1952, Subchapter G, concerning Repair of Motor Vehicles;

(ii) Insurance Code Chapter 542, Subchapter B, concerning Prompt Payment of Claims;

(iii) Insurance Code Chapter 542, Subchapter D, concerning Notice of Settlement of Claim Under Casualty Insurance Policy;

(iv) Insurance Code Chapter 542, Subchapter E, concerning Recovery of Deductible From Third Parties Under Certain Automobile Insurance Policies;

(v) §5.501 of this title (relating to Notice Requirements to Claimants Regarding Motor Vehicle Repairs); and

(vi) Penal Code Chapter 35, concerning Insurance Fraud;

(G) [~~(F)~~] corporate ethics;

(H) [~~(G)~~] ethical challenges of licensees;

(I) [~~(H)~~] ethical behavior of an insurance company;

(J) [~~(I)~~] ethical behavior of an agent or adjuster;

(K) [~~(J)~~] duties of the licensee to company, client, and customer;

(L) [~~(K)~~] duties of insurer/HMO to agents/clients;

(M) [~~(L)~~] fiduciary responsibility;

(N) [~~(M)~~] unfair marketing practices;

(O) [~~(N)~~] difference between ethics and laws;

(P) [~~(O)~~] confidentiality, privacy, and ethics;

(Q) [~~(P)~~] ethical analysis of the licensee's job;

(R) [~~(Q)~~] philosophical approaches to ethics; or

(S) [~~(R)~~] business ethics;

(9) fundamentals/principles of insurance;

(10) insurance accounting/actuarial considerations;

(11) insurance contract/policy comparison and analysis;

(12) insurance fraud;

(13) insurance laws, rules, regulations, and regulatory updates;

(14) insurance policy provisions;

(15) insurance product-specific knowledge;

(16) insurance rating/underwriting/claims;

(17) insurance tax laws;

(18) legal principles;

(19) long-term care/partnership;

(20) loss prevention, control, and mitigation;

(21) managed care;

(22) principles of risk management;

(23) proper uses of insurance products;

(24) Real Estate Settlement Procedures Act;

(25) restoration--addresses claims, loss control issues, and mitigation;

(26) retirement planning;

(27) securities;

(28) suitability in insurance products;

(29) surety bail bond;

(30) underwriting principles; and

(31) viaticals/life settlements.

(b) To be certified as an adjuster prelicensing education course or program, the course content must enhance the student's knowledge, understanding, and/or professional competence regarding the subjects set forth in §19.1017 and §19.1018 of this title (relating to Adjuster Prelicensing Education Course Content and Examination Requirements and Adjuster Prelicensing Examination Topics). Unless specifically stated otherwise, this subchapter applies equally to courses certified for continuing education and adjuster prelicensing purposes.

(c) To be certified as a long-term care partnership certification course, the course content must enhance the student's knowledge, understanding, and professional

competence regarding the subjects specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course). Unless specifically stated otherwise, this subchapter applies equally to courses certified for continuing education and long-term care partnership certification and long-term care partnership continuing education purposes.

(d) To be certified as a Medicare-related product certification course, the course content must enhance the student's knowledge, understanding, and professional competence regarding the subjects specified in §19.1024 of this title (relating to Medicare-Related Product Certification Course). Unless specifically stated otherwise, this subchapter applies equally to courses certified for continuing education, Medicare-related product certification, and Medicare-related product continuing education purposes.

(e) To be certified as a small employer health benefit plan specialty certification course, the course content must enhance the student's knowledge, understanding, and professional competence regarding the subjects specified in §19.1026 of this title (relating to Small Employer Health Benefit Plan Specialty Certification Course). Unless specifically stated otherwise, this subchapter applies equally to courses certified for continuing education and small employer health benefit plan specialty certification.

(f) To be certified as an annuity certification or continuing education course, the course content must enhance the student's knowledge, understanding, and professional competence regarding the subjects specified in §19.1028(g)(1) - (4) of this title (relating to Annuity Certification Course). Unless specifically stated otherwise, this section applies equally to courses certified for continuing education and annuity certification.

(g) The following course content is not applicable to a licensee's continuing education requirements:

(1) meetings held in conjunction with the regular business of the licensee or courses or training relating to the marketing and business practices of a specific company;

(2) course content teaching general accounting, speed reading, other general business skills, computer use, or computer software application use;

(3) course content teaching motivation, goal-setting, time management, communication, sales, or marketing skills;

(4) course content providing for prelicensing training qualifying examination preparation;

(5) course content that does not meet the requirement of subsection (a) of this section; and

(6) course content that is substantially:

(A) a glossary, dictionary, or index of insurance terms without independent distinction as to the application of these terms to the business of insurance through case studies or analysis based on actual or hypothetical factual situations that apply to the business of insurance; or

(B) a recitation of statutes, rules, legal principles, or theories without independent distinction as to the application of these issues to the business of insurance through case studies or analysis based on actual or hypothetical factual situations that apply to the business of insurance.

(h) A single continuing education course may include both ethics and consumer protection credit topics with other topics meeting the requirements of subsection (a) of this section.

§19.1028. Annuity Certification Course.

(a) An individual who obtains a current resident agent license issued by the department on or after April 1, 2010, or renews a resident agent license on or after April

1, 2010, may not sell, solicit, or negotiate a contract for an annuity or represent an insurer in relation to an annuity in this state until they have completed the annuity certification course as specified in this section.

