Subchapter G. Independent Review of Preauthorization Exemptions
28 TAC §12.601

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §12.601, concerning preauthorization exemptions. The amendments are adopted with changes to the proposed text published in the May 15, 2026 issue of the *Texas Register* (51 TexReg 3318). Section 12.601(f) as proposed was changed to improve clarity, consistent with corresponding changes in 28 TAC §19.1733(f), which is also adopted in this *Texas Register* issue.

REASONED JUSTIFICATION. Amending §12.601 is necessary to implement House Bill 3812, 89th Legislature, 2025, which amended Insurance Code §4201.656(a) to specify that a physician or provider has a right to an independent review of a health plan's determination to deny a preauthorization exemption. Related amendments are also adopted in 28 TAC §19.1733 in this issue of the Texas Register.

Descriptions of the section's adopted amendments follow.

Section 12.601. Subsection (e) of §12.601 is amended to clarify that it applies with respect to a review of recission of a preauthorization exemption, and to update a reference to the title of §19.1733. A nonsubstantive change is made for consistency with agency rule drafting style.

New subsection (f) is added to address a review of a preauthorization exemption denial. Subsection (f) permits an independent review organization (IRO), in some circumstances, to review a random sample. Under the subsection, if a denial of a preauthorization exemption is based on five or fewer adverse determinations that were

not previously upheld by an IRO or external reviewer, the IRO must review all the adverse determinations to determine whether to uphold or overturn the denial. If a denial of a preauthorization exemption is based on more than five adverse determinations that were not previously upheld by an IRO or external reviewer, the IRO may select a random sample of at least five and no more than 20 adverse determinations to review.

TDI modifies subsection (f) as proposed to clarify that the random sample of adverse determinations selected by the IRO for review must be adverse determinations that were not previously upheld by an IRO or external reviewer. This requirement aligns with the random sampling approach provided for rescission reviews in Insurance Code §4201.655 and helps ensure that IROs will be able to complete reviews within the timeframe provided in Insurance Code §4201.656(c). If the IRO determines that one or more of the adverse determinations reviewed met the applicable medical necessity criteria and should have been approved, the IRO must recalculate an adjusted approval rate. New Figure: 28 TAC §12.601(f) is included to provide guidance on calculating the adjusted approval rate as required in new subsection (f). TDI adopts without change from the proposal paragraphs (1) - (3) of §12.601(f), which specify the methodology for calculating the adjusted approval rate. Previous subsections (f) - (g) are redesignated as appropriate to reflect addition of new subsection (f).

New subsection (i) is added to clarify the meaning of the term "external reviewer," with reference to federal rules. Under federal law, most appeals of adverse determinations use the federal external review process, which might not involve an IRO as defined by 28 TAC Chapter 12.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on June 17, 2026.

Commenters: TDI received comments from four commenters. No commenters spoke at a public hearing on the proposal held on June 15, 2026. The Texas Hospital Association commented in support of the proposal. Commenters in support of the proposal with changes were Texas Medical Association and Quest Diagnostics. The Texas Association of Health Plans commented against the proposal.

Comments on §12.601

Comment. One commenter recommends that TDI take the opportunity to clarify the national provider identifier (NPI) attribution in §12.601(c), regarding the identifier under which a physician or provider makes preauthorization requests. The commenter expresses concerns that relying on adverse determinations previously upheld in calculating the approval percentage--without requiring correlation--unduly narrows the IRO's role. The commenter recommends that IROs be permitted to verify comparability between a previously upheld adverse determination and the particular health care service at issue. The commenter requests additional guidance, and states that misattributed NPIs can dilute approval rates and impair qualifications for exemptions, increasing the administrative burden. The commenter states that group practices and multi-location entities need TDI's guidance to ensure that NPI misattribution does not artificially split performance data and jeopardize exemption eligibility.

Agency Response. TDI declines to modify §12.601(c), as doing so would be outside the scope of this rulemaking. Further, the rule already dictates that the identification of NPIs be based on preauthorization request data; this avoids gamesmanship. The use of a

particular NPI when requesting a preauthorization is the provider's responsibility and may be a business decision for group practices and entities and multiple locations.

Comment. One commenter expresses general support for TDI's proposed new subsection §12.601(f) and Figure 28 TAC §12.601(f) and notes that the proposed formula for calculating the adjusted approval rate is reasonable.

Agency Response. TDI appreciates the commenter's support.

