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
28 TAC §§19.1702, 19.1705, 19.1706, 19.1709, and 19.1710

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28 TAC §§19.1730 - 19.1733 and 19.1734

Subchapter S. Forms to Request Prior Authorization

Division 1. Texas Standard Prior Authorization Request Forms
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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 commissioner of insurance adopts amendments to 28 TAC §19.1006 and §19.1028, concerning licensee continuing education courses; §§19.1702, 19.1705, 19.1706, 19.1709, and 19.1710, concerning health plan utilization reviews; §§19.1730 - 19.1733, concerning preauthorization exemptions; §19.1801 and §19.1803, concerning prior authorization request forms; and §§19.2005, 19.2006, 19.2009, and 19.2010, concerning utilization reviews for workers' compensation insurance. TDI also adopts new §19.1734, concerning an annual collection of preauthorization exemption data.

Amendments to §§19.1702, 19.1706, 19.1730, 19.1801, and 19.1803 are adopted without changes to the proposed text published in the May 15, 2026 issue of the *Texas Register* (51 TexReg 3320). Sections 19.1006, 19.1028, 19.1705, 19.1709, 19.1710, 19.1731, 19.1732, 19.1733, 19.1734, 19.2005, 19.2006, 19.2009, and 19.2010 are adopted with changes in response to public comment, and to make nonsubstantive changes to the proposed text. These include changes to update punctuation and grammar, reflecting current agency drafting style and plain language preferences.

REASONED JUSTIFICATION. The new and amended sections are necessary to implement legislation.

House Bill 2221, 89th Legislature, 2025, 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, §19.1006 and §19.1028, which reference Insurance Code Chapter 541, are amended to also reference Insurance Code Chapter 1702.

Senate Bill 815, 89th Legislature, 2025, prohibits a utilization review agent (URA) from using an automated decision system to make an adverse determination. To implement this provision, §19.1705(d) and §19.2005(d) are amended to reference new Insurance Code §4201.156. SB 815 also modifies the required contents of adverse determination notices. To implement these changes, §19.1709(c) and §19.2009(b) are amended to conform to Insurance Code §4201.303.

Senate Bill 644, 83rd Legislature, 2013, created Insurance Code §1369.254(b), later recodified as §1369.304(b), and Senate Bill 1216, 83rd Legislature, 2013, created Insurance Code §1217.004(b), which require issuers to exchange prior authorization requests electronically with a physician or provider who initiates a request electronically. These requirements apply "not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted." The Centers for Medicare & Medicaid Services recently 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 corresponding Insurance Code provisions. The amendments add a reference to Insurance Code Chapter 1217 in §19.1702 and amend §19.1705 to add new subsection (g) to implement §1217.004 and §1369.304 consistent with the implementation dates provided in the federal rules at 45 CFR §156.223.

House Bill 3812, 89th Legislature, 2025, 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, requirements in §19.1706 (for

health plans) and §19.2006 (for workers' compensation), related to URA personnel, are amended by adding a reference to Insurance Code Chapter 4201, and by adding a new subsection (f).

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

- 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, new §19.1734 specifies data submission requirements for issuers to report annual data and provides, consistent with Insurance Code §4201.660(b), that the reports are public information subject to disclosure

under the Public Information Act, Government Code Chapter 552. In a separate rulemaking published in this issue of the *Texas Register*, TDI adopts amendments to 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 this bill, §19.1801 and §19.1803 are amended 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 SB 644--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 amendments include 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, TDI proposed amending the notice requirements in §19.1709 to require inclusion of either the name or national provider (NPI) identifier of the physician or provider who made the adverse determination. However, in response to comments, this part of the proposal is not adopted.

Also in response to comments, TDI is not adopting proposed changes to §19.1710 and §19.2010 related to providing a "reasonable opportunity" for the physician or provider to discuss the treatment plan before an adverse determination.

Descriptions of the adopted 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 Insurance Code Chapter 1702. The reference to Insurance Code Chapter 541 in current §19.1006(a)(8)(A) is retained, as there are other provisions in Insurance Code 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.

Subsection §19.1006(f) as proposed is changed to update a citation to §19.1028. Rather than referencing subsection (g)(1) - (4), the citation simply references §19.1028. This change promotes regulatory efficiency by reducing the likelihood that future rule changes will be needed simply to update cross-references.

Section 19.1028. An amendment to subsection §19.1028(g) expands the subjects that must be included in an annuity certification course outline to reference Insurance Code Chapter 1702, which was added by HB 2221. The reference to Insurance Code §§541.051 - 541.061 is retained, as there are some provisions that continue to apply. 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 unnecessary uses of the word "the" in subsection (g)(1), (2), and (5), for consistency with agency rule drafting style.