(b) Licensees that may qualify for the exemption provided under §19.1004(b) or (c) of this title [~~subchapter~~] (relating to Licensee Exemption from and Extension of Time for Continuing Education) are not exempt from the provisions of this section.

(c) This subsection establishes the standards for an annuity certification course. The course must [~~shall~~]:

(1) be submitted to the department for approval in compliance with §19.1007 of this title [~~subchapter~~] (relating to Course Certification Submission Applications, Course Expirations, and Resubmissions);

(2) be at least four hours in length; and

(3) cover each of the subjects described in subsection (g) of this section.

(d) Licensees may count an annuity certification course toward completion of the continuing education requirements prescribed in §19.1003 of this title [~~subchapter~~] (relating to Licensee Requirements). If a licensee chooses to use an annuity certification course to satisfy a portion of the continuing education requirements prescribed in §19.1003 of this title [~~subchapter~~], the licensee must [~~shall~~] comply with §19.1013 of this title [~~subchapter~~] (relating to Licensee Record Maintenance).

(e) A licensee must [~~shall~~] maintain proof of completion of an annuity certification course for a period of four years from the date of completion of the course. Upon request, the licensee must [~~shall~~] provide proof of completion of the annuity certification course to the department.

(f) A provider issued completion certificate for an annuity certification course must comply with the requirements of §19.1011 of this title [~~subchapter~~] (relating to Requirements for Successful Completion of Continuing Education Courses).

(g) Course subjects for an annuity certification course outline must include each of the following topics:

(1) the requirements of [~~the~~] Insurance Code Chapters 1114 and 1115, and the requirements of Chapter 3, Subchapter NN of this title (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements);

(2) the prohibitions specified in [~~the~~] Insurance Code §§541.051 - 541.061;

(3) the provisions of Insurance Code Chapter 1702, concerning Regulation of Certain Trade Practices;

(4) [~~(3)~~] recognition of indicators that a prospective insured may lack the short-term memory or judgment to knowingly purchase an annuity; and

(5) [~~(4)~~] practices relating to annuities that are prohibited by [~~the~~] Penal Code Chapter 35.

(h) Course subjects for an annuity certification course outline may include additional topics addressing statutes enacted and rules adopted subsequent to the effective date of this section, provided that the statutes or rules relate specifically to annuities.

Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy
Division 1. Utilization Reviews
28 TAC §§ 19.1702, 19.1705, 19.1706, 19.1709, and 19.1710

STATUTORY AUTHORITY. TDI proposes amendments to §§19.1702, 19.1705, 19.1706, 19.1709, and 19.1710 under Insurance Code §§1217.004, 4201.003, and 36.001.

Insurance Code §1217.004 authorizes the commissioner to adopt rules related to the use of a standard form for requesting prior authorization of health care services.

Insurance Code §4201.003 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 4201.

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 amendments to §19.1702(b) and §19.1705(g) implement Insurance Code §1217.004(b), as added by SB 1216.

Proposed amendments to §19.1705(d) implement new Insurance Code §4201.156. Proposed amendments to §19.1709(c) conform to Insurance Code §4201.303. These amendments implement SB 815.

Proposed amendments to §19.1706(f) implement Insurance Code §4201.152 as amended by HB 3812.

TEXT.

§19.1702. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, concerning Utilization Review Agents, this subchapter applies to utilization review performed under a health benefit plan or a health insurance policy.

(1) This subchapter does not apply to utilization review performed under workers' compensation insurance coverage.

(2) This subchapter does not apply to a person who provides information to an enrollee; an individual acting on behalf of an enrollee; or an enrollee's physician, doctor, or other health care provider about scope of coverage or benefits, and does not determine the medical necessity, appropriateness, or the experimental or investigational nature of health care services.

(b) Applicability of other law. In addition to the requirements of this subchapter, provisions of Insurance Code Chapter 843, concerning Health Maintenance Organizations;

Insurance Code Chapter 1217, concerning Standard Request Form for Prior Authorization of Health Care Services, Insurance Code Chapter 1222, concerning Preauthorization for Medical or Health Care Service; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services; and Insurance Code Chapter 1451, Subchapter E, concerning Dental Care Benefits in Health Insurance Policies or Employee Benefit Plans, apply to this subchapter.

§19.1705. General Standards of Utilization Review.

(a) Review of utilization review plan. The utilization review plan must be reviewed and approved by a physician licensed to practice medicine in Texas and conducted under standards developed and periodically updated with input from both primary and specialty physicians, doctors, and other health care providers, as appropriate.

(b) Special circumstances.

(1) A utilization review determination must be made in a manner that takes into account special circumstances of the case that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.

(2) If coverage is available for stage-four advanced, metastatic cancer and associated conditions, as defined by Insurance Code §1369.211, concerning Definitions, the URA cannot require, before coverage of a prescription drug, that the enrollee:

(A) fail to successfully respond to a different drug; or

(B) prove a history of failure of a different drug.

(3) Paragraph (2) of this subsection only applies to a drug the use of which is:

(A) consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition, as defined by Insurance Code §1369.211;

(B) supported by peer-reviewed, evidence-based literature; and

(C) approved by the United States Food and Drug Administration.

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence based, scientifically valid, outcome focused, and that comply with the requirements in Insurance Code §4201.153, concerning Screening Criteria and Review Procedures. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. The screening criteria must not be more restrictive than the coverage standards in Title 8, Subtitle E, of the Insurance Code, concerning Benefits Payable Under Health Coverages.

(d) Referral and determination of adverse determinations. Consistent with Insurance Code §4201.156, concerning Use of Automated Decision System for Adverse Determinations, adverse [~~Adverse~~] determinations must be referred to and may only be determined by an appropriate physician, doctor, or other health care provider with appropriate credentials under §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) to determine the medical necessity, the appropriateness, or the experimental or investigational nature of health care services.

(e) Delegation of review. A URA, including a specialty URA, may delegate the utilization review to qualified personnel in a hospital or other health care facility in which the health care services to be reviewed were, or are, to be provided. The delegation does not relieve the URA of full responsibility for compliance with this subchapter and Insurance Code Chapter 4201, including the conduct of those to whom utilization review has been delegated.

(f) Complaint system. The URA must develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, individuals acting on behalf of the enrollee, or health care providers concerning the utilization review. The URA must maintain records of complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

(g) Electronic prior authorization. No later than January 1, 2027, an issuer must maintain an electronic prior authorization system that meets the national standards identified in 45 CFR §156.223, concerning Prior Authorization Requirements, and process prior authorization requests for health care services electronically, consistent with Insurance Code §1217.004, concerning Standard Form. For the purposes of this subsection, the term "health care services" has the meaning assigned by Insurance Code §1217.001, concerning Definitions.

§19.1706. Requirements and Prohibitions Relating to Personnel.

(a) Qualification requirements. Physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review must be appropriately trained, qualified, and currently licensed consistent with Insurance Code Chapter 4201, concerning Utilization Review Agents. Personnel conducting utilization review must hold an unrestricted license, an administrative license, or be otherwise authorized to provide health care services by a licensing agency in the United States.

(1) This subchapter does not supersede requirements in the Medical Practice Act; Texas Medical Board rules; Texas Occupations Code Chapter 201, concerning Chiropractors [~~(relating to Chiropractors)~~]; or Texas Board of Chiropractic Examiners rules.

Individuals licensed by the Texas Medical Board are subject to 22 TAC Chapter 180 (relating to Disciplinary Guidelines) [~~190, regarding disciplinary guidelines~~].

(2) Personnel who perform clerical or administrative tasks are not required to have the qualifications prescribed by this subsection.

(b) Disqualifying associations. For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association. A physician, doctor, or health care provider who conducts utilization review must not have any disqualifying associations with the:

(1) enrollee or health care provider who is requesting the utilization review or an appeal; or

(2) physician, doctor, or other health care provider who issued the initial adverse determination.

(c) Information to be sent to TDI. The URA must send to TDI the name, type, license number, state of licensure, and qualifications of the personnel either employed or under contract to perform the utilization review with an original or renewal application.

(d) Written procedures and maintenance of records. URAs must develop and implement written procedures and maintain documentation to demonstrate that all physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Training related to acquired brain injury treatment. A URA must provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury in accord with Insurance Code §1352.004, concerning Training for Certain Personnel Required. The purpose of the training is to prevent denial of coverage in violation of Insurance Code §1352.003, concerning Required Coverages--Health Benefit Plans Other Than Small

Employer Health Benefit Plans, and to avoid confusion of medical benefits with mental health benefits.

(f) Physician direction requirement. Utilization review conducted by a URA must be under the direction of a physician currently licensed without restriction to practice medicine in Texas, consistent with Insurance Code §4201.152, concerning Utilization Review Under Direction of Physician. The physician must be employed by or under contract with the URA.

§19.1709. Notice of Determinations Made in Utilization Review.

(a) Notice requirements. A URA must send written notification to the enrollee or an individual acting on behalf of the enrollee and the enrollee's provider of record, including the health care provider who rendered the service, of a determination made in a utilization review.

(b) Renewal of existing preauthorizations. If a health benefit plan issuer subject to Insurance Code Chapter 1222, concerning Preauthorization for Medical or Health Care Service, requires preauthorization as a condition of payment for a medical or health care service, the URA must provide a preauthorization renewal process that allows a physician or health care provider to request renewal of an existing preauthorization at least 60 days before the date the preauthorization expires.

(c) Required notice elements. In all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of and [~~or~~] the source of the screening criteria and review procedures that were utilized as guidelines in making the determination;

(4) the name or National Provider Identifier and the professional specialty of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.1705 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination);

(7) a copy of the request for a review by an IRO form, available at www.tdi.texas.gov;

(8) notice of the independent review process with instructions that:

(A) request for a review by an IRO form must be completed by the enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the insurance carrier or URA that made the adverse determination to begin the independent review process; and

(B) the release of medical information to the IRO, which is included as part of the independent review request for a review by an IRO form, must be signed by the enrollee or the enrollee's legal guardian; and

(9) a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an enrollee who has a life-threatening condition or who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy.

(d) Determination concerning an acquired brain injury. In addition to the notification required by this section, a URA must comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date an individual requests utilization review or requests an extension of coverage based on medical

necessity or appropriateness, a URA must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made for coverage under a small employer health benefit plan.

(e) Prospective and concurrent review.

(1) Favorable determinations. The written notification of a favorable determination made in utilization review must be mailed or electronically transmitted as required by Insurance Code §4201.302, concerning General Time for Notice.

(2) Preauthorization numbers. A URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 CFR [~~C.F.R.~~] §162.1102 (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction), based on the type of service in the preauthorization request.

(3) Required timeframes [~~time frames~~]. Except as otherwise provided by the Insurance Code, the time frames for notification of the adverse determination begin from the date of the request and must comply with Insurance Code §4201.304, concerning Time for Notice of Adverse Determination. A URA must provide the notice to the provider of record or other health care provider not later than one hour after the time of the request when denying post-stabilization care subsequent to emergency treatment as requested by a provider of record or other health care provider. The URA must send written notification within three working days of the telephone or electronic transmission.

(4) Required timeframe [~~time frame~~] for preauthorization renewal requests. A URA must review a request to renew a preauthorization for a medical or health care service and make and issue a determination before the existing preauthorization expires, if practicable. The determination must indicate whether the medical or health care service is preauthorized.

(f) Retrospective review.

(1) The URA must develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the timeframes [~~time frames~~] for the notice of adverse determination, that comply with Insurance Code §4201.305, concerning Notice of Adverse Determination for Retrospective Utilization Review, and this section.

(2) When a retrospective review of the medical necessity, appropriateness, or the experimental or investigational nature of the health care services is made in relation to health coverage, the URA may not require the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude requiring submission of:

(A) an enrollee's mental health medical record summary; or

(B) medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

§19.1710. Requirements Prior to Issuing an Adverse Determination.

(a) 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, before issuing [~~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.

(b) A URA must act in good faith to provide a reasonable opportunity as required by this section. However, if there are fewer than 12 hours available during normal business hours between the time a request is received and the time the determination must be issued, the URA must issue the determination within the required timeframe.

Division 2. Preauthorization Exemptions
28 TAC §§19.1730 - 19.1733 and 19.1734

STATUTORY AUTHORITY. TDI proposes amendments to §§19.1730 - 19.1733, and new §19.1734 under Insurance Code §§4201.003, 4202.002, and 36.001.

Insurance Code §4201.003 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §4202.002 authorizes the commissioner to adopt standards and rules for independent review organizations.

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 amendments to §§19.1730 - 19.1733 and new §19.1734 implement Insurance Code Chapter 4201, Subchapter N, and HB 3812, 89th Legislature.

§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 preauthorization requests or claims [~~retrospectively~~] reviewed as part of an evaluation [~~as defined in paragraph (4)(B)of this section,~~] 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, which [~~and~~] leads to an issuer's decision to deny or 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) Affiliate--Has the meaning assigned by Insurance Code §4201.651, concerning Definitions.

(3) [~~(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, as defined in paragraph (5)(A) [~~(4)(A)~~] of this section, of eligible preauthorization requests and demonstrating that the physician or provider

received approval for fewer than 90% of the eligible preauthorization requests made for a particular health care service during the most recent evaluation period.

(4) [~~(3)~~] Eligible preauthorization request--A preauthorization request for a particular health care service is eligible for the purposes of an evaluation under paragraph (5)(A) [~~(4)(A)~~] of this section if it is submitted by the physician or provider to the issuer or an affiliate of the issuer (regardless of whether the request was made in connection with a health insurance policy or health benefit plan that is subject to Insurance Code Chapter 4201, Subchapter N) and finalized by the health plan during the evaluation period, is not pending appeal, and has an outcome of either approving the particular health care service or issuing an adverse determination for the particular health care service. A preauthorization request that is modified with the acceptance of the physician or provider and approved by the plan as modified is an eligible preauthorization request for the purpose of conducting an evaluation under this section, with respect to the particular health care service that was approved. If a preauthorization request includes more than one particular health care service, the outcome for each service must be counted separately for the purposes of an evaluation.

(5) [~~(4)~~] Evaluation--

(A) with respect to a particular health care service for which a physician or provider does not have a preauthorization exemption but has at least five eligible preauthorization requests, a review of the outcomes of all eligible preauthorization requests submitted by the physician or provider to the issuer or an affiliate of the issuer 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 retrospective review of a

random sample of payable claims submitted by or in connection with the physician or provider during the most recent evaluation period to determine the percentage of claims that would have been approved, based on meeting the issuer's applicable medical necessity criteria at the time the service was provided, 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.

(6) [~~(5)~~] Evaluation period--[~~The six-month period preceding an evaluation.~~] The evaluation periods are as follows:

(A) for a [~~an initial~~] determination of a preauthorization exemption grant or denial that is issued on or after September 1, 2025, the evaluation period is the 12-month [~~six-month~~] period determined by the issuer that ends not more than 12 months from the last day of the previous evaluation period, or the subsequent 12-month periods that follow [~~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 12-month [~~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 12-month period determined by the issuer [~~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)~~].

(7) [~~(6)~~] 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.

(8) [~~(7)~~] 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).

(9) [~~(8)~~] Physician--Has the meaning assigned by Insurance Code §843.002, concerning Definitions.

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

(11) [~~(10)~~] 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.

(12) [~~(11)~~] Provider--Has the meaning assigned by Insurance Code §843.002.

(13) [~~(12)~~] 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.

(14) [~~(13)~~] Rescission of preauthorization exemption--An adverse determination regarding a preauthorization exemption based on an evaluation, as

defined in paragraph (5)(B) [~~(4)(B)~~] of this section and consistent with Insurance Code §4201.655(b), in which the issuer would have fully approved fewer than 90% of claims for a particular health care service.