Comment. One commenter notes that laboratories and other ancillary providers often have no face-to-face interaction with the patient, which makes it operationally unfeasible to secure signatures needed for the release of medical information. The commenter requests that the rules clarify that the health plan is responsible for securing patient consent for the release of information needed for their utilization management processes.

Agency Response. TDI declines to make a change because the issue of securing patient consent is outside the scope of the proposed rule. TDI also notes that the HIPAA privacy rules provide that health care providers generally do not need a patient's permission to share information with a health insurer for utilization management or payment processes.

Comment. One commenter expresses concern regarding the scope of the review to be performed by an IRO when a provider appeals a denial of a preauthorization exemption. The commenter opposes the requirement for the IRO to review each underlying adverse determination, rather than simply reviewing the exemption denial itself. The commenter states that framing the IRO process as a vehicle for providers to challenge old adverse determinations, many of which have already been resolved through the standard appeals

process, mischaracterizes the structure of the review system. The commenter also says that this approach overstates the scope of review the statute contemplates and creates cost concerns because IRO review fees are substantial. The commenter asks TDI to clarify that IRO review is limited to the exemption denial as a singular determination, and that the IRO conduct an aggregate evaluation, rather than adjudicating each underlying adverse determination on the merits.

Agency Response. TDI disagrees that the IRO rules are inconsistent with the review contemplated by the statute. Insurance Code §4201.656 provides a right to independent review of an "adverse determination regarding a preauthorization exemption." Insurance Code §4201.002 defines an "adverse determination" in relation to whether the health care services provided or proposed are medically necessary, appropriate, experimental, or investigational. Section 4201.401 also references an IRO's determination in relation to the medical necessity or appropriateness, or to the experimental or investigational nature, of health care items and services. If the IRO were required simply to review the exemption denial, it is unclear what the reviewer would look at beyond the calculation of the number of preauthorization requests approved, divided by the total number of preauthorization requests. Such a cursory review would not involve an inquiry into the medical necessity, appropriateness, experimental nature, or investigational nature of the health care item or service and would not require the clinical expertise of IRO reviewers. TDI also disagrees that the proposal creates cost concerns, because an IRO review of a rescission or denial is a singular determination, even if the review looks at multiple claims or preauthorization requests.

Comment. One commenter raises concerns with provisions in §12.601(f) that specify that a preauthorization request that was adversely determined is not eligible for an independent review if it was previously upheld by an external reviewer or IRO. The commenter is concerned about the possibility of gamesmanship in the scope of adverse determinations that are presented by issuers or utilization review agents (URAs) as eligible for IRO review. The commenter asks that the rule:

- before allowing previously upheld records to be excluded from a sample, require issuers and IROs to demonstrate that such determinations were 1) for the same service, 2) evaluated using appropriate criteria, and 3) not a result of incomplete records;

- require issuers to provide the full universe of eligible adverse determinations when a physician or provider requests an IRO to consider another random sample of claims and authorize IROs to conduct their own random sampling; and

- require minimum standards to ensure true random sampling by the IRO.

Agency Response. TDI declines to make a change and disagrees that the IRO's role is to verify "whether a previously upheld adverse determination is comparable to the particular health care service at issue." Under 28 TAC §19.1730(4), the definition of an eligible preauthorization request makes clear that "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." Under 28 TAC §19.1732(e)(3), the denial notice already requires issuers to identify each adverse determination included in the evaluation and whether it was appealed to the URA or to an external reviewer or IRO. Therefore, recipients of a denial notice can directly identify whether they have any concerns with the scope of preauthorization requests that formed the basis of an evaluation. For cases that were previously appealed to an IRO or external reviewer, the

physician or provider already had the opportunity to submit additional records and confirm that the adverse determination was based on appropriate criteria. As stated previously, TDI is not aware of any issues that necessitate additional rules on random sampling.

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STATUTORY AUTHORITY. TDI adopts amendments to §12.601 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 provides that the commissioner adopt standards and rules for the operation of 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.

TEXT.

§12.601. Preauthorization Exemptions.

(a) In this section, the following words and terms have the following meanings unless context clearly indicates otherwise.

(1) Adverse determination regarding a preauthorization exemption--Has the same meaning as defined in §19.1730 of this title (relating to Definitions).

(2) Issuer--Has the same meaning as defined in §19.1730 of this title.

(3) Physician--Has the same meaning as defined by Insurance Code §843.002, concerning Definitions.

(4) Preauthorization exemption--Has the same meaning as defined in §19.1730 of this title.

(5) Provider--Has the same meaning as defined in Insurance Code §843.002.

(b) An independent review of an adverse determination regarding a preauthorization exemption, the independent review organization (IRO) that performs the review, and the appropriate issuer are subject to Insurance Code Chapter 4201, Subchapter N, concerning Exemption from Preauthorization Requirements for Physicians and Providers Providing Certain Health Care Services, and the associated standards and requirements in this chapter, except as otherwise specified in this section.

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

(d) Notwithstanding §12.501 of this title (relating to Requests for Independent Review), an issuer must submit a request for independent review of an adverse determination regarding a preauthorization exemption to the department on behalf of a physician or provider.

(e) For a review of a rescission of a preauthorization exemption, if a second random sample is requested under Insurance Code §4201.656(d), concerning Independent Review of Exemption Determination, and available as provided in §19.1733(e) of this title (relating to Utilization Reviews and Appeals of Preauthorization Exemption Denials and Rescissions), the IRO must identify, from the list of eligible claims provided by the issuer,

a second random sample of at least five and no more than 20 claims. The IRO must review each claim that the issuer retrospectively reviewed and determined did not meet the applicable medical necessity criteria and, if applicable, each claim included in the second random sample identified by the IRO. Consistent with Insurance Code §4201.656(b), the IRO may request any medical records needed to evaluate the claims subject to review and must provide at least three business days for receipt of records. Based on the total number of claims in the initial random sample and, if applicable, the second random sample, the IRO must determine whether to affirm or overturn the issuer's determination that less than 90% of the claims met the applicable medical necessity criteria.

(f) For a review of a denial of a preauthorization exemption, if the denial notice provided by the issuer identifies five or fewer adverse determinations that have not previously been upheld by an IRO or external reviewer, the IRO must review all adverse determinations included on the denial notice that were not previously upheld by an IRO or external reviewer. Consistent with §19.1733(f) of this title, if the denial notice identifies more than five adverse determinations that have not previously been upheld by an IRO or external reviewer, the IRO may select a random sample of at least five and no more than 20 adverse determinations to review that were not previously upheld by an IRO or external reviewer. If the IRO determines that one or more of the adverse determinations reviewed met the medical necessity criteria and should have been approved, the IRO must calculate an adjusted approval rate to determine whether the denial of preauthorization exemption is overturned. Figure: 28 TAC §12.601(f) contains illustrative guidance on how to calculate an adjusted approval rate consistent with this section.

Figure: 28 TAC §12.601(f).

Guidance on calculating the adjusted approval rate as required in §12.601(f)

Percent Overturned (OT%)—Percent of reviewed adverse determinations that the IRO determines should have been approved and that would have been overturned had the physician or provider appealed to an IRO (i.e., the percent of adverse determinations reviewed that the IRO determined to be medically necessary and appropriate).

Number of Adverse Determinations (#ADs)—Number of preauthorization requests included in the evaluation that were adversely determined.

Number Approved (#APs)—Number of preauthorization requests included in the evaluation that were approved.

Total Preauthorization Requests (Total #PRs)—Total number of preauthorization requests included in the evaluation.

Adjusted Approval Rate—$\frac{(OT\% \times \#ADs) + \#APs}{\text{Total \#PRs}}$

(1) To calculate the adjusted number of approved preauthorization requests, multiply the percent of the adverse determinations reviewed that the IRO determines should have been approved by the number of preauthorization requests included in the evaluation that were adversely determined, and add that product to the number of preauthorization requests that were approved during the evaluation period.

(2) To calculate the adjusted approval rate, divide the adjusted number of approved preauthorization requests by the total number of preauthorization requests.

(3) If the adjusted approval rate is 90% or higher, the denial is overturned and the issuer must grant the preauthorization exemption.

(g) Appeals for an adverse determination regarding a preauthorization exemption to an IRO follow the department's process for assigning IROs under §12.502 of this title

(relating to Random Assignment), except that notification under §12.502(a) will only be made to the IRO, the issuer, and the physician or provider.

(h) Section 12.206 of this title (relating to Notice of Determinations Made by Independent Review Organizations) does not apply to a review by an IRO under this section. An IRO must complete its review and provide timely notice to an issuer regarding its determination, consistent with the timeframe provided under Insurance Code §4201.656(c).

(i) For the purposes of this section, the term "external reviewer" refers to an entity that conducts external review under 45 CFR §147.136, concerning Internal Claims and Appeals and External Review Processes.

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on November 9, 2026.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
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The amendments to 28 TAC §12.601 are adopted.

Signed by:
Amanda Crawford
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Amanda Crawford
Commissioner of Insurance

Commissioner's Order No. 2026-10220