As proposed, a reference to Insurance Code Chapter 1702 is added in new paragraph §19.1028(g)(3), which caused subsequent paragraphs to be redesignated as (g)(4) and (5). However, this would have created incorrect citations in §19.1009(f) and §19.1029(d)(2), which reference §19.1028(g)(1) - (4) and were not proposed for amendment. To avoid this issue, the text as proposed is changed to combine the new reference to Insurance Code Chapter 1702 with existing §19.1028(g)(2), rather than adding a new paragraph. This change removes the need to redesignate §19.1028(g)(3) and (4).

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 Insurance Code 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 Insurance Code Title 8, Subtitle E. 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) was proposed to be 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 would have clarified 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. In response to comments, the reference to Insurance Code §4201.156, which was proposed to be added into an existing requirement to refer adverse determinations to an appropriate physician or provider, is replaced with a reference to Insurance Code §4201.153. The reference to §4201.156 is instead added as a new sentence specifying that a URA may not use an automated decision system to make, wholly or partly, an adverse determination.

Subsection (g) is added to implement Insurance Code §1217.004 and §1369.304, consistent with SB 1216 and SB 644. It requires an issuer to maintain an electronic prior authorization system that meets national standards, consistent with the implementation dates identified in 45 CFR §156.223. The Insurance Code provisions require 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 regarding prior authorization requirements. Subsection (b) requires qualified health plans to use application programming interfaces (APIs) to make various types of information and transactions available electronically, including an API that "supports a HIPAA-

compliant prior authorization request and response." The federal rule applies to plan years beginning on or after January 1, 2027. The CMS rule originally provided an exception for prescription drugs because necessary standards for prescription drugs were still under development. Those standards have now been proposed for update, and on April 14, 2026, CMS proposed a rule (www.federalregister.gov/documents/2026/04/14/2026-07205/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-standards) to apply the requirements to prescription drugs, subject to a later implementation date. *See* 91 FR 19890 (April 14, 2026) (proposed to be codified at 42 CFR Parts 403, 422, 431, 438, 440, and 457; 45 CFR Parts 156, 162, and 170). While subsection (g) as proposed only referenced Insurance Code §1217.004, the provision is changed to also reference Insurance Code §1369.304, consistent with the consideration noted in the proposal's preamble. This change avoids the need for a separate rulemaking effort at a future date. The proposed text also is changed to replace the deadline of January 1, 2027, with a reference to the implementation dates provided in 45 CFR §156.223 and removes references to the term "health care services." These changes ensure that the statute is implemented and that state standards and implementation timeframes are closely aligned with federal rules. Subsection (g) as proposed is amended by adding a reference to the definition of "health care services" to clarify the meaning of the term in the subsection.

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 physician licensed in Texas, consistent with Insurance Code §4201.152, which, in addition, prohibits the physician from holding 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. In response to comments, TDI does not adopt amendments proposed in subsection (c)(4), which would have required URAs to include either the name or the NPI 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. 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." In response to comments, TDI does not adopt proposed new subsection (b) or redesignate existing text as subsection (a).

Subchapter R, Division 2

Section 19.1730. Amendments to §19.1730 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, and preauthorization requests in addition to claims. 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 align with HB 3812.

To simplify the contents of the definition, the requirement limiting the amount of time between the ending of the evaluation period and the provision of the notice of a preauthorization exemption rescission 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. Also, a conforming change is made to a cross-reference citation to reflect the renumbering of definitions in §19.1730. For ease of reading, proposed new text in subsection (c) is changed to organize it into paragraphs (1) and (2).

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. Also, language in subsection (b) concerning denial notice requirements is removed because more detailed requirements are provided in new subsection (e). The proposed reference to forms LHL011 and LHL012 is changed to use the word "sample" instead of "example."

Subsection (c) is amended to remove the initial evaluation period and notice deadlines, which have now passed and are no longer relevant, and to update a cross-reference citation to reflect the renumbering of definitions in §19.1730. 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) also is 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). Subsection (d) as proposed is changed to clarify that the rescission notice must be provided within three months following the last day of the evaluation period. In addition, a reference to the title of Insurance Code §4201.655 is added to the subsection.

To correct grammar and readability, a nonsubstantive change is made to subsection (d)(3)(C) by relocating the word "to."

Previous 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 implement Insurance Code §4201.656(a), as amended by HB 3812, and include information about the preauthorization requests that were evaluated under Insurance Code §4201.656)(c) and how to request an independent review of the denial. A grammatical change is made to new subsection (e)(3)(B) as proposed to make the word "result" plural.

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. To aid in readability, subsection (c) as proposed is modified to create two paragraphs to separately describe the different submission dates that apply to requests for review of a denial versus review of a rescission.

Subsection (d) is amended to broadly reference "an adverse determination regarding a preauthorization exemption," which includes both rescissions and denials of preauthorization exemptions, 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 already would have 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). 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. Subsection (f) as proposed is changed to clarify that the IRO will only review adverse determinations that were not previously upheld by an IRO or external reviewer.

The previous 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) requires submission of a report with an annual due date of March 1, as specified on TDI's website. TDI intends to collect the data using a JSON file format submitted through a TDI portal similar to other TDI data calls and will make a JSON file schema available after the rule is adopted on www.tdi.texas.gov/webinfo/datacall.html. 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 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.

TDI modifies subsection (b)(1) as proposed to require the issuer to provide direct links to the websites where the issuer posts preauthorization data as required under other state and federal reporting requirements. TDI also modifies subsection (b)(2) as proposed to clarify that if an affiliate does not have an NAIC number, the issuer should report the affiliate's license number.

As proposed, subsection (b)(3) would have required the issuer to report the number of prior authorization requests submitted during the previous year to the issuer and each affiliate under each applicable line of business. In response to comments expressing concern that such data would duplicate other state and federal reporting requirements related to prior authorization, TDI modifies subsection (b)(3) to require issuers to identify each applicable line of business that is included within the issuers' preauthorization exemption evaluations, rather than reporting the number of prior authorization requests for each line of business. Identification of each line of business included in the issuer's preauthorization exemption evaluations will allow TDI to ensure compliance with Insurance Code §4201.653(a-1) and provide context for policymakers on the scope of affiliates and lines of business included based on the statutory change. Lines of business include insurance products subject to Insurance Code Chapter 4201, Subchapter N, consisting of major medical and vision coverage; HMO products subject to Insurance Code Chapter 4201, Subchapter N, consisting of major medical, vision, and dental coverage; insurance and HMO products *not* subject to Insurance Code Chapter 4201, Subchapter N, consisting of major medical, vision, and dental coverage; Medicaid managed care; the Children's Health Insurance Program (CHIP); Medicare Advantage; and

administrative services only, consisting of services in connection with major medical, vision, and dental coverage.

Subsection (b)(7) 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 preauthorization exemptions were granted versus denied as a result; 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. TDI modifies subsection (b)(7) as proposed to clarify that exemption data must be reported for each particular health care service that is subject to a preauthorization requirement and that the service must be identified with a description and the associated billing codes.

Subsection (c) states that a report submitted under §19.1734 is public information under the Public Information Act, Government Code Chapter 552.

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 amendments 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.

In response to comments, the reference to Insurance Code §4201.156, which was proposed to be added to an existing requirement in subsection (d) to refer adverse determinations to an appropriate physician or provider, is changed by replacing it with a reference to Insurance Code §4201.153. A reference to §4201.156, which specifies that a URA may not use an automated decision system to make, wholly or partly, an adverse determination, is instead added as a separate sentence. Also, in response to comments, subsection (a) as proposed is modified to specify that the utilization review plan must be reviewed and approved by a physician "licensed to practice medicine in Texas." This is consistent with the corresponding provision in §19.1705(a) and Insurance Code §4201.151.

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. The text of subsection (a) as proposed is changed to correct a reference to the title for Labor Code §408.0043.

Subsection (e) is amended to add a requirement that utilization review conducted by a URA under the direction of a physician be "consistent with 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 is made to a federal code citation in subsection (a)(4) and a title is added to a code reference in subsection (b)(8).

The text of subsection (b)(6) as proposed is changed to correct a reference to the title of §19.2011.

Section 19.2010. 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." In response to comments, TDI does not adopt proposed new subsection (b) or redesignate existing text as subsection (a).

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 six commenters, and one of the commenters spoke at a public hearing on the proposal held on June 15, 2026. Commenters in support of the proposal with changes were Agendia, Inc.; Elevance Health, Inc.; Texas Association of Health Plans; Texas Medical Association; Texas Hospital Association; and Quest Diagnostics. TDI received one comment letter after the comment period closed that was not considered.

Comments on Chapter 19, Subchapter R--date of service

Comment. Two commenters raise general concerns with the rules in Chapter 19, Subchapter R, and health plan practices as they relate to "date of service" policies and laboratory testing. They state that the proposal overlooks the unique position of some laboratories and cancer testing companies that provide services downstream from the provider's prior authorization request. The commenters note that many payors follow a Medicare rule specifying that the "date of service" is the date a specimen is collected. For lab services, a specimen is often collected in a health care provider's office, and the provider sometimes does not obtain a preauthorization before collecting the specimen and sending it to the lab. In many cases, for the stability of the sample and the health of the patient, labs need to promptly conduct the ordered test, even if preauthorization has not yet been obtained. Some follow-up tests are conducted on the same biopsy sample and cannot be ordered until the doctor receives the results from the initial test.

The commenters note that these policies sometimes result in administrative denials for lack of preauthorization or in the treatment of preauthorization requests as retrospective reviews. To address these concerns, the commenters ask TDI to amend the rules to allow a preauthorization request for clinical laboratory services to be submitted and considered at any time prior to final claim submission, and to prohibit a plan from denying a preauthorization request for a laboratory service solely because it was submitted after the "date of service."

To prevent a laboratory from being unfairly penalized with non-payment, one of the commenters asks TDI to specify that an order for laboratory services from an in-network provider be considered "plan-directed care" and fully payable by the health plan.

The other commenter asks TDI to clarify that laboratories, when authorized by the ordering provider, can support or obtain prior authorization for some tests. The commenter states that allowing the laboratory to do this would reduce administrative burden on treating physicians, and would help ensure that the entity most familiar with the test and documentation can facilitate a complete and timely submission.

Agency Response. TDI declines to make the requested changes because they are outside the scope of the proposed rules. TDI agrees that health plan administrative requirements should acknowledge the unique nature of laboratory services and encourages health plans to ensure that administrative systems do not result in improper denials for medically necessary services simply based on lack of preauthorization. If a health plan is performing a retrospective review, such review must be completed within the applicable prompt pay periods (*see* Insurance Code §4201.305).

Laboratories can file complaints with TDI if health plans are issuing inappropriate denials or failing to process claims timely. TDI also encourages clinical laboratories to raise these concerns with health plans within the contracting process, so that payment terms and provider manuals clarify the responsibilities of ordering providers and clinical laboratories for preauthorization requirements and specify how "date of service" should be defined for laboratory services.

Comment on §19.1702

Comment. One commenter supports the amendments to §19.1702 that incorporate a reference to Insurance Code Chapter 1217, regarding the standard request form for prior authorization of health care services. The commenter agrees with TDI's statement that this addition clarifies that Chapter 1217 applies to Chapter 19, Subchapter R.

Agency Response. TDI appreciates the commenter's support.

Comments on §19.1705(c)

Comment. Two commenters support the proposed amendment in §19.1705(c), which specifies that screening criteria "must not be more restrictive" than Insurance Code coverage standards. However, one commenter raises concerns about potential confusion based on the statement in the public benefit and cost note for the rule proposal that the provision will have the benefit of ensuring that screening criteria is "no less restrictive" than Insurance Code coverage standards. The commenter recommends alignment between all explanatory and supporting text, and the rule language.

Agency Response. TDI appreciates the commenters' support and apologizes for the error in the Public Benefit and Cost note. The error was contained in the explanatory section of the rule proposal and not in the proposed rule text; a change in the rule is not necessary. That incorrect wording in the explanatory section should not be interpreted to change the meaning or intent of the rule text in §19.1705(c).

Comments on §19.1705(d) and §19.2005

Comment. One commenter supports the amendments to §19.1705(c) and (d), while another expresses concerns that the amendments to §19.1705(d) and §19.2005(d) do not adequately implement Insurance Code §4201.156.

The commenter who expresses concerns first opposes proposed added language in subsection (d), stating that the proposed placement of the new text referencing Insurance Code §4201.156 could create confusion about the source of the requirement for an adverse determination to be referred to an appropriate physician to determine medical necessity. The commenter suggests that §19.1705(d) and §19.2005(d) instead reference Insurance Code §4201.153. Second, the commenter provides example rule text and urges TDI to include more extensive limits in the usage of automated decision systems (ADS). The commenter also recommends that a new subsection (d)(1) be added to both rules to more accurately reflect the separation of the statutory screening and ADS provisions. The commenter suggests including limits on ADS usage in §19.1705(d) and §19.2005(d) that would:

- Provide a non-exhaustive list of when an ADS is used to make, wholly or partly, an adverse determination, such as using a system that:

-- suggests acceptance of a denial of or reduction in services by a human reviewer;

-- prompts the human reviewer with a prepopulated finding or denial rationale;

-- scores requests in a way that increases the probability of an adverse determination, including by incorporating non-clinical factors in the information considered by the automated decision system;

-- filters or selectively presents clinical information in a manner likely to bias the human reviewer toward an adverse determination; or

-- pressures a reviewer to reach a particular outcome or meet a quota, steers the reviewer's judgment toward a denial, or interferes with the reviewer's judgment.

- Clarify what constitutes permissible or prohibited administrative support.

- Limit fraud-detection functions and clarify who may determine whether fraud exists.

- Require auditable controls that prevent automated outputs from steering reviewers toward denials, including controls that:

-- require monitoring of workflow features that may increase adverse-determination rates or suppress meaningful reviewer overrides;

-- address procedures for the audit and inspection of a URA's use of an automated decision system;

-- require maintenance of a log on when an automated decision was used, who accessed or reviewed the output, and the final determination made;

-- require implementation of technical and administrative safeguards to prevent predisposing a reviewer toward an adverse determination;

-- require retention of records for at least seven years and require making them available to the commissioner on request for audit or inspection to determine compliance; and

-- require URAs to certify annually that they have implemented and tested controls to ensure compliance.

- Clarify that third-party entities must comply with applicable requirements and that URAs also remain responsible for compliance; any contract with a third party must require audit cooperation and preservation of necessary information.

- Authorize the commissioner to require production of policies, system documentation, testing results, audit logs, samples of determinations, and other records necessary to evaluate compliance.

The commenter suggests that §19.2005(a) be modified to specify that the utilization review plan be reviewed and approved by a physician "licensed to practice medicine in Texas," to be consistent with §19.1705(a).

Finally, if TDI rejects the commenter's recommended language, the commenter recommends that TDI include guardrails in the rule that address specified issues.

Agency Response. TDI appreciates the first commenter's support. With respect to the second commenter, TDI agrees in part and modifies subsection (d) in §19.1705 and §19.2005 to first reference Insurance Code §4201.153, and also to add a new sentence to reference and address the requirements of Insurance Code §4201.156. TDI disagrees that it is necessary to include a reference to Insurance Code §4201.156 in a separate paragraph.

TDI appreciates the commenter's suggestions regarding ADS but declines to provide more extensive rule provisions at this time. TDI will closely monitor compliance with SB 815, both through complaints and through audits and inspections of automated decision systems within TDI's targeted or triennial examinations.

TDI also agrees with the commenter's suggestion to add the phrase "licensed to practice medicine in Texas" to §19.2005(a), because this change aligns with Insurance Code §4201.151.

Comments on §19.1706 and §19.2006

Comment. One commenter supports the rule's reference to the physician licensure language in HB 3812 but suggests that because Insurance Code §4201.152 is located within Subchapter D, "Utilization Review: General Standards," the implementing rule provisions should be moved from §19.1706 and §19.2006, respectively, to §19.1705 and §19.2005. The commenter is concerned that the placement, as proposed, "risks recasting a structural statutory protection as a personnel rule and, in doing so, understating the role the Legislature assigned to physician direction." The commenter also notes that the rule language requires the physician directing utilization review to be "employed by or under contract with the URA," and questions how this comports with the prohibition on the corporate practice of medicine, particularly the requirement that the physician cannot have a license to practice administrative medicine.

Agency Response. TDI disagrees that the rule's organization weakens the statutory requirement and declines to make the requested change. The rule provisions that permit a URA to employ or contract with a physician have been in place since 2013; TDI defers

to the Texas Medical Board for interpretations regarding the corporate practice of medicine.

Comments on §19.1709(c)--URA name or NPI disclosure; notice requirements

Comment. One commenter supports the added changes to subsections (c)(3) and (4) with suggested revisions. The commenter notes that the amendments made to subsection (c)(3) align with Insurance Code §4201.303. The commenter supports the proposed amendment to subsection (c)(4), but suggests expanding it to require the "name, license number, and type of license" of the reviewer, noting that the name alone might not be sufficient to independently verify the information, since some physicians have common names. The commenter states that its recommended change to proposed subsection (c)(4) would streamline appeals, improve accountability, and "promote patient safety without revealing physician information that is not already publicly availably based upon state licensure board information."

Two commenters oppose the amendment proposed in subsection (c)(4), which would require adverse determination notices to include the reviewer's name or NPI. The commenters believe this requirement is not supported by statute and express concern that it could create safety risks for physicians and clinicians who conduct utilization review on behalf of health plans. One commenter notes that the rules already include sufficient documentation requirements to allow TDI to confirm that each reviewer has the required qualifications.

Agency Response. TDI appreciates the first commenter's support for the change to subsection (c)(3), and adopts the subsection as proposed.

In response to the concerns raised by the other commenters, the proposed change to subsection (c)(4) is not adopted. TDI agrees that the requirements in §19.1706(c) and (d) are sufficient to ensure that URAs maintain documentation to demonstrate that each review is conducted by qualified personnel. Also, TDI is already able to request additional information as needed. Within triennial examinations, TDI regularly obtains data that includes the name, license number, and specialty of the physician or provider who issued each adverse determination.

Comments on §19.1710(b) and §19.2010(b)

Comment. Two commenters oppose the amendments to add a new subsection (b) in §19.1710 and §19.2010, because the amendments appear to create an exception under which URAs are no longer required to provide a "reasonable opportunity" for a peer-to-peer discussion if there are fewer than 12 hours available during normal business hours between the time a request is received and the time the determination is to be issued.

One of the commenters says that if TDI does not remove new subsection (b), TDI should consider amending the definition of "reasonable opportunity" provided by an issuer to a provider with respect to the review of the services provided to a hospitalized patient.

The other commenter recommends that TDI consider clarifying proposed subsection (b), taking into account the intent of Insurance Code §4201.206. The commenter offers alternative language that would include deletion of the requirement in proposed subsection (b) that a URA act in good faith to provide a reasonable opportunity to discuss the plan of treatment prior to issuing an adverse determination.

Agency Response. TDI agrees that the statute requires a URA, in all circumstances, to offer a reasonable opportunity for a peer-to-peer discussion, and that the proposed rule could be interpreted to weaken the statutory requirement, which was not TDI's intent. In response to the commenters' concerns, TDI does not adopt the proposed new subsection (b) in §19.1710 or §19.2010.

Comments on §§19.1730 - 19.1734

Comment. One commenter offers support for amendments to §§19.1730 - 19.1733 and new §19.1734, and recommends that TDI adopt the sections as proposed. The commenter raises a concern that health plans may not be issuing preauthorization exemptions to hospitals and asks TDI to confirm that hospitals are considered providers eligible to receive exemptions.

Agency Response. TDI appreciates the commenter's support and will accept and review any information or complaints related to compliance concerns. Hospitals are eligible to receive preauthorization exemptions for any health care services for which the hospital is making the preauthorization request. The term "provider" is defined broadly in Insurance Code Chapter 4201, Subchapter N (specifically, in §4201.651(b)), which references the definition in Insurance Code §843.002(24). Exemptions are granted under the NPI number by which a physician or provider makes preauthorization requests.

Comment. One commenter asks TDI to amend §19.1730 to prevent denials based on administrative technicalities (if the authorization request otherwise would have been

approved on clinical merit) from being counted against the approval rate that is used to determine if a provider qualifies for a preauthorization exemption.

Agency Response. TDI does not make the requested change. No change is needed because this consideration is already addressed in the definition of an eligible preauthorization request under §19.1730(4). Paragraph (4) describes eligible preauthorization requests as those having (among other requirements) "an outcome of either approving the particular health care service or issuing an adverse determination for the particular health care service." Adverse determinations are defined as denials that are based on medical necessity and are distinct from administrative denials. A denial based on a failure to obtain preauthorization is not an adverse determination. Therefore, administrative denials are not included within the calculation of approval rates for the purposes of preauthorization exemption evaluations.

Comment. One commenter requests that TDI clarify and reconsider the requirements in Division 2 of Chapter 19, Subchapter R, for issuers to include claims for affiliated Medicare and Medicaid enrollees when conducting evaluations for preauthorization exemptions. The commenter states that the public programs operate under different statutory and regulatory frameworks and apply different definitions of medical necessity, different preauthorization policies, and distinct clinical criteria established by federal and state authorities. The commenter expresses concern that broadly including all Medicare and Medicaid claims creates a risk of plans granting or denying exemptions on the basis of preauthorization decisions that are not meaningfully comparable to the commercial market that the exemptions apply to. To mitigate this concern, the commenter asks TDI

to clarify that claims for Medicare and Medicaid should be included in exemption evaluations only when the utilization review criteria are substantially equivalent to the criteria applied under the issuer's Texas-regulated commercial health plans.

Agency Response. TDI declines to make a change because the rule as proposed is consistent with Insurance Code §4201.653(a-1). However, to monitor any unintended consequences of including Medicare and Medicaid data, TDI encourages issuers to share data with TDI that demonstrates how including Medicare and Medicaid data impacts the preauthorization exemption program. TDI also notes that under §19.1731(4), a preauthorization request is only eligible to be included in an evaluation if it results in an approval or adverse determination for the requested service. If a claim does not require preauthorization or receives an administrative denial as a noncovered service, it would not be eligible to be included in the evaluation.

Comments on §19.1732

Comment. One commenter expresses appreciation for TDI's efforts to implement the preauthorization exemption requirements under SB 3812. The commenter notes concerns that the definition of "random sample" could be much stronger and does not achieve true randomness, and that the rescission notice does not provide enough information for the physician, provider, or IRO to determine whether the sample was actually random. The commenter recommends the rule be revised to require issuers contemplating a rescission to address other elements, including reviewing preauthorization requests submitted during the evaluation period and disclosing the methodology for achieving a "random sample." The commenter requests changes to §19.1732(d)(3) to require the rescission

notice to include a detailed, "complete list" (rather than "a statement of the total number") of claims submitted "to an issuer or an affiliate of the issuer," "the methodology for achieving a random sample," and "a statement from [the] issuer attesting to their compliance with the requirement to evaluate a random sample under Insurance Code §4201.655(a)(2)." The commenter requests conforming changes to proposed §19.1732(e)(3).

Agency Response. As the commenter notes, no changes were proposed to §19.1732(d)(3) or the definition of "random sample." Therefore, TDI declines to add the requested new requirements in the adoption as the requested changes are outside the scope of this rulemaking. TDI also declines to make the suggested changes to §19.1732(e)(3). TDI closely monitors complaints about preauthorization exemptions and is not aware of any allegations that issuers are using nonrandom samples to justify rescissions. TDI also disagrees that claims from an issuer's affiliate are relevant to a rescission. The statute's inclusion of affiliate data is limited to preauthorization requests used in an initial evaluation under Insurance Code §4201.653; affiliate data are not included in a rescission evaluation under Insurance Code §4201.655 because the preauthorization exemption applies only to the issuer and not the affiliate.

Comments on §19.1733

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 states 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." TDI defines the term as taking into account the statute's inclusion of the term "adverse determination." Insurance Code §4201.002 defines "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 it 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 §19.1733(d) 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 or independent review organization. The commenter is concerned about the possibility of gamesmanship in the scope of adverse determinations that are presented by issuers or URAs as eligible for IRO review. The commenter asks that the rule be amended to include the following:

- before allowing previously upheld records to be excluded from a sample, require issuers and IROs to demonstrate that the determinations were for the same health care service, evaluated using appropriate criteria, and 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." The IRO's role is to verify whether an adverse determination is appropriate based on clinical guidelines. Under §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 §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.

Comment. One commenter notes that laboratories and other ancillary providers often have no face-to-face interaction with the patient, making 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 authorization to share information with a health insurer for utilization management or payment processes.

Comments on §19.1734--preauthorization exemption data collection and reporting

Comment. One commenter supports the transparency and oversight provided in new proposed §19.1734, asks TDI to adopt the rule as proposed, and encourages TDI to ensure the data is sufficient to allow policymakers and stakeholders to evaluate relevant patterns.

Agency Response. TDI appreciates the commenter's support.

Comment. One commenter opposes provisions in §19.1734(b)(2) - (6), stating that those provisions go beyond what the statute requires, duplicate data already collected by federal regulators, and, particularly with regard to affiliate volume and network composition requirements, sweep in federally regulated programs that are outside TDI's jurisdiction. The commenter notes that issuers are already required to report some prior authorization metrics under the 2024 CMS Interoperability and Prior Authorization rule, and raises concerns about compiling overlapping data and building new reporting infrastructure operating across multiple affiliated entities. The commenter asks that TDI limit the annual reporting requirements to those data elements expressly required by Insurance Code §4201.660, applied to Texas-regulated commercial health insurance and HMO products subject to Insurance Code Chapter 4201, Subchapter N.

Agency Response. In response to the commenter's concerns about duplicative data requirements, TDI modifies the data required under §19.1734(b) as proposed. In paragraph (1) of the adopted rule--to leverage data that issuers are already required to publish under state and federal law--the report requires issuers to provide links to the websites where the issuer publishes preauthorization metrics. In paragraph (3), the requirement to report the number of prior authorization requests within each line of business is replaced with a requirement to identify each line of business that is included within the issuer's evaluations for preauthorization exemptions.

While this information is not expressly required by Insurance Code §4201.660, it is necessary to enable TDI to monitor issuers' compliance with Insurance Code §4201.653(a-

1). That provision requires health plans, when conducting an evaluation, to include preauthorization requests submitted to the issuer or its affiliate, regardless of whether the request was made in connection with a health plan that is subject to Insurance Code Chapter 4201, Subchapter N. While TDI is not adopting a requirement for issuers to report quantitative data on the volume of preauthorization requests within each line of business, TDI encourages issuers to voluntarily share information with TDI and policymakers on how the inclusion of preauthorization requests from Medicare and Medicaid has affected the gold carding program.

TDI declines to remove data elements on the number of services requiring preauthorization because this information provides important context to policymakers. Likewise, collecting the number of physicians and providers in the issuer's network and the number of in-network physicians and providers with at least one exemption allows TDI to calculate the percentage of in-network physicians and providers with an exemption. This is a key metric that TDI has shared with policymakers in the past to quantify the impact of the legislation.

Comment. One commenter suggests expanding §19.1734 to include a description of why each denial or rescission that was reviewed by an IRO was upheld or overturned, as well as the number of determinations for which IRO review was requested and their outcome, to aid in TDI enforcement efforts.

Agency Response. The Legislature requires data to be collected for each health care service subject to an exemption. TDI declines to make the suggested change because it would significantly increase the granularity of the data and level of effort needed to

produce and maintain the data. Physicians and providers who request an IRO will receive the IRO's decision directly and can file complaints with TDI if needed.

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

STATUTORY AUTHORITY. TDI adopts 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 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.

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) Business and Commerce Code Chapter 17, Subchapter E, concerning Deceptive Trade Practices and Consumer Protection;

(F) 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) corporate ethics;

(H) ethical challenges of licensees;

(I) ethical behavior of an insurance company;

(J) ethical behavior of an agent or adjuster;

(K) duties of the licensee to company, client, and customer;

(L) duties of insurer/HMO to agents/clients;

(M) fiduciary responsibility;

(N) unfair marketing practices;

(O) difference between ethics and laws;

(P) confidentiality, privacy, and ethics;

(Q) ethical analysis of the licensee's job;

(R) philosophical approaches to ethics; or

(S) 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) 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 (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:

(1) be submitted to the department for approval in compliance with §19.1007 of this title (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 (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, the licensee must comply with §19.1013 of this title (relating to Licensee Record Maintenance).

(e) A licensee must 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 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 (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 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 provisions specified in Insurance Code §§541.051 - 541.061 and Insurance Code Chapter 1702, concerning Regulation of Certain Trade Practices;

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

(4) practices relating to annuities that are prohibited by 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 adopts 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 provides that the commissioner 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.

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 §4201.153, 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. Consistent with Insurance Code §4201.156, concerning Use of Automated Decision System for Adverse Determinations, a URA may not use an automated decision system to make, wholly or partly, an adverse determination.

(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. Consistent with Insurance Code §1217.004 and §1369.304, both concerning Standard Form, 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 electronically, no later than the implementation dates specified in that section.

§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; 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).

(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 the source of the screening criteria and review procedures that were utilized as guidelines in making the determination;

(4) 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 §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 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 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 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.

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 an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician

licensed to practice medicine in Texas. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. If the health care service was ordered, requested, or provided, or is to be provided, by a physician, then the opportunity must be with a physician licensed to practice medicine in Texas and who has the same or similar specialty as the physician.

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

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

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

STATUTORY AUTHORITY. TDI adopts 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 provides that the commissioner 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.

§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 reviewed as part of an evaluation with respect to a particular health care service did not meet the issuer's screening criteria, which 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) 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) 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) Eligible preauthorization request--A preauthorization request for a particular health care service is eligible for the purposes of an evaluation under paragraph (5)(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) 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) Evaluation period--The evaluation periods are as follows:

(A) for a determination of a preauthorization exemption grant or denial that is issued on or after September 1, 2025, the evaluation period is the 12-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;

(B) after a denial or rescission of a preauthorization exemption for a particular health care service, the subsequent 12-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.

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

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

(11) 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) Provider--Has the meaning assigned by Insurance Code §843.002.

(13) 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) Rescission of preauthorization exemption--An adverse determination regarding a preauthorization exemption based on an evaluation, as defined in paragraph (5)(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) 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. 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) 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 claims submitted during the most recent evaluation period, as follows.

(1) If there are five or more claims, the issuer must review at least five and no more than 20 claims.

(2) 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. 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. Sample forms LHL011 for rescissions and LHL012 for denials are available on TDI's website at www.tdi.texas.gov/forms.

(c) After completing an evaluation as defined under §19.1730(5)(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 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 last day of the evaluation period. The notice must include the following:

(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, 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 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 results 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) 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 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) 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. The request must be submitted as follows.

(1) For a denial, the request must be submitted no later than 30 days after the date listed on the denial notice. The date of the request must be documented on the form, and the form must be sent electronically or postmarked before the date the denial becomes effective.

(2) 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 preauthorization exemption, a physician or provider must submit the form provided by the issuer under §19.1732 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 that has not previously been upheld by an IRO or external reviewer. 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 that were not previously upheld by an IRO or external reviewer. 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) 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) 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, the contact information of the person responsible for submitting the report, and direct links to the websites containing information posted as required under Insurance Code §843.3481 and §1301.1351, both concerning Posting of Preauthorization Requirements, and 42 CFR §156.223(c), concerning Publicly Reporting Prior Authorization Metrics;

(2) the name and NAIC number of each affiliate of the issuer, or license number if the affiliate does not have an NAIC number;

(3) for the issuer and each affiliate, an identification of each line of business included within the issuer's evaluations for preauthorization exemptions, 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) for each particular health care service that is subject to a preauthorization requirement, a service description, associated billing codes, and data concerning preauthorization exemptions, 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 adopts amendments to §19.1801 and §19.1803 under Insurance Code §§1217.004, 1369.304, and 36.001.

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

Insurance Code §1369.304 provides that the commissioner 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.

TEXT.

§19.1801. Applicability.

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.

§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, 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.

(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 adopts 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.

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 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, 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 §4201.153, 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). Consistent with Insurance Code §4201.156, concerning Use of Automated Decision System for Adverse Determinations, a URA may not use an automated decision system to make, wholly or partly, an adverse determination. 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 Required for Certain Review, 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 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).

(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 §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 Determinations) 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 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.

In any instance in which a URA is questioning the medical necessity or appropriateness of the health care services, before issuing 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.

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
Texas Department of Insurance

New 28 TAC §19.1734 and amendments to §§19.1006, 19.1028, 19.1702, 19.1705, 19.1706, 19.1709, 19.1710, 19.1730 - 19.1733, 19.1801, 19.1803, 19.2005, 19.2006, 19.2009, and 19.2010 are adopted.

Signed by:
Amanda Crawford
FE10434BC41A470...

Amanda Crawford
Commissioner of Insurance

Commissioner's Order No. 2026-10221