(15) [~~(14)~~] Treating physician or provider--The physician or other provider who is primarily responsible for a patient's health and medical care. A "treating physician or provider" can include a rendering physician or provider or a referring or ordering 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 (NPI) 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 eligible preauthorization requests submitted by the physician or provider to the issuer or an affiliate of the issuer 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 five eligible 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, as defined in §19.1730(5)(B) [~~§19.1730(4)(B)~~] of this title (relating to Definitions), 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. If there are five or more claims, the issuer must review at least five and no more than 20 claims. If there are fewer than five claims, the issuer must review all the claims submitted by the physician or provider 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 or provider may not rely on another physician's or provider's preauthorization exemption. If a treating physician or provider does not have a preauthorization exemption and relies on another physician's or provider's preauthorization exemption in violation of this subsection, an issuer may consider the physician or provider who has qualified for the preauthorization exemption 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. It is not a violation of this subsection for a provider, such as a nurse or physician's assistant, who practices under the supervision of a physician, to rely on the supervising physician's exemption, if the provider appropriately orders care and requests preauthorization under the supervising physician's NPI.

(e) For 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, the treating physician or provider must include the name and NPI of the ordering physician or provider on the claim in fields 17 and 17B of CMS Form 1500, in fields 76 - 79 or another appropriate field in Form UB-04, or in the corresponding fields for electronic claims using the ASC X12N 837 format. The issuer may provide coding guidance to physicians and providers to ensure that this information is appropriately captured on the claim. If this information is not included, the issuer may treat the claim as subject to an otherwise applicable preauthorization requirement.

§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 notice must include a plain language explanation of the effect of the preauthorization exemption and any claim coding guidance needed to document the preauthorization exemption, consistent with §19.1731(e) of this title (relating to 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 rescinding or denying a preauthorization exemption, an issuer must provide a notice to the physician or provider that complies with this section and allows the physician or provider to appeal the rescission or denial to an IRO. Example forms LHL011 for rescissions and LHL012 for denials are available on TDI's website at www.tdi.texas.gov/forms. [~~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; a description of how to appeal the denial using the issuer's complaints and appeals processes; and information on how to file a complaint with the department.~~]

(c) After completing an evaluation as defined under §19.1730(5)(A) [~~§19.1730(4)(A)~~] of this title (relating to Definitions), an issuer must provide a notice granting or denying a preauthorization exemption within five days. For any evaluation period [~~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 five eligible preauthorization requests, as provided in §19.1731(b) of this title.

(d) When rescinding a preauthorization exemption, an issuer must provide notice to the physician or provider, consistent with Insurance Code §4201.655(a)(3), concerning Denial or Rescission of Preauthorization Exemption. Notice of the rescission must be provided during the months specified in Insurance Code §4201.655(a)(1). The notice must be provided no later than three months following the day after the end of the evaluation period. 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, the date the notice is issued, 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 by mail or electronic means to request an appeal;

(3) a statement of the total number of payable claims submitted by or in connection with the physician or provider during the most recent evaluation period that were eligible to be evaluated with respect to the health care service subject to rescission, the number of claims included in the random sample, and the sample information used to make the determination, including:

(A) identification of each claim included in the random sample;

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

(C) for any claim determined [~~to~~] not to 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, including, if applicable, a statement that the determination was based on a failure to submit specified medical records;

(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 who 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 and to include applicable medical records for any determination that was based on a failure to provide medical records.

(e) 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. The notice must include:

(1) an identification of the health care service for which a preauthorization exemption is being denied, the date the notice is issued, the date of the evaluation period that led to the denial, and the date of the subsequent evaluation period under which an exemption will next be considered;

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

(3) a statement of the total number of eligible preauthorization requests for the health care service that were submitted to the issuer and the issuer's affiliates by or in connection with the physician or provider during the most recent evaluation period, the percent of eligible preauthorization requests that were approved, and information about the preauthorization requests included in the evaluation that were adversely determined, including:

(A) identification of each preauthorization request included in the evaluation that was adversely determined;

(B) identification of whether each preauthorization request included in the evaluation was appealed to the utilization review agent or to an external or independent review organization and the result of those appeals; and

(C) the date of issuance of each adverse determination notice, including notice in connection with an adverse determination that is upheld on appeal;

(4) instructions on how to electronically access a copy of the adverse determination notice that was issued;

(5) 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) a listing of the adverse determinations for which the physician or provider is requesting an independent review; and

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

(6) an instruction for the physician or provider to return the form to the issuer and to include applicable medical records for any determination that was based on a failure to provide medical records.

(f) [~~(e)~~] An issuer must allow physicians and providers to designate an email address or a mailing address for communications regarding preauthorization exemptions, denials, and rescissions. An issuer must provide an option for physicians and providers to submit a request for appeal by mail or by email or other electronic method. Issuers must include an explanation of how the physician or provider may update their preferred contact information and delivery method on all communications issued under this section and on the website required under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans).

§19.1733. Utilization [~~Retrospective~~] Reviews and Appeals of Preauthorization Exemption Denials and 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 as defined in §19.1730(5)(B) [~~§19.1730(4)(B)~~] of this title (relating to Definitions) 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 requested in connection with a retrospective review of a random sample of claims as authorized under Insurance Code §4201.659(b)(1) should be limited to 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 a rescission or denial, 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~~]. For a denial, the request must be submitted no later than 30 days after the date listed on the denial notice. For a rescission, the request must be submitted before the rescission becomes effective. The date of the request must be documented on the form, and the form must be sent electronically or postmarked before the date the rescission becomes effective.

(d) In order to request an independent review of an adverse determination regarding [~~a rescission of~~] a preauthorization exemption, a physician or provider must submit the form provided by the issuer under §19.1732 [~~§19.1732(c)~~] of this title (relating to Notice of Preauthorization Exemption Grants, Denials, or Rescissions). A preauthorization request that was adversely determined and previously upheld by an external or independent review organization is not eligible for a subsequent independent review. If one or more determinations subject to review were based on a failure to provide

specified medical records, the physician or provider must include the applicable records with the request for an independent review. Upon receipt, if the issuer seeks to proceed with the proposed rescission or denial, 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), and provide information to the IRO consistent with Insurance Code §4201.402, concerning Information Provided to Independent Review Organization.

(e) If the notice of rescission of preauthorization exemption identified that at least five additional claims were eligible for review but not included in the original random sample, the physician or provider may request review of another random sample of claims, as authorized under Insurance Code §4201.656(d). If this request is made, the issuer must, when submitting the request for independent review to the department, provide a listing of all payable claims for the same health care service submitted by or in connection with the physician or provider during the most recent evaluation period that were eligible to be evaluated but that were not included in the original random sample. The listing must be sufficiently detailed to allow the IRO to identify each payable claim to be used in an additional random sample, as provided by §12.601(e) of this title.

(f) If the notice of denial of preauthorization exemption identified five or fewer adverse determinations that contributed to the denial of the preauthorization exemption, the IRO will review each adverse determination. Consistent with §12.601(f) of this title, if the notice of denial of preauthorization exemption identified more than five adverse determinations that contributed to the denial of the preauthorization exemption, the IRO may select a random sample of at least five and no more than 20 adverse determinations to review. If the IRO determines that one or more adverse determinations would have been overturned, the IRO will calculate an adjusted approval rate. An IRO's determination

that one or more adverse determinations reviewed in connection with a preauthorization exemption denial would have been overturned does not impact the status of the original preauthorization request.

(g) [~~(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.

(h) [~~(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.

§19.1734. Report.

(a) Not later than March 1 of each year, an issuer must submit a report to TDI concerning preauthorization exemptions for the previous calendar year. The report must be submitted electronically as specified on TDI's webpage.

(b) The report must include:

(1) identifying information for the issuer, including the issuer's name and National Association of Insurance Commissioners (NAIC) number, and the contact information of the person responsible for submitting the report;

(2) the name and NAIC number of each affiliate of the issuer;

(3) the number of prior authorization requests submitted during the previous calendar year to the issuer and each affiliate under each line of business in which the issuer or its affiliate offers health coverage that includes a preauthorization requirement, including:

(A) insurance products subject to Insurance Code Chapter 4201, Subchapter N, concerning Exemption from Preauthorization Requirements for Physicians and Providers Providing Certain Health Care Services, as follows:

(i) major medical coverage; and

(ii) vision coverage;

(B) HMO products subject to Insurance Code Chapter 4201, Subchapter N, as follows:

(i) major medical coverage;

(ii) vision coverage; and

(iii) dental coverage;

(C) insurance and HMO products not subject to Insurance Code Chapter 4201, Subchapter N, as follows:

(i) major medical coverage;

(ii) vision coverage; and

(iii) dental coverage;

(D) Medicaid managed care;

(E) the Children's Health Insurance Program (CHIP);

(F) Medicare Advantage; and

(G) administrative services only, in connection with the following:

(i) major medical coverage;

(ii) vision coverage; and

(iii) dental coverage;

(4) the number of particular health care services for which the issuer requires preauthorization;

(5) the number of physicians and providers included in the issuer's network on the last day of the previous calendar year;

(6) the number of in-network physicians and providers that had at least one preauthorization exemption on the last day of the previous calendar year; and

(7) data concerning preauthorization exemptions for each particular health care service, including:

(A) the number of evaluations conducted during the previous calendar year for physicians or providers without a preauthorization exemption and the number of exemptions newly granted or denied;

(B) the number of preauthorization exemptions granted prior to the previous calendar year, the number of evaluations of those exemptions, and the number of exemptions rescinded; and

(C) the number of appeals requested, identifying whether the appeal was for a denial or rescission of a preauthorization exemption and whether the denial or rescission was upheld or overturned on appeal.

(c) A report submitted under this section is public information subject to disclosure under Government Code Chapter 552, concerning Public Information.

Subchapter S. Forms to Request Prior Authorization
Division 1. Texas Standard Prior Authorization Request Forms
28 TAC §19.1801 and §19.1803

STATUTORY AUTHORITY. TDI proposes amendments to §19.1801 and §19.1803 under Insurance Code §§1217.004, 1369.304, and 36.001.

Insurance Code §1217.004 authorizes the commissioner to adopt rules related to the use of a standard form for requesting prior authorization of health care services.

Insurance Code §1369.304 authorizes the commissioner to adopt rules related to the use of a standard form for requesting prior authorization of prescription drug benefits.

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 amendments to §19.1801 and §19.1803 implement SB 1296 and HB 4611.

TEXT.

§19.1801. Applicability.

[~~(a)~~] Applicable health benefit plans. This subchapter applies only to a health benefit plan that is subject to Insurance Code Chapter 1217, concerning Standard Request Form for Prior Authorization of Health Care Services, or Insurance Code Chapter 1369, Subchapter G, concerning Standard Request Form for Prior Authorization of Prescription Drug Benefits. [~~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 Health and Safety Code Chapter 62 or the health benefits plan for children under Health and Safety Code Chapter 63.~~]

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

§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 or TDI--Texas Department of Insurance.

(4) Form--In Division 2 of this subchapter, the Texas Standard Prior Authorization Request Form for Health Care Services. In Division 3 of this subchapter, the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits.

(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, concerning Group Health Benefits for School Employees;

(ii) coverage under the child health program in Health and Safety Code Chapter 62, concerning Child Health Plan for Certain Low-Income Children, or the health benefits plan for children in Health and Safety Code Chapter 63, concerning Health Benefits Plan for Certain Children;

(iii) a Medicaid managed care program operated under Government Code Chapter 540, concerning Medicaid Managed Care Program [~~533~~], or a Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program;

(iv) a basic coverage plan under Insurance Code Chapter 1551, concerning Texas Employees Group Benefits Act;

(v) a basic plan under Insurance Code Chapter 1575, concerning Texas Public School Employees Group Benefits Program;

(vi) a primary care coverage plan under Insurance Code Chapter 1579, concerning Texas School Employees Uniform Group Health Coverage; and

(vii) basic coverage under Insurance Code Chapter 1601, concerning Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System.

(7) Health benefit plan issuer--An entity authorized under the 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, concerning Applicability of Chapter, or Insurance Code §1369.302, concerning Applicability of Subchapter. [~~§1369.252.~~]

(8) Health care service--A service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that 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 other than those included in the definition of prescription drugs in Occupations Code §551.003, concerning Definitions, and durable medical equipment. The term does not include prescription drugs or devices as defined by Occupations Code §551.003.

(9) ICD--International Classification of Diseases.

(10) 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.

(11) NDC--National Drug Code.

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

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

Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage
28 TAC §§ 19.2005, 19.2006, 19.2009, and 19.2010

STATUTORY AUTHORITY. TDI proposes amendments to §§19.2005, 19.2006, 19.2009, and 19.2010 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 4201.

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 amendments to §19.2005(d) implement new Insurance Code §4201.156. Proposed amendments to §19.2009(b) conform to Insurance Code §4201.303. These amendments implement SB 815.

Proposed amendments to §19.2006(e) implement Insurance Code §4201.152 as amended by HB 3812.

TEXT

§19.2005. General Standards of Utilization Review.

(a) Review of utilization review plan. A utilization review plan must be reviewed and approved by a physician and conducted under standards developed and periodically updated with input from both primary and specialty physicians, doctors, and other health care providers, including practicing health care providers, as appropriate.

(b) Special circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special

circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. For the purposes of this section, disability must not be construed to mean an injured employee who is off work or receiving income benefits.

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153, concerning Screening Criteria and Review Procedures. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. For workers' compensation network coverage, screening criteria must comply with Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks, and §10.101 of this title (relating to General Standards for Utilization Review and Retrospective Review); for workers' compensation non-network coverage and workers' compensation health plan, screening criteria must comply with Labor Code §§401.011, concerning General Definitions; 413.011, concerning Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols; and 413.014, concerning Preauthorization Requirements; Concurrent Review and Certification of Health Care; and Chapters 133, 134, and 137 of this title (relating to General Medical Provisions; Benefits-Guidelines for Medical Services, Charges, and Payments; and Disability Management, respectively).

(d) Referral and determination of adverse determinations. Consistent with Insurance Code §4201.156, concerning Use of Automated Decision System for Adverse Determinations, adverse [~~Adverse~~] determinations must be referred to and may only be determined by a physician, doctor, or other health care provider with appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement) and §19.2006 of this title (relating to Requirements and Prohibitions Relating to Personnel). Physicians and doctors performing utilization review must also comply with Labor Code

§§408.0043, concerning Professional Specialty Certification Required for Certain Review, 408.0044, concerning Review of Dental Services, and 408.0045, concerning Review of Chiropractic Services.

(e) Delegation of review. A URA, including a specialty URA, may delegate the utilization review to qualified personnel in a hospital or other health care facility in which the health care services to be reviewed were, or are, to be provided. The delegation does not relieve the URA of full responsibility for compliance with this subchapter, Insurance Code Chapter 4201, concerning Utilization Review Agents, the Texas Workers' Compensation Act, and applicable TDI-DWC rules, including responsibility for the conduct of those to whom utilization review has been delegated.

(f) Complaint system. The URA must develop and implement procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers concerning the utilization review. The URA must maintain records of complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

(g) Compliance with Labor Code §504.055. Utilization review plan written policies must evidence compliance with Labor Code §504.055, concerning Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responder in Course and Scope of Employment.

§19.2006. Requirements and Prohibitions Relating to Personnel.

(a) Qualification requirements. Physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review must be

appropriately trained, qualified, and currently licensed consistent with Insurance Code Chapter 4201, concerning Utilization Review Agents. Personnel conducting utilization review must hold an unrestricted license or an administrative license in Texas or be otherwise authorized to provide health care services in Texas. Physicians and doctors conducting utilization review must hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving as required by Labor Code §§408.0043, concerning Professional Specialty Certification, 408.0044, concerning Review of Dental Services, and 408.0045, concerning Review of Chiropractic Services. Physicians, doctors, and other health care providers conducting utilization review must have the appropriate credentials as required by Chapter 180 of this title (relating to Monitoring and Enforcement).

(1) This subchapter does not supersede requirements in the Medical Practice Act, Texas Medical Board rules, Texas Occupations Code Chapter 201, concerning [~~(relating to~~] Chiropractors[~~)~~], or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to 22 TAC Chapter 180 (relating to Disciplinary Guidelines) [~~190, regarding disciplinary guidelines~~].

(2) Personnel who perform clerical or administrative tasks are not required to have the qualifications prescribed by this subsection.

(b) Disqualifying associations. For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association. A physician, doctor, or other health care provider who conducts utilization review must not have any disqualifying associations with the:

(1) injured employee or health care provider who is requesting utilization review or an appeal; or

(2) physician, doctor, or other health care provider who issued the initial adverse determination.

(c) Information a URA must send to TDI. A URA must send to TDI the name, type, Texas license number, and qualifications of the personnel either employed or under contract to perform utilization review with an original or renewal application.

(d) Written procedures and maintenance of records. A URA must develop and implement written procedures, and maintain documentation, to demonstrate that all physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Physician direction requirement. Utilization review conducted by a URA must be under the direction of a physician currently licensed without restriction to practice medicine in Texas, consistent with Insurance Code §4201.152, concerning Utilization Review Under Direction of Physician. The physician must be employed by or under contract with the URA.

§19.2009. Notice of Determinations Made in Utilization Review.

(a) Notice requirements of favorable or adverse determinations.

(1) A URA must send written notification of a determination made in utilization review to the individuals specified in and within the timeframes required for utilization review.

(2) For prospective and concurrent review, the timeframes are specified by:

(A) Section 134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) for workers' compensation non-network coverage; and

(B) Insurance Code §1305.353, concerning Notice of Certain Utilization Review Determinations; Preauthorization Requirements; and §10.102 of this

title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements) for workers' compensation network coverage.

(3) For retrospective review, the timeframes are specified by:

(A) Sections 133.240 and 133.250 of this title (relating to Medical Payment and Denials, and Reconsideration for Payment of Medical Bills, respectively) for workers' compensation non-network coverage;

(B) Sections 133.240, 133.250, and 10.102 of this title, for workers' compensation network coverage.

(4) For workers' compensation non-network coverage and network coverage, a URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 CFR [~~Code of Federal Regulations~~] §162.1102 (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction) based on the type of service in the preauthorization request.

(b) Required notice elements. In all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of the procedure for filing a complaint with TDI;

(4) the professional specialty and Texas license number of the physician, doctor, or other health care provider that made the adverse determination;

(5) a description of the procedure for the URA's complaint system as required by §19.2005 of this title (relating to General Standards of Utilization Review);

(6) a description of the URA's appeal process, as required by §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determination) and a

statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination by an IRO and is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review;

(7) for workers' compensation network coverage, a description of and [~~or~~] the source of the screening criteria and review procedures used in making the determination, including a description of treatment guidelines used, as applicable;

(8) for workers' compensation non-network coverage, a description of and the source of the treatment guidelines and review procedures used under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b), concerning Contested Case Hearing on and Judicial Review of Independent Review, in making a determination; and

(9) notice of the independent review process. The notice of the independent review process required under this paragraph must include:

(A) a statement that:

(i) the request for a review by an IRO form must be completed by the injured employee, the injured employee's representative, or the injured employee's provider of record and be returned to the insurance carrier or URA that made the adverse determination to begin the independent review process;

(ii) a request for independent review of an adverse determination made under workers' compensation non-network coverage must be timely filed by the requestor consistent with §133.308 of this title (relating to MDR of Medical Necessity Disputes); and

(iii) a request for independent review of an adverse determination made under workers' compensation network coverage must be timely filed

by the requestor consistent with §10.104 of this title (relating to Independent Review of Adverse Determination); and

(B) either of the following:

(i) a copy of the request for a review by an IRO form, available at www.tdi.texas.gov/forms; or

(ii) notice in at least 12 point font that the injured employee can obtain a copy of the request for a review by an IRO form by:

(I) accessing TDI's website at www.tdi.texas.gov/forms; or

(II) calling {insert URA's telephone number} to request a copy of the form, at which time the URA will send a copy of the request for a review by an IRO form to the injured employee.

(c) Peer review reports. The notice of determination made in utilization review required under this section and the peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) may be combined into one document if all the requirements of both sections are met.

§19.2010. Requirements Prior to Issuing Adverse Determination.

(a) In any instance in which a URA is questioning the medical necessity or appropriateness of the health care services, before issuing [~~prior to issuance of~~] an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician, dentist, or chiropractor. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the services in question are within the

scope of the chiropractor's license to practice chiropractic. 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.

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

(2) The URA must maintain, and submit to TDI or TDI-DWC 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.

(b) A URA must act in good faith to provide a reasonable opportunity as required by this section. However, if there are fewer than 12 hours available during normal business hours between the time a request is received and the time the determination must be issued, the URA must issue the determination within the required timeframe.

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

Issued in Austin, Texas, on May 1, 2026.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance