SUBCHAPTER R. UTILIZATION REVIEW AGENTS
28 TAC §§19.1703, 19.1723, and 19.1724

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to §§19.1703, 19.1723, and 19.1724 concerning utilization review agents. These amendments are necessary to implement Senate Bill (SB) 51 (79th Regular Legislative Session), which in pertinent part establishes preauthorization and verification procedures for single service HMOs providing dental and routine vision services. The proposed amendments to §19.1703 add definitions for "routine vision services," consistent with the language of SB 51, and "single health care service plan." The proposed amendments to §§19.1723 and 19.1724 change the required periods for the availability of personnel to receive and respond to requests for preauthorization and verification for single service HMOs providing dental and routine vision services. In addition, changes were made to §§19.1723 and 19.1724(a) to update references and correct a typographical error.

The department will consider the adoption of the proposed amendments in a public hearing under Docket No. 2618 scheduled for September 7, 2005, at 10:00 a.m. in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street in Austin, Texas.

2. FISCAL NOTE. Kimberly Stokes, Senior Associate Commissioner for Life, Health and Licensing, has determined that for each year of the first five years the proposed

sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Stokes has determined that for each year of the first five years the amendments are in effect, the public benefits anticipated as a result of the proposed amendments will be more specific preauthorization and verification procedures for single service HMOs providing dental and routine vision services, as required by SB 51. Any cost to persons required to comply with these sections for each year of the first five years the proposed sections will be in effect is the result of the enactment of SB 51, and existing law, and not the result of the adoption, enforcement, or administration of the sections. SB 51 amends prompt pay laws that have been in effect since the enactment of Senate Bill (SB) 418 (78th Regular Legislative Session). Because these laws have applied to, among others, single service HMOs providing dental and routine vision services, such HMOs have been required to have systems and procedures in place to comply with the preauthorization and verification procedures. Because the preauthorization and verification procedures should have been in place for all HMOs, and because SB 51 merely changes the required periods for the availability of personnel to receive and respond to requests for preauthorization and verification for all single service HMOs providing dental and routine vision services, there is no additional cost to such HMOs for complying with these procedures. In addition, waiver of the rules could result in a competitive disadvantage

for those HMOs to whom the waiver would apply. As a result of this possibility, and because SB 51 applies to all single service HMOs providing dental or routine vision services, it would be neither legal nor feasible to waive or modify the requirements for single service HMOs that are small or micro businesses.

4. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 6, 2005, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Kimberly Stokes, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

5. STATUTORY AUTHORITY. The amendments are proposed under Insurance Code §§843.347(h) and (i), 843.348(i) and (j), and 36.001. Sections 843.347(h) and (i) and 843.348(i) and (j) provide that an HMO providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with the timeframes for receiving and responding to requests for preauthorization and verification set forth for other carriers, but must instead have appropriate personnel reasonably available between 8:00 a.m. and 5:00 p.m. central time Monday through Friday to receive and respond to such requests; have a telephone system capable of accepting and recording incoming requests during other times; and respond to those off-hour requests no later than the next business day after

the call is received. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

6. CROSS REFERENCE TO STATUTE. The following sections are affected by this proposal:

Rule	Statute
§§19.1703, 19.1723 and 19.1724	§§843.347 and 843.348

7. TEXT.

§19.1703. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (32) (No change.)

(33) Routine vision services--A routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(34) [~~(33)~~] Screening criteria--The written policies, decision rules, medical protocols, or guides used by the utilization review agent as part of the utilization review process (e.g., appropriateness evaluation protocol (AEP) and intensity of service, severity of illness, discharge, and appropriateness screens (ISD-A)).

(35) Single health care service plan--A single health care service plan as defined by Insurance Code Section 843.002(26).

(36) [~~(34)~~] Utilization review--A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within the state. Utilization review shall not include elective requests for clarification of coverage.

(37) [~~(35)~~] Utilization review agent--An entity that conducts utilization review, for an employer with employees in this state who are covered under a health benefit plan or health insurance policy, a payor, or an administrator.

(38) [~~(36)~~] Utilization review plan--The screening criteria and utilization review procedures of a utilization review agent.

(39) [~~(37)~~] Verification--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).

(40) [~~(38)~~] Working day--A weekday, excluding New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.

§19.1723. Preauthorization.

(a) - (c) (No change.)

(d) On receipt of a preauthorization request from a preferred provider for proposed services that require preauthorization, the HMO or preferred provider carrier shall issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. An HMO or preferred provider carrier shall respond to request for preauthorization within the following time periods.

(1) For services not included under paragraphs (2) and (3) of this subsection, the determination must be issued and transmitted not later than the third calendar day after the date the request is received by the HMO or preferred provider carrier. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections [~~subsection~~] (e) and (f) of this section, the determination must be issued and transmitted within three calendar days from the beginning of the next time period requiring such personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider carrier shall issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections [~~subsection~~] (e) and (f) of this section, the determination must be issued and transmitted within 24 hours from the beginning of the next time period requiring such personnel.

(3) If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this title (relating to Definitions), the HMO or preferred provider carrier shall issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections [~~subsection~~] (e) and (f) of this section, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring such personnel. In such circumstances, the determination shall be provided to the treating physician or health care provider. If the HMO or preferred provider carrier issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the HMO or preferred provider carrier shall provide to the enrollee or person acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1721(c) of this title (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may inquire via telephone as to the HMO or preferred provider carrier's preauthorization determination. An HMO or preferred provider carrier shall have appropriate personnel as described in §19.1706 of this title (relating to Personnel) reasonably available at a toll-free telephone number to provide the determination between 6:00 a.m. and 6:00 p.m. central time Monday through Friday on

each day that is not a legal holiday and between 9:00 a.m. and noon central time on Saturday, Sunday, and legal holidays. An HMO or preferred provider carrier must have a telephone system capable of accepting or recording incoming inquiries after 6:00 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and must acknowledge each of those calls not later than 24 hours after the call is received. An HMO or preferred provider carrier providing a preauthorization determination under [~~this~~] subsection (d) of this section shall, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(f) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (e) of this section with respect to those services. An HMO that is exempt from subsection (e), as described in this subsection, shall:

(1) have appropriate personnel as described in §19.1706 of this title (relating to Personnel) reasonably available at a toll-free telephone number to provide the preauthorization determination between 8:00 a.m. and 5:00 p.m. central time Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming inquiries after 5:00 p.m. central time Monday through Friday and all day on Saturday, Sunday, and legal holidays, and must acknowledge each of those calls not later than the next business day after the call is received; and

(3) when providing a preauthorization determination under subsection (d) of this section, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(g) [~~(f)~~] If an HMO or preferred provider carrier has preauthorized medical care or health care services, the HMO or preferred provider carrier may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the preauthorized medical or health care services.

(h) [~~(g)~~] If an HMO or preferred provider carrier issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1710(c) of this title (relating to Notice of Determinations Made by Utilization Review Agents) shall be provided to the enrollee, a person acting on behalf of the enrollee, or the enrollee's provider of record. An enrollee may appeal any adverse determination in accordance with §19.1712 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents).

(i) [~~(h)~~] This section applies to an agent or other person with whom an HMO or preferred provider carrier contracts to perform, or to whom the HMO or preferred provider carrier delegates the performance of preauthorization of proposed medical or health care services. Delegation of preauthorization services does not limit in any way the HMO or preferred provider carrier's responsibility to comply with all statutory and regulatory requirements.

(j) [~~(i)~~] The provisions of this section may not be waived, voided, or nullified by contract.

§19.1724. Verification.

(a) The provisions of this section apply to:

(1) HMOs;

(2) preferred provider carriers;

(3) preferred providers; and

(4) physicians or health care providers that provide to an enrollee of an HMO or preferred provider carrier:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the HMO, preferred provider carrier, or a preferred provider because the services are not reasonably available from a preferred provider who is included in the HMO or preferred provider carrier's network.

(b) - (c) (No change.)

(d) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (c) of this section with respect to those services. An HMO that is exempt from subsection (c) of this section, as described in this subsection, shall:

(1) have appropriate personnel reasonably available at a toll-free telephone number to accept telephone requests for verification and to provide determinations of previously requested verifications between 8:00 a.m. and 5:00 p.m. central time Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming inquiries after 5:00 p.m. central time Monday through Friday and all day on Saturday, Sunday, and legal holidays. The HMO must acknowledge each of those calls not later than the next business day after the call is received.

(e) [~~(d)~~] Any request for verification shall contain the following information:

(1) patient name;

(2) patient ID number, if included on an identification card issued by the HMO or preferred provider carrier;

(3) patient date of birth;

(4) name of enrollee or subscriber, if included on an identification card issued by the HMO or preferred provider carrier;

(5) patient relationship to enrollee or subscriber;

(6) presumptive diagnosis, if known, otherwise presenting symptoms;

(7) description of proposed procedure(s) or procedure code(s);

(8) place of service code where services will be provided and, if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided;

(9) proposed date of service;

(10) group number, if included on an identification card issued by the HMO or preferred provider carrier;

(11) if known to the provider, name and contact information of any other carrier, including the name, address and telephone number, name of enrollee, plan or ID number, group number (if applicable), and group name (if applicable);

(12) name of provider providing the proposed services; and

(13) provider's federal tax ID number.

(f) [~~(e)~~] Receipt of a written request or a written response to a request for verification under this section is subject to the provisions of §21.2816 of this title (relating to Date of Receipt).

(g) [~~(f)~~] If necessary to verify proposed medical care or health care services, an HMO or preferred provider carrier may, within one day of receipt of the request for verification, request information from the preferred provider in addition to the information provided in the request for verification. An HMO or preferred provider carrier may make only one request for additional information from the requesting preferred provider under this section.

(h) [~~(g)~~] A request for information under subsection (g) [~~(f)~~] of this section must:

(1) be specific to the verification request;

(2) describe with specificity the clinical and other information to be included in the response;

(3) be relevant and necessary for the resolution of the request; and

(4) be for information contained in or in the process of being incorporated into the enrollee's medical or billing record maintained by the preferred provider.

(i) [~~(h)~~] On receipt of a request for verification from a preferred provider, the HMO or preferred provider carrier shall issue a verification or declination. An HMO or preferred provider carrier shall issue the verification or declination within the following time periods.

(1) Except as provided in paragraphs (2) and (3) of this subsection, an HMO or preferred provider carrier shall provide a verification or declination in response to a request for verification without delay, and as appropriate to the circumstances of the particular request, but not later than five days after the date of receipt of the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections [~~subsection~~] (c) and (d) of this section, the determination must be provided within five days from the beginning of the next time period requiring such personnel.

(2) If the request is related to a concurrent hospitalization, the response must be sent to the preferred provider without delay but not later than 24 hours after the HMO or preferred provider carrier received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections [~~subsection~~] (c) and (d) of this section, the determination must be provided within 24 hours from the beginning of the next time period requiring such personnel.

(3) If the request is related to post-stabilization care or a life-threatening condition, the response must be sent to the preferred provider without delay but not later than one hour after the HMO or preferred provider carrier received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections [~~subsection~~] (c) and (d) of this section, the determination must be provided within one hour from the beginning of the next time period requiring such personnel.

(j) [~~(i)~~] If the request involves services for which preauthorization is required, the HMO or preferred provider carrier shall follow the procedures set forth in §19.1723 of this title (relating to Preauthorization) and respond regarding the preauthorization request in compliance with that section.

(k) [~~(j)~~] A verification or declination may be delivered via telephone call, in writing or by other means, including the Internet, as agreed to by the preferred provider and the HMO or preferred provider carrier. If the verification or declination is delivered via telephone call, the HMO or preferred provider carrier shall, within three calendar days of providing a verbal response, provide a written response which must include, at a minimum:

(1) enrollee name;

(2) enrollee ID number;

(3) requesting provider's name;

(4) hospital or other facility name, if applicable;

(5) a specific description, including relevant procedure codes, of the services that are verified or declined;

(6) if the services are verified, the effective period for the verification, which shall not be less than 30 days from the date of verification;

(7) if the services are verified, any applicable deductibles, copayments, or coinsurance for which the enrollee is responsible;

(8) if the verification is declined, the specific reason for the declination;

(9) a unique verification number that allows the HMO or preferred provider carrier to match the verification and subsequent claims related to the proposed service; and

(10) a statement that the proposed services are being verified or declined pursuant to Title 28 Texas Administrative Code §19.1724.

(l) [~~(k)~~] An HMO or preferred provider carrier that issues a verification may not deny or otherwise reduce payment to the preferred provider for those medical care or health care services if provided on or before the expiration date for the verification, which shall not be less than 30 days, unless the preferred provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the medical or health care services as verified.

(m) [~~(l)~~] The provisions of this section may not be waived, voided, or nullified by contract.

8. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2005.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance