Verification and Preauthorization Procedures

For contracted providers SB418 is effective for new contracts issued or contracts renewed on or after 8/16/2003.

Emergency Room Physicians and Non-contracted providers that have received a referral may begin utilizing the verification procedures under SB 418 as of 8/16/2003.

For any conflicts between the following reference materials and the rules, the rules prevail.

Topic	URA prior to SB 418	SB 418 and Emergency Rules	SB 418 and Final Rules
Verification, defined **28 TAC §19.1703 (37)**	NA	A guarantee by an HMO or preferred provider carrier that the HMO or preferred provider carrier will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the patient for whom the services are proposed. The term includes pre-certification, certification, re-certification and any other term that would be a reliable representation by an HMO or preferred provider carrier to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §19.1724(d) of this title (relating to Verification). Article 3.70-3C Sec. 1 (15) and §843.347, TIC contain statutory definitions.	A guarantee by an HMO or preferred provider carrier that the HMO or preferred provider carrier will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the patient for whom the services are proposed. The term includes pre-certification, certification, re-certification and any other term that would be a reliable representation by an HMO or preferred provider carrier to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §19.1724(d) of this title (relating to Verification). Article 3.70-3C Sec. 1 (15) and §843.347, TIC contain statutory definitions.

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Verification **28 TAC §19.1724**	NA	A verification is a guarantee of payment. A provider may request a verification by telephone, in writing or through other means of communication as agreed to by the provider and the carrier. Carriers may within 1 day of receiving a request for verification, request additional information from the provider. Carriers may make only 1 request for additional information. A carrier must either issue a verification or a declination no later than **5 days** after the date of the receipt of the request for a verification. For concurrent hospitalizations, a verification or declination must be issued within **24 hours** and for post-stabilization care or a life-threatening condition, a verification or declination must be issued within **1 hour**. Carriers must issue a verification in writing, but may also issue a verbal verification as long as a written verification is sent to the provider within 3 calendar days of the verbal reply. A verification is valid for at least **30 days**. Non-network providers, that have a referral for their services, and emergency room providers may also request a verification from the patient's carrier. Refer to the Verification Requirements Chart for more information on the content of a provider's verification request and the content of a carrier's declination or verification.	A verification is a guarantee of payment. A provider may request a verification by telephone, in writing or through other means of communication, including the Internet, as agreed to by the provider and the carrier. Carriers may within 1 day of receiving a request for verification, request additional information from the provider. Carriers may make only 1 request for additional information. A carrier must either issue a verification or a declination no later than **5 days** after the date of the receipt of the request for a verification. For concurrent hospitalizations, a verification or declination must be issued within **24 hours** and for post-stabilization care or a life-threatening condition, a verification or declination must be issued within **1 hour**. Carriers must issue a verification in writing, but may also issue a verbal verification as long as a written verification is sent to the provider within 3 calendar days of the verbal reply. A verification is valid for at least **30 days**. Non-network providers, that have a referral for their services, and emergency room providers may also request a verification from the patient's carrier. Refer to the Verification Requirements Chart for more information on the content of a provider's verification request and the content of a carrier's declination or verification.

Verification and Preauthorization Procedures

Topic	URA prior to SB 418	SB 418 and Emergency Rules	SB 418 and Final Rules
Preauthorization, defined **28 TAC §19.1703 (29)**	NA	A determination by an HMO or preferred provider carrier that medical care or health care services proposed to be provided to an enrollee are medically necessary and appropriate.	A determination by an HMO or preferred provider carrier that medical care or health care services proposed to be provided to an enrollee are medically necessary and appropriate.
Preauthorization	**28 TAC §19.1710(b) and Article 21.58A, Section 5 (b), TIC** If services are authorized a notification must be mailed or otherwise transmitted not later than **two working days** after the date of the request for utilization review and all medical information necessary to substantiate the need for the proposed treatment or service is received by the utilization review agent. **28 TAC §19.1710(d)** If services are not authorized (adverse determination) a notification must be provided: • within **3 working days** if the patient is not hospitalized • within **1 working day** if the patient is hospitalized • within **1 hour** when denying poststabilization care	**28 TAC §19.1723** A determination including an adverse determination must be issued and transmitted no later than the **3rd calendar day** after the date the request for a preauthorization is received. For concurrent hospitalizations, a preauthorization decision must be issued within **24 hours** and for post-stabilization care or a life-threatening condition, a preauthorization decision must be issued within **1 hour**. The notice of an adverse determination is the same as the notice required under **28 TAC §19.1710 (a), (c) & (d)**. For life threatening conditions and post-stabilization treatment, the adverse determination notice is the same as the notice required under **28 TAC §19.1721 (c)**. The appeal process for an adverse determination is the same the process under **28 TAC §19.1712**. These provisions have not changed as a result of SB 418.	**28 TAC §19.1723** A determination including an adverse determination must be issued and transmitted no later than the **3rd calendar day** after the date the request for a preauthorization is received. For concurrent hospitalizations, a preauthorization decision must be issued within **24 hours** and for post-stabilization care or a life-threatening condition, a preauthorization decision must be issued within **1 hour**. If the request is received after 6:00 PM Monday through Friday on a day that is not a legal holiday or after Noon on Saturday, Sunday or a legal holiday, a preauthorization must be issued and transmitted no later than the 3rd calendar day for routine requests, 24 hours for concurrent hospitalizations or 1 hour for post stabilization care or a life threatening condition from the beginning of the next day (6:00 AM Monday through Friday on a day that is not a legal holiday and 9:00 AM on Saturday, Sunday and legal holidays.)

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Preauthorization (continued from previous page)	**Refer to rules for specific requirements in the following areas:** **28 TAC §19.1710(c)** Content of adverse determination notification **28 TAC §19.1721 (c)** Review by an independent review organization **28 TAC §19.1712** Appeal of an adverse determination	Upon receipt of a request from a provider, carriers must furnish a list that allows a provider to determine which services require a preauthorization. This list must be provided within 10 business days of receiving a provider's request under **TAC §19.1723(b)**. Physician's or provider's right to request preauthorization is limited to those services for which the carrier requires preauthorization. SB 418 provisions regarding preauthorization do not apply to services from emergency room physicians or to services from non-contracted providers that have received a referral.	The notice of an adverse determination is the same as the notice required under **28 TAC §19.1710 (a), (c) & (d)**. For life threatening conditions and post-stabilization treatment, the adverse determination notice is the same as the notice required under **28 TAC §19.1721 (c)**. The appeal process for an adverse determination is the same the process under **28 TAC §19.1712**. These provisions have not changed as a result of SB 418. Upon receipt of a request from a provider, carriers must furnish a list that allows a provider to determine which services require a preauthorization. This list must be provided within 10 business days of receiving a provider's request under **TAC §19.1723(b)**. Physician's or provider's right to request preauthorization is limited to those services for which the carrier requires preauthorization. SB 418 provisions regarding preauthorization do not apply to services from emergency room physicians or to services from non-contracted providers that have received a referral.

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Preauthorization (continued from previous page)	**A preauthorization is not a guarantee of payment.**	**A preauthorization is not a guarantee of payment but once authorized, carriers cannot reduce or deny the claim on the basis that the services were not medically necessary or appropriate. The carrier may reduce or deny payment for other contractual reasons *so long as a verification was not obtained in conjunction with the preauthorization.***	**A preauthorization is not a guarantee of payment but once authorized, carriers cannot reduce or deny the claim on the basis that the services were not medically necessary or appropriate. The carrier may reduce or deny payment for other contractual reasons *so long as a verification was not obtained in conjunction with the preauthorization.***