SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY 28 TAC §§19.1701 – 19.1719

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE 28 TAC §§19.2001 – 19.2017

1. INTRODUCTION. The Texas Department of Insurance adopts §§19.1701 – 19.1719, concerning utilization reviews for health care provided under a health benefit plan or health insurance policy (referred to as Subchapter R, collectively), and §§19.2001 – 19.2017, concerning utilization reviews for health care provided under workers' compensation insurance coverage (referred to as Subchapter U, collectively). Sections 19.1701 – 19.1709, 19.1711, 19.1713, 19.1714, 19.1717, 19.1718, 19.2002 - 19.2006, 19.2008 – 19.2014, and 19.2017 are adopted with changes to the proposed text published in the August 24, 2012, issue of the *Texas Register* (37 TexReg 6466). Sections 19.1710, 19.1712, 19.1715, 19.1716, 19.1719, 19.2001, 19.2007, 19.2015, and 19.2016 are adopted without changes to the proposed text.

In conjunction with this adoption order, TDI is adopting the repeal of existing Subchapter R, §19.1701, concerning general provisions; §19.1702, concerning limitations on applicability; §19.1703, concerning definitions; §19.1704, concerning certification of utilization review agents; §19.1705, concerning general standards of utilization review; §19.1706, concerning personnel; §19.1707, concerning prohibitions of certain activities of utilization review agents; §19.1708, concerning utilization review

agent contact with and receipt of information from health care providers; §19.1709, concerning on-site review by the utilization review agent; §19.1710, concerning notice of determinations made by utilization review agents; §19.1711, concerning requirements prior to adverse determination; §19.1712, concerning appeal of adverse determination of utilization review agents; §19.1713, concerning utilization review agent's telephone access; §19.1714, concerning confidentiality; §19.1715, concerning retrospective review of medical necessity; §19.1716, concerning complaints and information; §19.1717, concerning administrative violations; §19.1718, concerning criminal penalties; §19.1719, concerning responsibility of HMOs and insurers performing utilization review under Insurance Code Article 21.58A, §14(g) and (h); §19.1720, concerning specialty utilization review agent; §19.1721, concerning independent review of adverse determinations; §19.1722, concerning Utilization Review Advisory Committee; §19.1723, concerning preauthorization; and §19.1724, concerning verification.

In addition, TDI is adopting the repeal of existing Subchapter U, §19.2001, concerning general provisions; §19.2002, concerning limitations on applicability; §19.2003, concerning definitions; §19.2004, concerning certification of utilization review agents; §19.2005, concerning general standards of utilization review; §19.2006, concerning personnel; §19.2007, concerning prohibitions of certain activities of utilization review agents; §19.2008, concerning utilization review agent contact with and receipt of information from health care providers; §19.2009, concerning on-site review by the utilization review agent; §19.2010, concerning notice of determinations made by utilization review agents, excluding retrospective review; §19.2011, concerning

requirements prior to adverse determination; §19.2012, concerning appeal of adverse determination of utilization review agents; §19.2013, concerning utilization review agent's telephone access; §19.2014, concerning confidentiality; §19.2015, concerning retrospective review of medical necessity; §19.2016, concerning complaints and reporting requirements; §19.2017, concerning administrative violations; §19.2018, concerning criminal penalties; §19.2019, concerning responsibility of insurance companies performing utilization review under Insurance Code Article 21.58A, §14(h); §19.2020, concerning specialty utilization review agent; and §19.2021, concerning independent review organizations non-involvement. The adoption of the repeal of Subchapters R and U is also published in this issue of the *Texas Register*.

In addition to the changes made as a result of comments, TDI revised references from "form No. LHL005 URA application" to "URA Application" in §§19.1703(b), 19.1704(b)(1), (b)(2), (d), and (h), 19.2003(b), 19.2004(b)(1), (b)(2), (d), and (h) to conform to current agency style. TDI revised references from "form No. 11 biographical affidavit" to "biographical affidavit" in §§19.1703(b), 19.1704(b), and 19.2003(b). As a conforming change, TDI redesignated the definitions under §19.1703(b) and §19.2003(b). TDI changed the word "or" to "and" before the phrases "the facilities rendering care," and "the plan of treatment prescribed by the provider of record" in §19.1707(b)(1) for consistency with Subchapter U. TDI revised references from "form No. LHL009 request for a review by an IRO" to "request for a review by an IRO" in §§19.1703(b); 19.1709(b)(7), (b)(8)(A), and (8)(B); 19.1711(a)(8)(G); 19.1717(a)(1) and (c); 19.2003(b); 19.2009(b)(9)(A)(i), (B)(i), and (B)(ii); 19.2011(a)(7)(D);

19.2017(a)(1)(C); and 19.2017(b). TDI added the word "or" and deleted a comma before the phrase "an individual acting on behalf of the enrollee," and changed the word "or" to "and" before the phrase "the enrollee's provider of record" in §19.1718(h), to clarify that the notice must be provided to the enrollee or an individual acting on behalf of the enrollee, and the enrollee's provider of record.

Additionally, TDI has adopted numerous non-substantive changes throughout the text of Subchapters R and U. These non-substantive changes include conforming to current agency style, reformatting, amending for consistency and clarity, and correcting typographical and grammatical errors.

The following paragraphs include a detailed, section-by-section description and reasoned justification of all of the amendments necessary to implement House Bill 4290 and to make the other changes that TDI and the Division of Workers' Compensation determined are necessary for effective compliance with and effective implementation and enforcement of Insurance Code Chapter 4201.

2. REASONED JUSTIFICATION.

These new sections are necessary to implement HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, which revises the definitions of "adverse determination" and "utilization review" in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service. The new sections also make other changes necessary for clarity,

effective implementation, and enforcement of Insurance Code Chapter 4201. The entire adoption order is part of the reasoned justification for the new sections.

The commissioner of insurance and the commissioner of workers' compensation, in their joint statement to the members of the Utilization Review Advisory Committee dated February 10, 2010, stressed that although Subchapters R and U address a function that is provided in both the health and workers' compensation systems, the rules derive from a common statute, Insurance Code Chapter 4201. Insurance Code §4201.054(a) states, "Except as provided by this section, {Chapter 4201} applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Under Insurance Code §4201.054(c), Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. Under Insurance Code §1305.351, Insurance Code Chapter 1305 prevails in the event of a conflict between Insurance Code Chapters 4201 and 1305. Insurance Code Chapter 4201, to the extent it is not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review.

The expertise of both TDI and TDI-DWC staff was utilized throughout the rulemaking process, and workers' compensation stakeholder feedback was considered and incorporated throughout the open meetings of the Utilization Review Advisory Committee and the informal draft and proposal process. TDI and TDI-DWC have

determined that Subchapter R and Subchapter U rules should be consistent whenever possible for the benefit of both regulated entities and consumers. Because there are statutes that specifically govern utilization review for workers' compensation coverage, there are differences between Subchapter R and Subchapter U rules as needed to implement and maintain consistency with the relevant statutes. However, because there are URAs that might be subject to both subchapters, TDI and TDI-DWC recognize the importance of consistency for ease of interpretation and compliance. Uniform standards offer a more consistent and efficient utilization review process for enrollees and injured employees, who are equally entitled to the highest quality of utilization review.

House Bill 4290

House Bill 4290 amends the definition of "utilization review" to specifically include retrospective review of the medical necessity and appropriateness of health care services. House Bill 4290 further amends the term to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services.

The Senate Committee on State Affairs' Bill Analysis for HB 4290 specifies the legislative intent of HB 4290:

> "...{C}urrent law does not require an independent review of a carrier's conclusion that treatment should be denied because it is experimental or investigational. In addition, current law does not provide

for an independent review of a carrier's conclusion after the fact that a treatment was not medically necessary.

"Health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review both prospectively and retroactively through a process coordinated by TDI. ... Texas is the only state with limitations on retrospective reviews of denials based on medical necessity and the only state with an independent review law that does not extend to retrospective reviews of at least emergency and urgent care.

"TDI has received numerous complaints regarding these issues, but there is little TDI can do to address them. Carriers have varying standards for what is considered experimental and investigational and, in regard to retrospective reviews, TDI's data regarding workers' compensation claim denials show that carriers incorrectly issue retrospective denials more often than prospective denials, with retrospective medical necessity decisions, including experimental and investigational denials, overturned 68% of the time after an independent review is conducted, while prospective medical necessity decisions are overturned approximately 30% of the time.

"C.S.H.B. 4290 amends current law relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service."

TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Substituted), C.S.H.B. 4290, 81st Leg., R.S. (May 12, 2009).

TDI conducted a public hearing on the published rule proposal on September 26, 2012, under Docket Number 2740. In response to written comments on the proposal and comments made at the hearing, TDI made several changes; however, none of the changes made in this adoption to the proposed text or proposed form materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Subchapters R and U new sections.

Section 19.1701 and §19.2001 address **General Provisions**. Section 19.1701(a) and §19.2001(a) change the existing provisions relating to the statutory basis for the rules in Subchapter R and Subchapter U, respectively, to reflect that the new subchapters incorporate the most recent amendments to Insurance Code Chapter 4201. Additionally, §19.2001(a) incorporates the most recent amendments to Insurance Code Chapter 1305 and to Labor Code Title 5. Section 19.1701(b) and §19.2001(b) amend the existing severability clause language to conform to current agency style. Section 19.1701(c) and §19.2001(c) track Insurance Code §4201.001, with the addition of the word "medical" as a clarifying change in §19.1701(c)(4) and §19.2001(c)(4).

Section 19.1702 and §19.2002 address **Applicability**. Section 19.1702(a) provides that Texas Administrative Code Title 28, Chapter 19, Subchapter R, applies to utilization review performed under a health benefit plan or a health insurance policy and does not apply to utilization review performed under workers' compensation insurance

coverage. Section 19.2002(a) specifies that Subchapter U applies to utilization review performed under workers' compensation insurance coverage, as set forth in Insurance Code Chapters 1305 and 4201, and Labor Code Title 5, and does not affect the authority of TDI-DWC to exercise the powers granted to it under Labor Code Title 5 and Insurance Code Chapter 4201. These subsections are necessary to state the applicability of Subchapters R and U.

Section 19.1702(a)(1) and §19.2002(a)(1), relating to the nonapplicability of Subchapters R and U, respectively, track Insurance Code §4201.051. Section 19.1702(a)(2) and §19.2002(a)(2) clarify that a person performing administrative tasks for a URA, who does not determine medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, is not subject to the requirements under Subchapter R or U, respectively. Insurance Code §4201.101 provides that a URA may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under Insurance Code Chapter 4201, Subchapter C. Utilization review is defined in Insurance Code §4201.002(13), which provides that utilization review includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services; and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Section 19.1702(b) explains that provisions of Insurance Code Chapter 843, concerning Health Maintenance Organizations; Insurance Code Chapter 1301,

concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; and Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to new Subchapter R. Insurance Code §4201.053 provides that Chapter 4201 does not apply to the state Medicaid program. However, Subchapter R does apply to the Texas Children's Health Insurance Program.

Section 19.2002(b)(1) provides that health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. The subsection requires health care providers to comply with Subchapter U; Labor Code Title 5; and rules adopted under the Texas Workers' Compensation Act, including monitoring and enforcement provisions. This new provision clarifies that some peer reviews are utilization review.

Section 19.2002(b)(2) provides that insurance carriers must process medical bills as required by Labor Code Title 5 and rules adopted under the Texas Workers' Compensation Act including Chapter 133, Subchapter A of this title (relating to General Rules for Medical Billing and Processing). This provision clarifies that these adopted rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify insurance carriers' duties under those rules.

To implement Insurance Code §4201.054(c), §19.2002(b)(3) provides that if there is a conflict between Subchapter U and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers'

compensation prevail. These required new rules are consistent with Insurance Code §4201.054(a), which states that except as provided by Insurance Code §4201.054, Insurance Code Chapter 4201 applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5. Additionally, Insurance Code §4201.054(c) provides that Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5.

Section 19.2002(b)(4) provides that if there is a conflict between the URA rules and the certified health care network rules adopted by TDI, the rules adopted for networks in 28 TAC Chapter 10 prevail. The rules for workers' compensation health care networks in 28 TAC Chapter 10 implement Insurance Code Chapter 1305. Insurance Code §1305.351(a) provides that in the event of a conflict between Insurance Code Chapter 4201 and Insurance Code Chapter 1305, Chapter 1305 prevails.

Section 19.1703 and §19.2003 address **Definitions**. Section 19.1703(a) and §19.2003(a) provide that the terms defined in Insurance Code Chapter 4201 have the same meaning when used in adopted new Subchapter R and Subchapter U rules, respectively.

The definition of "adverse determination" in §19.1703(b)(1) and §19.2003(b)(1) adds the phrase "made on behalf of any payor" to the definition of "adverse determination" in Insurance Code §4201.002(1) to clarify TDI's position that the definition includes determinations made on behalf of all payors, including payors that conduct utilization review in-house.

Further, the definitions of "adverse determination" in Subchapters R and U specifically implement HB 4290. Insurance Code §4201.002(1) defined "adverse determination," prior to the enactment of HB 4290, to mean a URA's determination that health care services provided or proposed to be provided to a patient are not medically necessary or appropriate, but the provision was not interpreted to include retrospective review of medical necessity. This interpretation was based on the definition of "utilization review" in Insurance Code §4201.002(13) as 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 in this state. After the enactment of HB 4290, the definitions of "adverse determination" and "utilization review" were revised in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service.

Additionally, §19.1703(b)(1) and §19.2003(b)(1) add the provision that the term "adverse determination" does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. This change is necessary to clarify that a denial of health care services for which the enrollee or injured employee, respectively, should have sought prospective or concurrent utilization review is not within the scope of the term.

The definition in §19.2003(b)(1) also clarifies that, for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. Although this clarification is inconsistent with the statutory definition of "adverse determination" under Insurance Code §4201.002(1), it is

consistent with Labor Code §408.021 and §413.014. Insurance Code §4201.054 provides that, in the event of a conflict, Labor Code Title 5 prevails. It is TDI's and TDI-DWC's position that based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services.

Labor Code §408.021 entitles an injured employee, under both network coverage and non-network coverage, to health care reasonably required by the nature of the injury as and when needed. Although injured employees under non-network coverage are entitled to experimental and investigational services, those services must be preauthorized under Labor Code §413.014, relating to preauthorization requirements, concurrent review, and certification of health care.

Despite this difference in the definition of the term "adverse determination" under Insurance Code Chapter 4201 and Labor Code Chapter 408, it is necessary that Subchapter U contain provisions relating to the experimental or investigational nature of care in the context of utilization review. Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of "utilization review."

The definition of "appeal" in §19.1703(b)(2) and §19.2003(b)(2) updates the existing definition and clarifies that the term refers to the URA's formal process in which an enrollee, or an injured employee, respectively, their representative, or provider of

record may request reconsideration of an adverse determination. Section 19.2003(b)(2) also provides that the term includes reconsideration processes prescribed by Labor Code Title 5 and applicable rules for workers' compensation.

Section 19.1703(b)(3) and §19.2003(b)(3) define the term "biographical affidavit" as the form that must be submitted to TDI as an attachment to the URA application form. The application form requires the name, biographical affidavit, and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under 28 TAC §1.503 (relating to Application of Fingerprint Requirement) and 28 TAC §1.504 (relating to Fingerprint Requirement). The biographical form is necessary because, under 28 TAC §1.502(c) and (e), TDI developed guidelines relating to the matters that TDI will consider in determining whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction. These matters include criminal background checks for each director, officer, and executive of the applicant.

The definition of the term "certificate" in §19.1703(b)(4) and §19.2003(b)(4) is more detailed and accurate than the existing definition to reflect that an insurance carrier or Health Maintenance Organization may be certified or registered, but that a "certificate" is not issued to an insurance carrier or HMO that is registered as a URA under §19.1704 or §19.2004, respectively.

The §19.1703(b)(5) and §19.2003(b)(5) definition of "commissioner" is as defined in Insurance Code §31.001, which provides that "In this code and other insurance laws: (1) "Commissioner" means the commissioner of insurance."

In §19.2003(b)(6), the term "compensable injury" is as defined in Labor Code §401.011, which provides that "Compensable injury means an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle."

Section 19.1703(b)(6) and §19.2003(b)(7) define "complaint" as an oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include: (A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351, or (B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party. This definition is necessary to track statutory language in Insurance Code §4201.351 and clarify that a misunderstanding promptly resolved to the complaining party's satisfaction does not constitute disagreement with an adverse determination or an appeal.

Section 19.1703(b)(7) and §19.2003(b)(8) define "concurrent utilization review" as a form of utilization review that is subject to these rules.

Section 19.1703(b)(8) defines "declination" and tracks existing §19.1703(9) with changes to replace the word "carrier" with "benefit plan" for clarity. The definition is necessary to clarify the term as used in §19.1719.

Section 19.1703(b)(9) and §19.2003(b)(9) define the term "disqualifying association" to ensure a consistent application in identifying situations in which conflicts of interest may exist for health care providers performing utilization review. The

definition of "disqualifying association" includes any association that may reasonably be perceived as having the potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider. For example, the reasonableness standard can be used to evaluate whether a personal or family relationship may be considered a disqualifying association and is more flexible than a detailed list of specific family relationships that are always considered to be disqualifying associations. The prohibition against disqualifying associations is necessary to prevent a reviewing physician, doctor, or other health care provider from directly or indirectly exercising bias, prejudice, or preferential treatment of determinations made by health care providers performing utilization review.

Section 19.1703(b)(10) and §19.2003(b)(10) define the term "doctor." This definition mirrors the definition in existing 28 TAC §19.2003(12) and tracks the statutory language in Labor Code §401.011(17).

Section 19.1703(b)(11) and §19.2003(b)(11) define the term "experimental or investigational." This definition is consistent with Labor Code §413.014(a), 28 TAC §134.600, and 28 TAC §12.5(12). This definition is necessary to ensure a uniform application of the term. To the extent a health plan defines the term "experimental or investigational" differently than the rules, the definition set forth in the rules will control. TDI and TDI-DWC determined that a common definition ensures that enrollees or injured employees, regardless of the plan under which they receive coverage, are treated similarly with respect to determinations on the experimental or investigational nature of care. TDI defined this new term based on its general rulemaking authority

under Insurance Code §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.2003(b)(12) defines the term "health care" and changes the existing definition in §19.2003(13) to include "a medical or surgical supply, appliance, brace, artificial member, or prosthetic or orthotic device, including the fitting of, change or repair to, or training in the use of the appliance, brace, member, or device," for consistency with the definition in Labor Code §401.011.

Section 19.1703(b)(12) and §19.2003(b)(13) define the term "health care facility." This definition is consistent with Labor Code §401.011(20).

Section 19.1703(b)(13) defines the term "health coverage" to provide a uniform understanding and application of what constitutes "health coverage" under the Subchapter R rules.

Section 19.1703(b)(14) defines the term "health maintenance organization or HMO" and references the statutory definition in Insurance Code §843.002.

Section 19.1703(b)(15) and §19.2003(b)(14) define the term "insurance carrier or insurer." The definitions are not identical, because the §19.2003(14) definition references workers' compensation insurance, which is not applicable under §19.1703(15).

Section 19.1703(b)(16) and §19.2003(b)(15) define the term "independent review organization or IRO" and reference the definition in 28 TAC §12.5.

Section 19.1703(b)(17) and §19.2003(b)(16) define the term "legal holiday" in accord with the definition of a "national holiday" in Government Code §662.003(a).

Section 19.2003(b)(17) defines the term "medical benefit" and references the statutory definition in Labor Code §401.011.

Section 19.2003(b)(18) defines the term "medical emergency" and tracks the definition in Insurance Code §1305.004(13), with a clarifying change from the use of the term "patient" to the term "injured employee." The definition in §19.2003(b)(18) also mirrors the definition of the term "emergency" in 28 TAC Chapter 133 (relating to General Medical Provisions), §133.2(a)(4)(A), adopted to be effective May 2, 2006.

The §19.1703(b)(18) and §19.2003(b)(19) definition of "medical records" is based on the definition of "medical records" in Insurance Code §1305.004(14), which defines the term for purposes of the Workers' Compensation Health Care Network Act. The definition of the term "medical records" from Insurance Code §1305.004(14) was also changed in new §19.1703(b)(18) and §19.2003(b)(19) to include the phrase "mental health records as allowed by law." The addition of the phrase "mental health records as allowed by law" was recommended by the Utilization Review Advisory Committee and is necessary to ensure the availability of mental health records as allowed. This new rule is adopted under the commissioner's authority to adopt rules to implement Chapter 4201 under Insurance Code §4201.003(a).

Section 19.1703(b)(19) and §19.2003(b)(20) define the term "mental health medical record summary." The Utilization Review Advisory Committee recommended adding this definition to the Subchapter U rules for uniform application and consistency with the Subchapter R rules.

Section 19.1703(b)(20) and §19.2003(b)(21) define the term "mental health therapist." This definition incorporates the Utilization Review Advisory Committee recommendation to add the qualifier "as appropriate" to indicate that not all of the individuals licensed under subparagraphs (A) – (H) are authorized to diagnose, evaluate, and treat any mental or emotional condition or disorder.

Section 19.1703(b)(21) and §19.2003(b)(22) define the term "mental or emotional condition or disorder." The definition of the term "mental or emotional condition or disorder" in existing §19.1703(22) was amended for new Subchapter R and Subchapter U to delete the phrase "revision of the" to clarify that the most current Diagnostic and Statistical Manual of Mental Disorders must be used, rather than just the new "revision" because both new "editions" and new "revisions" of the manual are published.

Section 19.2003(b)(23) defines the term "payor." For purposes of Subchapter R, the statutory definition under Insurance Code §4201.002(10) is used. For purposes of Subchapter U, in new §19.2003(b)(23), TDI and TDI-DWC tailored the definition of "payor" to include a person or entity that provides, offers to provide, or administers workers' compensation benefits, in recognition that the definition of "payor" under Subchapters R and U should not be identical. The clarifying change under Insurance Code §4201.002(10) is not in conflict with Insurance Code Chapter 1305 or Labor Code Title 5. The references to "payor" are also necessary because the rules specifically distinguish between insurance carriers based on whether or not they are the payor. The term "payor" is also necessary for consistency with the IRO rules under 28 TAC §12.1, which contemplate an IRO's interaction with URAs and payors.

Section 19.2003(b)(24) defines the term "peer review." This definition was recommended by the Utilization Review Advisory Committee. TDI and TDI-DWC clarify that the requirements contained in Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care. For example, the requirements in Subchapter U do not apply to compensability or an injured employee's ability to return to work. Section 19.2002(b)(1) specifies, in part, that:

> Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must generate a written report. Peer reviewers must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title, relating to Monitoring and Enforcement.

This provision describes requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care and does not apply to peer reviews performed for other issues, for example, extent of injury issues.

Section 19.1703(b)(22) and §19.2003(b)(25) define the term "person" for uniform application of Subchapter R and Subchapter U rules.

Section 19.1703(b)(23) and §19.2003(b)(26) define the term "preauthorization." The definition in existing §19.1703(29) is changed in adopted §19.1703(b)(23) and §19.2003(b)(26) to add the descriptor "form of prospective utilization review by a payor

or its URA of ... " to incorporate by reference reviews of medical necessity and appropriateness, which are included in the definition of "utilization review" in Insurance Code §4201.002(14). A separate reference to reviews of medical necessity and appropriateness in the definition of "preauthorization" is unnecessary.

Section 19.1703(b)(24) defines the term "preferred provider" and changes the existing definition in §19.1703(30) to use the term "benefit plan" instead of "carrier" for clarity and uniform implementation.

Section 19.1703(b)(25) and §19.2003(b)(27) define the term "provider of record" to closely track Insurance Code §4201.002(12). Changes are made to clarify that a doctor is included among the persons that do not necessarily have to render care, treatment, or services to be considered the provider of record. Section 19.1703(b)(25) and §19.2003(b)(27) also replace the terminology "care, treatment, and services" from Insurance Code §4201.002(12) with "health care services" for consistency with other uses of this phrase throughout the text. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201. There is no direct conflict with the use of "provider of record" and Labor Code Title 5, and TDI has the rulemaking authority to define and utilize the term "provider of record" throughout the Subchapter U rules.

Section 19.1703(b)(26) and §19.2003(b)(28) define the term "reasonable opportunity" as "at least one documented good faith attempt to contact the provider of

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record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination: (A) no less than one working day prior to issuing a prospective utilization review adverse determination; (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or (C) prior to issuing a concurrent or post-stabilization review adverse determination."

The definition of the term "reasonable opportunity" in new §19.1703(b)(26) and §19.2003(b)(28) recognizes the incompatibility of timeframes for concurrent utilization review and post-stabilization review. Under Insurance Code §843.348 and §1301.135, an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical or health care services for concurrent hospitalization care within 24 hours of receipt of the request. Additionally, an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical care or health care services involving post-stabilization treatment within one hour from receipt of the request.

It is often hard to get a provider of record on the phone with a URA when a call is made at the last minute before the adverse determination is issued. The definition of "reasonable opportunity" in §19.1703(b)(26) and §19.2003(b)(28) maximizes the opportunity for the provider of record to address the concerns and discuss the services under review with the URA prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination.

The required timeframes for notification of the adverse determination for workers' compensation non-network coverage must be provided within the timeframes specified by 28 TAC §134.600. Section 134.600(i) requires a decision for preauthorization requests within three working days and a decision for certain requests for concurrent review within one working day of receipt of the request.

Notification of the adverse determination for workers' compensation network coverage must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102. Under Insurance Code §1305.353(d), the URA must generally issue a determination on a preauthorization request not later than the third working day after the receipt of the request. However, under Insurance Code §1305.353(e), if the proposed services are for concurrent hospitalization care, the URA must transmit a determination within 24 hours of receipt of the request. Under Insurance Code §1305.353(f), if the proposed health care services involve post-stabilization treatment or a life-threatening condition, the URA must transmit a determination within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. Title 28 TAC §10.102 reiterates these statutory requirements.

Based on these timeframes, the URA must issue a determination for requests for prospective review no later than the third working day. This three-working-day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination. However, for concurrent review, TDI recognizes that requiring one working day for the peer-to-peer discussion

may prevent the URA from providing the determination within the required 24-hour timeframe. Additionally, for post-stabilization treatment requests, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required one-hour timeframe.

Under Insurance Code §4201.305, the URA must provide notice of a retrospective review adverse determination within a reasonable time, but not later than 30 days after the date on which the claim is received. Under Insurance Code §4201.305(b), this period may be extended once for a period not to exceed 15 days, if the URA takes certain additional steps. Because of the longer time granted to URAs to issue determinations when conducting retrospective utilization review, TDI and TDI-DWC determined that five working days is a reasonable time to afford the provider of record to discuss the determination. These new sections are implementing the required peer-to-peer discussion statutory requirements under Insurance Code §4201.206. These new sections are adopted under TDI's general rulemaking authority under both Insurance Code §36.001 and §4201.003 to implement Insurance Code Chapter 4201.

Section 19.1703(b)(27) and §19.2003(b)(29) define the term "registration." Insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but instead must register. The new definition clarifies that the registration process only applies to an insurer that performs utilization review solely for its own insureds or injured employees.

Section 19.1703(b)(28) and §19.2003(b)(30) define the term "request for a review by an IRO" as a request for a review by an independent review organization form. This

form is completed by the requesting party and submitted to the URA or insurance carrier that made the adverse determination. This definition is consistent with Insurance Code §4201.303(a)(4), which requires a URA to include a notice to the enrollee of their right to appeal an adverse determination to an IRO and of the procedures to obtain that review. The definition is also consistent with Insurance Code 4201.359(a)(3), which requires notice of the appealing party's right to notice of the procedures for obtaining review of a denial by an IRO.

Section 19.1703(b)(29) and §19.2003(b)(31) define the term "retrospective utilization review." These sections change the definition in existing §19.1703(32) and §19.2003(28) and incorporate the term "utilization review" into the definition. Because reviews of "medical necessity and appropriateness" are included in the scope of "utilization review," separate internal reference to reviews of "medical necessity and appropriateness" are deleted. The addition of the sentence "Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted" clarifies that health care services that require preauthorization are not subject to retrospective review.

Section 19.1703(b)(30) defines the term "routine vision services" and tracks existing §19.1703(33).

Section 19.1703(b)(31) and §19.2003(b)(32) define the term "screening criteria." The new definition tracks existing §19.1703(34) and deletes the reference to "(e.g., appropriateness evaluation protocol (AEP) and intensity of service; severity of illness;

discharge; and appropriateness screens (ISD-A))" because screening criteria must meet the requirements of Insurance Code §4201.153, and the examples provided in the definition are redundant.

Section 19.1703(b)(32) and §19.2003(b)(33) define the term "TDI" as the Texas Department of Insurance.

Section 19.2003(b)(34) defines the term "TDI-DWC" as the Texas Department of Insurance, Division of Workers' Compensation.

Section 19.2003(b)(35) defines the term "Texas Workers' Compensation Act" as Labor Code Title 5, Subtitle A.

Section 19.2003(b)(36) defines the term "treating doctor" to track the definition in Labor Code §401.011.

Section 19.1703(b)(33) and §19.2003(b)(37) define the term "URA."

Section 19.1703(b)(34) and §19.2003(b)(38) define the term "URA application" to clarify that the form is to be used to apply for certification or registration as a URA in Texas, for renewal of a certification or registration, and also to report a material change to a certification or registration form previously submitted to TDI. Insurance Code §4201.104 authorizes the commissioner to promulgate forms to be filed under Insurance Code Chapter 4201, Subchapter C, for initial certification. Additionally, this definition clarifies the use of the form and implements Insurance Code §4201.107, which provides that a URA must report any material change to the information disclosed in a form filed under Subchapter C of Chapter 4201 not later than the 30th day after the date the change takes effect.

Section 19.1703(35) defines the term "verification" and replaces the term "carrier" in existing §19.1703(39) with the term "benefit plan" for clarity and consistency.

Section 19.2003(b)(39) defines the term "workers' compensation health care network." This definition is consistent with Insurance Code §1305.004(16).

Section 19.2003(b)(40) defines the term "workers' compensation health plan" to reference the applicability of a political subdivision contracting directly with health care providers or through a health benefits pool under Labor Code §504.053 to Subchapter U.

Section 19.2003(b)(41) defines the term "workers' compensation insurance coverage" to track the definition in Labor Code §401.011.

Section 19.2003(b)(42) defines the term "workers' compensation network coverage" and §19.2003(43) defines the term "workers' compensation non-network coverage."

Section 19.1704 and §19.2004 address **Certification or Registration of URAs**. The change to the title of existing §19.2004 reflects the application of the section to persons holding a "registration" as a URA. Section 19.1704(a) and §19.2004(a), added to implement Insurance Code §4201.101, provide that a person acting as or holding itself out as a URA must be certified or registered under Insurance Code Chapter 4201; 28 TAC Chapter 19, Subchapter R; or 28 TAC Chapter 19, Subchapter U, respectively. Section 4201.101 provides that a URA may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under Chapter 4201, Subchapter C.

Section 19.1704(a)(1) and (2) and §19.2004(a)(1) and (2) are necessary to address certification and registration requirements for HMOs and insurers. Section 19.1704(a)(1) and §19.2004(a)(1) provide that if an HMO or insurer performs utilization review for an individual or entity subject to the subchapter for which it is not the payor, the HMO or insurer must have a valid certificate as required by Insurance Code §4201.101. This provision is consistent with Insurance Code §4201.057(e) and §4201.058(c).

Section 19.1704(a)(2) and §19.2004(a)(2) provide that if an HMO or insurer performs utilization review only for coverage for which it is the payor, the HMO or insurer must have a valid registration.

Section 19.1704(b) and §19.2004(b) specify the URA application requirements for both certification and registration. Section 19.1704(b) and §19.2004(b) adopt by reference the URA application, which is to be used for initial certification or registration, renewal of a certification or registration as a URA in this state, or to report a material change. Subsection (b)(1) provides that the URA application form must be used to apply for URA certification or registration. Subsection (b)(2) provides that the application form requires the biographical affidavit be submitted as an attachment to the application. The forms are adopted under the commissioner's authority to both promulgate forms under Insurance Code §4201.104 and to adopt rules to implement Chapter 4201 under §4201.003. Subsections (b) and (c) distinguish between the form and fee filing requirements for these two types of application.

Section 19.1704(c) and §19.2004(c) provide that an application for certification must be accompanied by the original application fee in the amount specified by §19.802, and that this fee requirement does not apply to an applicant for registration.

Section 19.1704(d) and §19.2004(d) provide information on where to obtain and send the application form.

Section 19.1704(e) and §19.2004(e) address the original application requirements and process, and are adopted under TDI's general rulemaking authority in Insurance Code §4201.003(a). Section 19.1704(e) and §19.2004(e) also clarify that TDI will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

Section 19.1704(f) and §19.2004(f) change the requirements in existing §19.1704(e)(2) and §19.2004(e)(2) by lessening the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days from the date of TDI's latest notice of the omissions or deficiencies. This reduction in time is necessary to streamline the application process, providing TDI with information more quickly. This increased efficiency will make URAs more quickly available to the Texas consumer. Section 19.1704(f) and §19.2004(f) also provide that the applicant may request in writing additional time to correct the omissions or deficiencies in the application, and that the request for the additional time must be approved by TDI in writing for the requested extension to be effective.

Section 19.1704(g) and §19.2004(g) provide that each active certification or registration expires two years after the date of issuance.

Section 19.1704(h) and §19.2004(h) clarify that the two-year renewal requirement applies to both certifications and registrations, the process of submitting a URA application to TDI, and the fees for renewal of a certification. Insurance Code §4201.103 provides that certification may be renewed biennially by filing with the commissioner, not later than March 1, a renewal form accompanied by a fee in an amount set by the commissioner. Insurance Code §4201.104(a) authorizes the commissioner to promulgate forms to be filed for a renewal certificate of registration.

Section 19.1704(h)(1) and §19.2004(h)(1), (relating to continued operation during TDI review), provides that a URA may continue to operate under its certification or registration until the renewal application is denied or issued by TDI if a URA meets two requirements. The URA must have sent to TDI, on or before the expiration of its certification or registration, the information specified in subsection (h); and the URA must have submitted the fee required for certification renewal, if applicable.

Section 19.1704(h)(2) and §19.2004(h)(2) specify the requirements for renewal if the certification or registration has been expired for 90 days or less. Under §19.1704(h)(2) and §19.2004(h)(2), the URA may renew the certification or registration by filing a completed renewal application, the fee as applicable for certification renewal, and the required information described in subsection (h). Section 19.1704(h)(2) and §19.2004(h)(2) prohibit the URA from operating from the time the certification or registration has expired until the time TDI grants the URA a renewal certification or registration.

Section 19.1704(h)(3) and §19.2004(h)(3) specify the requirements if the certification or registration has been expired for longer than 90 days. The URA may not renew the certification or registration but must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable for certification in accord with §19.1704 or §19.2004.

Section 19.1704(i) and §19.2004(i), regarding contesting a denial of an application or renewal, track existing §19.1704(g) and §19.2004(h) with nonsubstantive clarifications.

Section 19.1704(j) and §19.2004(j) describe an existing URA's obligation to update its application within 90 calendar days after the effective date of the rule. However, the submission of an updated application does not change the URA's existing renewal date, and subsection (h) of this section still governs the URA's renewal process.

Section 19.1705 and §19.2005 address **General Standards of Utilization Review.** The components listed in existing §19.1705(1) – (3) and §19.2005(1) – (3) to be included in the utilization review plan are not included in the new sections because TDI adopts updated required components in subsections (b) – (f) of §19.1705 and §19.2005 or the components are otherwise incorporated into other sections, and the retention of the provisions would be repetitive.

Section 19.1705(a) and §19.2005(a) require that the utilization review plan be approved by a physician; periodically updated; and include input from both primary and

specialty physicians, doctors, or other health care providers, in accord with Insurance Code §4201.151.

Section 19.1705(b) and §19.2005(b) add a statutorily required general standard of utilization review relating to special circumstances. It requires the utilization review determination to take into account special circumstances of each 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. This requirement is consistent with Insurance Code §4201.153.

Section 19.2005(b) also provides that for purposes of new §19.2005, disability must not be construed to mean an injured employee who is off work or receiving income benefits. This provision is included to further clarify the scope of special circumstances. In establishing general standards for utilization review, the language in §19.2005(b) distinguishes the term "disability" as it is used in general medical environments from how the term is used in the Texas workers' compensation system. The term "disability" as used in this section should not be confused with the Texas Workers' Compensation Act's definition of "disability." Labor Code §401.011(16) defines "disability" as "the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage."

Section 19.1705(c) and §19.2005(c) add screening criteria provisions. The sections describe the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome-focused, and compliant with Insurance

Code §4201.153. Insurance Code §4201.153(a) – (c) requires that a URA use written medically acceptable screening criteria and review procedures that are established, periodically evaluated, and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. It further requires that a utilization review determination be made in accord with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria. The screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, §19.1705(c) and §19.2005(c) require screening criteria to recognize that the URA must use generally accepted standards of medical practice recognized in the medical community if evidence-based medicine is not available for a particular health care service provided. This provision is necessary because evidence-based medicine is not always available. This provision also harmonizes the Subchapter R screening criteria requirements with Subchapter U screening criteria requirements. Section 19.2005(c) also incorporates requirements of Labor Code §401.011(22-a) and is necessary because evidence-based medicine is not always available. Insurance Code §4201.054(c) states that Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. TDI determined this conforming change is necessary in the Subchapter R rules to implement the existing requirements for screening criteria in accord with §4201.153 while maintaining

screening criteria standards that are consistent with the screening criteria standards under Subchapter U. This requirement is adopted under the commissioner's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Insurance Code Chapter 4201.

Section 19.1705(d) and §19.2005(d) require that adverse determinations be referred to and determined by an appropriate physician, doctor, or other health care provider. This requirement implements the expanded scope of adverse determinations under HB 4290. The requirement in §19.1705(d) and §19.2005(d) is consistent with Insurance Code §4201.153(d) and existing §19.1705(a)(3). Existing §19.1705(a)(3) already allowed a health care provider to make adverse determination decisions. New §19.2005(d) also requires that physicians and doctors performing utilization review comply with Labor Code §§408.0043 – 408.0045. References to these Labor Code provisions are necessary to ensure that physicians and doctors meet these professional certification requirements for conducting utilization review.

Section 19.1705(e) and §19.2005(e) permit a URA to delegate 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. These sections are consistent with Insurance Code §4201.251, regarding delegation of utilization review.

Section 19.1705(f) and §19.2005(f) require the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with Insurance Code §4201.204. Additionally, the sections add a new requirement that the written response include TDI's address, toll-

free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI. This information is necessary to inform the consumer of the right to file a complaint and the means by which the consumer may contact TDI.

Section 19.2005(g) requires utilization review plan written policies to evidence compliance with Labor Code §504.055. This adopted subsection corresponds with the requirements of Labor Code §504.055(c), which states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection (b)." Labor Code §504.055(b) provides, in part, that, "This section applies only to a first responder who sustains a serious bodily injury, as defined by Section 1.07, Penal Code, in the course and scope of employment."

Section 19.1706 and §19.2006 address **Requirements and Prohibitions Relating to Personnel**. Section 19.1706(a) and §19.2006(a) require all health care providers employed or contracted with the URA to perform utilization review to be appropriately trained, qualified, and currently licensed. This requirement is more stringent than the requirement in existing §19.1704(h)(1) and §19.2004(f)(1), which only requires that the URA have available the qualified medical personnel to provide the services requested. However, this more stringent requirement incorporates the existing requirement under §19.1706 and §19.2006 that personnel employed by or contracted with the URA to perform utilization review be appropriately trained, qualified, and, if applicable, currently licensed. The additional criteria will ensure that utilization review is

conducted by appropriate individuals and should ensure a higher quality of utilization review.

Section 19.1706(a) and §19.2006(a) also require personnel conducting utilization review to hold an unrestricted license, administrative license, or to be otherwise authorized to provide health care by a licensing agency in the United States, or in Texas, respectively. These new sections were unanimously recommended by the Utilization Review Advisory Committee and are consistent with Insurance Code §4201.252(a), which requires personnel employed by or contracted with a URA to perform utilization review to be appropriately trained and qualified.

Section 19.1706(a)(1) and §19.2006(a)(1) clarify that the adopted rules do not supersede requirements in the Medical Practice Act, Texas Medical Board rules, Texas Occupations Code Chapter 201 (relating to Chiropractors), or Texas Board of Chiropractic Examiners rules. Section 19.1706(a)(2) and §19.2006(a)(2) clarify that personnel who perform clerical or administrative tasks are not required to have the qualifications of personnel conducting utilization review, which is consistent with Insurance Code §4201.051.

Section 19.1706(b) and §19.2006(b) prohibit a physician, doctor, or other health care provider who conducts utilization review from having any disqualifying associations with the physician, doctor, or other health care provider who issued the initial adverse determination. Section 19.1706(b) and §19.2006(b) also prohibit a physician, doctor, or other health care provider who conducts utilization review from having any disqualifying associations with the enrollee, or the injured employee, respectively, or health care

provider who is requesting the utilization review or an appeal. The subsections also clarify that being employed by or contracted 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; however, another disqualifying association may apply.

Section 19.1706(c) and §19.2006(c) require that the URA provide to TDI information and qualifications of the personnel employed or contracted to perform the utilization review on filing an original or renewal application. This information is important because it allows TDI to monitor the credentials of staff performing utilization review. To avoid unnecessary administrative burdens, TDI clarifies that URAs do not have to provide information on any administrative staff who is not conducting utilization review.

Section 19.2006(c) requires all personnel performing utilization review of workers' compensation services to be licensed in Texas or be otherwise authorized to provide health care services in Texas. This requirement is consistent with the objectives of Labor Code §408.023(h) and HB 1006, 80th Legislature, Regular Session, effective September 1, 2007, and is necessary to ensure that appropriate health care providers, in accord with Insurance Code §4201.153(d), are used to determine medical necessity.

Section 19.1706(d) and §19.2006(d) require URAs to develop and implement written procedures to determine if physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

Section 19.2006(e) requires utilization review conducted by a URA to be under the direction of a physician currently licensed without restriction to practice medicine. This section implements Insurance Code §1305.351 and Labor Code §408.023(h), which provide that only doctors licensed to practice in this state may perform utilization review. The requirement that the physician be licensed without restriction will ensure that utilization review is conducted by appropriately trained and qualified individuals and ensure a higher quality of utilization review.

Section 19.1706(e) requires the URA to provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment related to acquired brain injury treatment, consistent with Insurance Code §1352.004. Section 1352.004 provides that "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider. Under Insurance Code §1352.004, the commissioner adopted 28 TAC §21.3104 to require that a health benefit plan issuer provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

The purpose of the training is to prevent denial of coverage in violation of §1352.003 and to avoid confusion of medical benefits with mental health benefits. Although Insurance Code §1352.004 specifies that a health benefit plan issuer must

provide this training and is silent concerning a URA, new §19.1706(e) will ensure that URA personnel will receive adequate training, consistent with the plain language of §1352.004 requiring training for personnel responsible for utilization review under the plan. The requirement that URA personnel receive the training is adopted under the commissioner's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201 and under Insurance Code §1352.004(b).

Section 19.1707 and §19.2007 address **URA Contact With and Receipt of Information from Health Care Providers.**

Section 19.1707(a) and §19.2007(a) clarify existing §19.1708(b) and §19.2008(b) requirements affecting the health care provider's charge for providing medical information by providing a specific citation to 28 TAC §134.120 (relating to Reimbursement for Medical Documentation). This clarification is necessary for purposes of readability and ease of compliance. Also, because there are no existing relevant TDI-DWC rules or guidelines specifying costs that may not be reimbursed separately, new §19.2007(a) also deletes the existing prohibition against inclusion of costs that may not be reimbursed separately in a health care provider's charge for providing medical information. Section 19.2007(a) also provides that a health care provider must submit required documentation to the URA when submitting a medical bill under 28 TAC Chapter 133. Under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

The reimbursement requirement in §19.2007(a) for workers' compensation utilization review mirrors the reimbursement requirement for URAs in §19.1707(a) of these rules and applies to requests for medical information related to all types of utilization review, including concurrent and retrospective review. This alignment is necessary to ensure consistent regulation of URAs and to prevent confusion for URAs that are certified for both health and workers' compensation.

In terms of prospective and concurrent utilization review, existing rules in Chapter 10 (for network care) and Chapter 134 (for non-network care) clarify that a health care provider submitting a request for health care services must include information to substantiate the medical necessity of the services requested. In terms of retrospective utilization review, existing rules in Chapter 133, which apply to both network and non-network care, clarify when medical information must be submitted and the types of information that must be submitted along with a medical bill for health care services that have already been rendered. Thus, the health care provider is bearing some of the cost.

An insurance carrier may already have provided written medical information that is later being requested by the URA. In that case, it is the insurance carrier's obligation to supply the URA with whatever medical information it may already have to avoid unnecessary requests for information from the health care provider. However, if the insurance carrier is not able to provide this information to the URA or does not have this information, and the URA has determined that the information is necessary to conduct utilization review, then the URA, with whatever financial arrangements the URA has with

the insurance carrier, is expected to reimburse the health care provider for the requested written medical information. It is in the requesting provider's interest to provide the relevant information to avoid a denial based on lack of the necessary documentation.

Adopted §19.1707(b) and §19.2007(b) require the URA conducting utilization review to request "all relevant and updated medical records" to complete the review. This ensures that the URA uses the most recent and complete information possible to review the treatment of the enrollee or injured employee, respectively. Although treatment may vary on a case-by-case basis, TDI determined that this requirement will enable the most effective review. Existing text under §19.1708(c) stated, "These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility." Thus, existing regulations already required that requested items be relevant to the utilization review.

Section 19.1707(b)(1) and §19.2007(b)(1) permit the URA to request records necessary to conduct the utilization review even if those records contain identifying information about the claim and about the treating physician, doctor, or other health care provider. This information clarifies the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records needed to complete the review. Information about the doctor is included as part of the medical record.

Section 19.1707(b)(2) and §19.2007(b)(2) prohibit a URA from routinely requesting copies of all medical records. These sections are designed to allow the URA to seek the information necessary for the review on a case-by-case basis without routinely requesting an entire medical record. These sections mirror existing requirements in §19.1708(b)(2) and §19.2008(c)(2). The intent of the new sections is to require the URA to evaluate what records are needed. Section 19.1708(b) and §19.2008(b) do not require an overly broad request that would result in the transmission of unnecessary information. A balance in the amount of information requested will result in more efficient review, because of the relevance of the provided documents and the reduced cost. Even though the requesting party must submit information to support the request, the URA should request missing information necessary to conduct the review.

Section 19.1707(c) and §19.2007(c) mirror the requirements in existing §19.1708(e) and §19.2008(e).

Section 19.1707(d) and §19.2007(d) add the modifying phrase "that relate to the mental health therapist's treatment of an injured employee's mental or emotional condition or disorder" to the prohibition in existing §19.1708(f) and §19.2008(f), and further describe the process or progress notes that are contemplated. The sections also provide that the prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes.

Section 19.1707(d)(1) and §19.2007(d)(1) provide that this prohibition does not preclude the URA from requiring submission of an injured employee's mental health

medical record summary. Section 19.1707(d)(2) and §19.2007(d)(2) provide that the prohibition does not preclude the URA from requiring submission of medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder. The consistency between the Subchapter R and Subchapter U adopted rules is necessary because the rules are based on the same underlying statute. Insurance Code §4201.203(a) prohibits a URA from requiring the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes, as a condition of treatment approval or for any other reason. Section 4201.203(b) clarifies that a URA may nonetheless require submission of a patient's medical record summary.

Section 19.1708 and §19.2008 address **On-Site Review by the URA**. Section 19.1708(a) and §19.2008(a) require URA staff members to identify themselves by name, organization, photo identification, and the URA's identification card with TDI's assigned certificate number. This requirement applies at all times while the members are engaged in utilization review and not just during "on-site reviews." This requirement is intended to ensure that all parties involved are aware that the URA is conducting the utilization review and are able to confirm the identity of the URA staff members who are engaged in utilization review.

Section 19.1708(b) and §19.2008(b), relating to on-site review at a health care facility, change the references in existing §19.1709(b) and §19.2009(b), from hospital to a "health care facility." The broader term "health care facility" includes a hospital,

emergency clinic, outpatient clinic, or other facility providing health care and is necessary for clarification and accuracy.

Section 19.1709 and §19.2009 address **Notice of Determinations Made in Utilization Review**. Section 19.2009(a) addresses requirements for both favorable and adverse determination notices. Section 19.1709(a) and §19.2009(a)(1) track the requirements in Insurance Code §4201.301.

To clarify distinctions between requirements within the sections that apply to prospective and concurrent review, versus retrospective review, the sections are formatted so that §19.2009(a)(2) and §19.1709(d) apply to prospective and concurrent review, and §19.2009(a)(3) and §19.1709(e) apply to retrospective review. Section 19.2009(a)(2) and §19.1709(d)(3) specify required timeframes for notification of an adverse determination for consistency with Insurance Code §4201.304. Section 19.1709(d)(3) also adds clarifying language that the denial of post-stabilization care subsequent to emergency treatment must be followed by a written notification within three working days of the telephone or electronic transmission. These rules do not repeat the rest of the requirements under Insurance Code §4201.304 because no other clarifying changes were made. Section 19.1709(d)(1) tracks the requirements in Insurance Code §4201.302.

Section 19.2009(a)(2)(A) and §19.2009(a)(2)(B) specify required timeframes for notification of a prospective or concurrent utilization review adverse determination and adopt timeframe requirements to be consistent with 28 TAC §134.600 for workers'

compensation non-network coverage, or with Insurance Code §1305.353 and 28 TAC §10.102 for workers' compensation network coverage, respectively.

Section 19.2009(a)(3)(A) and (B) require the notice of a retrospective adverse determination to be provided within the timeframes specified by TDI-DWC rules in 28 TAC Chapter 133 (relating to General Medical Provisions) for workers' compensation non-network coverage, and TDI rules in 28 TAC Chapter 10 (relating to Workers' Compensation Health Care Networks) and TDI-DWC rules in 28 TAC Chapter 133 for workers' compensation network coverage, respectively. These provisions are consistent with Insurance Code §4201.305.

Section 19.1709(b) and §19.2009(b) clarify that the subsections regulate the information that must be included in notices of prospective, concurrent, or retrospective utilization review adverse determinations. With the exception of §19.1709(b)(4) and §19.2009(b)(4), all of the information that must be included in all notices of adverse determinations in §19.1709(b) and §19.2009(b) are required by Insurance Code §4201.303(a). TDI added one notice element to the list in §4201.303(a). Insurance Code §1305.353(b) states, "Notification of an adverse determination must include" certain elements and §4201.303(a) states, "Notice of an adverse determination must include" certain elements. These lead-in sentences indicate that TDI does not have authority to exclude one of these statutory requirements, but these statutes do not limit the elements in the notice to only those elements. This adoption order includes all of the statutory elements and adds to the notice requirements under Insurance Code

§4201.003, which grants rulemaking authority to implement Insurance Code Chapter 4201.

Section 19.1709(b)(4) and §19.2009(b)(4) require notice of the professional specialty of the physician, doctor, or other health care provider who made the adverse determination. Section 19.2009(b)(4) also requires notice of the Texas license number of the physician, doctor, or other health care provider that made the adverse determination.

TDI determined that the additional notice element in §19.1709(b)(4) and §19.2009(b)(4) is necessary to provide important consumer information to the enrollee, or injured employee, respectively, and the provider of record should the adverse determination be appealed. Specifically, this information is necessary for the consumer's understanding of the professional background and training of that physician, doctor, or other health care provider. The information that would be provided under the adopted new notice element may also assist the provider of record in assessing whether the enrollee or injured employee, respectively, might benefit from requesting a physician or doctor of a particular specialty; other than the specialty of the physician, doctor, or other health care provider that made the adverse determination; if an appeal of the adverse determination is filed.

Section 19.1709(b)(5) – (9) and §19.2009(b)(3), (5), (6), and (9) are consistent with Insurance Code §4201.303(a)(4) and §4201.303(b). The requirement in §19.1709(b) and §19.2009(b), regarding the provision of information on the URA appeal process and notice of the independent review process, along with a copy of the request

for a review by an IRO form, will inform the enrollee, or injured employee, respectively, of available options following an adverse determination. The information will also inform the provider of record of what information is necessary for the appeal of an adverse determination. The release of information to an IRO must also comply with Insurance Code §4201.552, which prohibits a URA from disclosing individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent or except as otherwise required by law. Section 4201.552 also requires that if the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must be dated and contain the patient's signature.

Section 19.1709(c) specifies the requirements relating to a notice of determination concerning an acquired brain injury. A URA must comply with the notice requirements relating to notification of favorable determinations and relating to notice of adverse determinations. Additionally, in regard to a determination concerning an acquired brain injury as defined by 28 TAC §21.3102, not later than three business days after the date on which an individual requests utilization review or an extension of coverage that is based on medical necessity or appropriateness, the URA must notify the requestor of the determination through a direct telephone contact. Section 19.1709(c) also provides that the subsection does not apply to a determination made for coverage under a small employer health benefit plan, consistent with Insurance Code §1352.006.

Section 19.2009(c) clarifies that the URA may consolidate the notice of an adverse determination and the peer review report into one document if the document contains all the notice elements required under both §19.2009(c) and 28 TAC §180.28.

Section 19.1709(d)(2) and §19.2009(a)(4) require a URA to ensure that the preauthorization numbers it assigns comply with the data and format requirements contained in the standards adopted by the U.S. Department of Health and Human Services in 45 C.F.R. §162.1102. These standards apply under federal law to health insurers and HMOs and already apply to health insurers and HMOs conducting utilization review. For consistency among all URAs, TDI determined it is necessary to require preauthorization numbers issued by all URAs to comply with the federal data and format requirements. This requirement will prevent different numbering systems based on whether the URA is subject to the federal regulations.

Section 19.1709(e)(1) requires the notice of a retrospective adverse determination to be provided within the timeframes specified by Insurance Code §4201.305 and §19.1709(e). Section 19.1709(e)(2) tracks Insurance Code §4201.203.

Section 19.1710 and §19.2010 address **Requirements Prior to Issuing Adverse Determination**. Section 19.1710 and §19.2010 address requirements regarding any instance in which the URA is questioning health care services on the basis of medical necessity or appropriateness, or on the basis of the experimental or investigational nature of the services under §19.1710, prior to issuing a utilization review adverse determination. The URA must afford the provider of record a reasonable

opportunity, as defined in §19.1703(b)(28) and §19.2003(30), to discuss the plan of treatment with a physician.

Section 19.1710 and §19.2010 require that the discussion 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, in addition to the discussion of the plan of treatment for the enrollee. By specifying minimum elements, the adopted rules clarify that the required discussion may also include other matters as deemed necessary by the URA or provider of record.

Section 19.1710(1) and §19.2010(1) specify that when the URA provides the reasonable opportunity required under §19.1710 or §19.2010, respectively, the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination.

Section 19.1710(2) and §19.2010(2) require the URA to maintain documentation detailing 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 outcome. Section 19.1710(2) and §19.2010(2) also require that the URA submit this required documentation to TDI, or TDI-DWC, respectively, on request. These requirements are necessary to enable TDI to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist TDI in ensuring compliance with the requirement that URAs provide a reasonable opportunity

for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

These requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements resulting from the expanded definition of "utilization review" under HB 4290 to specifically incorporate "retrospective review." Insurance Code §4201.206 provides that, subject to the notice requirements of Chapter 4201, Subchapter G, and before an adverse determination is issued by a URA, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Because in pertinent part Insurance Code §4201.002 defines a "utilization review agent" as "an entity that conducts utilization review" and the term "utilization review" includes "retrospective review" under Insurance Code §4201.002(13), the §4201.206 requirement for a reasonable opportunity discussion applies to a URA conducting retrospective review.

Section 19.1711 and §19.2011 address **Written Procedures for Appeal of Adverse Determinations.** Section 19.1711(a) and §19.2011(a) govern appeal of prospective or concurrent adverse determinations. The sections require each URA to comply with its written procedures for appeals and require a URA's written procedures for appeals to comply with insurance Code Chapter 4201, Subchapter H.

Section 19.1711(a)(1) requires these procedures to include a statement specifying the timeframes for filing the written or oral appeal, which may not be less

than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the enrollee adequate time to appeal an adverse determination and specifies a uniform minimum time for all enrollees to submit an appeal.

Section 19.2011(a)(1) addresses the timeframes for filing the appeal for workers' compensation network coverage. It requires the URA's written procedures for appeals to include a statement specifying the timeframes for filing the oral or written appeal in accord with Insurance Code §1305.354, which may not be less than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the injured employee adequate time to appeal the adverse determination and is consistent with 28 TAC §10.103 (relating to Reconsideration of Adverse Determination).

Under §19.1711(a)(1) and §19.2011(a)(1), all enrollees, or injured employees, respectively, will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review. These provisions are also consistent with Insurance Code §4201.353, which provides that the procedures for appealing an adverse determination must be reasonable.

Section 19.2011(a)(2) addresses the timeframes for filing the appeal for workers' compensation non-network coverage and workers' compensation health plan. It requires the URA's written procedures for appeals to include a statement specifying that the timeframes for filing the oral or written appeal must comply with 28 TAC §134.600 (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) and 28 TAC Chapter 133, Subchapter D (relating to Dispute of Medical Bills).

Section 19.1711(a)(2) and §19.2011(a)(3) require the URA's written procedures for appeals to include a provision that an enrollee or injured employee, respectively; their representative; or the provider of record may appeal the adverse determination by making an oral or written request. This requirement is consistent with Insurance Code §4201.354.

Section 19.1711(a)(3)(A) – (D) maintains the existing requirements relating to an appeal acknowledgement letter to be sent by the URA to the appealing party.

Section 19.1711(a)(4) requires the written procedures for appeals to include a provision that an appeal decision must be made by a physician who has not previously reviewed the case. This provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b), relating to specialty provider reviews.

Section 19.2011(a)(4) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician, dentist, or chiropractor who has not previously reviewed the case. This provision is consistent with Insurance Code §4201.356(a), Insurance Code §1305.354, 28 TAC Chapter 180, and 28 TAC §10.103. This requirement provides consistency of utilization reviews for all injured employees.

Section 19.2011(a)(5) requires that in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, the URA must afford the provider of record a reasonable opportunity, as defined in

§19.2003(28), to discuss the plan of treatment for the injured employee with a physician before issuing an adverse determination. The discussion must include, at a minimum, the clinical basis for the URA's decision. Denial of an appeal is an adverse determination, which would require the URA to afford the provider of record a reasonable opportunity to discuss the plan of treatment before issuing an adverse determination. This provision is consistent with Insurance Code §4201.206.

Section 19.1711(a)(5) further requires the written procedures to include a provision that in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature of the health care services, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician before issuing an adverse determination. The provision must require the discussion to include, at a minimum, the clinical basis for the URA's decision.

Section 19.1711(a)(6) mirrors the requirement under Insurance Code §4201.356(b), which provides a process for requesting a particular type of specialty provider to review a case and requires the specialty review to be completed within 15 working days. Insurance Code §4201.457 governs the appeal decisions for specialty URAs.

Section 19.2011(a)(6) requires the URA's written procedures for appeals to include a provision that, after the URA has sought review of the appeal, the URA must issue a response letter explaining the resolution of the appeal to certain individuals specified on the basis of the underlying workers' compensation coverage.

Section 19.1711(a)(7) tracks the requirements in Insurance Code §4201.357. Section 19.1711(a)(7)(C) requires the written procedures for appeal to include a provision that an expedited appeal determination may be provided by telephone or electronic transmission but must be followed with a letter within three working days of the initial telephonic or electronic notification. The requirement for the follow-up letter is necessary to ensure that the appealing party receives prompt written documentation of the expedited appeal determination.

Section 19.2011(a)(7)(A) – (G) specify the elements of information that must be included in the response letter for both workers' compensation network and non-network coverage. Subparagraph (A) requires a statement of the specific medical or dental reasons for the resolution. Subparagraph (B) requires the clinical basis for the decision, including screening criteria. Subparagraph (C) requires the professional specialty and Texas license number of the physician who made the determination. Subparagraph (D) requires notice of the appealing party's right to seek review of the denied appeal by an IRO, the procedure for obtaining that review, and procedures for obtaining a copy of the request for a review by an IRO form. Subparagraph (E) states procedures for filing a complaint in accord with Insurance Code §4201.204. Subparagraph (F) requires a description of the screening criteria used in making the determination for workers' compensation network coverage, as well as a description of the network proposed treatment guidelines. Subparagraph (G) requires the URA conducting utilization review for workers' compensation non-network coverage to include a description of the treatment guidelines used in accord with 28 TAC Chapter

137 (relating to Disability Management) in making a determination. These requirements provide the injured employee with important information concerning the basis for the determination.

Section 19.1711(a)(8)(A) – (H) specify the elements of information that must be included in the response letter. Subparagraph (A) requires a statement of the specific medical, dental, or contractual reasons for the resolution, as required in existing §19.1712(b)(5)(A). Subparagraph (B) requires the clinical basis for the decision. Subparagraph (C) requires a description of, or the source of, the screening criteria used in making the determination. Subparagraph (D) requires the professional specialty of the physician who made the determination. Subparagraph (E) requires notice of the appealing party's right to seek review of the adverse determination by an IRO. Subparagraph (F) requires notice of the independent review process and the procedures for obtaining that review. Subparagraph (G) requires a copy of the request for a review by an IRO form in addition to the existing rule requirement for a notice of the appealing party's right to seek review of the denied appeal by an IRO and the procedures for obtaining that review. Subparagraph (H) requires procedures for filing a complaint in accord with Insurance Code §4201.204 and as described in §19.1705(f).

Section 19.2011(a)(8) specifies the timeframes for written notifications of the appeal determination as a required component of the response letter under the URA's procedures. These appeals must be resolved in accord with 28 TAC §10.103 for workers' compensation network coverage and 28 TAC §134.600 for workers' compensation non-network coverage.

Section 19.1711(a)(9) requires the URA's written appeal procedures to include a provision that the appeal must be resolved as soon as practical, but in accord with Insurance Code §4201.359, in no case later than 30 calendar days after the date the URA receives the appeal from the appealing party referenced in §19.1711(a)(3). TDI deleted the word "written" and the phrase "or the one-page appeal form" to more closely track the requirements under Insurance Code §4201.359.

Section 19.1711(a)(10) and §19.2011(a)(9) provide that an enrollee or injured employee, respectively, may request and is entitled to an immediate review by an IRO of an adverse determination in a circumstance involving a life-threatening condition. This provision is consistent with Insurance Code §4201.360. Section 19.2011(a)(9) also provides that in a circumstance involving a request for a medical interlocutory order under 28 TAC §134.550, the injured employee is entitled to an immediate review by an IRO of the adverse determination.

These rules implement statutory provisions of Insurance Code Chapter 4201. Insurance Code §4201.303(b) provides that, for an enrollee who has a life-threatening condition, the notice of an adverse determination must include a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review. Insurance Code §4201.360 provides that, notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of the URA's adverse determination.

The terms "life-threatening" and "medical emergency" overlap but are not synonymous. The term "life-threatening," under Insurance Code §4201.002(7), is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. There is no requirement that the likelihood of death is imminent or the condition is acute. The terms "emergency care," under Insurance Code §4201.002(2), and "medical emergency," under Insurance Code §1305.004(13), both require the condition to be of recent or sudden onset, respectively, and require immediate medical care or attention, in part, to avoid placing the individual's health in serious jeopardy. Section 19.2003(18) also contains a separate definition of "medical emergency" that tracks the definition in Insurance Code §1305.004(13) with a clarifying change from the use of the term "patient" to the term "injured employee."

Additionally, Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI's intent to apply the requirements regarding life-threatening conditions to emergency treatment.

Section 19.1711(b) and §19.2011(b) govern appeals of retrospective adverse determinations and require the URA to maintain and make available a written description of these appeal procedures. Section 19.2011(b) requires that these appeals comply with §19.2009.

Section 19.1711(b)(1) requires the appeal procedures to comply with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims), if applicable, because not all entities subject to Subchapter R may be subject

to 28 TAC Chapter 21, Subchapter T. Section 19.1711(b)(2) requires that these appeals comply with §19.1709.

Section 19.2011(b)(1) requires workers' compensation network coverage appeal procedures to comply with the requirements in Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133. This subsection clarifies that for claims under network coverage these requirements are to be applied in tandem with TDI's rules concerning workers' compensation health care networks and also with TDI-DWC's rules concerning general medical procedures.

Section 19.2011(b)(2) requires a URA's workers' compensation non-network coverage appeal procedure to comply with the requirements of 28 TAC Chapter 133. This provision clarifies that these adopted rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify their duties under those rules.

Section 19.1711(c) addresses appeals of adverse determinations concerning acquired brain injuries. A URA must make a determination concerning an acquired brain injury no later than three business days after the date an individual requests utilization review or an extension of coverage based on medical necessity or appropriateness. The URA must provide notification of the determination through a direct telephone contact to the requestor. This provision is consistent with Insurance Code §1352.006.

Section 19.1712 addresses **URA's Telephone Access,** and §19.2012 addresses **URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care.** Section 19.1712(a) and §19.2012(a) track Insurance

Code §4201.004, and clarify that a URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central Time and Mountain Time. The clarifying phrase "Central Time and Mountain Time" is necessary because Texas includes both time zones, and the location of the URA should not pose a barrier to care.

Section 19.1712(b) clarifies that the section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1718 or §19.1719. This exemption is necessary because §19.1718 and §19.1719 specify detailed telephone access requirements for HMOs or preferred provider benefit plans, respectively.

Section 19.2012(b) requires a URA to have and implement procedures when responding to two types of requests. The procedures must address requests for drugs that require preauthorization if the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency. They also must address requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment, as requested by a treating physician or provider of record.

The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or pharmacy the ability to obtain a medical interlocutory order in certain instances in which preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary pose an unreasonable risk of a

medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). Subchapter R rules do not have an equivalent requirement because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy. The purpose of new §19.2012(b) is to require the URA to have specific procedures for high-risk situations.

Section 19.1713 and §19.2013 address **Confidentiality.** Section 19.1713(a) and §19.2013(a) require a URA to provide its certification number, name, and professional qualifications when contacting a physician's, doctor's, or other health care provider's office. Section 19.1713(a)(1) and §19.2013(a)(1) require the URA to present written documentation that the URA is acting as an agent of the payor or insurance carrier, respectively, for the relevant enrollee or injured employee, respectively. These requirements are consistent with Insurance Code §4201.551(a).

Section 19.1713(a)(2) and §19.2013(a)(2) clarify that the duty to retain the information rests with the URA and are consistent with Insurance Code §4201.557, which states, "A utilization review agent shall maintain all data concerning a patient or physician or other health care provider in a confidential manner that prevents unauthorized disclosure to a third party."

Section 19.1713(a)(3) and §19.2013(a)(3) make the requirement that information be retained for "at least two years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened" in existing §19.1714(m) and §19.2014(m), respectively, obsolete. Section 19.1713(a)(3) and §19.2013(a)(2) require the information to be retained for at

least four years and broadens the scope of information that the URA must retain to include all information generated and obtained by a URA in the course of utilization review and not just that information relating to cases for which an adverse decision was made or information relating to a case that may be reopened.

TDI determined that an increased timeframe for retaining all information generated and obtained by a URA in the course of utilization review is necessary to address any potential issues that might arise in an appeal, including judicial review of an approval or adverse determination. The information retained may be necessary for the appeal process, which could take longer than two years. In addition, the four year retention requirement is consistent with confidentiality requirements for IROs under 28 TAC §12.208(h).

The longer retention period allows sufficient time for TDI to examine the information. TDI generally conducts URA examinations triennially, but does not always examine each URA exactly every three years. The requirement that the URA maintain information for four years will ensure that TDI has the opportunity to review the information.

Section 19.1713(a)(4) and §19.2013(a)(4) track the limitation on a URA's charges for providing a copy of recorded personal information to individuals in existing §19.1714(e) and §19.2014(e).

Section 19.1713(b) and §19.2013(b) clarify that the confidentiality requirements pertain to both: (1) the information received by the URA from the enrollee or injured employee, respectively; their representative; or the physician, doctor, or other health

care provider; and (2) the information exchanged between the URA and third parties. Section 19.1713(b) and §19.2013(b) address a URA's procedures for specific information exchanged for conducting reviews. Section 19.1713(b) and §19.2013(b) incorporate the requirements in existing §19.1714(k) and §19.2014(k) and restructure the requirements for ease of readability.

Section 19.1714 and §19.2014 address **Regulatory Requirements Subsequent to Certification or Registration.** TDI determined that the requirements in existing §19.1716(a) and §19.2016(a) are not necessary because they repeat the requirements in Insurance Code §4201.204.

Section 19.1714(a) and §19.2014(a) require that information related to complaints be included in the summary report submitted to TDI by March 1 of each year, which tracks existing §19.1716(b) and §19.2016(b). Section 19.1714(a) and §19.2014(a) also broaden the types of information that the URA must provide in the summary report to include information related to adverse determinations and appeals of adverse determinations. These sections are authorized under Insurance Code §4201.204(c) and Insurance Code §38.001.

Section 19.1714(b) and §19.2014(b) track the requirement in the last sentence in existing §19.1716(b) and §19.2016(c). Section 19.1714(b)(1) and §19.2014(b)(1) mirror the requirements in existing §19.1716(b)(1) and §19.2016(c)(1). Section 19.1714(b)(2) and §19.2014(b)(2) mirror the requirements in existing §19.1716(b)(2) and §19.2016(c)(2) and clarify that "successor codes and modifiers" are applicable as part of the requirement to include a listing of appeals of adverse determinations by the medical

condition that is the source of the dispute in the summary report submitted to TDI. The requirements in existing §19.1716(b)(4) are not included in the adopted rules because appeals of adverse determinations are not classified by the categories of "benefit denial," "timely determinations," or "screening criteria." TDI does not collect that information, and the requirements are unnecessary.

Section 19.1714(b)(3) and §19.2014(b)(3) track the requirements in existing §19.1716(b)(3) and §19.2016(c)(3), respectively. Section 19.1714(b)(4) and §19.2014(b)(4) track the requirements in existing §19.1716(b)(5), with a clarifying change from the phrase "at each level of the notification and appeal process" to the phrase "at each level within the internal utilization review process." This change clarifies that the summary does not need to include the outcomes for an IRO, contested case hearing, or judicial review. Section 19.1714(b)(5) and §19.2014(b)(5) track the requirements in existing §19.1716(b)(6).

Section 19.1714(c)(1) – (3) and §19.2014(c)(1) – (3) track the requirements in existing §19.1716(b)(6)(A) – (C) and existing §19.2016(b)(1) – (3). TDI determined that the more detailed complaint procedure requirements in existing §19.1716(c)(1) – (5) and existing §19.2016(d)(1) – (4) are not necessary because they are too restrictive and inconsistent with procedures that TDI follows for investigating and resolving other types of complaints. Those requirements are not included in the new rules, and supporting requirements in existing §19.1716(d) and existing §19.2016(e) are also deleted.

Section 19.1714(d) and §19.2014(d) provide that TDI must process complaints received against a URA under TDI's established procedures for investigation and

resolution of complaints. These sections are authorized under Insurance Code §4201.003(a) and Insurance Code §36.001.

Section 19.1714(e) and §19.2014(e) reiterate TDI's authority in Insurance Code §38.001 to address inquiries to a URA, related to any matter connected with the URA's transactions, that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA must respond in writing to an inquiry not later than the 10th day after receipt of the inquiry.

Section 19.2014(f) clarifies that Subchapter U does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or contracted with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5 or applicable TDI-DWC rules. This provision is necessary to clarify that the investigative authority of the commissioner of workers' compensation or TDI-DWC is not limited to the authority stated in Subchapter U.

Section 19.1714(f) and §19.2014(g) contain the same requirements that are in existing §19.1716(g) and §19.2016(h) and clarify that an on-site review by TDI may be scheduled or unscheduled. Under §19.1714(f) and §19.2014(g), an on-site review will only take place during working days and normal business hours. Section 19.1714(f) and §19.2014(g) incorporate the existing provisions in §19.1716(g)(3) and §19.2016(h)(3) that the URA must make available all records relating to its operation during any on-site review. Section 19.1714(f)(2) and §19.2014(g)(2) provide that, at a

minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

Existing §19.1716(f) and §19.2016(g), relating to lists of URAs, are not included in the adopted rules because TDI now maintains a list of certified URAs on its website that is available to individuals or organizations interested in learning about a URA's certification status. This list is updated in real time. Further, TDI determined that existing §19.1716(g)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is no longer necessary. Insurance Code §4201.601 authorizes TDI to take certain steps if a person or entity conducting utilization review is believed to be in violation of Chapter 4201 or applicable rules. These steps include the authority to compel the production of necessary information if TDI believes that the URA is in violation of the Insurance Code or rules relating to reasonable accessibility.

Section 19.1715 and §19.2015 address **Administrative Violations.** Section 19.1715 and §19.2015(a) provide that the commission of fraudulent or deceptive acts in obtaining or using a URA registration is a violation of Insurance Code Chapter 4201. Section 19.1715 and §19.2015(a) contain the same requirements that are in existing §19.1717(f) and §19.2017(e). Insurance Code §4201.601 authorizes TDI to take certain steps if a person or entity conducting utilization review is believed to be in violation of Chapter 4201 or applicable rules.

Section 19.1715 and §19.2015(b) clarify that the commissioner's authority under Subchapters R and U, respectively, is in addition to remedies provided under Insurance Code Chapter 4201, Subchapter M, concerning enforcement.

Section 19.2015(c) clarifies that the provisions in §19.2015 do not limit the joint enforcement actions of TDI and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

These provisions are consistent with Insurance Code Chapter 4201, Subchapter M. Insurance Code §4201.601 permits the commissioner to compel production of information necessary to determine whether a violation has occurred. Additionally, under Insurance Code §4201.603, the commissioner may impose a sanction under Insurance Code Chapter 82, issue a cease and desist order under Insurance Code Chapter 83, or assess an administrative penalty under Insurance Code Chapter 84 if the commissioner determines a person or entity conducting utilization review has violated Insurance Code Chapter 4201.

Section 19.1716 and §19.2016 address **Specialty URA** requirements. Section 19.1716(a) and §19.2016(a) require a specialty URA to submit to TDI the application, information, and fee required in §19.1704 or §19.2004, respectively, to be certified or registered as a specialty URA. This provision implements Insurance Code §4201.101.

Section 19.1716(b) and §19.2016(b) require a specialty URA to conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the U.S. For example, when

conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery. This provision tracks the requirements in Insurance Code §4201.454 and is consistent with Insurance Code §1305.351(d) and Labor Code §408.023(h).

Additionally, under Insurance Code §4201.456, the specialty URA must provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the specialty URA. A specialty URA must meet the requirements of Insurance Code §4201.002(5), regarding the definition of the term "health care provider," to qualify as a specialty URA.

Section 19.1716(c) and §19.2016(c) provide that a specialty URA is subject to the requirements of Subchapter R or Subchapter U, respectively, except for those rules implementing those statutory requirements from which a specialty URA is exempt. The rules that are not applicable to specialty URAs, as outlined in §19.1716(c)(1) – (4) and §19.2016(c)(1) – (4), are consistent with Insurance Code §4201.452, which provides that a specialty URA is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Section 19.1716(c)(1) and §19.2016(c)(1) provide that specialty URAs are not subject to the requirements of §19.1705(a) and §19.2005(a), respectively, because the requirements regarding review and approval of the utilization review plan are based on Insurance Code §4201.151, from which specialty URAs are exempt. Specialty URAs

are required, under §19.1716(d), to use only a health care provider of the appropriate specialty. Under §19.2016(d), specialty URAs are required to use only physicians, doctors, other health care providers, of the appropriate specialty in accord with 28 TAC Chapter 180 (relating to Monitoring and Enforcement). Under Insurance Code §4201.453, a specialty URA must have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accord with standards developed with input from a health care provider of the appropriate specialty.

Section 19.1716(c)(2) and §19.2016(c)(2) provide that specialty URAs are not subject to the requirements of §19.1706(a), (c), and (d) and §19.2006(a) and (c) – (e), respectively, because they implement Insurance Code §4201.252, from which specialty URAs are exempt.

Section 19.1716(c)(3) and §19.2016(c)(3) provide that specialty URAs are not subject to the requirements of §19.1710 and §19.2010, respectively, because those sections implement Insurance Code §4201.206, from which specialty URAs are exempt. Instead, these respective regulatory concerns are specifically addressed for specialty URAs in §19.1716(f) and §19.2016(g) based on the peer-to-peer discussion requirements that specifically apply to specialty URAs under Insurance Code §4201.456.

Section 19.1716(c)(4) and §19.2016(c)(4) provide that specialty URAs are not subject to the requirements of §19.1711(a)(4) – (6) and §19.2011(a)(4) – (5) because those sections implement Insurance Code §4201.206 and §4201.356, from which specialty URAs are exempt.

Section 19.1716(d) and §19.2016(d) require a specialty URA to have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accord with standards developed with input from a health care provider of the appropriate specialty. This provision implements Insurance Code §4201.453.

Section 19.1716(e) and §19.2016(e) address requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Section 19.1716(e) and §19.2016(e) incorporate the requirements of existing §19.1720(f) and §19.2020(f), respectively. Section 19.1716(e)(1) and §19.2016(e)(1) require physicians, doctors, other health care providers, and personnel employed by or contracted with a specialty URA to perform utilization review to be appropriately trained, qualified, and currently licensed. Section 19.2016(e)(1) further requires personnel listed in subsection (e) to be appropriately trained, qualified, and currently licensed in accord with 28 TAC Chapter 180 (relating to Monitoring and Enforcement).

Section 19.1716(e)(2) and §19.2016(e)(2) require personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by a state licensing board or the Texas Medical Board, respectively, or to be otherwise authorized to provide health care services in the U.S. or Texas, respectively. This requirement is based on the Utilization Review Advisory Committee recommendation and is necessary to ensure that all personnel are appropriately trained and qualified to conduct specialty utilization review.

Under §19.2016(f) the utilization review by a specialty URA must be conducted under the direction of a physician, doctor, or other health care provider of the same specialty, and the physician, doctor, or other health care provider must be currently licensed to provide the specialty health care service in Texas. This is consistent with Insurance Code §1305.351 and Labor Code §408.023(h).

Section 19.1716(f) and §19.2016(g) mirror existing §19.1716(h) and §19.2020(h). Section 19.1716(f)(1) and §19.2016(g)(1) provide that when the specialty URA provides the reasonable opportunity required under this subsection, the specialty URA must include its phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. This requirement is necessary to give the provider of record the necessary information should the provider of record require further discussion with the specialty URA.

Section 19.1716(f)(2) and §19.2016(g)(2) require the specialty URA to maintain documentation detailing the discussion opportunity provided, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the time any discussion took place, and the outcome. The specialty URA must submit this documentation to TDI or TDI-DWC, respectively, if requested. These requirements enable TDI to monitor whether reasonable opportunities for discussion are offered and to collect information on peer-to-peer discussion results. This information will assist TDI in ensuring compliance with these requirements and in determining the effectiveness of peer-to-peer discussions.

Section 19.1716(g) and §19.2016(h) clarify that an appeal decision must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination. These provisions are consistent with Insurance Code §4201.457, which governs the appeal decisions for specialty URAs.

Section 19.1717 and §19.2017 address **Independent Review of Adverse Determinations**. Section 19.1717(a) and §19.2017(a) address notification for life-threatening conditions and track the requirements in existing §19.1721(a). The notification of adverse determination subject to the timeframes discussed in the subparagraphs relate to notices of determination made in *prospective and concurrent* utilization review. These provisions implement Insurance Code §4201.304.

Section 19.2017(a)(1)(A) and (B) specify the timeframes for notification of an adverse determination based on the status of the coverage. For workers' compensation non-network coverage, the adverse determination notice must be provided within the timeframes specified by 28 TAC §134.600. For workers' compensation network coverage, the adverse determination notice must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102.

Section 19.1717(a)(1) and §19.2017(a)(1)(C) add a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process. Section 19.1717(a)(1) requires the URA to provide a copy of the request for a review by an IRO form to the enrollee or an individual acting on behalf of the enrollee, and the provider of record, at the time they are notified of the

adverse determination. This requirement will inform the enrollee of additional options following an adverse determination and enable the enrollee to quickly and efficiently request independent review. Section 19.2017(a)(1)(C) requires the URA to give notice of the procedure for obtaining a copy of the request for a review by an IRO form. The requirements in §19.1717(a)(1) and §19.2017(a)(1)(C) are necessary to inform the enrollee or injured employee, respectively, of the process for independent review in the event of life-threatening conditions.

Section 19.1717(a)(2) and §19.2017(a)(2) require that the enrollee, or injured employee, respectively, their representative, or their provider of record determine the existence of a life-threatening condition on the basis of the prudent layperson standard. This standard requires that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is life-threatening. This new requirement is necessary to clarify that a health care provider does not have to make the determination that the condition is life-threatening, which provides more flexibility to the enrollee or injured employee as long as the prudent layperson test is met.

Insurance Code §4201.002(7) defines "life-threatening" as a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The statute does not specify who must make the determination that the disease or condition is life-threatening. TDI interprets this provision broadly to allow determination of the existence of a life-threatening condition based on a prudent layperson standard, rather than more narrowly allowing only medical personnel to make

the determination. Under this interpretation, an enrollee or injured employee who cannot obtain a medical opinion that his or her condition is life-threatening may still be entitled to a faster notice of adverse determination and immediate access to independent review. This requirement is adopted under TDI's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Section 19.1717(b) and §19.2017(a)(3) clarify that a party who receives an adverse determination or is denied an appeal involving a life-threatening condition is entitled to review by an IRO. This provision implements Insurance Code §4201.360.

Section 19.1717(c) and §19.2017(b) govern independent review involving life-threatening and non life-threatening conditions. Section 19.1717(c) and §19.2017(b) require the URA, or insurance carrier that made the adverse determination, to notify TDI within one working day from the date the request for an independent review is received. A "working day" is defined by Insurance Code §4201.002(16). The requirement that the URA notify TDI within one working day from the date the request for an independent review is received is necessary because prompt action is needed to initiate the process of independent review to ensure proper and timely medical treatment for enrollees and injured employees. TDI determined that the "working day" requirement will avoid impractical deadlines in situations when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Section 19.1717(c) and §19.2017(b) also require the URA, or insurance carrier that made the adverse determination, to submit to TDI through TDI's Internet website the request for a review by an IRO form which is submitted to the URA, or insurance

carrier that made the adverse determination, by the party requesting independent review. This requirement should result in greater efficiency and in a quicker response time for the injured employee or enrollee who is requesting the independent review.

Under §19.1717(c)(1) and §19.2017(b)(1), TDI, within one working day of receipt of the complete request for independent review, will randomly assign an IRO to conduct the independent review. TDI will notify the URA; payor; IRO; enrollee; or injured employee, respectively; their representative; provider of record; and any other providers listed by the URA as having records relevant to the review of the assignment of the IRO. This prompt assignment is necessary for both life-threatening and non life-threatening conditions because assigning IROs is a primary function of TDI.

The requirements in existing §19.1721(h) are not included in the adopted rules because the requirements are found in Insurance Code §4201.402, and inclusion of the requirements would be repetitive.

Section 19.2017(b)(2) references additional requirements for an independent review of an adverse determination for workers' compensation non-network coverage review under the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to 28 TAC Chapter 133, Subchapter D. This provision clarifies that these adopted rules do not exempt insurance carriers from TDI-DWC's medical billing rules or otherwise modify their duties under those rules.

Section 19.2017(b)(3) references additional requirements for an independent review of an adverse determination for a workers' compensation network coverage review under Insurance Code Chapter 1305, TDI and TDI-DWC rules, including but not

limited to, 28 TAC Chapter 10, Subchapter F, and Chapter 133, Subchapter D. This subsection clarifies that for claims under network coverage these adopted sections are to be applied in tandem with TDI's rules concerning workers' compensation health care networks and with TDI-DWC's rules concerning general medical procedures.

Section 19.1717(c)(2) specifies that the payor, in addition to the URA, must comply with the IRO's determination. This clarification is necessary because sometimes the URA and the payor are different parties. This provision implements Insurance Code §4201.401. Section 19.1717(c)(3) retains the requirements in existing §19.1721(j) and (k) and implements Insurance Code §4201.403.

Section 19.1718 addresses **Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans** and implements Insurance Code §§843.348, 1301.135, and 4201.304. Insurance Code §1301.0042 provides, in part, that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider plan. Section 19.1718(a) clarifies that the words and terms used in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in §19.1718. Section 19.1718(b) retains the requirements in existing §19.1723(a), which track the requirements in Insurance Code §843.348. Section 19.1718(c) and §19.1718(f)(2) do not use the term "business day," as used in existing §19.1723(b) and (f)(2), but instead use the term "working day" for consistency with the other rule provisions that contain the "working day" requirement.

The requirements in existing §19.1723(c) are not included in the adopted rules because the requirements are found in Insurance Code §843.348(e), and inclusion of the requirements would be repetitive. Section 19.1718(d) – (i) retains the requirements in existing §19.1723(d) – (i).

Section 19.1718(d)(2) adds a requirement that the initial determination by an HMO or preferred provider benefit plan indicating whether proposed services are preauthorized must be transmitted within 24 hours of receipt of the request and must be followed, within three working days, by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. This requirement is necessary to ensure that prompt written documentation of the adverse determination is provided to the relevant parties.

Section 19.1719 addresses **Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans** and implements Insurance Code §§843.347, 1301.133, and 4201.304. Insurance Code §1301.0042 provides, in part, that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider plan. TDI clarifies that under Insurance Code §1301.069, in part, verification of medical care or health care services applies to a physician or provider who: (i) is not a preferred provider included in the preferred provider network; and (ii) provides to an insured: (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 insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network. Section 19.1719(a) clarifies that the words and terms used in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in §19.1719. Section 19.1719(a) – (c) retains the requirements in existing §19.1724(a) – (c). The requirements in existing §19.1724(d) are not included in the adopted rules because the requirements are in Insurance Code §843.347(h) and (i), and inclusion of the requirements would be repetitive. Section 19.1719(d) – (i) retain the requirements in existing §19.1724(e) – (k). The requirements in existing §19.1724(l) and (m) are not included in the adopted rules because the requirements are in Insurance Code §1301.133(g) and (h), and inclusion of the requirements would be repetitive.

3. HOW THE SECTIONS WILL FUNCTION. Section 19.1701 and §19.2001 specify the statutory basis, purpose, and severability of Subchapters R and U, respectively. Section 19.1702 and §19.2002 specify the applicability of Subchapters R and U, respectively. Section 19.1703 and §19.2003 specify the meaning of words and terms when used in subchapters R and U, respectively, unless the context clearly indicates otherwise. Section 19.1704 and §19.2004 specify the applicability of certification or registration requirements, the application and renewal process, procedures for contesting a denial, and the requirement to update information within 90 calendar days after the effective date of the rule.

Section 19.1705 and §19.2005 specify the general standards of utilization review, including the utilization review plan review, special circumstances, screening criteria, referral and determination of adverse determinations, delegation of review, and complaint system. Section 19.1706 and §19.2006 specify the requirements and prohibitions relating to personnel. Section 19.1707 and §19.2007 regulate URA's contact with and receipt of information from health care providers, including reimbursement for providing medical information, a requirement to request all relevant and updated information and medical records to complete the review, sharing information among URA divisions, and the prohibition against requiring observation of a psychotherapy session or submission of a mental health therapist's process or progress notes.

Section 19.1708 and §19.2008 specify on-site review by a URA. Section 19.1709 and §19.2009 specify notice requirements, elements, and timeframes for determinations made in utilization review. Section 19.1710 and §19.2010 specify requirements prior to issuing an adverse determination. Section 19.1711 and §19.2011 specify written procedures for appeals of adverse determinations. Section 19.1712 and §19.2012 specify the URA's telephone access, and §19.2012 specifies procedures for certain drug requests. Section 19.1713 and §19.2013 specify confidentiality requirements and written procedures on confidentiality. Section 19.1714 and §19.2014 specify regulatory requirements subsequent to certification or registration.

Section 19.1715 and §19.2015 specify administrative violations. Section 19.1716 and §19.2016 specify requirements for specialty URA applications; specialty

requirements; exceptions to rule requirements; utilization review plans; employed or contracted physicians, doctors, other health care providers, and personnel; reasonable opportunity for discussion; and appeals. Section 19.1717 and §19.2017 specify independent review of adverse determinations.

Section 19.1718 provides requirements for preauthorization for HMOs and preferred provider benefit plans. Section 19.1719 provides requirements for verification for health maintenance organizations and preferred provider benefit plans.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General.

Comment: Commenters appreciate the work of TDI staff and the Utilization Review Advisory Committee members in proposing these rules, which was a complex task. A commenter appreciates TDI's revisions to the regulations as previously informally proposed. A commenter states that TDI's proposed URA rules are much more streamlined and less complex than the set of utilization review agent rules that were proposed for adoption on June 23, 2011. A commenter generally agrees with the goal of TDI staff to make the utilization review rules for workers' compensation and health consistent whenever possible.

Agency Response: TDI appreciates the supportive comments and acknowledges the hard work of the Utilization Review Advisory Committee.

Comment: Commenters state that the proposal incorrectly attempts to make workers' compensation look more like group health insurance by using group health

insurance standards and terms in the workers' compensation system for the review of medical care. The commenters state that this attempt might have adverse effects because workers' compensation is different than health insurance, as is the medical coverage under the two types of insurance. The commenters state that workers' compensation is not a medical program, or a health benefit plan, but a no-fault disability program with a medical component. A commenter clarifies that workers' compensation coverage is limited to disabilities and medical conditions that arise out of a compensable on-the-job injury as set out by legislative enactments. The commenters say that there are very specific standards for entitlement to medical care and legal terms found in the Texas Workers' Compensation Act that are not common to health insurance policies and statutes. The commenters assert that blurring those differences by rule might confuse people and result in more medical disputes.

One commenter states that the Subchapter U proposed rules do not enhance the delivery of appropriate medical care to employees entitled to workers' compensation benefits. The commenter asserts that many of the proposed rules ignore legislative directives to TDI on how the Chapter 4201 statutes are to be applied to workers' compensation. As a result, the commenter asserts that many of these proposed rules are totally inappropriate to workers' compensation and undermine the workers' compensation system.

One commenter states that the changes necessary to align the rules with the Insurance Code, Labor Code, and the rule preamble are significant and need to be made prior to adopting the rules. The commenter requests the proposed rules be

withdrawn to allow the rules to be amended in a manner that aligns the rules with Labor Code and TDI-DWC rules to ensure the rules "fit" within the four corners of the law.

One commenter states that the proposed rules for Subchapter U should be withdrawn again and redrafted to properly comply with legislative directives concerning these rules. The commenter asserts that there are so many statutory violations imbedded in these rules that violate both the Insurance Code and Labor Code that this proposed Subchapter U should be withdrawn. The commenter explains that studies of the United States health care system indicate that approximately one-third of the money spent nationally on health care services is for unnecessary and inappropriate health care services. A study conducted by TDI indicates that overutilization of health care services in the Texas workers' compensation system is much higher than the overutilization of services for non-work related injuries and illnesses and produces worse health outcomes and return-to-work outcomes for workers. Despite the fact that overutilization of health care is a national workers' compensation health issue, the proposed rules make utilization review more difficult, more expensive, and discourage health care providers from assisting in utilization review. This has an adverse impact on patients, injured workers, families paying health insurance premiums, employers paying workers' compensation premiums, health benefit plans, and workers' compensation carriers.

This commenter asks (i) why is TDI and not TDI-DWC developing rules regulating persons who perform utilization review of workers' compensation benefits; (ii) why is TDI developing rules regulating persons who do not determine whether or not

workers' compensation health care is medically necessary or appropriate; (iii) why do these rules repeatedly resolve conflicts between the Labor Code and Insurance Code Chapter 4201 in favor of Chapter 4201; and (iv) why do these rules make utilization review more difficult and more expensive?

Commenters assert that it is important that the rules do not include non-workers' compensation term definitions and concepts that pose a conflict between the rules and Texas Workers' Compensation Act. The commenters explain that, as proposed, the URA rules include a provision that provides that if there is a conflict between the URA rules and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail. There should be no such provision in the rule. The URA rules should be drafted and adopted in a manner that conforms to the Labor Code, rules adopted by the commissioner of workers' compensation, and recognition of how workers' compensation works in Texas.

Commenters state that there are several inconsistencies between the preamble and rules that need to be addressed prior to the adoption of the rules.

Agency Response: TDI agrees that health insurance and workers' compensation coverage are different products, and issues specifically related to one might not apply to the other. However, one of the purposes of the proposed rules is to implement HB 4290, which includes amendments to Insurance Code Chapter 4201.

TDI disagrees that the proposed rules should be withdrawn for the following reasons. The commissioner of insurance and the commissioner of workers' compensation, in their joint statement to the members of the Utilization Review Advisory

Committee dated February 10, 2010, stressed that although Subchapters R and U address a function that is provided in both the health and workers' compensation systems, the rules derive from a common statute, Insurance Code Chapter 4201.

As previously discussed, Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review.

Labor Code §402.00111 addresses the relationship between, and respective authority of, the commissioner of insurance and the commissioner of workers' compensation regarding workers' compensation system administration. Section 402.00111(c) provides that the commissioner of insurance develop and implement policies that clearly separate the respective responsibilities of TDI and TDI-DWC. By official order dated October 28, 2005, the commissioner of insurance developed policies that clearly separated the respective responsibilities of TDI and TDI-DWC. The order provided, in part, that the commissioner of insurance and TDI must license and regulate workers' compensation URAs.

Also, Labor Code §402.00111(b) provides, among other things, that the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

By official order of the commissioner of workers' compensation dated June 21, 2011, the authority to adopt rules regulating utilization review of a health care service provided to a person eligible for workers' compensation benefits under Labor Code Title 5 was delegated to the commissioner of insurance.

TDI and TDI-DWC have determined that Subchapter R and Subchapter U rules should be consistent whenever possible for the benefit of both regulated entities and consumers.

TDI asserts that although these rules potentially increase the cost of utilization review, medical cost containment, premiums, or administrative costs, they are necessary to implement HB 4290, make other changes necessary for clarity and effective implementation of the Insurance Code Chapter 4201, and improve the regulatory framework for URAs.

Additionally, these rules promote efficient regulation of URAs through the alignment of health and workers' compensation URA certification and registration requirements, utilization review timeframes, and utilization review standards. These rules also align differences in utilization review timeframes and standards within workers' compensation for network and non-network claims.

TDI disagrees that there are any inconsistencies between the proposal preamble and the rules, and the commenter did not provide any examples of inconsistencies.

Comment: A commenter states that inconsistent use of terms, both internally and with reference to corollary but specialized uses in the Labor Code and TDI- DWC rules, in the rule proposal may introduce unintentional confusion leading to dispute.

Where definitions of terms in these proposed rules conflict with or confuse existing definitions in the Labor Code and TDI-DWC rules, the rules invite unnecessary inconsistency and should be modified or reconsidered.

A commenter notes that the use of group health terminology within the Subchapter U rules pertaining to workers' compensation, including "payor" and "provider" of record, may lead to unnecessary confusion and disputes. Under the rules of statutory construction embodied in Government Code Chapter 311 and relevant cases and rules, the use of differing terms are assigned deferent meanings to give meaning to the entire statute (or rule) and each word used.

Agency Response: TDI considered Labor Code provisions when developing both terminology and timeframes. However, as previously discussed, Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review.

Comment: A commenter notes that TDI references the report of the Utilization Review Advisory Committee in support of some of the proposals but has not included references when the committee opposed the requirements now included in these proposals. The commenter suggests that such references be included in the adoption order for complete background information.

Agency Response: TDI declines to make the suggested change. TDI acknowledges that there are many stakeholders affected by the rule in addition to the Utilization Review Advisory Committee members. TDI also recognizes that the Utilization Review Advisory Committee's role was to advise the commissioner on

development of rules regarding the administration of Insurance Code Chapter 4201, as provided in Insurance Code §4201.003. TDI recognizes that the Utilization Review Advisory Committee has since been abolished by HB 1951, 82nd Legislature, Regular Session, effective September 1, 2011. However, in recognition of the Utilization Review Advisory Committee's statutory charge prior to its abolishment, TDI has considered all of the Utilization Review Advisory Committee recommendations, and this adoption order identifies the reasoned justification for the adoption of each of these rules.

Comment: A commenter states that prior informal drafts of these rules took into account the possibility that a URA would use performance tracking data. The law and rule neither require nor prohibit the use of performance tracking data. However, if performance tracking data is used, the utilization review plan must provide prior written notice to a physician, doctor, or other health care provider and an opportunity to correct reports prior to publishing data that identifies the particular physician, doctor, or other health care provider, including quality review studies or performance tracking data. This section should be amended to add a new subsection (g) that would include such requirements if performance tracking data were used.

Agency Response: TDI declines to make the suggested change. The suggested provisions reflect the statutory requirements of Insurance Code §4201.556, which states, "A utilization review agent may not publish data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or

other provider." The suggested change would not require anything additional to the statutory requirements under Insurance Code §4201.556(a), and would be redundant.

Comment: A commenter states that prior informal drafts of these rules included the issue of a prescription drug being the subject of an adverse determination. The commenter asserts that the provision should be included so that the rules can address the specific denial of a particular drug, especially in the case where the patient's physician has determined that the drug is medically necessary. As an adverse determination, the patient can take a drug denial through the established process. The commenter states that the language should be retained and added as a new subsection (h) which would read as follows: (h) Pursuant to the Insurance Code §1369.056, the refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of this subchapter if: (1) the drug is not included in a drug formulary used by the group health benefit plan; and (2) the enrollee's physician has determined that the drug is medically necessary.

Agency Response: TDI declines to make the suggested change. The requirement is already contained in Insurance Code §1369.056, and adopted §19.1702(b) explains that provisions of Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to Subchapter R. The suggested change would not require anything additional to the statutory requirements under Insurance Code §1369.056, and would be redundant.

Comment: A commenter suggests that all references to providing notice to or permitting action by injured employees, their representatives, and health care providers

also include ombudsmen as persons acting on behalf of injured employees. The commenter points out that many injured employees proceed through the medical dispute resolution process with the assistance of the OIEC ombudsmen because of the unavailability of attorneys' fees. Because the medical dispute resolution process has many tight deadlines, the commenter reasons that it is critical that the Ombudsmen receive notice and be permitted to act on behalf of the injured employee to satisfy the mandate of Labor Code §404.151(b)(5) to "assist unrepresented claimants to enable those persons to protect their right in the workers' compensation system."

The commenter believes that the ombudsmen are representatives under 28 TAC §150.3(a)(3) and Labor Code §401.011(37). The commenter states that OIEC is required under the Memorandum of Understanding Concerning Confidential Information with TDI-DWC to file written authorization from the claimant allowing the Ombudsmen access to confidential records. OIEC ombudsmen do not receive a fee or remuneration directly or indirectly from claimants. Although OIEC ombudsmen maintain an adjuster's license, they do not function as an adjuster when they assist injured employees in the dispute resolution process. In fact, they are only required to have an adjuster's license because the agency adopted that requirement as part of the training and continuing education standards for Ombudsmen. See 28 TAC §276.10. OIEC ombudsmen serving as lay representatives, even though they have an adjuster's license, is comparable to TDI-DWC's long-standing policy of permitting licensed attorneys, who also maintain an adjuster's license, to appear as adjusters in the dispute resolution process.

Agency Response: TDI disagrees with the suggested change. The proposed rules do not prohibit the OIEC Ombudsman from assisting the injured employee. However, expanding the role of the OIEC to act on behalf of the injured employee is beyond TDI's authority. Labor Code Chapter 404 does not authorize an OIEC Ombudsman to act as a representative for the injured employee. The adopted language mirrors language in Insurance Code §1305.355(a), which relates to the independent review of adverse determinations in certified network cases.

Comment: A commenter requests that TDI review §§19.2005, 19.2006, and 19.2009 – 19.2011 to assure consistency of terminology among the sections. Sometimes the term "physician, doctor, or health care provider" is used and sometimes only the term "physician" is used.

Agency Response: TDI clarifies that under §19.2005(e), a physician, doctor, or health care provider may issue an adverse determination under certain circumstances. This provision is consistent with Insurance Code §4201.153, that provides appropriate non-physician and non-doctor health care providers may issue an adverse determination on a health care service in certain circumstances. However, under §19.2005(a), the utilization review plan must be reviewed and approved by a physician. This provision is consistent with Insurance Code §4201.152, that requires utilization review be performed under the supervision of a physician.

Section 19.2006(b) includes the terms "physician, doctor, or health care provider" to reflect the fact that a health care provider can render an adverse determination. Section 19.2009(b) requires the written notification of an adverse determination to

include the professional specialty and Texas license number of the physician, doctor, or other health care provider that made the adverse determination. This provision is also consistent with the fact that a health care provider can render an adverse determination under Insurance Code §4201.153.

Comment: A commenter requests that §19.2001(c)(1) be amended to align it closely with one of the core goals of §408.021 of the Texas Workers' Compensation Act, which is to promote the cost effective delivery of quality health care that cures or relieves the effects naturally resulting from a compensable injury, including reasonable expenses incurred by the employee for necessary treatment to cure and relieve the employee from the effects of an occupational disease before and after the employee knew or should have known the nature of the disability and its relationship to the employment; promotes recovery; or enhances the ability of the employee to return to or retain employment. The commenter states that, as currently proposed, the rule provides that the focus of utilization review should be on promoting the delivery of quality health care in a cost-effective manner and providing for the injured employees' safety. The stated purpose of the rules ignores the intent of the Legislature, which is clearly stated in Labor Code §402.021 and §408.021. The commenter suggests the words "cost effective" be added in §19.2001(c)(1) after the words "promote the." The commenter further suggests that the words "in a cost-effective manner, including protection of injured employee safety" be deleted and replaced with "reasonably required to treat the injured employee's compensable injury and that cures or relieves the effects naturally resulting from the compensable injury, including reasonable

expenses incurred by the employee for necessary treatment to cure and relieve the employee from the effects of an occupational disease before and after the employee knew or should have known the nature of the disability and its relationship to the employment; promotes recovery; or enhances the ability of the employee to return to or retain employment."

A commenter requests that the term "health" be replaced with the term "medical" in §19.2001(c)(1) to bring 28 TAC §19.2001(c)(1) more in line with 28 TAC §180.19(a)(5), which provides that one of the key regulatory goals for workers' compensation is to "ensure each injured employee shall have access to prompt, high quality, cost-effective medical care."

A commenter asserts that the proposed rule fails to specify that workers' compensation utilization review must include the concept that the planned medical care is both reasonable and appropriate to treat the workplace injury and in accord with evidence-based medicine. The commenter asserts that §19.2001(c)(1) of the proposed rule should be modified to include the concept that the purpose of utilization review is to determine if the service or proposed service is actually reasonably required by the nature of the compensable injury and whether the service or proposed service is clinically appropriate and effective for the injury and provided in accord with best practices consistent with evidence-based medicine or, if evidence-based medicine is not available, generally accepted standards of medical practice recognized in the medical community.

Agency Response: TDI disagrees with the suggested changes. Adopted §19.1701(c) and §19.2001(c) track Insurance Code §4201.001, regarding the purpose of Insurance Code Chapter 4201, with the addition of the word "medical" as a clarifying change in §19.1701(c)(4) and §19.2001(c)(4) because "medical records" is a defined term. TDI asserts that the use of the term "medical care" instead of the term "health care" in §19.2001(c)(1) would not add clarity because the term "health care" is used throughout Subchapter U. The concepts of cost-effectiveness, reasonableness, and appropriateness are adequately contained in the applicable statutes and adopted rule.

Comment: A commenter requests that the proposal preamble language for §19.2002(a)(2) be set forth directly in the applicability section to specifically clarify that persons performing administrative tasks are not subject to the proposed rules.

A commenter asserts that the agency generated amendment to Insurance Code §4201.051 changes the meaning of the statute. The commenter asserts that the apparent purpose of this change is to limit the applicability of Insurance Code §4201.051 and to expand the authority of TDI to regulate a wide variety of persons who do not determine medical necessity or appropriateness. This commenter further notes that Texas appellate courts have told TDI that it can only exercise such authority as is conferred upon it in "clear and unmistakable terms by the legislature" and "its authority will not be extended by inference but must be strictly construed." *Hamaker v. American States Ins. Co. of Texas* 493 S.W.2d 893 (Tex. Civ. App. Austin 1973, ref. n.r.e.); *Key Western Life Insurance Co. v. State Bd. of Ins.* 350 S.W.2d 839 (Tex. Sup. 1961); *Lawyers Title Ins. Corp. v. Board of Insurance Commissioners* 207 S.W.2d 972 (Tex.

Civ. App.- Austin 1948). The commenter asserts that TDI's interpretation of this statute is based on a legally impermissible inference and is inappropriate.

A commenter requests that TDI amend the rule to replace the word "person" with "administrative staff" and to replace the phrase "provided for under workers' compensation insurance coverage, but that does not determine medically necessary or appropriate or necessity or appropriateness or the experimental or investigational nature of health care services" with "benefits whether a particular health care service provided or to be provided to an injured employee is medically necessary or appropriate or experimental or investigational." The commenter asserts the recommended language tracks more closely the actual language of Insurance Code §4201.051 and more clearly clarifies that the rules do not apply to persons who handle administrative processes within the utilization review process and do not determine the medical necessity or appropriateness or the experimental or investigational nature of the health care service.

Agency Response: TDI agrees in part and disagrees in part. TDI agrees that the clarification should be made to §19.2002(a)(2) to more closely track Insurance Code §4201.051; however, TDI disagrees with the commenter's suggested language. TDI made changes to §19.2002(a)(2), and conforming changes to §19.1702(a)(2), to more closely track Insurance Code §4201.051 by replacing the word "that" with "who" and replacing the words "but that" with "and." The preamble states that the proposed rules "clarify that a person performing administrative tasks for a URA, that does not determine medical necessity or appropriateness, or the experimental or investigational nature, of

the health care services, is not subject to the proposed regulations." TDI declines to replace the word "person" with "administrative staff" because the language in adopted §19.2002(a)(2) and §19.1702(a)(2) tracks the language in Insurance Code §4201.051 and the suggested change would not add any clarity. TDI asserts that the purpose of §19.2002(a)(2) is to track Insurance Code §4201.051 and not to expand the authority of TDI to regulate a wide variety of persons, who do not determine medical necessity or appropriateness.

Comment: Commenters raise concerns regarding the proposed rules' requirements that physicians performing required medical examinations be subject to the proposed utilization review rules in §19.2002(b)(1). Commenters assert that proposed §19.2002(b)(1) is being read by the insurance and utilization review industries as requiring peer review and requiring medical examination doctors to comply with all provisions of the proposed URA rules. The commenters explain that peer review doctors, who conduct an administrative review of medical records, and required medical examination doctors, who conduct a hands-on examination of an injured employee and review their medical records, render an opinion of the medical necessity and appropriateness of healthcare treatment. The commenters state that peer review doctors and required medical examination doctors are not subject to Chapter 4201 of the Insurance Code and TDI's URA rules.

Commenters explain that the Legislature has defined the role of required medical examinations in the Texas Workers' Compensation Act. Commenters further state that Labor Code §408.004 provides that the commissioner of workers' compensation may

require an employee to submit to required medical examinations to resolve any question about the appropriateness of the health care received by the employee. Labor Code §408.004 also provides that the commissioner may require an employee to submit to a medical examination at the request of the insurance carrier, but only after the insurance carrier has attempted and failed to receive the permission and concurrence of the employee. The Labor Code also provides that required medical examinations can be requested and performed to determine whether there has been a change in the employee's condition and whether it is necessary to change the employee's diagnosis.

Commenters assert that the Labor Code does not define required medical examinations as utilization review, and the Insurance Code does not define required medical examinations as utilization review. The commenters note that a required medical examination is not a utilization review process, as no specific claim action is taken as the result of the hands-on examination and review of medical records of an injured employee. The required medical examination doctor provides an opinion as to whether the treatment is appropriate, but the ultimate decision whether to adopt that position is made by the carrier's medical advisor or utilization review agent. Required medical examinations are no more utilization review than is an independent review of health care by an independent review organization or a health care quality review conducted by TDI-DWC's Medical Quality Review Program. All of these processes have a specific purpose defined in the Labor Code. The commenters request that TDI delete all requirements that a required medical examination physician be subject to the proposed utilization review rules because there is no statutory authority to require

medical examination physicians to be subject to the utilization review rules, and such requirements jeopardize the independence of required medical examination physicians. The commenters further state that, if required medical examinations and peer reviews are deemed to be utilization review, then this provision of the rule would also have to apply to employee requested post designated doctor required medical examinations, designated doctors, and all referral and consulting doctors selected by the treating doctor. The commenters further explain that the utilization review statute was never intended to regulate examining doctors, but rather was only intended to regulate utilization review agents that address medical necessity issues.

A commenter states that, at the request of an insurance industry work group that reviewed the proposed URA rules, the commenter contacted TDI-DWC and discussed this rule provision with a senior member of TDI-DWC's staff who has been involved in drafting the URA rules. The commenter asserts that they were informed that the intent of this subsection of §19.2002 is to clarify that the peer review doctor and required medical examination doctor must be an employee of or contracted with the URA doctor rendering the adverse determination if relying on the peer review or required medical examination report when making the retrospective utilization review adverse determination. The commenter respectfully points out that neither the Insurance Code nor the Labor Code requires peer review and required medical examination doctors to either be an employee of or contracted with a URA under any circumstances. As such, there is no statutory provision that allows or directs TDI to include the requirement set

forth in this subsection in the URA rules. The commenter requests that TDI delete §19.2002(b)(1).

Alternatively, this commenter requests that §19.2002(b)(1) be amended to include an alternative that the paragraph track the language of the Chapter 180 rule addressing the duties and responsibilities of a peer review doctor and eliminate all reference to required medical examination doctors.

A commenter opines that the apparent purpose behind §19.2002(a)(2) of the rules is to allow TDI to regulate peer reviewers and required medical examination doctors under §19.2002(b)(1). The commenter states that there is no statutory language in Chapter 4201 that justifies the expansion of the applicability of that chapter and these rules to a person who "does not determine whether a particular health care service provided or to be provided is medically necessary or appropriate . . . " and the statutes prohibit applicability in this regard. The commenter asserts that peer reviewers and required medical examination doctors do not determine medical necessity.

Additionally, the commenter asserts that TDI-DWC, and not TDI, has limited authority to regulate peer reviewers and required medical examination doctors under Labor Code §408.004 and §408.0231 and not the Insurance Code. The commenter asserts that for TDI to usurp and exceed this authority granted to TDI-DWC is inappropriate. The commenter further notes that TDI-DWC has already exercised this authority as found in 28 TAC §§126.6, 180.22, and 180.28. The commenter further asserts that TDI regulations directly conflict with existing TDI-DWC regulations. The

commenter explains that the conflict can be avoided by deleting these illegal and unnecessary rule provisions.

The commenter asks whether all health care providers who express opinions on the necessity and appropriateness of medical care should be regulated under the URA rules. The commenter also asks whether TDI is attempting to ensure that all medical opinions utilized by the URA to make a utilization review determination are rendered by a health care provider that is employed by or under contract with the URA, and states that, if so, this would be sheer foolishness. The commenter notes that there is no statutory authority in the Insurance Code or the Labor Code to allow TDI to mandate such an employment or contractual relationship.

A commenter asks whether §19.2002(b)(1), that the commenter opines is a TDI generated statutory rewrite and expansion of authority, is aimed at correcting a problem with the utilization of medical care in the workers' compensation system. The commenter explains that TDI studied the utilization of health care in the workers' compensation system in 2001 and found that injured workers in Texas receive six times as much treatment as persons with the same injury who were not injured on the job. This overutilization of medical care produced worse return to work and health outcomes for workers' compensation claimants than for persons treated outside of the workers' compensation system. The commenter further states that peer reviewers and required medical examination doctors did not create this problem. There is some evidence that the overutilization of medical care in the workers' compensation system has moderated since the enactment of workers' compensation reforms in 2001 and 2005. However,

there is no evidence that overutilization of health care in the workers' compensation system has abated to the point that treatment in the workers' compensation system mirrors treatment outside of the system. The commenter requests that TDI repeat the 2001 study and publish the results.

Finally, the commenter states that §19.2002(b)(1), together with proposed §19.2004(a), requires all peer reviewers and required medical examination doctors to become registered utilization review agents and is inappropriate. The commenter recommends §19.2002(b)(1) be deleted in its entirety.

A commenter states that the issue is not whether peer reviews and required medical examination doctors should be regulated; they should be regulated and already are regulated by statute and rule. However, they are not performing utilization review, are not determining whether health care services should be paid or denied reimbursement, and should not be regulated as utilization review agents. The commenter asserts that proposed §19.2002(b)(1) should be stricken as inconsistent with the workers' compensation law and the Insurance Code and as outside the authority of TDI.

A commenter asserts that 28 TAC §180(g) recognizes that peer reviewers are URAs in some cases, but does not provide the same for required medical examinations.

A commenter requested clarification of §19.2002(b)(1), because the rule appears to require all peer reviews to comply with all utilization review requirements of the entirety of Subchapter U, which may be overly broad and unnecessarily burdensome. The commenter explains that peer reviews may be used for a multitude of purposes

from internal information and decision making unrelated to health care provider utilization requests, as tools to decide if utilization review is needed, or to opine on extent of injury issues. The commenter offers that it may be more appropriate to require peer review compliance with Subchapter U in cases where the health care provider is seeking authorization that is either wholly or partly denied based in part on a peer review report. The commenter states that the provisions of 28 TAC §180.22(g), making Insurance Code Chapter 4201 applicable to peer reviewers who perform utilization review, should not be expanded beyond this applicable rule.

Agency Response: TDI agrees to clarify §19.2002(b)(1) to avoid confusion among system participants as to the applicability of the URA rules to all required medical examinations; however, TDI notes that a required medical examination may qualify as utilization review under certain limited circumstances. Specifically, a required medical examination that is performed pursuant to Labor Code §408.004 may qualify as utilization review under the current definition of utilization review if the examination is intended to review the medical necessity or appropriateness of an injured employee's health care services. TDI further clarifies that designated doctor examinations and required medical examinations under Labor Code §408.0041 never qualify as utilization review, because these examinations do not review the medical necessity or appropriateness of an injured employee's health care services and only address issues such as the ability of an injured employee to return to work, the injured employee's maximum medical improvement date or impairment rating, the extent of the injured employee's compensable injury, and other related issues.

In terms of the applicability of utilization review requirements to peer review functions in the Texas workers' compensation system, TDI reminds stakeholders that §180.22(g), which was first adopted in 2006 and later updated in 2011, states, in part, that "a peer reviewer who performs prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and TDI and TDI-DWC rules." This rule further states that a peer reviewer who performs utilization review must be certified or registered as a URA by TDI or be employed by or under contract with a certified or registered URA. The language in §19.2002(b)(1) reminds stakeholders of the requirements that already apply to peer reviewers under the 28 TAC Chapter 180 rules.

TDI clarified §19.2002(b)(1) by deleting "or required medical examinations under Labor Code §408.004," and by making the section into one sentence to clarify the applicability to peer reviewers, by moving "and" to the end of the phrase "must generate a written report," and deleting both the period at the end of the sentence, and "Peer reviewers" at the beginning of the following sentence. TDI deleted the sentence, "Required medical examination doctors must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 126 of this title (relating to General Provisions Applicable to All Benefits); Chapter 134, Subchapter B, of this title (relating to Miscellaneous Reimbursement); and Chapter 180 of this title."

Comment: A commenter strongly supports §19.2002(b)(1) which clarifies that required medical examination doctors must comply with regulations under Subchapter U, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act. Such regulation protects the injured worker by assuring that all physicians who perform peer reviews meet and comply with appropriate standard of care and regulatory requirements.

Agency Response: TDI appreciates the supportive comment. However, as previously discussed, TDI deleted the required medical examination language from adopted §19.2002(b)(1).

Comment: A commenter appreciates that clarification in §19.2002(b)(3). Another commenter supports the adoption of §19.2002(b)(3) and §19.2002(b)(4).

Agency Response: TDI appreciates the supportive comments.

§19.1703 and §19.2003. Definitions.

Comment: A commenter requested TDI add language to the definition of "adverse determination" in §19.2003(b)(1) to explain, "this term does not include a peer review by a URA that is not used as a basis to deny authorization or reimbursement for health care."

Agency Response: TDI declines to make the suggested change. Peer review is defined in adopted §19.2003(b)(24), and TDI clarifies that the requirements contained in adopted Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care, such as compensability or an injured employee's ability to return to work.

Comment: A commenter asserts that TDI introduces terms into Subchapter U that conflict with existing terms and definitions found in the Labor Code. Insurance Code §4201.054(c) expressly mandates that Labor Code Title 5 prevails over Insurance Code Chapter 4201 when there is a conflict. The commenter notes that TDI has corrected some of the conflicts but has maintained other conflicts. The commenter expresses concern that introducing new and conflicting concepts into this subchapter creates confusion for stakeholders and can lead to the misapplication of the rules. The commenter asserts that terms that should be deleted and not used in the rules include the following: "insurer," "mental health therapist," "payor," "person," and "provider of record. " In addition, TDI introduces other terms not found in the definitions section that should be deleted, including "physician" and "life-threatening condition" which are inappropriate for the workers' compensation subchapter.

Agency Response: TDI declines to delete "payor," "mental health therapist," "person," and "provider of record" from the terms defined in §19.2003(b) because it would result in inconsistent definitions between these adopted rules and Insurance Code Chapter 4201 as well as result in inconsistent definitions under Subchapters R and U. TDI clarifies that the terms "physician" and "life-threatening condition" are defined in Insurance Code §4201.002.

For purposes of clarification, the term "payor" includes an insurance carrier or insurer. The statutory definition of "payor" in Insurance Code §4201.002(10) does not conflict with Insurance Code Chapter 1305 or Labor Code Title 5. TDI has tailored the definition of "payor" to include a person or entity that provides, offers to provide, or

administers workers' compensation benefits, in recognition that the definition of "payor" under Subchapters R and U should not be identical.

Retaining the reference to "payor" in Subchapter U also is necessary because sections specifically distinguish between situations where the insurance carrier is, or is not, the payor. Under §19.2017(b)(1), the term "payor" is also necessary for consistency with the IRO rules under 28 TAC §12.1, which contemplate an IRO's interaction with URAs and payors.

The term "mental health therapist" is used in §19.2007(d), which implements Insurance Code §4201.303. Under Insurance Code §4201.303, a URA is prohibited from requiring, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes.

TDI clarifies that the "provider of record" is the individual requesting treatment on behalf of the injured employee and is the point of contact for the URA to discuss a pending adverse determination, request records, and provide notice of favorable or adverse determinations. This definition of "provider of record" mirrors the definition in proposed §19.1703 and is necessary to track Insurance Code §4201.002(12). Insurance Code §4201.002(12) defines "provider of record" as the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers'

compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201. TDI asserts that there is no direct conflict with the use of "provider of record" and Labor Code Title 5. Thus, TDI has rulemaking authority to define and utilize the term "provider of record" throughout the Subchapter U rules.

The term "life-threatening" is defined in Insurance Code §4201.002(7), and proposed §19.2003(a) provides that the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise. TDI clarifies that the concept of "life-threatening" conditions is already introduced into the workers' compensation system. For example, the IRO regulations under 28 TAC §12.5 define "life-threatening condition," and §12.205 and §12.206 contain requirements specific to instances of life-threatening conditions. Title 28 TAC §133.305 also defines "life-threatening," and 28 TAC §133.308(h) provides that in a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to comply with procedures for a reconsideration. TDI is not introducing a new concept into the workers' compensation system by adopting these regulations.

The term "physician" is defined in Insurance Code §4201.002(11), and proposed §19.2003(a) provides that the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise. TDI clarifies

that under §19.2005(d), a physician, doctor, or health care provider may issue an adverse determination under certain circumstances. This provision is consistent with Insurance Code §4201.153, that provides appropriate non-physician and non-doctor health care providers may issue an adverse determination on a health care service in certain circumstances. However, under §19.2005(a), the utilization review plan must be reviewed and approved by a physician. This provision is consistent with Insurance Code §4201.152, that requires utilization review be performed under the supervision of a physician.

Comment: A commenter asserts the provision in §19.1703(b)(1) and §19.2003(b)(1) that "adverse determination" does not include a denial of health care services due to the lack of prospective or concurrent utilization review will close any loophole that would allow a provider to request a retrospective review after their medical bill has been denied for lack of prior authorization.

A commenter supports the definition of "adverse determination," specifically the second sentence of the definition

Agency Response: TDI appreciates the supportive comments.

Comment: A commenter requests clarification as to whether §19.2003(b)(1) means that determinations that services or devices are experimental or investigational is not grounds for an automatic denial based solely on the finding that the service or device is experimental or investigational. The commenter asserts that such experimental or investigational services or devices may independently be denied under an adverse determination based on other proper reasons for a denial, for example, the

service or device is otherwise medically inappropriate or unnecessary on stated grounds in the same way a proposed spinal surgery must pass through preauthorization or concurrent review based on its medical merits. The commenter explains that 28 TAC §134.600(p)(6) and (q)(4) effective July 1, 2012, mandates preauthorization and concurrent review for experimental or investigational services or devices. The commenter notes that proposed rule language is readily misconstrued to mean that no adverse determination may be made when proposed services or devices are experimental or investigational. The commenter recommends that this definition be changed to conform with the workers' compensation standard for entitlement to medical care found in Labor Code §401.011(22-a) and §408.021.

Commenters explain that the language in the proposed rule suggests that the standard for entitlement to workers' compensation medical treatment is "medically necessary or appropriate." Labor Code §408.021 expressly states that the injured worker is entitled to "... all health care reasonably required by the nature of the injury as and when needed." The term "health care reasonably required" is specifically defined in the Texas Workers' Compensation Act at Labor Code §401 .011(22-a). This term is not defined in the Texas Workers' Compensation Act and is subject to an interpretation that could differ from the statutory standard of "health care reasonably required."

A commenter asserts that this definition conflicts with the statutory definition found in Insurance Code §4201.002(1) and the standards for health care coverage found in the Texas Workers' Compensation Act. Insurance Code §4201.054(c) expressly mandates that Labor Code Title 5 prevails over Insurance Code Chapter 4201

when there is a conflict. The commenter asserts that this is another incident in which TDI wrongly decided that Insurance Code Chapter 4201 prevails over the Labor Code.

A commenter recommends alternative language to replace "medically necessary or appropriate" with "reasonably required."

A commenter recommends §19.2003(b)(1) be modified to state that an adverse determination is a determination that the health care services provided or to be provided are not "reasonably required by the nature of the injury and is not clinically appropriate and considered effective for the injured employee's injury and provided in accord with best practices consistent with evidence based medicine or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

A commenter suggests that §19.2003(b)(1) be clarified to state that the term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review in accord with the requirements specified by the URA or payor.

A commenter recommends that §19.1703(b)(1) be clarified to state that the term does not include a peer review by a URA that is not used as a basis to deny authorization or reimbursement for health care.

A commenter asserts that the sentence, "the term does not include a denial of health care services due to the failure to request prospective or concurrent review," in §19.1703(b)(1) is inappropriate and should be struck. The commenter explains that the

sentence is contrary to what the definition of "utilization review" allows in Insurance Code §4201.002.

Commenters express a variety of concerns over the definition of adverse determination in §19.1703(b)(1). The commenters note that the definition classifies an insurer and workers' compensation carrier retrospective denial for medical necessity as an adverse determination and provides access to an IRO if requested. Most requests for retrospective review will be because a prospective or concurrent review for medically necessity was neither requested by the provider nor performed by the carrier. Denials for failure to request a prospective or concurrent review for medical necessity are included under the definition of retrospective review when one reads the statutory definition of "adverse determination" together with the statutory definition of "utilization review." The result is that retrospective review requests for denials for medical necessity should be considered adverse determinations. The commenter asserts that the proposed definition conflicts with current statutory language as it would negate the ability to request and obtain an actual review of medical necessity after a service or procedure is rendered. The commenter asserts that TDI is revoking the statutory inclusion of retrospective review as part of the definition of utilization review. The service or procedure is no less entitled to review for medical necessity because such review is retrospective.

A commenter asks TDI to consider instances where a physician wants to use an experimental or investigational treatment when other established treatments with the same outcomes are available.

Agency Response: TDI declines to make the suggested deletion. The phrase "medically necessary or appropriate" is consistent with the definition of "adverse determination" under the Insurance Code §4201.002, which defines "adverse determination" as a determination by a URA that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational. Also, the phrase "medically necessary or appropriate" is used in 28 TAC §12.5(1), which defines "adverse determination" for purposes of independent review. Introducing the phrase "health care reasonably required" would result in inconsistent definitions of "adverse determination" in the context of utilization review and independent review.

Nothing may be construed to limit healthcare reasonably required under Labor Code §408.021. TDI's position is that, based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to health care reasonably required by the nature of the injury as and when needed, including experimental and investigational health care services. For this reason, TDI further clarifies in §19.2003(b)(1) that for purposes of Subchapter U, the term "adverse determination" does not include a determination that health care services are experimental or investigational.

Comment: A commenter raises concerns with the term "appeal" in §19.2003(b)(2), which also applies to reconsideration processes prescribed by Labor Code Title 5. The commenter notes that one concern is that medical bill review might be treated as a utilization review because it is a retrospective review. The commenter

requests clarification in the proposed rule between the terms "utilization review" and "retrospective review."

Agency Response: TDI clarifies that the term "utilization review" is defined in Insurance Code §4201.002. Section 19.2003(a) states that the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

Comment: Commenters do not support including the phrase "that may reasonably be perceived as having potential to" in the definition of "disqualifying association" in §19.2003(b)(8) because it is too subjective and should be deleted. Commenters assert that the phrase "may reasonably be perceived as having potential to" in §19.2003(b)(8) is too broad, ambiguous, extremely subjective, and confusing. Commenters recommend the definition be modified by deleting the phrase "that may reasonably be perceived as having potential to."

A commenter states that the standard for determining a "disqualifying association" should be an association that actually influences the conduct or decision of a reviewing physician, doctor, or health care provider.

A commenter notes that certain subjective bases contained in the rule (for example, respecting disqualifying associations) do not provide adequate guidance to participants in determining appropriate conduct.

A commenter states that the proposed definition for disqualifying association based on personal or family relationships is vague in that it fails to specify the degree of

consanguinity that would create a relationship that is a disqualifying association. For consistency, Government Code Chapter 573 may aid in clarification.

A commenter requests that TDI amend the definition of "disqualifying association" to prevent the requesting provider of exercising bias and prejudice based solely on the fact that they received an adverse determination by a reviewer.

Agency Response: TDI disagrees with the suggested changes. The definition of "disqualifying association" includes "any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician or doctor." This reasonableness standard can be used to evaluate whether a personal or family relationship may be considered a disqualifying association.

TDI declines to further clarify the definition of "disqualifying association." The reasonableness standard is more flexible than a detailed list of specific family relationships that are always considered to be disqualifying associations.

Comment: A commenter raises concerns of the term "doctor" in §19.2003(b)(9). The commenter notes that the definition of the term "doctor" under proposed §19.2003(b)(9) mirrors the definition in Labor Code §401.011. However, this definition specifically excludes psychologists, doctorate in pharmacology and doctorate in physical therapy and other licensed health professionals – all of whom are "health care practitioners" as defined by Labor Code §401.011(21) and as such might need to be used in the utilization review process for the reconsideration process. The commenter suggests the addition of the definition for health care provider in the Insurance Code §4201.002. The commenter recommends the Insurance Code

reference (in contrast to the Labor Code definition) due to the limited scope of the definition of "health care provider" in the Labor Code. Additionally, the commenter notes that the definition of this term is in the existing utilization rules that are proposed to be repealed, but it was not included in these new proposed rules.

A commenter notes that the proposed rules do not use the term "health care practitioner" throughout the rules as one of the persons that may conduct utilization review. The commenter believes that TDI should define the term "health care practitioner" as it is defined in Labor Code §401.11{sic}. The term should be used in the manner set out in several of the commenter's written comments so as to clarify that psychiatrists, psychologists, and other health care provider specialties, e.g. physical therapists, may conduct utilization review when appropriate. The commenter requests that TDI add a definition for the term "health care provider" to §19.2003 as "an individual who is licensed to provide or render and provides or renders health care or a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor."

A commenter notes that the proposed rules use the term "health care provider" throughout the rules as one of the persons that may conduct utilization review. The term "health care provider" is not defined. The commenter believes that TDI should replace the term "health care provider" with the term "health care practitioner" and adopt the definition of the term "health care practitioner" that is set out in Labor Code §401.11{sic} to clarify that psychiatrists, psychologists, and other health care provider

specialties, for example, physical therapists, may conduct utilization review when appropriate.

Agency Response: TDI clarifies that under §19.1703(a) and §19.2003(a), the words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in the subchapters. The definition of "health care provider" in Insurance Code §4201.002(5) has the same meaning in both Subchapter R and U rules. TDI agrees that the definition of "doctor" in proposed §19.2003(b)(9) tracks the definition of "doctor" in Labor Code §401.011, and, so, TDI clarified in the adopted rules under §19.2003(b)(10) that the definition of doctor in adopted Subchapter U rules is as defined in Labor Code §401.011.

TDI clarifies that, although physical therapists, occupational therapists, and psychologists cannot be "treating doctors" under the Texas Workers' Compensation Act, they can be health care providers, request preauthorization of their services, and dispute an adverse retrospective review of their services. A URA is not precluded from using a properly credentialed physical therapist, occupational therapist, or psychologist to perform utilization review of these services.

Under Insurance Code §4201.153, appropriate non-physician and non-doctor health care providers may issue an adverse determination on a health care service in certain circumstances. However, in accord with Insurance Code §4201.152, all utilization review must still be performed under the supervision of a physician. Additionally, the peer-to-peer discussion requirements under Subchapters R and U require the provider of record to have an opportunity to discuss the determination with a

physician. TDI clarifies that under Insurance Code §4201.153, non-doctor, non-physician health care providers must still be appropriate to review the health care services at issue, so those health care providers must still have an appropriate specialty to review the health service and be licensed in Texas or otherwise authorized to provide health care services in Texas when performing utilization review.

Comment: A commenter remains concerned regarding the application of the Labor Code definition of experimental and investigational to health benefit plans as provided in §19.1703(b)(10). The commenter explains that while the legislature adopted a standard definition for the highly regulated workers' compensation program, it did not do so when amending the Utilization Review Act in HB 4290. The commenter asserts that the proposed definition varies from the definition commonly approved by TDI and used in health benefit plan policy form filings. Adoption of this definition by rule will likely require carriers to revise existing approved policy form filings, resulting in new administrative costs for health benefit plans. A commenter recommends leaving this term undefined to avoid potential conflicts with health plan definitions.

A commenter, while not disagreeing with the general nature of this definition in §19.1703(10), requests that TDI allow for definitions used in approved policy forms be an alternative to this definition. The commenter explains that policy forms use more specific definitions of experimental and investigational so as to more clearly delineate acceptable evidence that a procedure is or is not experimental or investigational, thus avoiding disputes between health plans and providers.

Agency Response: TDI disagrees with the suggested changes. TDI clarifies that the definition of the term "experimental or investigational" is at §19.1703(11) in the adopted rules. This definition is consistent with the definition under 28 TAC §12.5(12). It is important that the phrase be defined consistently at the utilization review and independent review stages.

Comment: A commenter states that one provision of the proposed rules could result in the delay of emergent care being rendered to injured employees, who are faced with a medical emergency, by providing for prospective and concurrent review of health care that is proposed to be rendered under emergent or life-threatening conditions. In workers' compensation, a medical emergency precludes the need for preauthorization or concurrent review. Instead, the health care should be rendered, the emergent nature of the delivery of the health care should be documented, and the insurer must then review the health care on a retrospective basis.

A commenter asserts that the definition for "medical emergency" is taken verbatim from Insurance Code §1305.004(a)(13). The commenter notes that the proposed rule therefore applies Chapter 1305, which is only applicable to certified workers' compensation networks, to all workers' compensation entities regardless of network certification status. The commenter asserts this is not what the Legislature intended. Were it otherwise, the Legislature would not have needed to incorporate a separate definition for medical emergency within Insurance Code Chapter 1305, as no potential conflict could exist where neither chapter defines "medical emergency" as in case of conflict, Insurance Code Chapter 1305 controls. The commenter explains that,

by making the Insurance Code Chapter 1305 definition of medical emergency applicable to all workers' compensation utilization review, a conflict is introduced. The commenter states that it would be more appropriate to provide that no preauthorization is required for medical emergencies, as both Chapter 1305 and the Act share this standard as it applies to utilization review.

A commenter suggests that psychiatric disturbances and symptoms of substance abuse be added to the definition of medical emergency in §19.2003(b)(20). The commenter points out that psychiatric disturbances and symptoms of substance abuse are specifically included in the definition of medical emergency in the federal regulations that apply to Medicare hospitals, 42 C.F.R. §489.24. The commenter argues that to be complete the definition of medical emergency in these rules should also include these references.

Agency Response: TDI disagrees that a conflict exists with the definition of "medical emergency" in the Insurance Code and the Texas Workers' Compensation Act. As the commenter stated, Insurance Code §1305.004 includes a definition for "medical emergency." The Texas Workers' Compensation Act does not include a definition of "medical emergency;" however, TDI-DWC rules have included a definition of "medical emergency" for many years. The term medical emergency is defined in 28 TAC §133.2 and §134.500, which applies to workers' compensation non-network and network claims, and tracks the definition in Insurance Code §1305.004(a)(13), which is applicable to certified workers' compensation network claims. The term is not new in the workers' compensation system. TDI further clarifies that for both workers'

compensation non-network claims and certified workers' compensation network claims, preauthorization is not required for situations that meet the definition of "medical emergencies."

TDI cannot make medical determinations on which specific situations could lead to a medical emergency. The purpose of the adopted rules is to require the URA to have specific procedures for high-risk situations. Additionally, 42 C.F.R. §489.24 specifically applies to the special responsibilities of Medicare hospitals in emergency cases.

Comment: Commenters express concern with the modifier "entire history" in defining medical records. This concern would be allayed by clarification that a URA would not have to request the entire medical record in conducting utilization review, but would only have to request those portions of the medical records pertinent to the service that is subject to the current instance of utilization review.

Agency Response: TDI agrees and has made the suggested change to delete the word "entire" in adopted §19.1703(18) and made a conforming change to adopted §19.2003(19).

Comment: A commenter states that the definition for "medical records" only includes those records pertaining to a compensable injury. However, often injuries that are claimed to be compensable may be non-compensable. The commenter explains that access is necessary to all medical records for both (i) injuries found to be compensable; and (ii) those injuries where compensability either is or could become an issue in dispute. The commenter asserts that this point is particularly true in cases

of extent injuries, or injuries or illnesses that could be reasonably attributed to either a workplace injury or natural degeneration, aging, ordinary diseases of life, or accidental trauma that is not work-related.

Agency Response: TDI agrees to make the suggested change because utilization review must be completed even if the injury is non-compensable, and TDI does not want to limit access to relevant records. TDI deletes the word "compensable" in the adopted definition of "medical records" for Subchapter U. TDI further clarifies that adopted §19.2007(b) provides that, when conducting utilization review, a URA must request all relevant and updated information and medical records to complete the review. TDI clarifies that there is a difference between all relevant records and all records. The intent of adopted §19.2007(b) is to prevent the URA from requiring unlimited amounts of medical records from the requestor, some of which may not inform the decision of whether care is medically necessary or appropriate. Additionally, under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

Comment: Commenters state that the definition of "medical records" could create confusion and lead to withholding of records that must be provided under applicable law. The commenters note that HIPAA, including the provisions under HIPAA applicable to mental health records, is not applicable to workers' compensation and utilization review conducted under workers' compensation. Although Insurance Code §4201.054(c) notes that Labor Code Title 5 prevails in the event of a conflict between that chapter and Labor Code Title 5, it would be preferable not to imply by rule

or otherwise that there exists any impediment to utilization review of all records available under Texas workers' compensation law.

Agency Response: TDI declines to expand on the scenarios in which mental health records are permitted to be provided to a URA, and clarifies that Insurance Code §4201.203(a), in part, prohibits a URA from requiring, as a condition of treatment approval or for any other reason, the submission or review of a mental health therapist's process or progress notes.

Comment: A commenter seeks clarification of the purpose of including the phrase "as appropriate" in proposed §19.2003(b)(23). The parameters of what a licensed professional can do are set by the licensing board and, so, need not be included in this definition.

A commenter notes that the words "as appropriate" appear in the introductory paragraph of §19.2003(b)(23) but are not specifically included in subparagraph (H). The commenter explains that physicians licensed by the Texas Medical Board are permitted to "diagnose." Other professionals are not permitted to make a medical diagnosis. This is why, through the relevant licensing statutes, such words do not appear; rather they are permitted to evaluate, assess, and analyze. The word "diagnose" in the "catch all" subparagraph should be struck.

Agency Response: TDI clarifies that the individuals listed under adopted §19.1703(b)(20) and §19.2003(b)(21) are not all qualified to diagnose, evaluate, and treat any mental or emotional condition or disorder. However, the language in this definition provides that a "mental health therapist" is any of the listed individuals who, in

the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder. The language allows for individuals that are only authorized to conduct one or two of those activities. TDI made a clarifying change to subparagraph (H) to add "as appropriate" and made a conforming change to §19.1703(b)(20).

Comment: Commenters assert that the term "payor" in the Subchapter U rules is not appropriate for workers' compensation. The commenters explain that, in the Texas workers' compensation system, the equivalent terms used are "insurance carrier" and "insurance company."

A commenter asserts that the term "payor" is not used in the Texas Workers' Compensation Act but instead is used within group health under the Insurance Code and applicable rules. The commenter notes that Insurance Code §4021.002(10) does not include a workers' compensation insurance carrier as a "Payor." The commenter believes that it is not appropriate that terms not used in the Texas workers' compensation system and not defined in the Labor Code be utilized in or defined by the URA rules. Labor Code §401.011(27) defines "insurance carrier" as an insurance company, a certified self-insurer for workers' compensation insurance, a certified self-insurance group under Chapter 407A, or a governmental entity that self-insures, either individually or collectively. Labor Code §401.011(28) defines "insurance company" as a person authorized and admitted by TDI to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance. Insurance Code §4201.054(c) provides that in the event of a conflict

between Insurance Code Chapter 4201 and the Labor Code, the Labor Code prevails. Thus, any attempt to use a term or apply a requirement from Chapter 4201 of the Insurance Code that conflicts with the Labor Code, for example, the use of the term "payor," is not appropriate given the deference given to the Labor Code. The commenter requests that TDI delete the proposed definition and, instead, include a definition of the term "insurance carrier." The commenter further requests that TDI amend the rule to include the definition of the term "insurance carrier" that is set out in Labor Code §401.011(27).

A commenter asserts that that the term "payor" could be interpreted to include third party administrators, pharmacy benefit managers, cost containment vendors, and utilization review agents. In the workers' compensation system, the "payor" is always the insurance carrier or self insured. Third and fourth party vendors who perform services are not and should not be considered "payors."

A commenter objects to the use of the term "payor" as included in the definition for "preauthorization" as this is not a term utilized in the workers' compensation system.

Agency Response: TDI declines to delete the term "payor" in Subchapter U. For clarification, the term includes an insurance carrier or insurer. The statutory definition under Insurance Code §4201.002(10) is not in conflict with Insurance Code Chapter 1305 or Labor Code Title 5. TDI has tailored the definition of "payor" to include a person or entity that provides, offers to provide, or administers workers' compensation benefits, in recognition that the definition of "payor" under Subchapters R and U should not be identical. TDI declines to replace the term "payor" with the term "insurance

carrier" or "insurer" in the definitions of "adverse determination" or "preauthorization," because such replacement would result in inconsistent definitions under Subchapters R and U. It is also necessary to retain the references to "payor" because the rules specifically distinguish between insurance carriers for which it is or is not the payor. The term "payor" is also necessary for consistency with the IRO rules under 28 TAC §12.1, which contemplate an IRO's interaction with URAs and payors.

Comment: Commenters assert that the proposed definition of "peer review" is too broad and will capture peer reviews not performed retrospectively to determine medical necessity or appropriateness of health care. Peer reviews may be conducted in workers' compensation for many purposes other than retrospective utilization review. Peer reviews are performed for return to work issues, the appropriateness of experimental healthcare procedures, contribution issues, length of treatment determinations, and other claim related issues. They are not done solely for retrospective utilization review. The commenters assert that the definition of peer review should be limited by specifying that peer review for purposes of these rules is an administrative review by a health care provider regarding the medical necessity or appropriateness of health services performed by a health care provider at the insurance carrier's request without a physical examination of the injured employee.

A commenter expresses concern that the proposed definition of "peer review" limits peer reviews to reviews based on medical necessity. The commenter explains that HB 4290 expanded this to cover a review regarding the experimental or investigational nature of health care services. However, the rule as proposed potentially

expands the focus beyond these limitations. The commenter requests that the definition be amended to the following, "An administrative review regarding the medical necessity and/or experimental/investigational nature of health care services requested or performed by a health care provider performed at insurance carrier's request without a physical examination of the injured employee."

A commenter asserts that neither the Insurance Code nor the Labor Code provides the commissioner with the authority to restrict the use of peer reviews to retrospective reviews. The commenter requests that TDI amend the rule by adding, "regarding the medical necessity or appropriateness of health performed" after "an administrative review" in the definition.

A commenter agrees that "peer review" is a component of utilization review and that the rules should be followed; however, the commenter feels that further definition is needed. Typically, when an insurance carrier asks for a peer review/retrospective utilization, review multiple questions are asked including medical necessity, causation, extent of injury, compliance with ODG and MDA to name just a few, along with addressing services that took place over several years.

Agency Response: TDI clarifies that these adopted rules apply to the performance of utilization review and adopted §19.2002(b) specifies that "Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review, must generate a written report, and must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers'

Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement)." This provision and the provisions of Chapter 180 already distinguish between the requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care versus peer reviews performed for other issues, such as extent of injury or an injured employee's ability to return to work. Further, having different definitions for the same term in TDI and TDI-DWC rules would create confusion among system participants who are responsible for complying with both the Chapter 180 rules and the workers' compensation utilization review rules.

Comment: A commenter asks whether it was TDI's intent to incorporate "artificial limbs" of individuals with prostheses as part of the "person." The commenter notes that, if this was in fact the intent, then perhaps a better definition would be, "Any person (including his or her prosthetic devices)…."

Agency Response: TDI clarifies that the definition of "person" in adopted Subchapters R and U includes natural persons or entities. TDI amended the definitions of "person" in Subchapters R and U to remove the phrase "natural or artificial person," added the phrase "and any similar entity," and made editorial changes to the definitions of "person" for clarity. A natural person with prostheses would fall under the definition of "person" because he or she is an "individual."

Comment: Commenters express support for the definition of "reasonable opportunity."

A commenter believes that it will benefit patient care and the appropriate interaction of physician and URA. This physician to physician discussion can only benefit communication and, as a direct result, the most efficient clinical treatment of the patient.

A commenter believes that requiring the URA to make a documented, good faith effort to contact the enrollee's provider before issuing an adverse determination benefits consumers by increasing the likelihood that differences of opinion can be reconciled and reducing the need for appeals. The commenter believes that listing reasonable timeframes in which the call to the provider must occur is essential to enable URAs, providers, and TDI to track compliance and increase the likelihood that effective peer-to-peer communication occurs.

Agency Response: TDI appreciates the supportive comments indicating that the definition of "reasonable opportunity" will improve the peer-to-peer discussion process.

Comment: A commenter expresses concern that the requirement under the definition of "reasonable opportunity" to allow at least one business day for a peer-to-peer discussion excessively compresses the URA's timeframe in which to perform its review and could even conflict with the three calendar day timeframe when applicable.

A commenter believes that the provision relating to retrospective review adverse determinations in the definition of the term "reasonable opportunity" should be deleted. The commenter does not think it is appropriate to require a peer-to-peer discussion in the case of a retrospective review. The commenter explains that by the time a

retrospective review is conducted, the medical services at issue have already been rendered and only a claim is in dispute, and the rationale for the peer-to-peer requirement does not apply. In addition, in many retrospective claim reviews, for example, hospital claims, it is not evident to the utilization review entity which provider of services should be contacted to offer a peer-to-peer review.

Commenters assert that the five-day requirement for retrospective reviews effectively reduces the prompt pay deadlines imposed by statute.

A commenter notes that a retrospective utilization review is actually a claim review and so the prompt payment requirements will apply to claims and retrospective reviews submitted by network providers. The commenter asserts that utilization review regulations cannot reduce the timeframes provided for claim processing in Insurance Code Chapters 1301 and 843. In fact, Insurance Code §4201.305 specifically provides that the time limits for claim payments in Chapters 1301 and 843 supersede the utilization review timeframes.

A commenter explains that, if in the claim review process it appears that an adverse determination may be necessary, by allowing the provider of record five business days to have an opportunity to discuss the service, the time for complying with the prompt payment period is in effect shorted by this five business day period which, in nearly every instance would be seven or more calendar days, because the only time five business days would not extend over a weekend would be in a case where the attempt to contact the provider is made first thing on a Monday morning. The

commenter requests that the times for reasonable opportunity be shorted to take into account the deadline for prompt payment of claims.

A commenter objects to the reasonable opportunity requirement for the provider of record to discuss the plan of treatment with a physician prior to issuing an adverse determination in a retrospective situation. The commenter asserts that, when a service has already been provided, there is no regulatory rationale for providing the opportunity for a peer-to-peer discussion prior to issuing an adverse determination. It would be more cost-effective to require a peer-to-peer consultation for retrospective utilization review only in those instances in which the provider of record makes such a request on receipt of the notice of adverse determination. This solution accomplishes the goal of allowing a peer-to-peer review in those instances in which a provider of record desires such review, without adding unnecessary expense to the process in those instances in which a provider of record may not desire a peer-to-peer review. The commenter urges TDI to revise the rules to require peer-to-peer consultation only in those instances in which the provider of record requests such consultation within a reasonable time of receiving the notice of adverse determination.

A commenter requests that the adoption order clarify that an attempt to contact a provider, which includes an instance where a URA makes such an attempt during regular business hours, but the provider is not available at that moment, and the URA leaves a call back number at which the URA may be contacted to discuss the services under review, constitutes a reasonable opportunity under this definition.

A commenter does not believe a peer-to-peer discussion is appropriate for retrospective review as multiple providers are reviewed over multiple years. A commenter states that this provision has been added to comply with the codes, and anticipates that this provision will not go away regardless of the concerns of physicians. The commenter would like for there to be a clearer indication of who the peer-to-peer discussion should take place with and at what time. When an insurance carrier asks for a peer review (retrospective utilization review) the reviewer gives his opinion at the time he conducts his report, and has no idea what the insurance carrier will do with this information. A commenter asks whether the peer-to-peer discussion only takes place if a medical bill is denied based on the peer review. The commenter asks, when the peer review is being done on a case that has multiple years or multiple reviewers, who is the appropriate party to contact.

A commenter explains that they have no issue with affording the requesting provider a reasonable opportunity. The commenter believes that the term "provider of record" is unclear because the term is not listed in Chapter 180 (relating to Monitoring and Enforcement) or Labor Code §401.011. The commenter suggests that the term should either be the treating doctor or consulting doctor, as appropriate.

A commenter asserts that one working day is an inadequate time to allow the provider of record to get back to the URA. The commenter requests that the wording of this section be changed to read "no less than three working days. . . "

A commenter asserts that the definition of "reasonable opportunity" exceeds the rulemaking authority of TDI. A commenter asserts that the definition of "reasonable opportunity" is inconsistent with existing statute and other workers' compensation rules.

A commenter asserts that TDI engaged in creative drafting to create the appearance that its proposed rule will not conflict with TDI-DWC rules or with other portions of the Insurance Code.

Commenters assert that the standard of "no less than one working day" conflicts with §134.600(i) and (j) of this title and Insurance Code §1305.353 and §4201.304, which guarantee three working days to make a determination. The statute does not provide for a lesser review period nor does it allow the agency, through rulemaking, to shorten the time. Section 4201.054(c) of the Insurance Code specifically provides that in the event of a conflict between Chapter 4201 and the Texas Workers' Compensation Act (Labor Code, Title 5), the Texas Workers' Compensation Act prevails. The commenters assert that TDI may not shorten the timeframe for making an adverse determination to the "no less than one working day" proposed in the rule.

Commenters assert that this proposed rule effectively shortens the time for making an adverse determination for prospective or concurrent review from three working days to two working days. A commenter explains that the conflict drafted into the definition of "reasonable opportunity" is not necessary and can be eliminated. Commenters recommend, after the phrase "Reasonable opportunity--At least one documented good faith attempt to contact the provider of record," inserting the phrase "that provides an opportunity for the provider of record to discuss the services under

review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination." The commenters recommend deleting subparagraphs (A) through (C).

Agency Response: TDI disagrees that the rulemaking authority of TDI is exceeded by defining the term "reasonable opportunity." Existing §19.1711 and §19.2011 already require the URA to afford the health care provider who ordered the services a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the URA's decision with a physician or, in the case of a dental plan, with a dentist, prior to issuance of an adverse determination. TDI declines to make the recommended changes to the rule text since the proposed language does not provide any guidance as to what it really means for a URA to provide a "reasonable opportunity" for the provider of record to discuss a potential adverse determination with the URA. TDI further notes that under the commenter's recommended language, a single documented phone call to the provider an hour before issuing an adverse determination would meet the criteria for a "reasonable opportunity," which does not align with the legislative intent behind this requirement to facilitate communication between URAs and health care providers to avoid unnecessary denials.

TDI clarifies that the notification of the adverse determination for workers' compensation non-network coverage must be provided within the timeframes specified by 28 TAC §134.600. Section 134.600(i) requires a decision for preauthorization requests within three working days and a decision for certain requests for concurrent review within one working day of the receipt of the request.

The notification of the adverse determination for workers' compensation network coverage must be provided within the timeframes specified by Insurance Code §1305.353 and 28 TAC §10.102.

Under Insurance Code §1305.353(d), the URA must generally issue a determination on a preauthorization request not later than the third working day after the receipt of the request. However, under Insurance Code §1305.353(e), if the proposed services are for concurrent hospitalization care, the URA must transmit a determination within 24 hours of receipt of the request.

Under Insurance Code §1305.353(f), if the proposed health care services involve post-stabilization treatment or a life-threatening condition, the URA must transmit a determination within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. Title 28 TAC §10.102 reiterates these statutory requirements.

Based on these timeframes, a URA must issue a determination for request for prospective review no later than the third working day after receipt. This three-working day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination.

Insurance Code §4201.206 provides that, subject to certain notice requirements, before an adverse determination is issued by a URA that questions a health care service on the basis of medical necessity or appropriateness or the experimental or investigational nature of the service, the URA must provide the health care provider who

ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

TDI declines to delete the peer-to-peer requirement for retrospective reviews or to amend the requirement that a good faith opportunity includes no less than five working days prior to issuing a retrospective review adverse determination. As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review." The Insurance Code §4201.206 provides that, subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions a health care service on the basis of medical necessity or appropriateness or the experimental or investigational nature of the service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Because "utilization review agent," means "an entity that conducts utilization review ..." under Insurance Code §4201.002, and the term "utilization review" includes "retrospective review" under Insurance Code §4201.002(13), the requirements in §4201.206 apply to URAs conducting retrospective review.

Under Insurance Code §4201.305, the URA must provide notice of a retrospective review adverse determination within a reasonable time, but not later than 30 days after the date on which the claim is received. Under Insurance Code §4201.305(b), this period may be extended once for a period not to exceed 15 days, if

the URA takes certain additional steps. Because of the longer time granted to URAs to issue determinations when conducting retrospective utilization review, TDI finds that five working days is a reasonable amount of time to afford the provider of record to discuss the determination.

TDI disagrees that compliance with the reasonable opportunity requirement will create additional difficulty for plans to comply with prompt pay requirements. None of the timeframes are incompatible with prompt pay deadlines, such that providing the reasonable opportunity will result in non-compliance with these deadlines.

Insurance Code §4201.206 requires a reasonable opportunity, and TDI asserts that further defining parameters for what constitutes a "reasonable opportunity" will assist in ensuring such an opportunity is actually afforded to the provider of record. The definition, as revised, does not cause any conflict with existing timeframes for decisions.

TDI clarifies that the provider of record is entitled to a reasonable opportunity, as defined in §19.1703(b)(26) and §19.2003(28), to speak to a physician or doctor before an adverse determination is issued by a URA who questions the necessity or appropriateness, or the experimental or investigational nature, of a health care service. Insurance Code §4201.206 specifically requires an opportunity for the requesting provider to speak with a physician.

In response to the question on the appropriate party to contact, TDI clarifies that the provider of record, as defined in Insurance Code §4201.002(12), must be given the reasonable opportunity to speak to a physician or doctor.

In response to the comment that one working day is inadequate to allow the provider of record to respond to the URA, TDI declines to require additional days. TDI has to consider not only the interest of the provider of record in having a reasonable opportunity to discuss the determination, but also the interest of the URA in rendering a timely decision and having sufficient time to do so.

Comment: A commenter asserts that the inclusion of a definition for and use of the term "provider of record" is not appropriate, is misleading, and is potentially confusing as the term does not appear in the Texas Workers' Compensation Act. In workers' compensation the applicable term would instead be referred to as "treating doctor." An appropriate expansion might entail including treating doctor with "or the healthcare provider requesting services or review."

A commenter notes that while "provider of record" may be applicable to general health, the term "provider of record" is not used in workers' compensation medical services. The commenter asserts the term is unnecessary, creates the potential for confusion, and should be withdrawn.

A commenter requests that TDI either consider replacing "provider of record" with "requestor" or add the definition for "requestor."

A commenter asserts that Chapter 180 relating to Monitoring and Enforcement and Labor Code §401.011 do not include the term "provider of record." The commenter believes this term confuses the system in which the treating doctor is the doctor primarily responsible for the efficient management of health care with coordinating health care for an injured employee's compensable injury as outlined in Chapter 180.

Agency Response: TDI declines to make the suggested change. The provider of record is the individual requesting treatment on behalf of the injured employee and is the point of contact for the URA to discuss a pending adverse determination, request records, and provide notice of favorable or adverse determinations. The provider of record could be the treating doctor or requestor.

This definition of "provider of record" mirrors the definition in Subchapter R and is necessary to track Insurance Code §4201.002(12), which defines "provider of record" as the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, applies to workers' compensation utilization review. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201. TDI asserts that there is no direct conflict with the use of "provider of record" and Labor Code Title 5. TDI has the rulemaking authority to define and utilize the term "provider of record" throughout the Subchapter U rules.

Comment: Commenters assert that the definition of "retrospective utilization review" should include the requirement that the review be for purposes of determining medical necessity or appropriateness.

A commenter asserts that the definition of "retrospective utilization review" should include the requirement that the review be for purposes of determining medical

necessity or the experimental or investigational nature of the health care services that have been provided to the injured employee.

Agency Response: TDI declines to make the suggested change. The definition of the term "utilization review" in Insurance Code §4201.002(13) includes medical necessity and appropriateness, as well as the experimental or investigational nature of a health care service. The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in Subchapters R and U, so inclusion of the phrase would be redundant.

Comment: A commenter asserts that the definition of the term "screening criteria" conflicts with the description of screening criteria in §19.2005(c), regarding general standards of utilization review, which is much more appropriate and includes a requirement that the screening criteria must be evidence-based, scientifically valid, outcome-based, and in compliance with the requirements in Section 4201 of the Insurance Code. The commenter requests that TDI delete the phrase "such as appropriateness evaluation protocol (AEP) and intensity of service; severity of illness; discharge; or appropriateness screens (ISD-A)."

The commenter further requests TDI add "must be evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153" to the definition of "screening criteria." The screening criteria must also comply with §19.2005(c) of this title (relating to General Standards for Utilization Review and Retrospective Review)."

Agency Response: TDI declines to make the suggested deletion because this language does not appear in the proposal and no deletion is required. TDI declines to add the language "must be evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153" to the definition of "screening criteria" because this language is already in adopted §19.2005(c) and §19.1705(c), and inclusion of the same phrase in the definition would be redundant and unnecessary. TDI declines to add language requiring compliance with §19.2005(c) in the definition of "screening criteria," because compliance with the rules is already required, and inclusion of the phrase in the definition would not add any clarity.

Comment: A commenter asserts that the term "health plan" is a group health insurance term. The commenter recommends that the term "workers' compensation health plan" be deleted and replaced with the term "workers' compensation political subdivision health care networks" with the same proposed definition.

Agency Response: TDI declines to make the suggested deletion. The term "health plan" is used in rules applicable to workers' compensation in 28 TAC §110.7(a), which defines "health plan" as a political subdivision contracting with health care providers under Labor Code §504.053(b)(2). TDI clarifies that the term is necessary to harmonize these rules with other TDI-DWC rules.

§19.1704 and §19.2004. Certification or Registration of URAs.

Comment: A commenter requests, for purposes of clarity and completeness, that the statutory sections that differentiate between certification and registration be

referenced in the rule itself. Therefore, Insurance Code §4201.057 and §4201.058 should be cited in the initial wording of subsection (a) of section 19.1704.

Agency Response: TDI agrees with the commenter's suggested change and added "§§4201.057, 4201.058, and 4201.101" to §19.1704(a) and made a conforming change to §19.2004(a).

Comment: A commenter asserts that the requirement for workers' compensation carriers to register as URAs when the workers' compensation carrier only performs utilization review for coverage for which it is the "payor" exceeds the requirements of Chapter 4201, and raises the issue of whether this provision may be beyond the authority of TDI to promulgate. The applicable statutory provisions requiring registration only speak to "other than a person or entity for which the insurer is the payor." Furthermore, the statutory requirement is for a "certificate of registration" and does not split the requirement for registration and certification into two requirements as the rule proposal does. Certificates of registration are only required under Chapter 4201 for URAs or HMOs performing utilization review for persons or entities other than a person or entity for which the HMO is the payor. The only time registration should otherwise be required is when a workers' compensation carrier is certified as a network under Chapter 1305. With respect to the state program, the office does not issue a policy, plan, or contract to provide coverage as coverage is provided as a statutory requirement; the office cannot in any event qualify as a "payor" and thus has no need to register as a URA.

Agency Response: TDI changed the definition of "payor" to include the words "or statute" to clarify that the term applies to the State Office of Risk Management. Under Insurance Code §4201.054(c), Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. Insurance Code Chapter 4201 applies to workers' compensation utilization review. Labor Code Chapter 412 provides that the state is self-insuring with respect to an employee's compensable injury. Labor Code §501.021 provides that an employee with a compensable injury is entitled to compensation by the director as provided by Chapter 501. Labor Code §501.001(3) provides that "director" means the director of the State Office of Risk Management. Labor Code §501.002(a) provides that Labor Code §401.011 and §451.001 apply to and are included in Labor Code Chapter 501, except to the extent that they are inconsistent with Labor Code Chapter 501. Section 501.002(c) provides that, for purposes of applying the provisions listed by Subsection (a) to this chapter, "insurer" means "state," "office," "director," or "state agency," as applicable.

Comment: A commenter expresses concern with the requirement that an applicant correct the omissions or deficiencies in the application, or request additional time in writing, within 15 working days of the date of TDI's latest notice of omissions or deficiencies. The commenter notes that the existing rule provides that the applicant must correct the omissions or deficiencies in the application within 30 days of the date of TDI's latest notice of such omissions or deficiencies. The commenter asserts that the proposed 15-day requirement to submit corrections to the URA application does not provide an applicant with adequate time to gather any omitted information and to correct

deficiencies found by TDI staff. The commenter asserts that the stated reason for the reduction from 30 days to 15 days does not make sense because URAs do not provide services or products to Texas consumers. URAs provide utilization review services to insurance carriers and certified self-insured employers. As such, Texas consumers derive no benefit from the current 30-day timeframe being reduced to 15 days. The commenter requests that the existing 30-day timeframe for submitting application corrections to TDI not be changed.

A commenter appreciates that the 15-day deadline is working rather than calendar days. The commenter prefers the 30-day response time currently required by the rules. The commenter also notes that deficiency letters from TDI were received that provide only 10 days to respond under Insurance Code §38.001.

Agency Response: TDI declines to make the requested change. As stated in the proposal, this proposed reduction in time to correct the omissions or deficiencies is necessary to streamline the application process, providing TDI with information more quickly. Making more URAs more quickly available allows the provider or claimant to have access to a more efficient administrative process coordinated by TDI. Also, §19.2004(f) allows the applicant to request extra time in writing, and TDI will grant an extension as warranted.

Under adopted §19.1704(f) and §19.2004(f), applicants have 15 working days from the date of TDI's latest notice of omissions or deficiencies in the application. Insurance Code §38.001(b), in part, provides that TDI may address a reasonable inquiry to a holder of an authorization relating to the person's business condition or any matter

connected with the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Insurance Code §38.001(c) further provides that a person receiving an inquiry under Subsection (b) must respond to the inquiry in writing not later than the 10th day after the date the inquiry is received.

Comment: A commenter believes it is more reasonable to wait until the license renewal to file revisions and application updates required by §19.1704(j) because URAs must renew licenses every two years. The commenter also believes this approach would avoid all licensed entities filing with TDI at one time and result in a more efficient allocation of TDI resources.

A commenter objects to the requirement that currently certified or registered URAs submit updated applications to TDI within 90 days of the effective date of this rule in §19.1704(j). Currently certified or registered URAs are legally bound to comply with all regulatory requirements and TDI has the ability to enforce these regulations on becoming aware of non-compliance through complaints or other avenues. The exercise of filing updated applications to illustrate compliance is costly, both to URAs and TDI, and is unnecessary. The commenter recommends that this requirement be deleted.

Agency Response: TDI declines to delete the effective date from the rule. TDI, as explained in the reasoned justification, has determined that the effective date of the adopted rules, which gives stakeholders 90 days to comply from the date the adoption order is filed with the Secretary of State, is sufficient. Based on this effective date, TDI also clarifies that existing URAs have an obligation to update their applications, but their submission of updated information does not change their existing renewal date.

§19.1705 and §19.2005. General Standards of Utilization Review.

Comment: A commenter asserts that §19.1705 has been severely amended to remove many of the specific requirements placed on utilization review agents and the required plan. The result is that the plan is given general direction and no specifics. The result is that the ability of TDI to enforce any provisions, or lack thereof, is also severely limited. The commenter suggests that most, if not all, of the current rule be retained.

Agency Response: TDI clarifies that the components listed in existing §19.1705(1) – (3) and §19.2005(1) – (3) to be included in the utilization review plan are not included in the proposed new sections because TDI proposes updated required components in subsections (b) – (f) of §19.1705 and §19.2005 or the components are otherwise incorporated into other sections, and the retention of the provisions would be repetitive.

For example, requirements in the introductory paragraph of existing rules, regarding the utilization review plan, are retained in Insurance Code §4201.151. Requirements in existing §19.1705(2)(A) are retained in Insurance Code §4201.153(b), regarding special circumstances. Requirements in existing §19.1705(2)(B) are retained in adopted §19.1709(a). Requirements in existing §19.1705(2)(C) are retained in §19.1711, regarding Written Procedures for Appeal of Adverse Determinations, and Form LHL005 requires submission of template letters. Requirements in existing §19.1705(2)(D) are retained in adopted §19.1712, regarding URA's Telephone Access.

Comment: A commenter asserts that §19.2005(b) should be stricken as it is inconsistent with the Texas Workers' Compensation Act and is beyond TDI's rulemaking authority. The commenter explains that the purpose of utilization review is to review health care services or proposed health care services to determine whether the services are in line with the Texas Workers' Compensation Act's requirement that the health care be reasonably required by the nature of the injury under Labor Code §408.021. Health care is reasonably required if the services are "clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence–based medicine or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community" under Labor Code §401.011(22a).

Commenters assert that §19.2005(b) is inappropriate for rules applicable to workers' compensation health care. Commenters assert that §19.2005(b) should be deleted in its entirety. There are only two "special circumstances" identified in the Texas Workers' Compensation Act that potentially impact the timing of utilization review services. The first is "emergency" medical treatment which is exempt from preauthorization and concurrent review under Labor Code §413.014 and Insurance Code §1305.351, as well as 28 TAC §134.600. The second "special circumstance" applies to serious bodily injuries sustained by first responders who are employed by political subdivisions under Labor Code §504.055. The commenters assert that §19.2005(b) is not needed because "emergency treatment" is only subject to

retrospective medical utilization review and because the "special circumstance" related to first responders is dealt with in §19.2005(g).

Commenters assert that there are no other "special circumstances" found in the Texas Workers' Compensation Act. Neither the Insurance Code nor the Labor Code provide TDI with rulemaking authority to create additional "special circumstances" applicable to the review of workers' compensation health care. Such a rule conflicts with the clear language of the Labor Code. In addition, the use of the terms "acute condition," "disability," and "life-threatening illness" are inappropriate for the workers' compensation rules and are unnecessary. The term "disability" is defined in Labor Code §401.011(16) as the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage. The term is relevant to the entitlement to income benefits but is not relevant to the entitlement to medical benefits.

A commenter asserts that §19.2005(b) is not needed since the "special circumstance" related to first responders is dealt with in other sections of the proposed rules.

Commenters state that the term "life–threatening" is borrowed from statutory requirements for health insurance and health benefit plans. The Texas Workers' Compensation Act does not use that term but instead utilizes the term "emergency," which has broader meaning and application. Commenters note that the term "life-threatening" is not included in any section of the Act. The use of the term "life-threatening" in a TDI-DWC rule is inappropriate and could lead to confusion among the system stakeholders.

A commenter reminds TDI staff that Insurance Code §4201.054(c) specifically provides that in the event of a conflict between Chapter 4201 of the Insurance Code and the Labor Code, the Texas Workers' Compensation Act prevails. The commenter asserts that any attempt to use a term or apply a requirement from Chapter 4201 or TDI rules that conflicts with the Texas Workers' Compensation Act and TDI-DWC rules, is not appropriate given the deference to the Texas Workers' Compensation Act. The commenter requests that §19.2005(b) be deleted.

A commenter explains that medical conditions requiring emergency services include life-threatening illnesses. These are not separate concepts that can be handled with conflicting regulations. The commenter further asserts that life-threatening illnesses requiring emergency services are exempt from prospective and concurrent utilization review. However, these proposed rules consistently state that life-threatening illnesses that require emergency treatment require immediate prospective and concurrent utilization review and an immediate appeal to an IRO. The commenter states this is wrong and is dangerous for workers with life-threatening conditions and health care providers rendering treatment.

A commenter states that since the term "disability" is not going to have the commonly understood definition, this rule should provide a definition of the term to ensure that all system participants have the same understanding of its meaning.

A commenter asserts that §19.2005(b) lists examples of special circumstances a utilization review must consider that may require deviation from the norm stated in the screening criteria or relevant guidelines. However, the given examples appear to be in

general unrelated to the treatment of the compensable injury. In workers' compensation, utilization review should properly consider special circumstances to devise a treatment plan to treat a compensable injury and return the employee back to work that will not aggravate, exacerbate, or otherwise harm the patient.

Agency Response: TDI declines to make the suggested deletion. TDI clarifies that these are requirements under existing §19.1705(2)(A) and §19.2005(2)(A), which have been in place for years and have not caused confusion or created problems for URAs during that time.

Section 19.1705(b) and §19.2005(b) provide some specific examples in association with the statutorily imposed general standard of utilization review relating to special circumstances. Insurance Code §4201.153 requires the utilization review determination to take into account special circumstances of each 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. This requirement is consistent with Insurance Code §4201.153.

The clarifying sentence, "Disability shall not be construed to mean an injured employee who is off work or receiving income benefits" is sufficient. As stated in the proposal preamble, in establishing general standards for utilization review, the language in §19.2005(b) distinguishes the term "disability" as it is used in general medical environments from how the term is used in the Texas workers' compensation system. The term "disability" as used in this section should not be confused with the Texas

Workers' Compensation Act's definition of "disability." Labor Code §401.011(16) defines "disability" as "the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage." Additionally, Labor Code §401.011(23) defines "impairment" as "any anatomic or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Utilization review is solely for the purpose of determining the medical necessity and appropriateness of health care services. The ability to retain employment or the determination of medical maximum improvement has no relevance in the utilization review process.

TDI and TDI-DWC disagree that the terms as used in this rule are inappropriate. As previously discussed in the agency response to general comments regarding the use of the term "life-threatening" in Subchapter R, the concept of "life-threatening" conditions is already introduced in the workers' compensation system. TDI and TDI-DWC agree that Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI and TDI-DWC's intent to apply the requirements regarding life-threatening conditions to emergency treatment. The terms "life-threatening condition" and "emergency treatment" are not the same. "Life-threatening" is an existing term that is defined in Insurance Code §4201.002 and 28 TAC §12.5 and §133.305. "Emergency care" and "emergency" are defined in Insurance Code §4201.002 and 28 TAC §133.2, respectively. These terms have been used without any noted disruption or confusion reported to the TDI-DWC by system participants.

Comment: A commenter asserts that the requirement in the second sentence of §19.1705(c) that, if evidence based medicine is not available for a particular health care service, the URA must use "generally accepted standards of medical practice recognized in the medical community" is vague at best. The commenter suggests that the provision simply reference the statute, as it does in the first sentence, and delete this second sentence.

A commenter asserts that such terms as "evidence-based," "scientifically valid," and "outcome-focused" are requirements that are used in the regulation of workers' compensation networks when selecting a guideline to be used only in workers' compensation utilization review under Labor Code §413.011(e). To use the requirements for selecting a workers' compensation guideline for the screening criteria in §19.2005(c) is inappropriate. Screening criteria and guidelines are not interchangeable and do not denote the same requirements or usage. Insurance Code §4201.153 does not mention "evidence-based" and "scientifically valid" is not used. Rather, the words "clinically valid" are used and denote a different type of review. The commenter asserts that the attempt to blend the selection of guidelines, used for maximum medical improvement, and not for precertification or concurrent review, and workers' compensation screening criteria, is an inappropriate and confusing mix of the two types of review.

A commenter notes that the language of the rule appears to require URAs to permit either evidence-based or community-based medicine if evidence-based medicine is not available for the service: an either or proposition. However, the commenter

asserts that the standard incorporated into Labor Code 401.011(22-a) is not an either or type proposition. It is more stringent in its overarching requirement that the health care be both clinically appropriate and considered effective for the injured employee's injury.

Agency Response: TDI declines to make the suggested change. Insurance Code §4201.153(a) – (c) imposes three requirements. First, a URA must use written medically acceptable screening criteria and review procedures that are established, periodically evaluated, and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. Second, a utilization review determination must be made in accord with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria. Third, screening criteria must be: (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Also, proposed §19.1705(c) requires screening criteria to 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. This provision recognizes that evidence-based medicine will not always be available. This provision is necessary to harmonize the Subchapter R screening criteria requirements with proposed §19.2005(c), which incorporates the Labor Code requirements. Under the commissioner's authority in §4201.003 to adopt rules to implement Chapter 4201, TDI determined this conforming change to be

necessary in Subchapter R rules to implement the existing requirements for screening criteria in accord with §4201.153 while keeping screening criteria standards that are consistent with those under Subchapter U.

TDI disagrees that adopted §19.2005(c) provides a different standard than Labor Code §401.011(22-a) for the use of evidence-based medicine. Labor Code §401.011(22-a) provides that the term "health care reasonably required" means health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accord with best practices consistent with: (A) evidence-based medicine; and (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community.

Comment: A commenter supports screening criteria requirements in §19.1705(c) and §19.2005(c).

Agency Response: TDI appreciates the supportive comment.

Comment: A commenter notes that standard utilization management practices on a national level allow for initial preauthorization and or concurrent utilization review requests be determined by a physician, or other health care provider. For example if a request comes in from an M.D. then another M.D. could conduct the review; likewise, if a request comes in from a D.C., an M.D. could also conduct the review, however, a D.C. could not review a request from an M.D. as the M.D. has more medical training. The requirement for like-to-like specialty only comes into play when a second level review or appeal is requested. The commenter asks whether §19.2005(d) is saying an M.D. cannot review a request from a D.C. The commenter also asks whether

§19.2005(d) is saying that M.D. to M.D. never plays a role and that at all times we have to consider like-to-like specialty.

Agency Response: TDI clarifies that a doctor performing a peer review for the review of medical necessity or appropriateness of care of a specific workers' compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving, as required under Labor Code §408.0043. The reference in adopted §19.2005(d) to Labor Code §§408.0043 – 408.0045, is to clarify that physicians and doctors performing utilization review must also comply with the Labor Code. In addition, a doctor performing a peer review for medical necessity or appropriateness of care of a specific workers' compensation case must also hold the "appropriate credentials" as defined by 28 TAC §180.1.

Comment: A commenter asserts that the language in §19.2005(e) should be corrected to reflect that the delegation is to hospitals or other health care facilities. If the section is intended to merely describe the person who may perform the utilization review for the hospital, and omit other health care facilities in the rule, the rule should be amended to reflect that they are part of the "qualified personnel" at the hospital that may perform such review for the hospital.

A commenter explains that Insurance Code §4201.251 permits delegation to personnel at the hospital or other health care facility, not to "qualified health care providers." The statute establishes a limited set of delegates and "qualified health care providers" are not contained within the statute. The commenter asserts that the

proposed additional language in §19.1705(e) goes beyond the authority set in statute. The language should be corrected to reflect that the delegation is to hospitals or other health care facilities.

Agency Response: TDI agrees to make the suggested change to more closely track Insurance Code §4201.251. TDI inserted the word "utilization" before the term "review" and deleted the phrases "utilization review program," and "a qualified health care provider." TDI replaced the deleted phrases with "other health care facility in which the health care services to be reviewed were, or are, to be provided."

Comment: A commenter asserts that §19.1705 (f) should be amended to reflect that a complaint system includes an appeal process. The appeal process is an important part of a fair process and is required by Insurance Code §4201.303(a)(4). The appeal process, at a minimum, can be incorporated by reference to §19.1709(b)(6) and §19.1711.

A commenter asserts that any complaint system must have a mechanism for appeal. The requirement here is no different. The ability to have a viable and robust complaint and appeal mechanism will help injured workers', their representatives, or health care providers better access the system and provide facts and information necessary for a full and fair presentation of the injured worker's issues.

Agency Response: TDI disagrees that Insurance Code §4201.303(a)(4) requires a URA's complaint system to include an appeal process. Insurance Code Chapter 4201, Subchapter H, provides the requirements for an appeal process for appealing an adverse determination, §4201.2352 requires the URA to maintain and

make available the written procedures for appealing an adverse determination, and §4201.303(a)(4) requires the description of the procedure for the appeal process be included in the notice of an adverse determination. Insurance Code §4201.204, regarding complaint system, outlines the requirements for a URA's complaint system and does not include a requirement for a complaint appeal process. Insurance Code §4201.351 provides that a complaint concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. An individual may file a complaint with TDI after filing a complaint with the URA. Adopted §19.1705(f) requires the URA to include with their written response to the complainant TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.

Comment: A commenter asserts that in regard to §19.2005(f), the complaint system should include complaints filed by a person acting on the injured worker's behalf. The commenter knows of no reason to restrict the ability to complain to representatives and to exclude others acting on behalf of the injured worker.

Agency Response: TDI disagrees with adding the commenter's suggested language to adopted §19.2005(f) because that subsection is consistent with existing TDI-DWC rules in Chapter 150 which govern representation of parties before the agency and qualifications of the representatives.

Comment: A commenter asserts that they agree that first responders who sustain a serious bodily injury be given priority; however, the commenter does not understand how this can be part of the URA's responsibility in §19.2005(g). The

commenter asserts that emergency care for workers' compensation does not require preauthorization. The commenter states that, depending on how the carrier has their account set up with the URA, the URA has to rely on the insurance carrier to notify them of a requested service. The commenter asks if the carrier has the requested utilization review for any length of time prior to providing it to the URA, how the URA can be held responsible for their actions.

Agency Response: TDI clarifies that §19.2005(g) requires URAs to include in their written policies evidence that the URA's policies are in compliance with Labor Code §504.055, but is not intended to hold URAs responsible for an insurance carrier's failure to comply with the law. Labor Code §504.055 requires, in part, that the political subdivision, division, and insurance carrier accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Labor Code §504.055(b).

§19.1706 and §19.2006. Requirements and Prohibitions Relating to Personnel.

Comment: A commenter recommends amendment to the licensure requirements for utilization review personnel under §19.1706 and §19.2006. In both sections, while physician utilization review agents are required to be licensed as a physician in the United States, the proposed rules do not require Texas physician licensure. The commenter strongly supports amending the proposed rules so that they are consistent with the proposed language of §19.2006 that requires Texas physician licensure. The commenter asserts that utilization review performed by physicians

cannot help but require physicians to exercise medical judgment that has a direct impact on patient care. Texas Medical Board rule 22 TAC §190.8(1)(E) adopted in November 2003, provides that a Texas physician may be disciplined by the Texas Medical Board for failure to practice in an acceptable manner consistent with public health and welfare within the meaning of the Act, including failure to perform proper utilization review. The commenter believes the rule is consistent with Insurance Code §4201.002(13) that defines "utilization review" as the "review of the medical necessity and appropriateness of health care services." The commenter explains that requiring physician utilization review agents to be licensed, without requiring Texas licensure, renders the requirement irrelevant.

The commenter explains that the Texas Medical Board is charged with protecting public health and welfare through the regulation of the practice of medicine. This includes giving Texas patients the ability to exercise their right to file complaints with the Texas Medical Board against physicians that fail to meet the standard of care. If physician utilization review agents are not licensed in Texas, the physicians will be insulated from the Texas Medical Board, and any action that TDI might take against an insurer or utilization review agent will very likely have no affect on a physician's licensure in another state. While TDI's proposed rules require that physician URAs have current and unrestricted licenses in any state, this is not a difficult requirement to meet or maintain. In the case of a URA physician not licensed in Texas that is disciplined by TDI, that physician's out-of-state licensing boards are likely to never be put on notice of the physician's out-of-state violation of the standard of care, and even if

they were, it would be unlikely for them to take action without the Texas Medical Board first taking action, when their own state's residents are unaffected. As a result, the Texas Medical Board could not take necessary corrective action against a physician unlicensed in Texas and disciplined by TDI based on findings that the physician has deficiencies in medical knowledge, which would seriously weaken the Texas Medical Board's ability to protect the public. If the intent is to ensure that the physicians have the requisite medical knowledge to perform utilization review, TDI could just require board certification by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. However, requiring licensure means requiring that the physicians be held accountable not only to TDI, but to medical licensing authorities where the medical treatment is provided, namely Texas.

The commenter requests that the proposed rules be amended to be consistent with the proposed language of §19.2006, which requires that a URA for workers' compensation coverage be licensed in Texas.

Agency Response: TDI made clarifying changes to add the following paragraph to §19.1706(a), "(1) This subchapter does not supersede requirements in the Medical Practice Act, Texas Medical Board rules, Texas Occupations Code Chapter 201 (relating to Chiropractors), or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to Title 22 TAC Chapter 190, regarding disciplinary guidelines."

TDI clarifies that adopted §19.1706 and §19.1716 are not meant to be in conflict with the Medical Practice Act or Texas Medical Board rules. Section 19.1706(a)

requires personnel conducting utilization review to hold an unrestricted license, administrative license, or to be otherwise authorized to provide health care by a licensing agency in the United States, consistent with Insurance Code §4201.252(a). This new section was unanimously recommended by the Utilization Review Advisory Committee.

Comment: A commenter asks if TDI will identify what appropriately trained and qualified is under §19.1706(a) and §19.2006(a). The commenter asks, if a provider is currently licensed, this in itself shows that they are appropriately trained and qualified as the medical board has continued to issue licensure.

Agency Response: TDI clarifies that adopted §19.1706(a) and §19.2006(a) already address licensure requirements. Adopted §19.1706(a) and §19.2006(a) require personnel conducting utilization review to hold an unrestricted license or an administrative license in or be otherwise authorized to provide health care services by a licensing agency in the United States, and Texas, respectively. Insurance Code §4201.152 requires a URA to conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States. Adopted §19.2006(a) also requires physicians and doctors conducting utilization review to 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, 408.0044, and 408.0045. 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). Adopted §19.2006(e)

requires that the URA's utilization review be under the direction of a physician currently licensed without restriction to practice medicine in Texas.

Comment: A commenter asserts that the qualification requirements in proposed §19.2006(a) go beyond the statutory requirements and rulemaking authority of TDI. The commenter asserts that the proposed rule violates Labor Code §408.0231(g) and §413.014(f). Insurance Code §4201.054(c) expressly requires the Labor Code provisions to prevail over the Insurance Code provisions. This proposed rule clearly violates the "in state" provisions of Labor Code §408.0231(g), which expressly states, in relevant part, "A doctor who performs peer review under this subtitle must hold the appropriate professional license issued by this state . . . " This statutory in-state licensure requirement applies to "doctors" and does not apply to all personnel conducting utilization review. In addition, the qualification requirements do not apply to all forms of utilization review.

The commenter states that the clear thrust of Labor Code §413.014(f) is that the legislature does not want TDI-DWC to interfere with the voluntary discussions between the carrier and health care providers regarding health care treatment and plans "either prospectively or concurrently" and likewise should not prohibit or restrict the carrier " . . . from certifying or agreeing to pay for health care consistent with those agreements." There is no statutory authority to justify applying these requirements to personnel or nurses who certify or agree to pay for health care on behalf of the carrier. These qualification requirements only have applicability to "adverse determinations" and not to utilization reviews that lead to voluntary certification or agreement to pay for health care

services. The commenter recommends replacing the phrase "to perform utilization review" with the phrase "who render adverse determinations." The commenter recommends deleting the phrase "Personnel conducting utilization review" and replacing the phrase with "Doctors rendering adverse determinations."

Agency Response: TDI declines to make the suggested changes. Requiring all personnel performing utilization review of workers' compensation services to be licensed in Texas or be otherwise authorized to provide health care services in Texas is consistent with the objectives of Labor Code §408.023(h) and House Bill 1006, 80th Legislature, Regular Session, effective September 1, 2007. The requirement is necessary to ensure that appropriate health care providers, in accord with Insurance Code §4201.153(d), are used to determine medical necessity. TDI has rulemaking authority under Insurance Code §4201.003 and §36.001 to adopt this requirement.

TDI clarifies, however, that this licensing requirement only applies to personnel performing utilization review of workers' compensation services under the Insurance Code Chapter 4201, not all personnel involved in a URA's utilization review operations.

Comment: A commenter appreciates the introductory discussion's acknowledgement in §19.1706(a) that the personnel conducting utilization review activities for nonworkers' compensation plans are required to hold a license issued by "a" state license board and that a Texas Medical Board license is required for workers' compensation utilization review activities only. The commenter requests including an acknowledgement that a Texas Medical Board license is not required for utilization

review activities, unless such activities are related to a workers' compensation plan, in the adoption order also.

Commenters express concerns regarding proposed §19.1706(a) and §19.2006(a) related to qualification requirements. Insurance Code §4201.252 is very specific regarding the qualifications of personnel. Specifically, Insurance Code §4201.252(c) makes clear that personnel who perform clerical or administrative tasks are not required to be licensed, clinical staff. The commenters express confusion over the reference in the second sentence to an administrative license and are concerned TDI would require administrative staff to be licensed in some capacity. The commenters believe §19.1706(a) and §19.2006(a) should more closely track the statutory requirements in Insurance Code §4201.252, including the inapplicability of licensure requirement when performing clerical or administrative functions.

A commenter expresses concern over §19.2006(a). The commenter asserts that the proposed rule is too broad in defining the scope of utilization review and goes beyond the requirements of the statute. In addition, the language, if read literally, could be interpreted to apply to even routine administrative tasks that are part of utilization review, such as requesting medical records. The commenter asserts that §19.2006(a) should be modified to include an exception that persons conducting strictly administrative functions do not need to be licensed. The commenter recommends adding a phrase after "physicians, doctors, and other health care providers employed by or under contract with a URA to perform utilization review" to state "and who render adverse determinations."

Agency Response: TDI agrees to make changes to §19.1706(a) and §19.2006(a) to clarify that it does not require qualifications for clerical or administrative staff and to more closely track the statutory requirements in Insurance Code §4201.252. TDI added paragraph (2) that states, "Personnel who perform clerical or administrative tasks are not required to have the qualifications prescribed by this subsection." TDI also clarifies that this information may also be found in the applicability section of both Subchapters R and U in §19.1702(a)(2) and §19.2002(a)(2), respectively.

Comment: A commenter appreciates and supports §19.2006(b). However, the commenter recommends that the words "in itself" be deleted as they could result in confusion about the intent of this provision of the rule.

A commenter asserts that §19.2006(b) should be stricken as unnecessary, redundant, and potentially confusing. The subsection attempts to set forth potential "disqualifying associations," but §19.2003(b)(8) of the definitions section already contains a full provision regarding what constitutes a disqualifying association. A commenter asserts that proposed §19.2006(b) should be withdrawn.

A commenter requested clarification that this provision would not prohibit a URA from providing services to its affiliate HMO or affiliate insurer. A commenter notes that while §19.1706(b) is laudable, it is administratively difficult and may reduce the pool of potential reviewers.

A commenter notes that certain subjective bases contained in the rule, for example, disqualifying associations, do not provide adequate guidance to participants in determining appropriate conduct.

A commenter disagrees with the language in §19.2006(b) that addresses disqualifying associations for the doctor performing the appeal of the initial URA determination. The commenter believes that the fact that the reviewing doctor is employed by or under contract with the same URA that issued the initial adverse determination should be a disqualifying association. It is important for the efficacy of the system that the review of the initial determination be conducted by a person whose objectivity cannot be reasonably questioned. That goal would be significantly undermined if the review of the adverse determination can be made by someone who is employed by or under contract with the same URA that issued the initial adverse determination. The commenter also suggests adding §19.2006(b)(3) stating "any designated doctor or IRO doctor in the case." The commenter notes that giving this more expansive definition of disqualifying association will further the objective of avoiding impropriety or the appearance of impropriety.

Agency Response: TDI declines to make the suggested changes and clarifies that being employed by or contracted 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; however, another disqualifying association may apply.

These provisions are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of adopted §19.1706(b) is to prohibit the physician who reviews the appeal from being improperly influenced based on a relationship that he or she has with the physician,

doctor, or other health care provider who issued the initial adverse determination, or the enrollee who is requesting the appeal. This concept is an extension of the prohibition that an appeal must include a review by a health care provider who has not previously reviewed the case under Insurance Code §4201.357.

In response to the comment that TDI give a more expansive definition of disqualifying association, TDI declines to make the suggested change because such an interpretation of a disqualifying association is overly narrow. If the reviewing physician or doctor has already been involved in the case, then the individual is already disqualified under the proposed requirements. Existing rules do not even define "disqualifying association," so proposed §19.2006(b), along with the definition under proposed §19.2003(8), adds important safeguards without being overly burdensome or restrictive. TDI disagrees that objectivity will be compromised solely on the basis that the individual is employed by or under contract with the same URA as the physician, doctor, other health care provider who issued the initial adverse determination.

Comment: A commenter is perplexed regarding the rationale for the new requirement to file names and licensing information of utilization review personnel in §19.1706(c). The commenter knows of no other licensed entity that is required by TDI to identify personnel by name other than required officer and director filings. While this task is not impossible, the commenter indicates that it is very burdensome, particularly in regard to contract physician reviewers. The commenter indicated that it had 100 nurses dedicated to utilization reviews in Texas and, nationwide, the entity employed over 1,400 nurses that might provide services and would possibly need to be identified

in the application process. Further, it is the commenter's understanding that many health plans contract with hundreds of physician reviewers, many associated with academic institutions. The commenter believes it will be difficult to ensure that accurate information is on file with TDI due to the volume of personnel employed by or under contract with a URA, especially those affiliated with large national health plans. The commenter prefers deletion of this requirement.

The commenter requests clarification of the "number" reporting requirement and suggests limiting the requirement to personnel employed by or under contract with the URA on a full–time basis to avoid having to identify all contracted peer reviewers that may provide services only on a very limited or case-by-case basis.

Agency Response: TDI declines to make the suggested deletion of the entire section. This information is important because it allows TDI to monitor the credentials of staff performing utilization review. To avoid unnecessary administrative burden, TDI clarifies that URAs are not required to provide information on any administrative staff not conducting utilization review. These sections clarify that the URA is only required to notify TDI when filing its original or renewal applications.

Additionally, the URA application Form LHL005 requires the URA to notify TDI of a material change. For example, if one nurse stops working for the URA, the change might not be material. However, if the URA loses all of its nurses, notification would be required.

TDI deleted "number" from the requirements, because the license number reporting requirement is already included in the section.

Comment: One commenter expresses support for §19.2006(e), as it requires a Texas licensed physician who is without restriction on his or her license to be utilized.

Agency Response: TDI appreciates the supportive comment.

§19.1707 and §19.2007. URA Contact with and Receipt of Information from Health Care Providers.

Comment: A commenter expresses concern over proposed §19.2007(a). The commenter requests that the commissioner of insurance and TDI staff take notice of the fact that the issue of the need for medical records to be submitted with medical bills has been dealt with in the not too distant past by TDI-DWC when there were discussions about limiting the amount of medical records insurance carriers could receive with medical bills. The commenter asserts that, after much discussion among system stakeholders, health care providers and insurance carriers rejected limiting the amount of medical records that health care providers submit with medical records. The role of medical documentation is one of great significance in the Texas workers' compensation system. The receipt and review of medical records drives forward the evolution of a workers' compensation claim from one stage to another, and directly influences the efficiency and appropriateness of claims handling and stakeholder decision making at each level.

The commenter further explains that the Texas workers' compensation system mandates that the injured worker receive health care reasonably required to treat the compensable injury based on the application of evidence-based medicine. A utilization review agent cannot form a reasoned and appropriate opinion on the medical necessity

or appropriateness of health care services without reviewing medical records. Further, the URA cannot appropriately apply the evidence-based treatment guidelines adopted by the DWC or adopted by the health care network without reviewing the medical evidence found in the records. The commenter believes that it is imperative that TDI not attempt to limit the amount of medical records that are made available to insurance carriers, as such a public policy will have a significant negative impact on claims handling in the Texas workers' compensation system.

The commenter suggests TDI delete the phrase, "If a URA must reimburse health care providers for providing" and replace the phrase with "If a URA requests required," in §19.2007(a). The commenter suggests that TDI require reimbursements to be made by the insurance carrier and suggests addition of the phrase, "The provider of record must obtain and provide all relevant and updated medical records to the URA so that a complete review of the health care may be conducted by the URA."

A commenter states that §19.1707(a) rewrites the current 19.1708(b) related to reimbursement for medical records and removes the language related to "modification by contract." The current language is preferable because provider contracts generally either obligate the provider to provide records at no cost or contain a negotiated cost. The revision of this provision appears to consider only two options, the provider must provide at no cost or at a cost limited to the current TDI-DWC rule cap on medical records. The commenter requests that the rule be revised to address negotiated rates for medical records.

A commenter notes that 28 TAC §134.600 requires the medical provider to submit any and all information necessary to support and substantiate the medical necessity of the requested services. Section 19.2007 appears to be in conflict with 28 TAC §134.600. The commenter requests that §19.2007(a) be amended to exclude any information that is required by 28 TAC §134.600 to be included with the information request.

Agency Response: TDI declines to make the suggested changes. TDI clarifies that there is a difference between all relevant records and all records. TDI is not asserting that a determination of whether medical care is appropriate and necessary can be made without reviewing any medical records. The necessary or pertinent sections of the medical records are the relevant records.

In response to the comment that §19.2007 improperly limits the amount of medical records and is in conflict with §134.600, TDI clarifies that the intent of the rule is to prevent the URA from requiring unlimited amounts of medical records from the requestor, some of which may not inform the decision of whether care is medically necessary or appropriate. This rule will help control costs in harmony with the legislative intent.

TDI clarifies that adopted §19.1707(a) only requires a URA to reimburse a health care provider for the reasonable costs of providing medical information in writing if required under Insurance Code §4201.207. If the reimbursement is precluded or modified by contract, then the URA is not required to reimburse the health care provider

under Insurance Code §4201.207, and adopted §19.1707(a) will not apply. The language related to "modified by contract" is retained in Insurance Code §4201.207.

Comment: A commenter asserts that §19.2007(b) exceeds the statutory rulemaking authority of TDI. The commenter asserts that this is another incident in which TDI drafted rules as if the Insurance Code prevailed over the Labor Code in violation of Insurance Code §4201.054(c). The statutory basis for this proposed rule provision appears to be Labor Code §408.0046. That statute expressly provides that the rules adopted under §408.0046 ". . . must require an entity requesting a peer review to obtain and provide to the doctor performing peer review services all relevant and updated medical records." A health care provider that is requesting preauthorization or concurrent review of healthcare services is an entity requesting a URA peer review doctor to review and approve requested health care services. In those instances, the statutory duty is on the health care provider to obtain and provide all relevant and updated medical records to the URA. When the carrier is requesting the URA to perform retrospective review of medical services that have already been provided, then the carrier is the entity requesting a peer review and must obtain and provide all relevant and updated medical records. The statute does not impose a duty on the URA to request all relevant and updated medical records. The commenter recommends requiring the provider of record to obtain and provide all relevant and updated medical records in order to complete the review. The commenter suggests adding the sentence, "When conducting retrospective utilization review, the carrier must obtain and provide all relevant and updated medical records to complete the review."

A commenter asserts that the problems in proposed §19.2007(b) are accentuated in proposed §19.2007(b)(2). The commenter asserts that limitations on requesting necessary and pertinent medical records conflicts with proposed §19.2007(b) and Labor Code §408.0046. The commenter asserts that TDI is exceeding its rulemaking authority by eliminating the duty of the entity to obtain and provide all relevant and updated medical records and imposing a duty on the URA to request the records, and restricting the right to receive and review the statutorily mandated records. The commenter asserts that TDI is prohibited from turning the requirements of the Labor Code upside down in favor of the Insurance Code as legislatively mandated in Insurance Code §4201.054(c).

A commenter asserts that a mandatory requirement in §19.1707(b) and §19.2007(b) will add cost and delay. The URA would certainly argue that even if all "relevant" records were not needed to complete the review, the rule mandates that they be demanded and submitted. Further, the mandate for all records may conflict with the requirement of paragraph (2) which prohibits routinely requesting copies of medical records. The proposed language should be changed to provide authority to require records but not mandate every record if not needed to complete the review. The commenter asserts that the language should be amended to read, "When conducting routine utilization review, the URA may request only relevant and updated medical records in order to complete the review."

A commenter states that a previous informal draft to §19.2007(b) prevented a mandatory requirement for such things as CPT codes. The commenter notes that the

requirement would have required, for example, a surgeon to be clairvoyant as he or she would not know the exact coding of a procedure until after a particular procedure was performed. The commenter asserts that this type of regulation should be included in the current proposal to prevent abuse.

The commenter suggests adding the following language as a paragraph to §19.2007(b) "URAs must not routinely require hospitals and physicians to supply numerically codified diagnoses or procedures. URAs may ask for such coding, when it is known and its inclusion in the data collected increases the effectiveness of the communication." The commenter suggests adding, "Additional information may be requested by the URA or voluntarily submitted by the provider of record when there is significant lack of agreement between the URA and provider of record regarding the medical necessity and appropriateness of health care during the review of appeal process." "Significant lack of agreement" means that the URA: (1) tentatively determined that a health care service cannot be approved; (2) referred the case to a physician, doctor, or other health care provider for review; and (3) discussed or attempted to discuss obtaining further information with the provider of record." The commenter asserts that the suggested language would be of great value to patients and their health care providers. It would enable physicians and the patients they serve to provide additional information to resolve an impasse or perceived impasse concerning medical necessity. The voluntary nature allows a physician or patient to proactively be an advocate.

A commenter objects to the requirement to obtain all medical records as overly burdensome, particularly for providers. The commenter also believes it conflicts with the recommendation of the Utilization Review Advisory Committee. In addition, the commenter states that it appears to contradict paragraph (2), which prohibits routinely collecting copies of all medical records. Finally, as raised at the stakeholder meeting, the language regarding "all relevant medical records" is based on Labor Code §408.0046. This Labor Code provision also contains an obligation on the requesting provider to provide all relevant and updated medical records. There is no corresponding provision in the Insurance Code, nor is there a statutory obligation on the provider. The commenter prefers the language contained in the current rules.

A commenter recommends amending §19.2007(b) by moving the phrase "relevant and updated" to the end of the sentence. The commenter asserts that the proposed change clarifies that the URA must request relevant medical records to conduct the utilization review.

A commenter expresses concern that §19.2007(b) exceeds the statutory rulemaking authority of TDI. The statutory basis for this proposed rule provision appears to be Labor Code §408.0046. However, that statute limits appropriate rulemaking authority to the commissioner of the Division of Workers' Compensation and does not provide rulemaking authority to the commissioner of the Texas Department of Insurance.

A commenter expresses concern over §19.2007(b)(2). The commenter does not understand how a URA can make an informed decision regarding medical treatment

without the injured employee's medical records. The provision goes on to say that records should be required only when difficulty develops in determining whether the health care is medically necessary or appropriate "or experimental or investigational in nature." The commenter does not understand the reference to treatment being experimental or investigational in nature since that status is not a basis for denying medical treatment in workers' compensation. Labor Code §413.014(c)(6) and 28 TAC §134.600(p)(6) identify investigational or experimental services or devices as health care requiring preauthorization. By identifying such treatment as requiring preauthorization in workers' compensation, the statute and rule clearly envision that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. Accordingly, the commenter believes further explanation is required as to the purpose and effect of having a URA make a determination that the proposed treatment is experimental or investigational.

A commenter asserts that §19.2007(b)(2) is inconsistent with the proposed §19.2007(b) mandate that a URA "must request all relevant and updated medical records." The section is also confusing, ambiguous, and fails to set forth a real standard to guide actions. A URA needs all relevant medical information to make an informed determination regarding whether the health care service is medically necessary and appropriate under the workers' compensation law. This proposed rule is inconsistent with the goal of providing effective utilization review. To suggest that relevant medical records can only be requested "when a difficulty develops in determining whether the health care is medically necessary or appropriate or

experimental or investigational in nature" reverses the entire meaning of utilization review as set forth by the Texas Workers' Compensation Act. A URA may only perform effective, meaningful utilization review after the provider has supplied all relevant medical records. It is simply impossible to determine whether "a difficulty" has developed until after the medical provider has supplied the URA with all relevant medical records. The commenter asserts that proposed section 19.2007(b)(2) should be withdrawn.

A commenter asserts that §19.2007(b)(2) and (c) is problematic on several levels and should be removed. The first sentence seems to conflict with the proposed introductory paragraph of subsection (b) that expressly requires the URA to request all relevant and updated medical records to complete a utilization review. The second sentence suggests that utilization review can be completed without a review of medical records, which conflicts with the proposed introductory paragraph to subsection (b). Section 19.2007(b)(2) appears to conflict with the introductory paragraph to subsection (b) and is impractical. It is unknown how the URA will know what sections of records to ask for, because the URA has not seen them.

Because it is the duty of the health care provider to substantiate the medical necessity and appropriateness of medical services submitted to the URA for review, the commenter seeks clarification on any authority to require URAs to share medical records already in their possession but related to separately-submitted utilization review requests on separate issues, injuries, or body parts. Additionally, clarification is sought that no carrier or URA liability or waiver will attach based on medical records on an

injured worker already in the possession of a URA, but not submitted by the health care provider with the utilization review request that may or could otherwise be found to substantiate the medical necessity and appropriateness of the health care provider services. Liability or waiver would effectively shift the burden of production onto the reviewer and not the health care provider. Utilization review is a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services. A URA cannot form a reasoned expert opinion on the medical necessity or appropriateness of health care services without reviewing medical records, therefore health care providers should provide the entire record rather than redacting sections before submitting "necessary or pertinent" sections for review. The Texas workers' compensation system mandates that the injured worker receive health care reasonably required to treat the compensable injury based on the application of evidence-based medicine. The URA cannot apply the evidence-based treatment guidelines adopted by TDI-DWC or adopted by the health care network without reviewing the medical evidence found in the records. To encourage utilization review based on no records or partial records puts the injured employee's health and livelihood at substantial risk.

Agency Response: TDI declines to make the suggested changes. In accord with Labor Code §§402.00111, 402.00116, and 402.00128 and Insurance Code §4201.054, the commissioner of workers' compensation has delegated to the commissioner of insurance the authority to adopt rules regulating utilization review of a

health care service provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5, in Order No. DWC-11-0063, dated June 21, 2011.

TDI relies on rulemaking authority under Insurance Code §4201.003 and §36.001 in adopting these rules, not on Labor Code §408.0046.

As previously discussed, in terms of prospective and concurrent utilization review, existing Chapter 10 rules (for network care) and Chapter 134 rules (for non-network care) clarify that a health care provider submitting a request for health care services must include information to substantiate the medical necessity of the services requested.

In terms of retrospective utilization review, existing Chapter 133 rules, which apply to both network and non-network care, clarify both when medical information must be submitted and the types of information that must be submitted along with a medical bill for health care services that have already been rendered.

Existing §19.2008(c) requires the URA to require information necessary to complete the utilization review and provides that such information should be obtained from the appropriate source. Section 19.2008(c), like §19.1708(c), is designed to allow the URA to seek the information necessary for the review on a case-by-case basis without routinely requesting an entire medical record for an injured employee. Such a balance in the amount of information requested will result in a more efficient review because of both the relevance of the provided documents and the reduced cost. Even though the requesting party is required to submit information to support the request, the URA should request missing information, if known, as a matter of due diligence.

Additionally, a description of any documentation or evidence that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision, should be discussed in the peer-to-peer discussion, as required under existing §19.2010.

TDI clarifies that this subsection is not a new concept as suggested by the commenter, except that the adopted rules now match the payment responsibility for medical information requested by the URA in Subchapter U with the payment responsibility described in §19.1707 of Subchapter R. Additionally, §19.2007(a) as published updates outdated rule references relating to the reimbursement of medical documentation by eliminating references to the former Texas Workers' Compensation Commission and including 28 TAC §134.120 (relating to Reimbursement for Medical Documentation). Under existing rules, the URA was already required to request the information necessary to complete the review and could only request information relevant to the review.

TDI disagrees that §19.2007(b) limits the number of medical records that are made available to insurance carriers. An insurance carrier may already have been provided written medical information that is now being requested by the URA. In such a case, the insurance carrier is obligated to supply the URA with whatever medical information it may already have received from the health care provider to avoid unnecessary requests for information from the health care provider. However, if the insurance carrier is not able to provide this information to the URA or does not have this information and the URA has determined that the information is necessary to conduct

utilization review, then the URA, with whatever financial arrangements it has with the insurance carrier, is expected to reimburse the health care provider for the requested written medical information. In response to comments, TDI modified §19.2007(b) by deleting "A health care provider must" and inserting "Nothing in this subsection removes the health care provider's requirement to," to clarify that the health care provider must still provide information to substantiate the medical necessity of health care requested under 28 TAC Chapter 134.

TDI declines to revise §19.1707(b). The URA should determine the medical records that are relevant for the review. Section 19.1707 is designed to allow the URA to seek the information necessary for the review on a case-by-case basis without routinely requesting an entire medical record. The intent is to require the URA to identify the records it needs. Section 19.1707(b) does not require an overly broad request that would result in the transmission of unnecessary information. Existing text under §19.1708(c) states, "These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility." Thus, existing regulations already require that requested items be relevant to the utilization review.

In response to comments that the rules should prevent a mandatory requirement for CPT codes, TDI declines to make the suggested change because the prohibition is outside the scope of the URA rules.

TDI is not asserting that a determination of whether medical care is appropriate and necessary can be made without reviewing any medical records. This provision is

intended to clarify that a URA should not routinely request a copy of all of the injured employee's medical records on injured employees reviewed. Additional language in §19.2007(b)(1) states that the URA must request all relevant and updated information and medical records to complete the review. All of the provisions of §19.2007 should be read together to fully understand the circumstances in which medical records may be requested by the URA. These provisions read together are intended to clarify that a URA should request additional medical records that are pertinent to the health care services that the URA is actually reviewing. However, the URA should not request a complete copy of all medical records for every injured employee if those records are not pertinent to the services being reviewed.

Additionally, TDI clarifies that under Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services, so the URA has the ability to ask for those records if needed.

The definition of adverse determination in adopted §19.2003(b)(1) clarifies that, for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. However, TDI further clarifies that the determination of whether a service is experimental or investigational must be made by a URA, and not a claims adjuster, because the URA possesses the medical expertise needed to make that determination. To make this determination, the URA may need to request additional medical records as necessary on a case-by-case basis.

TDI asserts that no conflict with the last sentence and the introductory paragraph to §19.2007(b) exists. The necessary or pertinent sections are the relevant records.

Comment: A commenter seeks clarification on the perceived conflict between provisions of §19.2007(c) that require a URA to share among its divisions all clinical and demographic information on individual injured employees, and the provisions of §19.2013(b)(1)(A) that address written procedures on confidentiality of information received and exchange of that information.

A commenter asserts that §19.2007(c) is inconsistent with other requirements that the medical information be kept confidential and that only those records relevant to the utilization review be reviewed. The commenter asserts that proposed §19.2007(c) should be stricken.

Agency Response: TDI clarifies that URAs must comply with Insurance Code Chapter 4201, Subchapter L (regarding confidentiality of information: access to other information and applicable laws). Adopted §19.2007(c) mirrors the requirements in existing §19.2008(e). The provision is necessary to avoid duplicate requests for information from injured employees, physicians, doctors, and other health care providers, and is not meant to supersede or conflict with the confidentiality requirements under the law.

Comment: A commenter asserts that proposed §19.2007(d) is arbitrary and unreasonable. Where an injured claimant puts his emotional condition in dispute and is requesting indemnity and medical benefits for such condition and where the therapist is requesting payment for such services, it is absolutely essential that the URA be able to

review all records for the treatment for such emotional condition. These records include the process or progress notes relating to the treatment. Utilization review is an extremely critical process to make sure the injured worker is getting the proper treatment so that the worker's condition can improve. It is also critical to make sure that the health care provider is dispensing service in a productive an effective manner. To put a blanket prohibition on the review of the mental health provider's process and progress notes would render effective utilization review of mental health care impractical. A full and complete review of such health care is essential for effective utilization review. The commenter asserts that proposed §19.2007(d) should be withdrawn.

Agency Response: TDI declines to make the suggested deletion. TDI clarifies that §19.2007(d) implements Insurance Code §4201.303, which prohibits a URA from requiring, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes.

§19.1708 and §19.2008. On-Site Review by a URA.

Comment: A commenter asserts that several health care facilities are requiring URA on-site review staff, which includes case managers, to not only register with the health care facility but do so with an outside credentialing vendor who charges a registration fee. The level of the registration fees per URA staff member has purportedly been significant. This practice is inappropriate and could interfere with the on-site audit process and prevent access to health care facilities. To prevent this

inappropriate practice, the commenter requests that TDI amend the rule by adding a subsection (b) that states, "The health care facility or an agent of the health care facility shall not charge an insurance carrier or the URA or the URA's staff a registration or other fee as a condition to enter the health care facility to conduct onsite audit or to visit an injured employee."

Agency Response: Insurance Code §4201.207 already provides limits on a health care provider's charges for medical information, unless precluded or modified by contract with the URA, and Insurance Code §4201.202 provides that these sections cannot be construed to otherwise limit or deny contact with a patient for purposes of conducting utilization review, unless otherwise specifically prohibited by law.

If the commenter has concerns about on-site reviews at health care facilities, the commenter can file a complaint and TDI will consider whether the health care provider or health care facility has violated the Insurance Code, Labor Code, or TDI-DWC rules regarding charges for on-site review.

Comment: A commenter requests that TDI clarify that the requirement in §19.1708(b) for requesting medical records when conducting utilization review applies only to those medical records that are relevant to the service under review, particularly given the expansive definition of medical record.

Agency Response: TDI clarifies that this provision is found in §19.1707(b). Adopted §19.1707(b) and §19.2007(b) require the URA conducting utilization review to request "all relevant and updated information and medical records" to complete the review. This ensures that the URA uses the most recent and complete information

possible to review the treatment of the enrollee or injured employee, respectively. Although treatment may vary on a case-by-case basis, TDI determined that this requirement will enable the most effective review. Existing text under §19.1708(c) stated, "These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility." Thus, existing regulations already required that requested items be relevant to the utilization review.

§19.1709 and §19.2009. Notice of Determinations Made in Utilization Review.

Comment: Regarding the data elements and format requirements noted in proposed §19.2009, the commenter respectfully requests that TDI-DWC be mindful of the time it will take to comply with these changes in the various systems and allow for such changes that are not currently in place. It is the commenter's opinion that it could take approximately 12 months to be able to change current systems and be able to fully comply.

Agency Response: TDI declines to make the suggested change to the effective date of the adopted rules. TDI, as explained in the reasoned justification, has determined that giving stakeholders 90 days to comply from the date the adoption order is filed with the Secretary of State is sufficient.

Comment: A commenter expresses concern over §19.2009. The commenter states that the rule is overreaching and would create unintended confusion in the system. The commenter states that it appears the rules require the commenter to, before issuing a peer review report, consult with a treating provider and then, once the

report is issued, provide notice of the peer review's opinion, including a description of TDI's complaint procedure, a description of the commenter's complaint system, and notice of the independent review process. Such actions would appear to be premature and initiate confusion in the system. In some cases, the commenter may address care that has not been proposed or has already been authorized, performed, and reimbursed. For example, the commenter may be asked to address what possible surgery may be appropriate for a specific injury, even though surgery has not been discussed or proposed, or whether a surgery that has either been already authorized or performed and reimbursed was necessary and appropriate. In these cases, the commenter's peer review would have no impact on the authorization of such care, as either preauthorization has not been requested (which would go through the carrier's own URA) or the care has already been authorized, rendered, or paid (actions that would typically be handled through the carrier's own URA).

The commenter states that requiring contact with a treating physician and issuing the required notices would be premature because, the commenter has no authority to deny authorization or reimbursement on behalf of a carrier. Under Labor Code §413.031, a party is only entitled to seek medical dispute resolution after there has been a denial of authorization or payment for care, neither of which the commenter is authorized to perform on behalf of its clients. To require the commenter and similar entities to perform the required consultations and issue the required notices would, at the very least, result in the provision of unnecessary notices to system participants and encourage premature complaints or appeals, as there has been no denial of

authorization or reimbursement for care. Indeed, carriers, utilizing their own URA's, often authorize or reimburse care that the commenter's peer review physician indicated may not be necessary or appropriate. This happens for a number of reasons, including the progression of an injury or treatment that has occurred between the time of peer review and the date authorization is requested or treatment is sought.

Agency Response: TDI clarifies that the requirements contained in adopted Subchapter U do not apply to peer reviews performed for issues other than the review of medical necessity or appropriateness of health care, such as compensability or an injured employee's ability to return to work. This provision delineates requirements for peer reviews performed for the evaluation of medical necessity or appropriateness of health care versus peer reviews performed for other issues, such as extent of injury issues.

Comment: A commenter questions the need to identify the specialty of the physician reviewer in §19.1709(b). While the URA would have this information available, adding this requirement to the standardized notices will only add to the administrative costs of providing utilization review services.

The commenter requests TDI clarify that leaving a message, with a live person or a machine, qualifies as "direct telephone contact to the individual making the request" as required under §19.1709(c) because it is very difficult to get physicians on the phone. The plans will offer a peer–to–peer if the physician calls back.

Although the commenter recognizes the requirement for a "letter" for adverse determinations, the utilization review statutes do not require a written notice of a

favorable determination, which would create an additional administrative burden, especially for plans that only have CHIP and Medicaid lines of business.

The commenter suggests that §19.1709(d)(3) be clarified by including all of the statutorily required timeframes.

Agency Response: TDI asserts that although these rules potentially increase administrative costs, they are nevertheless necessary to implement HB 4290, make other changes necessary for clarity and effective implementation of Insurance Code Chapter 4201, and improve the regulatory framework for URAs. TDI has determined that the benefit of such information outweighs the fact that providing it may be burdensome, expand the length of the letters, or add to cost. This information may assist the provider of record in assessing whether the enrollee will benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

TDI clarifies that leaving a message is not considered direct telephone contact between the health benefit plan issuer to a representative of the issuer in proposed §19.1709(c). Section 19.1709(c) is consistent with the Insurance Code §1352.006. Section 1352.006 provides that in that section, "utilization review" has the meaning assigned by §4201.002. Notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under the Insurance Code, §1352.006 requires a health benefit plan to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than

three business days after the date on which the person makes the request or submits the appeal. Section 1352.006 further requires the person to make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document. To comply with these requirements, §1352.006 requires the health benefit plan issuer to respond through a direct telephone contact made by a representative of the issuer.

Section 19.1709(a) addresses requirements for both favorable and adverse determination notices and tracks the requirements in existing §19.1710(a). TDI declines to make the suggested change because §19.1709(a) implements a statutory provision. Insurance Code §4201.301 requires the URA to provide notice of a determination made in utilization review, not only adverse determinations.

TDI declines to make the suggested change to §19.1709(d)(3) because the required timeframes for notice of an adverse determination are provided in Insurance Code §4201.304, and repetition of the provisions would be redundant.

Comment: A commenter requests that TDI add the sentence "This section does not apply to a peer review by a URA that is not used as a basis to deny authorization or reimbursement for health care" to the end of §19.1709(a).

Agency Response: TDI declines to make the suggested change. In terms of the applicability of utilization review requirements to peer review functions in the Texas workers' compensation system, TDI reminds stakeholders that §180.22(g), which was first adopted in 2006 and later updated in 2011 states, in part, that "a peer reviewer who performs prospective, concurrent, or retrospective review of the medical necessity or

reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and TDI and TDI-DWC rules." This rule further states that a peer reviewer who performs utilization review must be certified or registered as a URA by TDI or be employed by or under contract with a certified or registered URA. The language in §19.2002(b)(1) reminds stakeholders of the requirements that already apply to peer reviewers under TDI-DWC's Chapter 180 rules.

Comment: A commenter objects to the references to other codes and rules and the cross-referencing to other sections of this title in §19.2009(a)(2), (3), and (4). The use of these references and cross-references make it impossible to understand what these sections mean without consulting other material and thus makes this material difficult to follow, particularly by lay people.

The commenter recommends that §19.2009(a)(2) and (3) be revised to specifically identify the parties to whom notice of the determination of prospective, concurrent, and retrospective utilization review must be given in both network and non-network claims rather than referencing other provisions in the administrative code.

Agency Response: TDI declines to delete the references to other codes and rules because URAs are required to comply with the cited rules and statutes, and inclusion of the entire text from other rules and statutes would be repetitive. TDI has determined that the rules are more streamlined and easier to understand by including cross-references, and also URAs are on notice that they are subject to the requirements in other rules and statutes.

Comment: A commenter asserts that §19.2009(a)(3) does not include a reference to the notice timeframe established by DWC in 28 TAC §133.250 for reconsideration of payment of medical bills.

Agency Response: TDI clarifies that the reference to 28 TAC §133.250 already appeared in the proposal under §19.2009(a)(3), so no addition is required.

Comment: A commenter requests clarification in §19.2009(a)(3)(A) and (B). The commenter questions whether the notice of appeal and peer-to-peer discussion for retrospective utilization review only need to take place at the time of a medical bill adverse determination

Agency Response: TDI clarifies that the provider of record is entitled to a reasonable opportunity, as defined in §19.1703(b)(26) and §19.2003(28), to speak to a physician or doctor before an adverse determination is issued by a URA who questions the necessity or appropriateness, or the experimental or investigational nature, of a health care service.

Comment: A commenter asserts that the requirements in 45 C.F.R. §162.1102 have to do with medical bill review, which is not the same as utilization review. In addition, these federal rules and electronic billing formats only say this can be assigned by the carrier to identify the preauthorization. It can be alphanumeric, one to 30 characters. The commenter is not sure how TDI believes this requirement will prevent different numbering systems. Utilization review is not subject to the federal regulation as a preauthorization determination and is not considered a billing form.

Agency Response: TDI clarifies that the preauthorization number assigned by the insurer's URA is the preauthorization number that health care providers must include in medical bills submitted using the implementation specifications adopted by federal and state regulations. While the electronic transmission of data may or may not occur during the utilization review process, it does occur when a health care provider submits a medical bill for payment.

Title 45 C.F.R. §160.1102 applies the federally adopted standards, requirements, and implementation specifications to health plans, health care clearinghouses, and health care providers "who transmit any health information in electronic form in connection with a transaction covered by this subchapter." While these federal requirements do not apply to all insurers or insurance carriers, the definition of health care providers is broad and includes any health care provider that electronically submits a medical bill.

Texas regulations already require the use of these billing standards and requirements for health plans and workers' compensation insurance carriers, which are the lines of insurance applicable to the utilization review rules. Insurance Code §1213.002 establishes that the insurer of a health benefit plan may contractually require health care providers and facilities to electronically submit medical bills and, if the contract provides for this type of submission, 28 TAC §21.3701 requires the use of the federal standards for electronic submissions. Labor Code §408.0251 and 28 TAC §133.501 require the electronic submission of medical bills for services provided under the Texas Workers' Compensation Act using these same standards and requirements.

A URA working on behalf of an insurer or insurance carrier that assigns a preauthorization number that is inconsistent with these electronic standards unilaterally imposes an obstacle to the accomplishment of the full purposes and objectives of administrative simplification, at both the federal and state level. For example, a URA that assigns an alphanumeric preauthorization number for a prescription medication could create a situation in which a retail pharmacy's electronic medical bill is rejected by the insurer's or insurance carrier's clearinghouse (the current federal and state mandated transaction sets requires a numeric format). It would be incongruous for TDI to require a health care provider to submit an electronic medical bill while permitting a situation where the insurer's contracted agent can assign a number that would delay prompt payment or penalize the health care provider for submitting the medical bill electronically.

Accordingly, compliance with these standards and implementation specifications already exists for health plans and workers' compensation insurance carriers, including their agents or business associates. Requiring the use of the required billing format in the assignment of these numbers by the insurer's URA removes a potential insurer-imposed barrier to the electronic submission of medical bills by health care providers.

TDI clarifies that the defined format for the preauthorization number is the format required for the applicable data element in the transaction standards adopted by the Federal Department of Health and Human Services (HHS) related to the submission of electronic health claims (billing requirements). Requiring the same format contained in these standards ensures that the health care provider can submit an electronic health

care claim or bill, and that the health care claim or bill will be accepted by the health plan or insurer, as opposed to being rejected because the preauthorization number assigned by the URA did not meet these format requirements.

The Code of Federal Regulations may be accessed on the Internet at: www.gpoaccess.gov/cfr/index.html.

Comment: A commenter requests a delay in the effective date for §19.2009(a)(4) regarding the preauthorization numbers, claiming it will require a minimum of four months to program the utilization review system to comply with proposed §19.2009(a)(4).

Agency Response: TDI declines to extend the effective date. Texas regulations already require the use of these billing standards and requirements for health plans and workers' compensation insurance carriers, which are the lines of insurance applicable to the utilization review rules. TDI received input from one industry group that a 90-day period would be sufficient, and TDI agrees that 90 days is reasonable.

Comment: A commenter recommends that §19.2009(b) be changed to require the URA to include a list of the documents reviewed in making the adverse determination. Proposed §19.2010 requires the URA to provide the medical provider a reasonable opportunity to discuss "a description of documentation or evidence, if any, that can be submitted by the provider of record, that upon reconsideration or appeal, might lead to a different utilization review decision." If that information were supplemented with the list of documentation reviewed, it would permit the provider to determine if such evidence already exists and simply was not provided to the URA or

whether additional evidence must be obtained before requesting reconsideration. The determination of how to supplement the initial request has to be made quickly to ensure compliance with the deadlines for requesting reconsideration. The commenter asserts that inclusion of a requirement that the URA list the documentation reviewed would provide greater efficiency in the process.

A commenter urges TDI to include in §19.1709(b) a requirement that all notices of adverse determination include a description of documentation or evidence, if any, that can be submitted that might lead to a different utilization review decision on appeal, as was required in §19.1715(b)(2)(D) of the URA rules proposed in 2011. This information could be critical to a consumer obtaining needed health care. Providing this information is a key step in setting up transparent and understandable processes for utilization review and appeals that consumers can successfully navigate. As was expressed in TDI's preamble to its 2011 proposed rule, this information is "necessary to provide important consumer information to the enrollee and the provider of record in the event that the adverse determination is appealed." In some cases, all that is needed to prove medical necessity in an appeal is missing medical imaging or diagnostic test results.

Ensuring that URAs inform consumers of what medical record is missing or what evidence could reverse the decision will improve a patient's access to medically necessary and appropriate care. Sharing this information with consumers and providers will promote the delivery of quality care in a cost-effective manner and foster greater coordination and cooperation between providers and URAs – two key goals of these rules. Consumers will benefit from having this information in two ways. If they choose

to appeal, it will help them be more successful in getting needed care in a timely fashion. The information could also help educate consumers about accepted medical practice and appropriate utilization. For example, if the key information for an appeal is documentation of a more severe condition or symptom, the consumer could choose to talk to her or his provider about alternate (and possibly more appropriate) treatment options or get a second opinion, instead of pursuing an appeal. Either way, having access to this information will enable patients to be more engaged and informed health care consumers.

The commenter recognizes that the proposed rules require URAs to share this information with providers, but asserts that these rules have moved the information key to an appeal from the adverse determination letter to the peer–to–peer call between the URA and provider prior to the adverse determination in §19.1710. The commenter supports the inclusion of this information in the peer-to-peer call and believes this will enable providers to identify and submit any missing or needed documentation quickly, reducing the need for appeals. However, providing this information only to providers is not sufficient. Although appeals for adverse determinations are likely generally conducted by providers on behalf of patients, consumers have a right to appeal adverse determinations and do so. As proposed, these rules empower providers to appeal more effectively, but do not provide the same transparency and knowledge to consumers who appeal adverse determinations. Concerns may be raised that, in some cases, the information URAs would have to provide would be lengthy and complex. That may be true, but does not justify making information critical to a consumer obtaining needed

health care difficult or impossible to obtain. Consumers who want to appeal but need help understanding information from the URA can consult with their provider or may be able to enlist other assistance, possibly from TDI's Consumer Protection Division. Including information in the notice that could reverse an adverse determination on appeal would benefit providers as well as consumers. Though providers would have access to this information in a peer-to-peer call, URAs and providers are not always successful at connecting for a peer-to-peer call. Putting the information in the notice would ensure providers get the information even if they cannot connect by phone with the URA.

The commenter asserts that, if TDI does not require information that could help on appeal be included in the notice of adverse determination, it should, at a minimum, require that URAs make the information readily available to consumers on request; and inform consumers of how to request this information from the URA in the notice of adverse determination. The commenter believes TDI has statutory authority to require that information key to an appeal be included in the notice of adverse determination under Insurance Code §4201.303(a). Though this information is not explicitly listed in statute as required in the notice, the statute does not preclude adding other elements to the list of what must be in notices. Providing the information in question that could aid in an appeal, for example, missing lab results, is an extension of the principal reason and clinical basis for the adverse determination, which are listed as required notice elements in Insurance Code §4201.303(a)(1) and (2). TDI has statutory authority to add

elements to the adverse determination notice under Insurance Code §4201.003, which provides broad rulemaking authority to implement Insurance Code Chapter 4201.

Agency Response: TDI agrees that this information might be helpful but asserts that it is more efficient for this information to be obtained through the peer-to-peer discussion, rather than through a written notice requirement that might not always be necessary and might impose additional costs on the URA. The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could prevent unnecessary adverse determinations initially as well as be helpful information on appeal.

Comment: A commenter seeks clarification of §19.2009(b)(6). The commenter would like to know what happens in a case where the URA disagrees with the injured employee that the injured employee's condition is life-threatening and does not immediately forward an adverse determination to an IRO. The commenter asks what the injured employee's recourse would be in such a circumstance.

Agency Response: TDI clarifies that, in all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include 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. Further, the injured employee is not required to comply with procedures for an internal

review of the adverse determination by the URA for prospective and concurrent utilization review.

TDI clarifies that under §19.2017(a)(2), an injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition. Paragraph (3) of §19.2017(a) provides that any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek an IRO review. URAs are required under §19.2017 to notify TDI within one working day from the date a request for an IRO review is received. A URA who does not comply with these rules may be subject to administrative penalties for noncompliance. Parties who have concerns about the utilization review process may file a complaint with TDI. A copy of the TDI complaint form can be found on TDI's website.

Title 28 TAC §12.205(f), amended to be effective December 26, 2010, provides additional clarification that nothing in the section prohibits a patient, representative of a patient, or a provider of record from submitting pertinent records to an IRO conducting the independent review. Section 12.205(c) also provides that in instances of life-threatening conditions, the IRO must contact the patient and provider directly for medical information.

Comment: A commenter notes that proposed §19.2009(b) sets forth a lengthy list of written notice requirements for the URA to provide when making an adverse determination. The commenter asserts that the list is inconsistent with the requirements of the Workers' Compensation Act. Labor Code §1305.353 provides five specific notification requirements for the URA when making an adverse determination. The commenter asserts that §19.2009(b) should be modified to remain consistent with the language of the Workers' Compensation Act.

Agency Response: TDI disagrees with the suggested change. The statutory lists are not exhaustive. Insurance Code §1305.353(b) states, "Notification of an adverse determination must include" certain elements and §4201.303(a) states, "Notice of an adverse determination must include" certain elements. These lead-in sentences indicate that TDI does not have authority to exclude one of these statutory requirements, but these statutes do not limit the elements in the notice to only those elements. There is no conflict between §19.2009(b) and Insurance Code §1305.353.

Comment: A commenter notes that the requirement for who signs the release of medical information is limited to the enrollee or the enrollee's legal guardian in §19.1709(b)(8)(B). The commenter suggests that TDI address circumstances in which the enrollee is unable to sign a release or the enrollee has authorized another person to act on their behalf with regard to releases of medical information.

Agency Response: TDI declines to make the suggested changes. TDI clarifies that this requirement is based on Insurance Code §4201.552, which prohibits a URA from disclosing individual medical records, personal information, or other confidential

information about a patient obtained in the performance of utilization review without the patient's prior written consent, except as otherwise required by law. Section 4201.552 also requires that if the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must be dated and contain the patient's signature.

Comment: A commenter requests clarification of §19.2009(c). The commenter asks, if one document can serve to both deny a request and be a peer review report, the doctor reviewing a utilization review (preauthorization, concurrent, or retrospective review) can discuss causation or compensability in a determination letter. This would potentially keep medical necessity and claims issues co-mingled.

Agency Response: TDI clarifies that if a peer review is for the review of the medical necessity and appropriateness of health care services the peer reviewer is performing utilization review and must comply with Chapter 4201 and applicable TDI-DWC rules, including 28 TAC Chapter 180. Title 28 TAC §180.22(g) establishes that peer reviews may be performed for the review of the medical necessity or reasonableness of health care and for any issues other than medical necessity, for example, compensability, and ability of an injured employee to return to work. Section19.2009(c) is only applicable to peer review reports regarding the review of medical necessity or reasonableness of health care. Additionally, the rule does not require a URA to consolidate the notice of adverse determination and the peer review report into one document, but gives the URA the administrative flexibility to consolidate these two documents into one if it is appropriate.

Comment: A commenter notes that §19.1709(d)(3) uses the phrase "date of request." The commenter suggests that TDI add to this subsection (or to the "definitions" section in §19.1703) a definition for "date of request" that addresses how requests received after-hours, on weekends, and on state approved holidays are treated differently from requests received during normal business hours.

Agency Response: TDI declines to make the suggested change. TDI clarifies that if the request is received outside of the period requiring the availability of appropriate personnel, the determination must be issued and transmitted within the required timeframes calculated from the beginning of the next time requiring such personnel, and must comply with Insurance Code §4201.302 and §4201.304 timeframes. The URA must also provide the commissioner with the procedures used when responding to poststabilization care subsequent to emergency treatment under Insurance Code §4201.004.

Comment: A commenter expressed confusion regarding the timeframes required under §19.1709, three working days (under Insurance Code §4201.304) versus §19.1718, three calendar days (under Insurance Code §843.348 and §1301.135). It would be helpful if the rules specifically addressed which sections apply and which sections do not or no longer apply in different situations, such as when a URA is providing utilization review services to an HMO or preferred provider benefit plan regarding requests from network providers and requests from non-network providers. In addition, it would be helpful to cross reference 28 TAC §21.2826, which provides that

§843.348 and §1301.135 (and thus §19.1718) do not apply to services provided by an HMO or preferred provider benefit carrier to Medicaid and CHIP enrollees.

Agency Response: The timelines for Health Maintenance Organization and Preferred Provider Benefit Plans regarding responses for network and non-network providers are statutory. TDI clarifies that §19.1709 does not apply to CHIP in accord with 28 TAC §21.2826.

§19.1710 and §19.2010. Requirements Prior to Issuing Adverse Determination.

Comment: A commenter asserts that it is unreasonable and unnecessary to mandate that the URA must discuss "a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review." The proposed mandate would require the URA to engage in speculation of what might lead to a different decision during a future appeal. The URA's responsibility and obligation is to review whether the specific health care service provided, or proposed to be provided, to the injured employee is clinically appropriate, effective, and provided in accord with best practices consistent with evidence-based medicine. If the URA makes an adverse determination, then the URA is statutorily obligated under Labor Code §1305.353 to provide the principal reasons and clinical basis for the adverse determination, the screening criteria used during the review and a description of the reconsideration and independent review process. The URA is not obligated to speculate about what might be done differently for a different result to occur during a future appeal and, indeed, such speculation is not part of utilization review. The commenter asserts that the language "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" in the initial paragraph of proposed §19.2010 should be deleted.

A commenter asserts that the broad requirement for adverse determinations for prospective or concurrent utilization review to list "a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision" requires a URA to speculate as to all possible variables that might affect the decision regardless of the likelihood of whether or not any such documents or evidence exists, shifting evidentiary responsibilities. The rule is potentially highly burdensome when combined with the possibility of sanctions or reversal upon a subjective determination of failure to comply with the rule.

A commenter asserts that it is the responsibility of the requesting provider to submit the necessary documentation to substantiate the need for the requested medical treatment. It would be impossible for the commenter to cover every possible medical scenario which could potentially result in circumstances leading to an authorization. The Official Disability Guidelines (ODG) has crafted an entire appendix (Appendix D), titled "Documenting Exceptions to the Guidelines" specifically for this purpose. It is not and should not be the responsibility of the URA to provide this to the requesting provider.

Additionally, the commenter requests that the word "physician" be changed to "healthcare provider."

A commenter objects to the requirement in this definition and §19.1710 that a reasonable opportunity for the provider of record to discuss the plan of treatment with a physician prior to issuing an adverse determination in a retrospective situation. In an instance in which a service has already been provided, there is no regulatory rationale for providing the opportunity for a peer-to-peer discussion prior to issuing an adverse determination. It would be more cost-effective to require a peer-to-peer consultation for retrospective utilization review only in those instances in which the provider of record makes such a request upon receipt of the notice of adverse determination. This solution accomplishes the goal of allowing a peer-to-peer review whenh a provider of record desires a review, without adding unnecessary expense to the process when a provider of record may not desire a peer-to-peer review. The commenter urges TDI to revise the rules to require peer-to-peer consultation only when the provider of record requests such consultation within a reasonable time of receiving the notice of adverse determination.

A commenter explains that retrospective review is a review of multiple services and providers for services that already took place. The commenter requests clarification of the purpose of calling a provider who may or may not still be treating an injured employee to discuss what they already did, which was either not documented appropriately or not within the treatment guidelines. Whatever the case may be, they cannot go back and change it as it already took place. Additionally, the commenter asks when the call takes place. At the time the insurance carrier requests the retrospective review, the reviewing provider does not know what the carrier will be doing

with the information obtained. It might be used just for the adjuster's information, making an attempt for peer-to-peer discussion to provide an opinion based on the records reviewed is unreasonable and time consuming.

Agency Response: TDI declines to make the suggested deletion. TDI believes the information is important and has added a requirement to include this information in the peer-to-peer discussion under adopted §19.1710 and adopted §19.2010. The last sentence of the introductory language of each of these sections states, "The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision." The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could be helpful information on appeal.

In response to the request to change the term "physician" to "health care provider," TDI clarifies that the first sentence in §19.2010 tracks Insurance Code §4201.206, and so, TDI declines to make the suggested change.

As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review." Insurance Code §4201.206 provides that, subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions a health care service on the basis of medical necessity or

appropriateness or the experimental or investigational nature of the service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination.

Comment: A commenter believes that §19.2010 is inappropriate and should be deleted prior to the rule being adopted. The health care provider who proposed to or has rendered healthcare services to an injured employee has the burden to substantiate the medical necessity and appropriateness of proposed or rendered healthcare services. Neither the Labor Code nor the Insurance Code require an insurance carrier or a URA to provide a health care provider with 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. The commenter asserts that this rule provision exceeds TDI's statutory authority as it relates to the regulation of utilization review.

A commenter respectfully requests that the language "dentist, chiropractor or other appropriate health care provider" be added to the end of the first sentence after the word "physician." The commenter requests that the language "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" be deleted. The commenter also requests that the words "an appropriate" be added to describe the telephone number that must be provided under proposed §19.2010(a)(1).

Agency Response: TDI agrees in part and disagrees in part. TDI declines to make the suggested deletion, because, as previously discussed, the requirement to include this information in the peer-to-peer discussion facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could prevent unnecessary initial adverse determinations as well as be helpful information on appeal.

TDI agrees to add the suggested language to the introductory paragraph, in part, to include a dentist or chiropractor in the reasonable opportunity for discussion with the provider of record prior to issuance of an adverse determination. TDI declines to add "or other appropriate health care provider." Insurance Code §4201.206 establishes that the peer-to-peer discussion before an adverse determination is issued must be with a physician. However, Labor Code §408.0044 and §408.0045 are also applicable, so dentist or chiropractor have been added as recommended by the commenter.

Comment: A commenter strongly supports the last sentence in the initial paragraph of §19.1710 and §19.2010 that includes "a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision." As was stated by TDI in the July 8, 2011, *Texas Register* when proposing §19.1710(c)(1)(D) which has similar language to §19.1710, "the additional notice element relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the patient to understand what evidence or documentation the provider of record will need

to submit." That reasoning is still valid and supports the adoption of this provision of the rule with the inclusion of a written notice to the enrollee.

Agency Response: TDI appreciates the supportive comment, but declines to make the suggested change. TDI believes the information is important and has added a requirement to include this information in the peer-to-peer discussion under adopted §19.1710 and adopted §19.2010. The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could be helpful information upon appeal.

Comment: A commenter recommends adding the following language to the beginning of proposed §19.1710 "In any instance in which the URA that is authorized to and deny authorization or reimbursement for health care..."

Agency Response: TDI declines to add the suggested language. The requirement to provide an opportunity to discuss treatment before an adverse determination tracks Insurance Code §4201.456, and the addition of the suggested language would not be consistent with statutory language.

Comment: A commenter supports the requirement that the peer-to-peer call include a description of documentation or evidence, if any, that can be submitted that might lead to a different utilization review decision. The commenter recommends that the wording in this section be changed to clarify that the documentation or evidence in question could be provided to possibly "prevent" an adverse determination, as opposed

to leading to a different determination "upon appeal." The commenter hopes that by requiring URAs and physicians to discuss this evidence before an adverse determination is made, physicians will be able to submit needed information prior to an adverse determination and appeals can be avoided altogether in some cases. The commenter asserts that consumers, who have every right to appeal and do so, also need access to information on what evidence could possibly make their appeal more successful.

Agency Response: TDI appreciates the supportive comment, but declines to make the suggested change. By specifying minimum elements, the proposed rules clarify that the required discussion may also include other matters as deemed necessary by the URA or provider of record. Additionally, the discussion could prevent an adverse determination because the reasonable opportunity for discussion occurs before an adverse determination is issued. The suggested language would not add any clarity to the rules.

Comment: A commenter would like to see further clarification of what the information required in §19.2010(2) will look like so systems can be programmed to populate this information. The commenter states that perhaps it can be a standard like the information that is currently sent in March annually.

Agency Response: TDI declines to further clarify how the URA is required from a logistical standpoint to program their systems with the information required to be submitted to TDI on request. Section 19.2010(2) provides that 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.

Comment: A commenter supports the requirement that the URA maintain documentation detailing the discussion opportunity provided to the provider of record, whether a discussion took place, and the outcome. The commenter also supports the requirement that URAs submit the required documentation to TDI on request. These steps will allow TDI to track compliance and likely increase the likelihood that URAs and providers are able to connect for peer-to-peer calls, which will help consumers get appropriate health care.

Agency Response: TDI appreciates the supportive comment.

§19.1711 and §19.2011. Written Procedures for Appeal of Adverse Determinations.

Comment: A commenter notes that it appears in §19.1711(a)(3)(D) that receipt of the written appeal form by the URA is a prerequisite for the URA to process an oral appeal. The commenter requests that TDI confirm this in the adoption order.

Agency Response: TDI clarifies that adopted §19.1711(a)(3)(D) tracks Insurance Code §4201.355. Receipt of a written appeal form by the URA is not a prerequisite to process an oral appeal. Insurance Code §4201.354 provides, in part, that an adverse determination may be appealed orally or in writing.

Comment: A commenter recommends that the deadlines for appealing the initial determination of the URA and for requesting IRO review of the second adverse

determination be specifically identified in §19.2011(a)(1) and (2) and §19.2011(a)(8)(A) and (B). The proposed URA rules are lengthy and complex and should include all the information related to the process rather than referencing other rule sections. This change would ensure that system participants could more readily determine their responsibilities under the rules.

Agency Response: TDI declines to delete the references to other codes and rules because URAs are required to comply with the cited rules and statutes, and inclusion of the entire text of other rules and statutes would be repetitive. TDI has determined that the rules are more streamlined and easier to understand by including cross-references, and URAs are on notice that they are subject to the requirements in other rules and statutes.

Comment: A commenter notes that it appears in §19.1711(a)(5) that the opportunity for a peer-to-peer discussion is now being contemplated on appeals of adverse determinations. The commenter objects to this requirement, and question the statutory authority for this requirement on the appeal level. A peer-to-peer opportunity has already been provided prior to issuing the adverse determination and the rationale for such an opportunity no longer exists on appeal. The commenter requests that this requirement be deleted.

A commenter asserts that if TDI intended to use the language of §19.1711(a)(5) to impose a requirement on a URA to provide a second "reasonable opportunity" to have a peer-to-peer discussion with the same provider of record as part of the appeal process, the commenter objects to the inclusion of such a step, which would be

repetitive and unduly burdensome. In the introductory discussion, TDI seems to indicate that the rules as proposed to require a peer–to–peer discussion opportunity for an appeal, "consistent with §4201.206." Insurance Code §4201.206 specifically references Subchapter G, which is limited to initial determinations, while the appeal process is addressed under Subchapter H. Subchapter G does not address appeal requirements, so §4201.206 is not an appropriate basis for creating a new peer-to-peer requirement for appeals. There is no statutory authority for imposing such a new requirement.

Agency Response: TDI clarifies that this discussion is a second peer-to-peer discussion. Insurance Code §4201.206 does not limit the peer-to-peer discussion requirement to initial adverse determinations. It requires the peer-to-peer discussion "before an adverse determination is issued by a utilization review agent." A denial of an appeal of an initial adverse determination is also considered an adverse determination.

Comment: A commenter asserts that there is no legislative authority supporting a blanket prohibition on the same doctor reviewing his or her previous adverse determination on appeal in §19.2011(a)(4). The authorities cited in support limit any such prohibition to certain circumstances and even if taken altogether, do not comprise a blanket prohibition.

A commenter asserts that §19.2011(a)(4) establishes what must, as a minimum, be included in a URA's written procedures for appeal of adverse determinations. The commenter asserts that the subsection limits who may make a decision on behalf of the URA on appeals of adverse determinations to physicians, dentists, or chiropractors who

have not previously reviewed the case. The subsection ignores the provisions of other URA rules that provide for the review of healthcare by other appropriate healthcare providers. The commenter asserts that the words "or other appropriate healthcare provider" be added to §19.2011(a)(4) and (a)(5).

A commenter notes that §19.1711(a)(5) states, "In any instance in which the URA is questioning the medical necessity or appropriateness . . . prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment . . . ". If this sentence is intended to speak of procedures to be followed "prior to issuance of an adverse determination," it should be moved to §19.1710 of these rules (Requirements Prior to Issuing Adverse Determination).

Agency Response: TDI declines to make the suggested changes. TDI clarifies that this provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b) relating to specialty provider reviews.

TDI also clarifies that §19.1711(a)(5) provides the requirements of a URA's written procedures for appeals.

Comment: A commenter supports §19.2011(a)(5) and appreciates its inclusion in the proposed rule.

Agency Response: TDI appreciates the supportive comment.

Comment: A commenter asserts that, to stay consistent with the use of the term "provider of record", §19.1711(a)(6) should be changed to reflect "provider of record" and not "health care provider."

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.356(b), relating to specialty provider reviews.

Comment: A commenter asserts that §19.1711(a)(7)(A) should be clarified to assure that the health care provider performing the review is not only the same or similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review but also of the same licensure. This matches the reviewer with similar statutory requirements for education, training, and standards as the provider of record who has performed the service. The commenter suggests that the words "of the same licensure as the requesting health care provider" be added to §19.1711(a)(7)(A).

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.357(a), relating to expedited appeal for denial of emergency care or continued hospitalization.

Comment: A commenter asserts that proposed §19.2011(a)(7)(C) strongly implies that all URA reviewers making adverse determinations are required to have a medical specialty. The commenter recommends that the language be changed to add "if any" after the words "professional specialty."

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.357(a), relating to expedited appeal for denial of emergency care or continued hospitalization.

Comment: A commenter asserts that §19.2011(a)(9) has no applicability in the workers' compensation context. The Workers' Compensation Act already provides that health care provided in medical emergencies is not subject to prospective review under Labor Code §413.014. A URA may perform utilization review for medical emergency services only on a retrospective basis. Expedited review is not necessary for a retrospective review determination. The commenter asserts that proposed §19.2011(a)(9) should be withdrawn.

Agency Response: TDI declines to make the suggested deletion. This provision is consistent with Insurance Code §4201.360. Section 19.2011(a)(9) also provides that in a circumstance involving a request for a medical interlocutory order under 28 TAC §134.550, the injured employee is entitled to an immediate review by an IRO of the adverse determination.

Comment: A commenter asserts that the term "life-threatening" in §19.2011(a)(9) is borrowed from statutory requirements for health insurance and health benefit plans. However, the Texas Workers Compensation Act does not use that term but instead utilizes the term "emergency" which has broader meaning and application. Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization. The commenter asserts that 28 TAC §134.600 exempts emergency medical treatment and services from prospective and

concurrent utilization review requirements. Interjecting that term into the workers' compensation rules could mislead stakeholders into believing that the expedited utilization review and appeal provisions for life-threatening conditions covered by health insurance and health benefit plans also applies to workers' compensation. This can be bad for workers if emergency medical care for a life-threatening condition is delayed in order to obtain unnecessary preauthorization or concurrent medical review. For example, a convenience store cashier who receives a gunshot wound to the chest in the course and scope of employment does not and should not be required to obtain preauthorization and concurrent medical review for the inpatient hospitalization and surgery that is necessary to save the cashier's life. A hospital that is aware of the "life-threatening" conditions provisions in the workers' compensation rules may be erroneously led to believe that preauthorization or concurrent review by the URA or IRO is necessary before it can admit the patient and perform surgery. Likewise, a carrier bill reviewer who is aware of the "life-threatening" conditions provisions in the workers' compensation rules may erroneously decide that the hospital is not entitled to reimbursement for the hospital admission and surgery if the medical or claims records reflect that no preauthorization or concurrent review was obtained prior to admission and surgery. The only time that a URA or IRO is supposed to perform utilization review of medical treatment rendered for a life-threatening condition is retrospective utilization review after the services have already been rendered. No expedited review process is necessary for retrospective review. The commenter asserts that §19.2011(a)(9) should be deleted.

Agency Response: TDI declines to make the suggested deletion. These rules implement statutory provisions of Insurance Code Chapter 4201. Insurance Code §4201.303(b) provides that for an enrollee who has a life-threatening condition, the notice of an adverse determination must include a description of the enrollee's right to an immediate review by an IRO and of the procedures to obtain that review. Insurance Code §4201.360 provides that, notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of the URA's adverse determination.

The terms "life-threatening" and "medical emergency" overlap in certain circumstances, but are not synonymous. The term "life-threatening," under Insurance Code §4201.002(7), is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. There is no requirement that the likelihood of death is imminent or the condition is acute. The terms "emergency care," under Insurance Code §4201.002(2), and "medical emergency," under Insurance Code §1305.004(13), both require the condition to be of recent or sudden onset, respectively, and requiring immediate medical care or attention, in part, to avoid placing the individual's health in serious jeopardy. Section 19.2003(18) also contains a separate definition of "medical emergency" that tracks the definition in Insurance Code §1305.004(a)(13) with a clarifying change from the use of the term "patient" to the term "injured employee."

The concept of "life-threatening" conditions may also be found in the workers' compensation system in the IRO regulations under 28 TAC §12.5, which defines "life-threatening condition," and §12.205 and §12.206, which contain requirements specific to instances of life-threatening conditions. TDI is not introducing a new concept in these rules. For example, 28 TAC §133.305 also defines "life-threatening," and 28 TAC §133.308(h) provides that in a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to comply with procedures for a reconsideration.

Additionally, Labor Code §413.014, Insurance Code §1305.351, and 28 TAC §134.600 exempt emergency treatment and services from prospective and concurrent utilization review, but it is not TDI's intent to apply the requirements regarding life-threatening conditions to emergency treatment.

Comment: A commenter notes that §19.1711(c) is titled "Appeals concerning an acquired brain injury" but the language seems to reference initial requests or extension requests. It is not clear whether the three business day timeframe applies to appeals. If TDI wants to create a special timeframe for the acquired brain injury service appeals, then the commenter's recommendation is to make the language more clearly related to appeals, by adding "Not later than three business days after the date on which an individual requests a utilization review appeal, a URA must . . . "

Agency Response: TDI declines to make the suggested change. TDI clarifies that a URA must make a determination concerning an acquired brain injury no later than three business days after the date an individual requests utilization review or an

extension of coverage based on medical necessity or appropriateness. The URA must provide notification of the determination through a direct telephone contact to the requestor. This provision is consistent with Insurance Code §1352.006.

§19.1712. URA's Telephone Access; and §19.2012. URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care.

Comment: Commenters note that proposed §19.2012(b) addresses procedures for responding to requests for drugs that require preauthorization, post-stabilization care, and pain management medication immediately subsequent to surgery or emergency treatment, as requested by the treating physician or provider of record.

The commenters assert that this subsection was inappropriately included in the rule as it is basically a closed prescription drug formulary implementation issue. Additionally, this type of activity does not occur currently in the Texas workers' compensation system. There is no requirement for such a rule provision set out in either the Insurance Code or the Labor Code. The closed prescription drug formulary rules adopted by the commissioner of workers' compensation in TAC Chapter 134 should address the concerns related to the provisions of this subsection.

The commenters request that this subsection be deleted and that TDI-DWC take appropriate action to address this issue in the closed drug formulary rules.

Agency Response: TDI declines to make the suggested deletion. The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or

pharmacy with the ability to obtain a medical interlocutory order in certain instances in which preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). The purpose of new §19.2012(b) is to require the URA to have specific procedures for these high-risk situations.

Comment: A commenter asks for clarification as to why §19.2012(b) is in the telephone access section. The commenter states that the treating doctor or consulting doctor, as appropriate, would have responsibility to ensure that requests for drugs that require preauthorization are made. For example, if the injured employee has a 30 day script; they would ask for preauthorization on the 25th day to ensure the preauthorization process is completed prior to expiring. For post-stabilization care this should be part of the request for surgery and, for emergency treatment, this does not require preauthorization for an injured employee. The commenter suggests these two areas can be addressed somewhere other than in the telephone access section and asks that, if TDI disagrees, to provide an example of an acceptable solution.

A commenter asserts that §19.2012 does not relate to utilization review. Instead, the topic relates to implementing the closed drug formulary. The activity described is not utilization review and the proposed mandate is not in the Texas Insurance Code or the Workers' Compensation Act. The commenter asserts that §19.2012 should be withdrawn.

Agency Response: TDI clarifies that the title of the section is URA's Telephone Access and Procedures for Certain Drug Requests. TDI added the phrase "and Post-Stabilization Care" to accurately reflect the content of the section.

TDI clarifies that §19.2012(b) requires a URA to have and implement procedures when responding to two types of requests. The procedures must address requests for drugs that require preauthorization if the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency. They also must address requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by a treating physician or provider of record.

The requirement in §19.2012(b) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, for both certified network and non-network claims in workers' compensation. Section 134.550 provides a prescribing doctor or pharmacy with the ability to obtain a medical interlocutory order in certain instances in which preauthorization denial of a previously prescribed and dispensed drug, excluded from the closed formulary, poses an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and Insurance Code §1305.004(a)(13). Subchapter R rules do not have an equivalent requirement because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy. The purpose of new §19.2012(b) is to require the URA to have specific procedures for high-risk situations.

§19.1713 and §19.2013. Confidentiality.

Comment: A commenter asserts that, in contrast to §19.2013(a)(4), other rules permit health care providers to charge insurance carriers and URAs 50 cents per copied page. The same maximum charge should apply to health care providers' requests for copying as well as copies produced by health care providers. Either URAs should be able to charge health care providers 50 cents per page or existing rules should be modified to require that health care providers not charge insurance carriers and URAs more than 10 cents per copied page.

A commenter questions the 10 cents per page charge limit given the fact other rules allow physicians to charge insurance carriers and URAs 50 cents per page. The commenter asserts that there is no justification for such a discrepancy. The commenter requests TDI delete "10" and replace it with "50."

Agency Response: TDI declines to make the suggested change. The provision tracks the limitation on a URA's charges for providing a copy of recorded personal information to individuals in existing §19.2014(e).

§19.1714 and §19.2014. Regulatory Requirements Subsequent to Certification or Registration.

Comment: A commenter notes that in §19.2014(c)(3), the "and" should be replaced with an "or" in the proposed rule as the rule lists examples and is not exhaustive.

Agency Response: TDI agrees to make the suggested change for clarity and consistency with adopted §19.1714(c)(3).

Comment: A commenter requests that TDI discuss in its rule adoption preamble that unscheduled on-site reviews under §19.2014(g)(2) will not be conducted as a normal course of TDI's business practices and will be restricted to instances where there is reasonable suspicion of criminal or other inappropriate activity that precludes the need for prior notice of an on-site review.

Agency Response: TDI declines to further restrict unscheduled on-site reviews and clarifies that unscheduled on-site reviews are conducted by TDI as deemed necessary for the public good or for a proper discharge of its duties.

Comment: A commenter raises a variety of concerns about proposed §19.2014(g). A commenter did not see any grant of authority for TDI to make unannounced on-site reviews of utilization review agents' operations in HB 4290. The commenter did not see any grant of authority for TDI to make unannounced visits to an URA's place of business to demand and seize records relating to operations by the URA.

The commenter's review of the Insurance Code did not reveal any requirement that an insurance carrier or URA waive its constitutional rights to obtain a certificate, license, or permit to do business in Texas. The commenter notes that the grant of free access to books and records is not the same as a grant of free access to the place of business of a carrier or URA to demand to see their operations, books and records, and to seize the books and records. The commenter believes that the unannounced on-site visits to review operations, review books and records, and possibly seize the books and records as proposed by TDI, are in violation of other laws and would be invalid if

adopted. In addition, the commenter asserts proposed subsection (g) of §19.2014 conflicts with subsection (e) of §19.2014 which gives the URA ten days to respond to "an inquiry." According to subsection (g), the URA must make available all records relating to its operation during any scheduled or unscheduled on-site reviews. The commenter notes that, at a minimum, this conflict should be addressed if TDI adopts §19.2014 as proposed.

Agency Response: TDI disagrees that the adopted rules pertaining to unannounced visits are invalid because they are based on a statute that violates Article 1, §9, and §29 of the Texas Constitution and the Fourth Amendment to the United States Constitution.

The provision for TDI to perform on-site reviews may be found in existing §19.2016(h), adopted to be effective September 20, 1998, which provides that URAs will be notified by letter providing the identity of the commissioner's designated representative and the expected arrival date and time. Adopted §19.2014(g) clarifies that the on-site reviews may be unscheduled, and that the notice will be in writing and presented by TDI's designated representative on arrival.

Insurance Code §4201.601 authorizes TDI to take certain steps if it believes that a person or entity conducting utilization review is in violation of Chapter 4201 or applicable rules. These steps include authority to compel the production of necessary information if it believes that the URA is in violation of Insurance Code or rules relating to reasonable accessibility.

TDI has rulemaking authority under Insurance Code §36.001 and §4201.003 to adopt this requirement.

§19.1716 and §19.2016. Specialty URA.

Comment: A commenter requests an explanation of when a specialty URA would be required and whether that determination itself is subject to challenge and review under §19.2016.

Agency Response: TDI clarifies that Insurance Code §4201.451 provides that, for purposes of this subchapter, "specialty utilization review agent" means a utilization review agent who conducts utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy. Specialty review agents are subject to adopted §19.2017, regarding independent review of adverse determinations. Insurance Code §4201.452, regarding inapplicability of certain other law, provides that a specialty utilization review agent is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356. Additionally, §19.1716(b) and §19.2016(b) require a specialty URA to conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the U.S. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery. This provision tracks the requirements in Insurance Code §4201.454 and is consistent with Insurance Code §1305.351(d) and Labor Code §408.023(h).

Comment: A commenter strongly supports the language in §19.1716 and §19.2016 concerning 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 is included. The commenter also recommends that a written notice of such adverse determination be provided to the injured employee or enrollee.

Agency Response: TDI appreciates the supportive comment but declines to add the requirement that 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 be included in the written notice of adverse determination. As previously discussed, the requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could be helpful information upon appeal.

Comment: A commenter expresses concern over §19.2016(g). The commenter notes that the broad requirement for adverse determinations for prospective or concurrent URA to list 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 requires a URA to speculate as to all possible variables that might affect the decision regardless of the likelihood of whether or not any such documents or evidence exists, shifting evidentiary responsibilities. The rule is potentially highly

burdensome when combined with the possibility of sanctions or reversal on a subjective determination of the URA's failure to comply with the rule.

Agency Response: TDI declines to make the suggested deletion of the requirement that a URA include a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision. TDI believes the information is important and has added a requirement to include this information in the peer-to-peer discussion under adopted §19.2016(g) and adopted §19.2010(a) The requirement to include this information in the peer-to-peer discussion is less onerous than having to document it in the notice of adverse determination, but it still facilitates the discussion of what documentation, if any, might lead to a different utilization review determination, which could potentially prevent unnecessary adverse determinations in the first place as well as provide helpful information upon appeal.

Comment: A commenter asserts that there is no legislative authority supporting a blanket prohibition on the same doctor reviewing his or her previous adverse determination on appeal in proposed §19.2016(h).

Agency Response: TDI declines to make the suggested change. This provision is consistent with Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b) relating to specialty provider reviews. Insurance Code §4201.003(a) grants the commissioner general rulemaking authority to implement Insurance Code Chapter 4201.

§19.1717 and §19.2017. Independent Review of Adverse Determinations.

Comment: A commenter asserts that proposed §19.2017(a) attempts to create a process for addressing adverse determinations when an injured employee is faced with a "life-threatening condition." The commenter asserts that the introduction of the "life-threatening condition" term and concept is inappropriate for these rules. The term "life-threatening condition" is borrowed from statutory requirements for health insurance and health benefit plans. The Texas Workers' Compensation Act does not use that term but instead utilizes the term of "emergency," which has broader meaning and application. The inclusion of this subsection would create a new utilization review process that is not appropriate for workers' compensation claims, because Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization. Likewise, 28 TAC §134.600 exempts emergency medical treatment and services from prospective and concurrent utilization review requirements. The commenter asserts that it is inappropriate to create a process for the independent review of adverse determinations regarding treatment for which a life-threatening condition or medical emergency exists because Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization.

Commenters request that proposed §19.2017(a) be deleted.

Agency Response: TDI declines to make the suggested deletion. See TDI's response earlier to §19.2011(a)(9). Section 19.2017(a) provides, in part, that for life-threatening conditions, notification of adverse determination by a URA must be provided

within the timeframes specified in §19.1709(d)(3) of this title (relating to Notice of Determinations Made in Utilization Review).

Comment: A commenter asserts that §19.2017(b) shifts the responsibility to the URA and conflicts with 28 TAC §133.308(h), which states, "Timeliness. A requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify TDI of a request for an independent review within one working day from the date the request is received by the insurance carrier or it's URA. In a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for an appeal to the insurance carrier." The commenter recommends this section be changed to mirror the section of the Texas Administrative Code noted above, which places the responsibility on the insurance carrier or the URA.

Agency Response: TDI agrees to make the suggested change. TDI made revisions requiring the independent review request form LHL009 to be returned to the entity that issued the adverse determination, whether the carrier or the URA. TDI revised adopted §19.2017(b), to state, "A URA, or insurance carrier that made the adverse determination, must notify TDI within one working day from the date a request for an independent review is received. The URA, or insurance carrier that made the

adverse determination, must submit the completed request for a review by an IRO form to TDI through TDI's internet website."

Comment: A commenter seeks clarification of §19.2017(a)(2), and is concerned with the result if the URA disagrees with the injured employee's determination that a condition is life-threatening and how such a disagreement would be reviewed.

Agency Response: TDI clarifies that in all instances of a prospective, concurrent, or retrospective utilization review adverse determination, written notification of the adverse determination by the URA must include 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. The injured employee is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review.

The new requirement under §19.2017(a)(2) is necessary to clarify that a health care provider does not have to make the determination that the condition is life-threatening, which provides more flexibility to the injured employee as long as the prudent layperson test is met. Insurance Code §4201.002(7) defines "life-threatening" as a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The statute does not specify who is required to make the determination that the disease or condition is life-threatening. TDI interprets this provision broadly to allow determination of the existence of a life-threatening condition based on a prudent layperson standard, rather than more narrowly to allow only medical personnel to make the determination. Under this interpretation, an

injured employee who cannot obtain a medical opinion that his or her condition is life-threatening may still be entitled to a faster notice of adverse determination and immediate access to independent review. This requirement is proposed under TDI's rulemaking authority in Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

TDI clarifies that under §19.2017(a)(2), an injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition. Paragraph (3) of §19.2017(a) states that any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek an IRO review. URAs are required under §19.2017 to notify TDI within one working day from the date a request for an IRO review is received. A URA who does not comply with these rules may be subject to administrative penalties for noncompliance. Parties who have concerns about the utilization review process may file a complaint with TDI. A copy of the TDI complaint form can be found on TDI's website.

Title 28 TAC §12.205(f), amended to be effective December 26, 2010, provides additional clarification that nothing in the section prohibits a patient, representative of a patient, or a provider of record from submitting pertinent records to an IRO conducting independent review. Section 12.205(c) also provides that in instances of life-

threatening conditions, the IRO must contact the patient and provider directly for medical information.

Comment: A commenter strongly supports §19.2017(a)(2), which would permit an individual acting on behalf of the injured worker, or the injured worker's provider of record, to determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured worker's disease or condition is a life-threatening condition. This will minimize delay when a delay can be harmful or even deadly to the patient. The rule also conforms to the "prudent layperson" standard as is defined under Insurance Code §4201.002. The provision enables and benefits the injured worker and a person acting on behalf of the enrollee in accessing the care that is necessary to prevent further injury and perhaps even death.

A commenter supports §19.1717(a)(2), which will permit an enrollee, person acting on behalf of an enrollee, or the enrollee's provider of record to determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's disease or condition is a life-threatening condition. This standard is reasonable and appropriate, especially considering that enrollees and people acting on their behalf have the right to appeal and will have to make this determination. This standard will help ensure access to necessary care in a timely matter when time is of the essence.

Agency Response: TDI appreciates the supportive comments.

Comment: A commenter asserts that proposed §19.2017(a)(9) is in conflict with 28 TAC §133.308(h), which provides that a requestor must file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's URA that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The rule also provides that the insurance carrier shall notify TDI of a request for an independent review within one working day from the date the request is received by the insurance carrier or URA. The commenter requests that the rule be amended by deleting "Independent review involving life-threatening and non-life threatening conditions," and by adding the language "must file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's URA that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify TDI of a request for an independent review within one working day from the date the request is received by the insurance carrier or URA." The commenter suggests deleting the language "TDI within one working day from the date a request for an independent review is received."

Agency Response: TDI declines to make the suggested change to §19.2017(b), and clarifies that the suggested language is contained in §19.2009(b)(9)(A). This requirement in §19.2017(b) should result in greater efficiency and less required time for the URA and in a quicker response time for the injured

employee or enrollee who is requesting the independent review. TDI clarifies that the provision implements Insurance Code §4201.402.

Comment: A commenter submits that the deadline to respond in regard to life-threatening conditions in §19.2017(b) should be a matter of hours, not a matter of days, noting that other provisions have shorter deadlines and that this provision should as well.

Agency Response: TDI declines to reduce the deadline for a URA to notify TDI because the URA needs time to gather all of the required documentation that needs to be submitted with the IRO request. TDI expects that all parties will expedite life-threatening cases.

Comment: A commenter asserts that §19.2017(b) is inappropriate for the workers' compensation rules and should be deleted in its entirety including its subparts.

Agency Response: TDI declines to make the suggested deletion. See TDI's response to §19.2011(a)(9). TDI clarifies that the provision implements Insurance Code §4201.402. This notification requirement should result in faster processing time, efficiency for the URA, and in a quicker response time for the injured employee or enrollee who is requesting the independent review.

Comment: A commenter notes that, just as in the comments to proposed §19.2011(a)(9), §19.2017 has no applicability to the workers' compensation context. The Workers' Compensation Act already provides that health care provided in medical emergencies is not subject to prospective review under Labor Code §413.014. A URA may perform utilization review for medical emergency services only on a retrospective

basis. Expedited review and special independent review organization procedures are not necessary for a retrospective review determination. The commenter asserts that proposed §19.2017 should be withdrawn.

Agency Response: TDI declines to make the suggested deletion. See TDI's response to §19.2011(a)(9).

§19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

Comment: A commenter asks for clarification of when the three calendar days in §19.1718 versus the three working days of §19.1709 is applicable because the requirement to allow one business day for a peer-to-peer discussion may conflict with the three calendar day timeframe.

Agency Response: TDI clarifies that an HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical or health care services for concurrent hospitalization care within 24 hours of receipt of the request. An HMO or preferred provider benefit plan must issue and transmit a determination for proposed medical care or health care services involving post-stabilization treatment within one hour from receipt of the request.

URAs must issue a determination for requests for prospective review no later than the third working day. This three-working day timeframe is compatible with the requirement that the provider of record be afforded no less than one working day to discuss the determination. However, for concurrent review, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from

providing the determination within the required 24-hour timeframes. Additionally, for post-stabilization treatment requests, TDI recognizes that requiring one working day for the peer-to-peer discussion may prevent the URA from providing the determination within the required one-hour timeframes. The adopted rules provide that a reasonable opportunity means at least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination: (A) no less than one working day prior to issuing a prospective utilization review adverse determination; (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or (C) prior to issuing a concurrent or post-stabilization review adverse determination.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: Office of Public Insurance Counsel.

For, with recommended changes: Scott and White Health Plan, Texas Medical Board, and Texas Mutual Insurance Company.

Neither for nor against, with recommended changes: American Insurance Association, Center for Public Policy Priorities, Forte, MedConfirm, Office of Injured Employee Counsel, Review Med, State Office of Risk Management, Texas Association of Health Plans, Texas Association of School Boards, Texas Medical Association, Unimed Direct, and two individuals.

Against, with recommended changes: Insurance Council of Texas, Property Casualty Insurers Association of America, and PRIUM.

6. STATUTORY AUTHORITY. The new sections are adopted under Insurance Code Chapter 4201 (Utilization Review Agents), §38.001 (Data Collection and Reports: Inquiries), §843.151 (Regulation of Health Maintenance Organizations: Rules), §1301.007 (Preferred Provider Benefit Plans: Rules), §1305.007 (Workers' Compensation Health Care Networks: Rules), §1352.003(g) (Brain Injury: Required Coverages–Health Benefit Plans Other than Small Employer Health Benefit Plans), §1352.004(b) (Brain Injury: Training for Certain Personnel Required), §1369.057 (Benefits Related to Prescription Drugs and Devices and Related Services: Rules), and Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority).

Additionally, the new sections are adopted under Labor Code §401.011 (Definitions: General Definitions); Chapter 402 (Operation and Administration of Workers' Compensation System), including §§402.00111(b) (Relationship between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking), 402.00116 (Chief Executive), 402.00128 (General Powers and Duties of Commissioner), and 402.061 (Adoption of Rules); Chapter 408 (Workers' Compensation Benefits), including §§408.0043 (Professional Specialty Certification Required for Certain Review), 408.0044 (Review of Dental Services), 408.0045 (Review of Chiropractic Services), 408.0046 (Rules), 408.021 (Entitlement to Medical Benefits),

408.023 (List of Approved Doctors; Duties of Treating Doctors), and 408.0231 (Maintenance of List of Approved Doctors; Sanctions and Privileges Relating to Health Care); §412.0215 (Sanctions); Chapter 413 (Medical Review), including §§413.011 (Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols), 413.014 (Preauthorization Requirements; Concurrent Review and Certification of Health Care), 413.015 (Payment by Insurance Carriers; Audit and Review), 413.017 (Presumption of Reasonableness), 413.031 (Medical Dispute Resolution), 413.0511 (Medical Advisor), 413.0512 (Medical Quality Review Panel), 413.0513 (Confidentiality Requirements), 413.052 (Production of Documents); and the Occupations Code §155.001 (License to Practice Medicine: Examination Required).

The purpose of Chapter 4201 is stated in Subchapter A §4201.001, which is to: (i) promote the delivery of quality health care in a cost-effective manner; (ii) ensure that a URA adheres to reasonable standards for conducting utilization review; (iii) foster greater coordination and cooperation between a health care provider and URA; (iv) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and (v) ensure that a URA maintains the confidentiality of medical records in accord with applicable law.

Insurance Code §4201.002 defines the various terms used in the chapter, among them "adverse determination" in §4201.002(1) and "utilization review" in §4201.002(13), which are incorporated into the adopted rules. Section 4201.003 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter

4201. Section 4201.004 specifies the statutory requirements concerning telephone access to a URA.

Subchapter B (Applicability of Chapter) of Chapter 4201 addresses persons providing information about scope of coverage or benefits; certain contracts with the federal government; Medicaid and certain other state health or mental health programs; workers' compensation benefits; health care service provided under automobile insurance policies; employee welfare benefit plans; HMOs; and insurers. Regarding workers' compensation benefits, §4201.054(a) provides, in relevant part, "The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Section 4201.054(c) also states, "Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code." Section 4201.054(d) further provides, "The commissioner of workers' compensation may adopt rules as necessary to implement this section."

Subchapter C (Certification) specifies that a certification of registration is required to conduct utilization review, requirements for certification, certificate renewal, certification and renewal forms, fees, non-transferability of certificate, reporting material changes, and list of URAs. Section 4201.101 provides, "A utilization review agent may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under this subchapter." Further, §4201.102(a) provides, "The commissioner may issue a certificate of registration only to an applicant who has met all

the requirements of this chapter and all the applicable rules adopted by the commissioner."

Subchapter D (Utilization Review: General Standards) sets forth statutory standards regarding utilization review plans under §4201.151; the mandate under §4201.152 that a utilization review must be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States; and the mandate under §4201.153 that screening criteria be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case–by–case basis. Section 4201.154 provides for review and inspection of screening criteria and review procedures. Section 4201.155 provides that a URA may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

Subchapter E (Utilization Review: Relations with Patients and Health Care Providers) §§4201.201, 4201.202, 4201.203, 4201.204, 4201.205, 4201.206, and 4201.207 address utilization review relations with patients and health care providers, including repetitive contacts; frequency of reviews; observing or participating in patient's care; mental health therapy; complaint system of the URA; designated initial contact; and opportunity to discuss treatment before issuance of adverse determination.

Subchapter F (Utilization Review: Personnel) §§4201.251, 4201.252, and 4201.253 address personnel matters, including delegation of utilization review, appropriate training, qualification of employed or contracted personnel, and prohibited bases for employment, compensation, evaluation, or performance standards.

Subchapter G (Notice of Determinations) specifies the general duty to notify under §4201.301, the general time for notice under §4201.302, what the contents of the notice of an adverse determination must include under §4201.303, the timeframes for notice of adverse determination under §4201.304, and what the notice of adverse determination for retrospective utilization review must include under §4201.305.

Subchapter H (Appeal of Adverse Determination) specifies the procedure for appeal of an adverse determination, including a provision in §4201.351 that for purposes of Subchapter H, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. Section 4201.352 requires a URA to maintain and make available a written description of the procedures for appealing an adverse determination, and §4201.353 mandates that these procedures be reasonable. Subchapter H further addresses requirements for persons or entities that may appeal in §4201.354, acknowledgement of appeal in §4201.355, specialty review procedures in §4201.356, expedited appeal for denial of emergency care or continued hospitalization in §4201.357, response letter to interested persons in §4201.358, written notice to the appealing party of the determination of the appeal as soon as practicable in §4201.359, and immediate appeal to an IRO in life-threatening circumstances in §4201.360.

Subchapter I (Independent Review of Adverse Determination) sets forth the statutory requirements for the independent review of an adverse determination, addresses the review by the IRO and the URA's compliance with the independent

determination in §4201.401, the information a URA must provide to the appropriate IRO in §4201.402, and payment for independent review in §4201.403.

Subchapter J (Specialty Utilization Review Agents) §4201.451 specifies definitions and requirements governing URAs that conduct utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Subchapter K (Claims Review of Medical Necessity and Appropriateness) of Chapter 4201 was repealed effective September 1, 2009.

Subchapter L (Confidentiality of Information; Access to Other Information) addresses general confidentiality requirements, consent requirements, providing information to affiliated entities, providing information to the commissioner of insurance, access to recorded personal information, publishing information identifiable to a health care provider, the requirement to maintain data in a confidential manner, and the destruction of certain confidential documents.

Subchapter M (Enforcement) concerns notice of suspected violation, compelling production of information, enforcement proceedings, and remedies and penalties for violation. Section 4201.602 authorizes the commissioner of insurance to initiate a proceeding under Subchapter M, which is a contested case for purposes of Government Code Chapter 2001. Under §4201.603, the commissioner of insurance may impose remedies and penalties for violations of Chapter 4201, including a sanction under Chapter 82, an issuance of a cease and desist order under Chapter 83, or an assessment of an administrative penalty under Chapter 84.

Insurance Code §38.001 provides, in relevant part, that TDI may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (i) the person's business condition; or (ii) any matter connected with the person's transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties.

Insurance Code §843.151 provides, in relevant part, that the commissioner of insurance may adopt reasonable rules as necessary and proper to implement Insurance Code Chapter 843.

Insurance Code §1301.007 requires, in relevant part, the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1301.

Insurance Code §1305.007 provides that the commissioner of insurance may adopt rules as necessary to implement Insurance Code Chapter 1305.

Insurance Code §1352.003(g) requires the commissioner of insurance to adopt rules as necessary to implement Insurance Code Chapter 1352.

Insurance Code §1352.004(b) requires the commissioner of insurance by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

Insurance Code §1369.057 provides that the commissioner of insurance may adopt rules to implement Insurance Code Chapter 1369, Subchapter B (Coverage of Prescription Drugs Specified by Drug Formulary).

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

Labor Code §401.011 specifies definitions used in the Texas Workers' Compensation Act. In particular, §401.011(17) defines the term "doctor"; §401.011(19) defines the term "health care," which includes a prescription drug, medicine, or other remedy under §401.011(19)(E); §401.011(20) defines "health care facility"; and §401.011(22-a) defines the terminology "health care reasonably required." Section 401.011(27) defines the term "insurance carrier"; §401.011(28) defines "insurance company"; and §401.011(44) defines "workers' compensation insurance coverage."

Labor Code §402.00111(b) provides that the commissioner of insurance may delegate to the commissioner of workers' compensation or to that person's designee and may redact any delegation, and the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under Labor Code Title 5, including the authority to make final orders or decisions. The delegation must be made in writing.

Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the commissioner of workers' compensation and the authority to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to TDI-DWC or the commissioner of workers' compensation.

Labor Code §402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate, assess, and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5.

Labor Code §402.061 grants the commissioner of workers' compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §412.0215(a) provides that TDI-DWC may impose sanctions against any person regulated by TDI-DWC.

Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who performs health care services under Labor Code Title 5, as a doctor performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serves on the medical quality review panel or as a designated doctor for TDI-DWC. Labor Code §408.0043(b) requires that a person described by Labor Code §408.0043(a), who reviews a specific workers' compensation case, hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

Labor Code §408.0044 pertains to dentists who perform dental services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case be licensed to practice dentistry.

Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for TDI-DWC. Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case be licensed to engage in the practice of chiropractic services.

Labor Code §408.0046 authorizes the commissioner of workers' compensation to adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries, and the rules must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records. Labor Code §408.021(a) specifies that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

Labor Code §408.023(h) requires that a URA or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state. Section 408.023(n) requires the commissioner of workers' compensation to adopt rules to establish reasonable requirements for doctors and health care providers financially related to those doctors, including training, impairment rating testing, financial disclosure, and monitoring.

Labor Code §408.0231(g) requires the commissioner of workers' compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers. Those rules may include standards for peer review; imposition of sanctions on doctors performing peer review functions, including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system; and other issues important to the quality of peer review, as determined by the commissioner.

Labor Code §413.011 requires the commissioner of workers' compensation by rule to establish medical policies and guidelines relating to necessary treatment for injuries designed to ensure the quality of medical care and achieve effective medical cost control.

Labor Code §413.014 requires preauthorization by insurance carriers for specified health care treatments and services. Section 413.014(a) defines the terminology "investigational or experimental service or device."

Labor Code §413.015 requires insurance carriers to pay for medical services as provided in the statute and requires that TDI-DWC ensure compliance with the medical policies and fee guidelines through audit and review.

Labor Code §413.017 provides a presumption of reasonableness for medical services consistent with TDI-DWC medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent, or retrospective review as required by TDI-DWC policies and authorized by the insurance carrier.

Labor Code §413.031(d) provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner of workers' compensation rules promulgated under §413.014 or §413.011(g) be conducted by an IRO under Insurance Code Chapter 4202 in the same manner as reviews of utilization review decisions by HMOs.

Labor Code §413.0511(b) provides that the TDI-DWC medical advisor shall make recommendations regarding the adoption of rules and policies relating to medical benefits as required by the commissioner of workers' compensation.

Labor Code §413.0512(a) requires the TDI-DWC medical advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the required duties under §413.0511.

Labor Code §413.0513(a) provides that information collected, assembled, or maintained by or on behalf of TDI-DWC under §413.0511 or §413.0512 constitutes an investigation file and may not be disclosed.

Labor Code §413.052 provides that the commissioner of workers' compensation by rule shall establish procedures to enable TDI-DWC to compel the production of documents.

Labor Code §504.053(b)(2) provides that if a political subdivision or a pool determines that a workers' compensation health care network certified under Insurance Code Chapter 1305 is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool by directly contracting with health

care providers or by contracting through a health benefits pool established under Local Government Code Chapter 172.

Labor Code §504.055(b) provides that §504.055 applies only to a first responder who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

Labor Code §504.055(c), states that, "The political subdivision, division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Subsection (b)."

Labor Code §504.056 provides that the purpose of Labor Code §504.055 is to ensure that an injured first responder's claim for medical benefits is accelerated by a political subdivision, insurance carrier, and the division to the full extent authorized by current law.

The Occupations Code §155.001 provides that a person may not practice medicine in this state unless the person holds a license issued under Occupations Code, Title 3, Subtitle B.

7. TEXT.

SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY
28 TAC §§19.1701 – 19.1719

§19.1701. General Provisions.

(a) Statutory basis. This subchapter implements Insurance Code Chapter 4201, concerning Utilization Review Agents.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of this subchapter is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of enrollee safety;

(2) ensure that URAs adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and URAs;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that URAs maintain the confidentiality of medical records in accord with applicable law.

§19.1702. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, 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 medical necessity or 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 1301, concerning Preferred Provider Benefit Plans; Insurance Code Chapter 1352, concerning Brain Injury; and Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, apply to this subchapter.

§19.1703. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(2) Appeal--A URA's formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.

(3) Biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to the URA application.

(4) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier or health maintenance organization that is registered as a URA under §19.1704 of this title (relating to Certification or Registration of URAs).

(5) Commissioner--As defined in Insurance Code §31.001.

(6) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(7) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(8) Declination--A response to a request for verification in which an HMO or preferred provider benefit plan does not issue a verification for proposed medical care or health care services. A declination is not necessarily a determination that a claim resulting from the proposed services will not ultimately be paid.

(9) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Insurance Code or applicable TDI rules, or any other association with the enrollee, employer, insurance carrier, or HMO that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(10) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(11) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

(12) Health care facility--A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(13) Health coverage--Payment for health care services provided under a health benefit plan or a health insurance policy.

(14) Health maintenance organization or HMO--As defined in Insurance Code §843.002.

(15) Insurance carrier or insurer--An entity authorized and admitted to do the business of insurance in Texas under a certificate of authority issued by TDI.

(16) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(17) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a);

(B) the Friday after Thanksgiving Day;

(C) December 24; and

(D) December 26.

(18) Medical records--The history of diagnosis and treatment, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an enrollee.

(19) Mental health medical record summary--A summary of process or progress notes relevant to understanding the enrollee's need for treatment of a mental or emotional condition or disorder, including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of enrollee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(20) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, a psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas, as appropriate, to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(21) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

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(22) Person--Any individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, limited liability partnership, the statewide rural health care system under Insurance Code Chapter 845, and any similar entity.

(23) Preauthorization--A form of prospective utilization review by a payor or its URA of health care services proposed to be provided to an enrollee.

(24) Preferred provider--

(A) with regard to a preferred provider benefit plan, a preferred provider as defined in Insurance Code Chapter 1301.

(B) with regard to an HMO:

(i) a physician, as defined in Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined in Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(25) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the enrollee or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to the enrollee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(26) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(27) Registration--The process for a licensed insurance carrier or HMO to register with TDI to perform utilization review solely for its own enrollees.

(28) Request for a review by an IRO--Form to request a review by an independent review organization that is completed by the requesting party and submitted to the URA.

(29) Retrospective utilization review--A form of utilization review for health care services that have been provided to an enrollee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(30) 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.

(31) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by the URA as part of the utilization review process.

(32) TDI--The Texas Department of Insurance.

(33) URA--Utilization review agent.

(34) URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(35) Verification--A guarantee by an HMO or preferred provider benefit plan that the HMO or preferred provider benefit plan will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the enrollee 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 benefit plan to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

§19.1704. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code §§4201.057, 4201.058, 4201.101, and this subchapter.

(1) If an insurance carrier or HMO performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier or HMO must be certified.

(2) If an insurance carrier or HMO performs utilization review only for coverage for which it is the payor, the insurance carrier or HMO must be registered.

(b) Application form. The commissioner adopts by reference the:

(1) URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Biographical affidavit, to be used as an attachment to the URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send the URA application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application or request additional time in writing within 15 working days of the date of TDI's latest notice of the omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting the URA application form to TDI. The URA must also submit a renewal fee in the amount specified by §19.802(b)(19) of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the

certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, a URA may renew the certification or registration by sending a completed renewal application and fee, as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

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§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 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. 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.

(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. 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.

(d) Referral and determination of adverse determinations. 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 medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

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

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

§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. 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 (relating to Chiropractors); or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to 22 TAC Chapter 190, regarding disciplinary guidelines.

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

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

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

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

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

(d) Written procedures and maintenance of records. URAs must develop and implement written procedures and maintain documentation to demonstrate that all

physicians, doctors, and other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced.

(e) Training related to acquired brain injury treatment. A URA must provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury in accord with Insurance Code §1352.004. The purpose of the training is to prevent denial of coverage in violation of Insurance Code §1352.003 and to avoid confusion of medical benefits with mental health benefits.

§19.1707. URA Contact with and Receipt of Information from Health Care Providers.

(a) If a URA must reimburse health care providers for providing medical information under Insurance Code §4201.207, reimbursement is limited to the reasonable costs for providing medical records relevant to the utilization review that were requested by the URA in writing. A health care provider's charge for providing medical information to a URA must comply with §134.120 of this title (relating to Reimbursement for Medical Documentation) and may not include any costs that are recouped as a part of the charge for health care.

(b) When conducting routine utilization review, the URA must request all relevant and updated information and medical records to complete the review.

(1) This information may include identifying information about the enrollee; the benefit plan or claim; the treating physician, doctor, or other health care

provider; and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the enrollee and the medical history of the enrollee relevant to the diagnoses; the enrollee's prognosis; and the plan of treatment prescribed by the provider of record, along with the provider of record's justification for the plan of treatment. The required information should be obtained from the appropriate source.

(2) URAs must not routinely request copies of all medical records on enrollees reviewed. During utilization review, copies of the necessary or pertinent sections of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate, or experimental or investigational.

(c) The URA must share among its various divisions all clinical and demographic information on individual enrollees to avoid duplicate requests for information from enrollees, physicians, doctors, and other health care providers.

(d) A URA may not require as a condition of approval of a health care service, or for any other reason, the observation of a psychotherapy session or 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 the URA from requiring submission of:

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

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

§19.1708. On-Site Review by a URA.

(a) Identification of URAs. If a URA's staff member is conducting an on-site or off-site review, each staff member must provide his or her name, the name of his or her organization, photo identification, and the URA identification card with the certification or registration number assigned by TDI when requested by an individual, including an enrollee or health care provider.

(b) On-site review. For on-site review conducted at a health care facility, URAs:

(1) must ensure that their on-site review staff:

(A) register with the appropriate contact individual, if available, prior to requesting any clinical information or assistance from health care facility staff; and

(B) wear appropriate health care facility supplied identification tags while on the health care facility premises;

(2) must agree, if so requested, that the medical records remain available in the designated areas during the on-site review and that reasonable health care facility administrative procedures will be followed by on-site review staff to avoid disrupting health care facility operations or enrollee care. The procedures, however, should not obstruct or limit the ability of the URA to efficiently conduct the necessary review.

§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) 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 or the source of the screening criteria 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/forms;

(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.

(c) 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.

(d) 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.

(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 C.F.R. §162.1102, (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction), based on the type of service in the preauthorization request.

(3) Required timeframes. Except as otherwise provided by the Insurance Code, the timeframes for notification of the adverse determination begin from the date of the request and must comply with Insurance Code §4201.304. 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.

(e) Retrospective review.

(1) The URA must develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the timeframes for the notice of adverse determination, that comply with Insurance Code §4201.305 and this section.

(2) When a retrospective review of the medical necessity or 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 Adverse Determination. In any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to the issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. 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.

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(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.

§19.1711. Written Procedures for Appeal of Adverse Determinations.

(a) Appeal of prospective or concurrent review adverse determinations. Each URA must comply with its written procedures for appeals. The written procedures for appeals must comply with Insurance Code Chapter 4201, Subchapter H, concerning Appeal of Adverse Determination, and must include provisions that specify the following:

(1) timeframes for filing the written or oral appeal, which may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination;

(2) an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing;

(3) an appeal acknowledgement letter must:

(A) be sent to the appealing party within five working days from receipt of the appeal;

(B) acknowledge the date the URA received the appeal;

(C) include a list of relevant documents that must be submitted by the appealing party to the URA; and

(D) include a one-page appeal form to be filled out by the appealing party when the URA receives an oral appeal of an adverse determination.

(4) Appeal decisions must be made by a physician who has not previously reviewed the case.

(5) In any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. The provision must require that the discussion include, at a minimum, the clinical basis for the URA's decision.

(6) If an appeal is denied and, within 10 working days from the denial, the health care provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial must be reviewed by a health care provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination. The specialty review must be completed within 15 working days of receipt of the request. The provision must state that notification of the appeal under this paragraph must be in writing.

(7) In addition to the written appeal, a method for expedited appeals for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized enrollees is available. The provision must state that:

(A) the procedure must include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review;

(B) an expedited appeal must be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received; and

(C) an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification;

(8) After the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter to the enrollee or an individual acting on behalf of the enrollee, and the provider of record, explaining the resolution of the appeal. The provision must state that the letter must include:

(A) a statement of the specific medical, dental, or contractual reasons for the resolution;

(B) the clinical basis for the decision;

(C) a description of or the source of the screening criteria that were utilized in making the determination;

(D) the professional specialty of the physician who made the determination;

(E) notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.1717 of this title (relating to Independent Review of Adverse Determinations);

(F) notice of the independent review process;

(G) a copy of a request for a review by an IRO form; and

(H) procedures for filing a complaint as described in §19.1705(f) of this title (relating to General Standards of Utilization Review).

(9) A statement that the appeal must be resolved as soon as practical, but, under Insurance Code §4201.359 and §1352.006, in no case later than 30 calendar days after the date the URA receives the appeal from the appealing party referenced under paragraph (3) of this subsection.

(10) In a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an appeal of the URA's adverse determination.

(b) Appeal of retrospective review adverse determinations. A URA must maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The written procedures for appeals must specify that an enrollee, an individual acting on behalf of the enrollee, or the

provider of record may appeal the adverse determination orally or in writing. The appeal procedures must comply with:

(1) Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims), if applicable;

(2) Section 19.1709 of this title (relating to Notice of Determinations Made in Utilization Review), for retrospective utilization review adverse determination appeals; and

(3) Insurance Code §4201.359.

(c) Appeals concerning an acquired brain injury. 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 on which 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.

§19.1712. URA's Telephone Access.

(a) Except as otherwise provided by the Insurance Code, a URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central Time and Mountain Time, to discuss enrollees' care and to respond to telephone review requests.

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(b) This section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1718 of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) or §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

§19.1713. Confidentiality.

(a) Confidentiality requirements. To ensure confidentiality, a URA must, when contacting a physician's, doctor's, or other health care provider's office, provide its certification number, name, and professional qualifications.

(1) If requested by the physician, doctor, or other health care provider, the URA must present written documentation that it is acting as an agent of the payor for the relevant enrollee.

(2) Medical records and enrollee specific information must be maintained by the URA in a secure area with access limited to essential personnel only.

(3) A URA must retain information generated and obtained by a URA in the course of utilization review for at least four years.

(4) A URA's charges for providing a copy of recorded personal information to individuals may not exceed 10 cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(b) Written procedures on confidentiality.

(1) The URA must specify in writing the procedures that the URA will implement pertaining to confidentiality of information received from the enrollee; the individual acting on behalf of the enrollee; and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting utilization review. These procedures must specify that:

(A) specific information received from the enrollee; the individual acting on behalf of the enrollee; and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting reviews will be considered confidential, be used by the review agent solely for utilization review, and be shared by the URA with only those third parties who have authority to receive the information, for example, the claim administrator; and

(B) the URA has procedures in place to address confidentiality and that the URA agrees to abide by any federal and state laws governing confidentiality.

(2) Summary data which does not provide sufficient information to allow identification of individual enrollees, physicians, doctors, or other health care providers is not considered confidential.

§19.1714. Regulatory Requirements Subsequent to Certification or Registration.

(a) Summary report to TDI. By March 1 of each year, each URA certified or registered under this subchapter must submit to TDI through TDI's internet website a complete summary report of information related to complaints, adverse determinations, and appeals of adverse determinations.

(b) Contents of summary report. The summary report required by this section must cover reviews performed by the URA during the preceding calendar year and must include:

(1) the total number of written notices of adverse determinations;

(2) a listing of appeals of adverse determinations, by the medical condition that is the source of the dispute using the approved physical diagnosis or DSM-IV (mental health diagnosis) coding that is in effect at the time, or successor codes and modifiers, and by the treatment in dispute, if any, using CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure;

(3) the classification of appellant, for example, "health care provider" or "enrollee";

(4) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level within the internal utilization review process; and

(5) the subject matter of any complaint filed with the URA.

(c) Complaints included in the summary report. Complaints listed in the summary report under subsection (b)(5) of this section must be categorized as follows:

(1) administration, for example, copies of medical records not paid for, too many calls or written requests for information from provider, or too much information requested from provider;

(2) qualifications of URA's personnel; or

(3) appeal or complaint process, for example, the treating physician is unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, or written procedures for appeal not provided.

(d) Complaints to TDI. Complaints received by TDI against a URA must be processed under TDI's established procedures for investigation and resolution of complaints.

(e) TDI inquiries. TDI may address inquiries to a URA related to any matter connected with URA transactions that TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA that receives an inquiry from TDI must respond to the inquiry in writing not later than the 10th day after the date the inquiry is received.

(f) On-site review by TDI. For scheduled and unscheduled on-site reviews, TDI may make a complete on-site review of the operations of each URA at the principal place of business for each agent as often as is deemed necessary. An on-site review will only be conducted during working days and normal business hours. The URA must make available all records relating to its operation during any scheduled and unscheduled on-site review.

(1) Scheduled on-site reviews. URAs will be notified of any scheduled on-site review by letter, which will specify, at a minimum, the identity of TDI's designated representative and the expected arrival date and time.

(2) Unscheduled on-site reviews. At a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

§19.1715. Administrative Violations. A fraudulent or deceptive act or omission in obtaining, attempting to obtain, or use of certification or registration as a URA is a violation of Insurance Code Chapter 4201. The commissioner's authority under this subchapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law, including remedies under Insurance Code Chapter 4201, Subchapter M, concerning Enforcement.

§19.1716. Specialty URA.

(a) Application. To be certified or registered as a specialty URA, an applicant must submit to TDI the application, information, and fee required in §19.1704 of this title (relating to Certification or Registration of URAs).

(b) Same specialty required. A specialty URA must conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. To conduct utilization review, a specialty URA must be of the same specialty as the health care provider who ordered the service. For example, when conducting utilization review of prescription drugs

prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery.

(c) Rule requirements. A specialty URA is subject to the requirements of this subchapter, except for the following provisions:

(1) Section 19.1705(a) of this title (relating to General Standards of Utilization Review);

(2) Section 19.1706(a), (c), and (d) of this title (relating to Requirements and Prohibitions Relating to Personnel);

(3) Section 19.1710 of this title (relating to Requirements Prior to Issuing Adverse Determination); and

(4) Section 19.1711(a)(4) - (6) of this title (relating to Written Procedures for Appeal of Adverse Determination).

(d) Utilization review plan. A specialty URA must have its utilization review plan, including appeal requirements, reviewed by a health care provider of the appropriate specialty, and the plan must be implemented under standards developed with input from a health care provider of the appropriate specialty. The specialty URA must have written procedures to ensure that these requirements are implemented.

(e) Requirements of employed or contracted physicians, doctors, other health care providers, and personnel.

(1) Physicians, doctors, other health care providers, and personnel employed by or under contract with the specialty URA to perform utilization review must be appropriately trained, qualified, and currently licensed.

(2) Personnel conducting specialty utilization review must hold an unrestricted license, an administrative license issued by a state licensing board, or be otherwise authorized to provide health care services by a licensing agency in the United States.

(f) Reasonable opportunity for discussion. In any instance in which a specialty URA questions the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, the health care provider of record must, prior to the issuance of an adverse determination, be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision of the URA with a health care provider of the same specialty as the URA. The discussion must include, at a minimum, the clinical basis for the specialty 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 specialty URA's telephone number must be provided to the provider of record so that the provider of record may contact the specialty URA to discuss the pending adverse determination. For a retrospective utilization review, the specialty URA must allow the provider of record five working days to respond orally or in writing.

(2) The specialty 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 specialty URA offered the opportunity to discuss the

adverse determination; the date and time that the discussion, if any, took place; and the discussion outcome.

(g) Appeal. The decision in any appeal of an adverse determination by a specialty URA must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination.

§19.1717. Independent Review of Adverse Determinations.

(a) Notification for life-threatening conditions. For life-threatening conditions, notification of adverse determination by a URA must be provided within the timeframes specified in §19.1709(d)(3) of this title (relating to Notice of Determinations Made in Utilization Review).

(1) At the time of notification of the adverse determination, the URA must provide to the enrollee or individual acting on behalf of the enrollee, and to the enrollee's provider of record, the notice of the independent review process and a copy of the request for a review by an IRO form. The notice must describe how to obtain independent review of the adverse determination.

(2) The enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's disease or condition is a life-threatening condition.

(b) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA may seek review of that determination or denial by an IRO assigned under Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(c) Independent review involving life-threatening and non life-threatening conditions. A URA, or insurance carrier that made the adverse determination, must notify TDI within one working day from the date the request for an independent review is received. The URA, or insurance carrier that made the adverse determination, must submit the completed request for a review by an IRO form to TDI through TDI's Internet website.

(1) Assignment of IRO. TDI will, within one working day of receipt of a complete request for independent review, randomly assign an IRO to conduct an independent review and notify the URA, payor, IRO, the enrollee or individual acting on behalf of the enrollee, enrollee's provider of record, and any other providers listed by the URA as having records relevant to the review of the assignment.

(2) Payor and URA compliance. The payor and URA must comply with the IRO's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services for an enrollee.

(3) Costs of independent review. The URA must pay for the independent review and may recover costs associated with the independent review from the payor.

§19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The words and terms defined in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in this section, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) An HMO or preferred provider benefit plan that requires preauthorization as a condition of payment to a preferred provider must comply with the procedures of this section for determinations of medical necessity or appropriateness, or the experimental or investigational nature, of care for those services the HMO or preferred provider benefit plan identifies under subsection (c) of this section.

(c) An HMO or preferred provider benefit plan that uses a preauthorization process for medical care and health care services must provide to each contracted preferred provider, not later than the 10th working day after the date a request is made, a list of medical care and health care services that allows a preferred provider to determine which services require preauthorization and information concerning the preauthorization process.

(d) An HMO or preferred provider benefit plan must issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. This determination must be issued and transmitted once a preauthorization request for proposed services that require preauthorization is received

from a preferred provider. The HMO or preferred provider benefit plan must respond to a request for preauthorization within the following time periods:

(1) For services not included under paragraphs (2) and (3) of this subsection, a 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 benefit plan. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (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 appropriate personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request, followed within three working days after the transmittal of the determination by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. If the request for medical or health care services for concurrent hospitalization care is received outside of the period requiring the availability of appropriate personnel as required in subsections (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 appropriate 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 benefit plan must 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 enrollee, 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 (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 appropriate personnel. The determination must be provided to the provider of record. If the HMO or preferred provider benefit plan 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 benefit plan must provide to the enrollee or individual acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1717(a) and (b) of this title (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may request a preauthorization determination via telephone from the HMO or preferred provider benefit plan. An HMO or preferred provider benefit plan must have appropriate personnel as described in §19.1706 of this title (relating to Requirements and Prohibitions 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 benefit plan must have a telephone system capable of accepting or recording incoming requests 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 benefit plan providing a preauthorization determination under subsection (d) of this section must, 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 providing routine vision services or dental health care services as a single health care service plan must:

(1) have appropriate personnel as described in §19.1706 of this title 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 requests 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 working 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) If an HMO or preferred provider benefit plan has preauthorized medical care or health care services, the HMO or preferred provider benefit plan may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness, or the experimental or investigational nature, 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) If an HMO or preferred provider benefit plan issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1709 of this title (relating to Notice of Determinations Made in Utilization Review) and §19.1710 of this title (relating to Requirements Prior to Issuing Adverse Determination) must be provided to the enrollee or an individual acting on behalf of the enrollee, and the enrollee's provider of record. An enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record may appeal any adverse determination under §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination).

(i) This section applies to an agent or other person with whom an HMO or preferred provider benefit plan contracts to perform utilization review, or to whom the HMO or preferred provider benefit plan 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 benefit plan's responsibility to comply with all statutory and regulatory requirements.

§19.1719. Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The words and terms defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and Chapter 843, concerning Health Maintenance Organizations, have the same meaning when used in this section, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise. This section applies to:

(1) HMOs;

(2) preferred provider benefit plans;

(3) preferred providers; and

(4) physicians, doctors, or other health care providers that provide to an enrollee of an HMO or preferred provider benefit plan:

(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 benefit plan, or a preferred provider because the services are not reasonably available from a preferred provider who is included in the HMO or preferred provider benefit plan's network.

(b) An HMO or preferred provider benefit plan must be able to receive a request for verification of proposed medical care or health care services:

(1) by telephone call;

(2) in writing; and

(3) by other means, including the Internet, as agreed to by the preferred provider and the HMO or preferred provider benefit plan, provided that the agreement may not limit the preferred provider's option to request a verification by telephone call.

(c) An HMO or preferred provider benefit plan must have appropriate personnel reasonably available at a toll-free telephone number under Insurance Code §1301.133. The HMO or preferred provider benefit plan must acknowledge calls not later than:

(1) for requests relating to post-stabilization care or a life-threatening condition, within one hour after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number;

(2) for requests relating to concurrent hospitalization, within 24 hours after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number; and

(3) for all other requests, within two calendar days after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number.

(d) Any request for verification must contain the following information:

(1) enrollee name;

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

(3) enrollee date of birth;

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

(5) enrollee relationship to enrollee or subscriber;

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

(7) description of proposed procedures or procedure codes;

(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 benefit plan;

(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.

(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).

(f) If necessary to verify proposed medical care or health care services, an HMO or preferred provider benefit plan may, within one day of receipt of a 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 benefit plan may make only one request for additional information from the requesting preferred provider under this section.

(g) A request for information under subsection (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.

(h) On receipt of a request for verification from a preferred provider, an HMO or preferred provider benefit plan must issue a verification or declination. The HMO or preferred provider benefit plan must 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 benefit plan must 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 calendar 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 subsection (c) of this section, the determination must be provided within five calendar days from the beginning of the next time period requiring appropriate 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 benefit plan received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsection (c) of this section, the determination must be provided within 24 hours from the beginning of the next time period requiring appropriate 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 benefit plan received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (c) and (d) of this section, the determination must be provided within one hour from the beginning of the next time period requiring appropriate personnel.

(i) If the request involves services for which preauthorization is required, the HMO or preferred provider benefit plan must implement the procedures set forth in §19.1718 of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and respond regarding the preauthorization request in compliance with that section.

(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 benefit plan. If a verification or declination is delivered via

telephone call, the HMO or preferred provider benefit plan must, 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 must not be less than 30 calendar 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 benefit plan 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.

SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE 28 TAC §§19.2001 – 19.2017

§19.2001. General Provisions.

(a) Statutory basis. This subchapter implements Insurance Code Chapter 4201, concerning Utilization Review Agents; Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks; and Labor Code Title 5, concerning Workers' Compensation.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of this subchapter is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of injured employee safety;

(2) ensure that URAs adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and URAs;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that URAs maintain the confidentiality of medical records under applicable law.

§19.2002. Applicability.

(a) Limitations on applicability. Except as provided in Insurance Code Chapter 4201, this subchapter applies to utilization review performed under workers' compensation insurance coverage. This subchapter does not affect the authority of TDI-DWC to exercise the powers granted to it under Labor Code Title 5 and Insurance Code Chapter 4201. This subchapter applies to utilization review as set forth in Insurance Code Chapters 1305 and 4201 and Labor Code Title 5.

(1) This subchapter does not apply to utilization review performed under a health benefit plan or a health insurance policy.

(2) This subchapter does not apply to a person who provides information to an injured employee or an injured employee's representative, physician, doctor, or other health care provider about scope of coverage or benefits provided for under workers' compensation insurance coverage, and does not determine medical necessity or appropriateness or the experimental or investigational nature of health care services.

(b) Applicability of other law.

(1) Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review, must generate a written report, and must comply with this subchapter, Labor Code Title 5, and rules adopted under the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement).

(2) Insurance carriers must process medical bills as required by Labor Code Title 5 and rules adopted under the Texas Workers' Compensation Act including,

but not limited to, Chapter 133, Subchapter A, of this title (relating to General Rules for Medical Billing and Processing).

(3) If there is a conflict between this subchapter and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail.

(4) If there is a conflict between this subchapter and the rules in Chapter 10 of this title, regarding Workers' Compensation Health Care Networks, the rules in Chapter 10 of this title prevail.

§19.2003. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a URA made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational.

(2) Appeal--The URA's formal process by which an injured employee, an injured employee's representative, or an injured employee's provider of record may request reconsideration of an adverse determination. For the purposes of this subchapter the term also applies to reconsideration processes prescribed by Labor Code Title 5 and applicable rules for workers' compensation.

(3) Biographical affidavit--National Association of Insurance Commissioners biographical affidavit to be used as an attachment to the URA application.

(4) Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a URA in the State of Texas. A certificate is not issued to an insurance carrier that is registered as a URA under §19.2004 of this title (relating to Certification or Registration of URAs).

(5) Commissioner--As defined in Insurance Code §31.001.

(6) Compensable injury--As defined in Labor Code §401.011.

(7) Complaint--An oral or written expression of dissatisfaction with a URA concerning the URA's process in conducting a utilization review. The term "complaint" does not include:

(A) an expression of dissatisfaction constituting an appeal under Insurance Code §4201.351; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(8) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(9) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician, doctor, or other health care provider, which may include:

(A) shared investment or ownership interest;

(B) contracts or agreements that provide incentives, for example, referral fees, payments based on volume or value, or waiver of beneficiary coinsurance and deductible amounts;

(C) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of a physician's, doctor's, or other health care provider's practice;

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under Labor Code or applicable TDI-DWC rules, Insurance Code or applicable TDI rules, or any other association with the injured employee, employer, or insurance carrier that may give the appearance of preventing the reviewing physician, doctor, or other health care provider from rendering an unbiased opinion.

(10) Doctor--As defined in Labor Code §401.011.

(11) Experimental or investigational--A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating

the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

(12) Health care--As defined in Labor Code §401.011.

(13) Health care facility--As defined in Labor Code §401.011.

(14) Insurance carrier or insurer--As defined in Labor Code §401.011.

(15) Independent review organization or IRO--As defined in §12.5 of this title (relating to Definitions).

(16) Legal holiday--

(A) a holiday as provided in Government Code §662.003(a);

(B) the Friday after Thanksgiving Day;

(C) December 24; and

(D) December 26.

(17) Medical benefit--As defined in Labor Code §401.011.

(18) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the injured employee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(19) Medical records--The history of diagnosis of and treatment for an injury, including medical, mental health records as allowed by law, dental, and other health care records from all disciplines providing care to an injured employee.

(20) Mental health medical record summary--A summary of process or progress notes relevant to understanding the injured employee's need for treatment of a mental or emotional condition or disorder including:

(A) identifying information; and

(B) a treatment plan that includes a:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of injured employee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(21) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist, psychological associate, or a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(D) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(E) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(F) an individual licensed as a physician assistant by the Texas Medical Board;

(G) an individual licensed as a registered professional nurse by the Texas Board of Nursing; or

(H) any other individual who is licensed or certified by a state licensing board in the State of Texas, as appropriate, to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(22) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

(23) Payor--Any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits, including workers' compensation benefits, to an individual treated by a health care provider under a policy, plan, statute, or contract.

(24) Peer review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

(25) Person--Any individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, limited

liability partnership, a political subdivision of this state, the statewide rural health care system under Insurance Code Chapter 845, and any similar entity.

(26) Preauthorization--A form of prospective utilization review by a payor or a payor's URA of health care services proposed to be provided to an injured employee.

(27) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of an injured employee, or a physician, doctor, or other health care provider that has rendered or has been requested to provide health care services to an injured employee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(28) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(29) Registration--The process for an insurance carrier to register with TDI to perform utilization review solely for injured employees covered by workers' compensation insurance coverage issued by the insurance carrier.

(30) Request for a review by an IRO--Form to request a review by an independent review organization that is completed by the requesting party and submitted to the URA, or insurance carrier that made the adverse determination.

(31) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

(32) Screening criteria--The written policies, decision rules, medical protocols, or treatment guidelines used by a URA as part of the utilization review process.

(33) TDI--The Texas Department of Insurance.

(34) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(35) Texas Workers' Compensation Act--Labor Code Title 5, Subtitle A.

(36) Treating doctor--As defined in Labor Code §401.011.

(37) URA--Utilization review agent.

(38) URA application--Form for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state.

(39) Workers' compensation health care network--As defined in Insurance Code §1305.004.

(40) Workers' compensation health plan--Health care provided by a political subdivision contracting directly with health care providers or through a health benefits pool, under Labor Code §504.053(b)(2).

(41) Workers' compensation insurance coverage--As defined in Labor Code §401.011.

(42) Workers' compensation network coverage--Health care provided under a workers' compensation health care network.

(43) Workers' compensation non-network coverage--Health care delivered under Labor Code Title 5, excluding health care provided under Insurance Code Chapter 1305.

§19.2004. Certification or Registration of URAs.

(a) Applicability of certification or registration requirements. A person acting as or holding itself out as a URA under this subchapter must be certified or registered, as applicable, under Insurance Code §§4201.057, 4201.058, 4201.101, and this subchapter.

(1) If an insurance carrier performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, the insurance carrier must be certified.

(2) If an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must be registered.

(b) Application form. The commissioner adopts by reference the:

(1) URA application, for application for, renewal of, and reporting a material change to a certification or registration as a URA in this state; and

(2) Biographical affidavit, to be used as an attachment to the URA application.

(c) Original application fee. The original application fee specified in §19.802 of this title (relating to Amount of Fees) must be sent to TDI with the application for certification. A person applying for registration is not required to pay a fee.

(d) Where to obtain and send the URA application form. Forms may be obtained from www.tdi.texas.gov/forms and must be sent to: Texas Department of Insurance, Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(e) Original application process. Within 60 calendar days after receipt of a complete application, TDI will process the application and issue or deny a certification or registration. TDI will send a certificate or a letter of registration to an entity that is granted certification or registration. The applicant may waive the time limit described in this subsection.

(f) Omissions or deficiencies. TDI will send the applicant written notice of any omissions or deficiencies in the application. The applicant must correct the omissions or deficiencies in the application, or request additional time in writing, within 15 working

days of the date of TDI's latest notice of omissions or deficiencies. If the applicant fails to do so, the application will not be processed and the file will be closed as an incomplete application. The application fee is not refundable. The request for additional time must be approved by TDI in writing to be effective.

(g) Certification and registration expiration. Each URA registration or certification issued by TDI and not suspended or revoked by the commissioner expires on the second anniversary of the date of issuance.

(h) Renewal requirements. A URA must apply for renewal of certification or registration every two years from the date of issuance by submitting the URA application to TDI. A URA must also submit a renewal fee in the amount specified by §19.802 of this title for renewal of a certification. A person applying for renewal of a registration is not required to pay a fee.

(1) Continued operation during review. If a URA submits the required information and fees specified in this subsection on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is denied or issued.

(2) Expiration for 90 calendar days or less. If the certification or registration has been expired for 90 calendar days or less, the URA may renew the certification or registration by sending a completed renewal application and fee as applicable. The URA may not operate from the time the certification or registration has expired until the time TDI has issued a renewal certification or registration.

(3) Expiration for longer than 90 calendar days. If a URA's certification or registration has been expired for longer than 90 calendar days, the URA may not renew the certification or registration. The URA must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable.

(i) Contesting a denial. If an application for an original or renewal certification or registration is denied, the applicant may contest the denial under the provisions of Chapter 1, Subchapter A, of this title (relating to Rules of Practice and Procedure) and Government Code Chapter 2001, concerning Administrative Procedure.

(j) Updating information on effective date. A URA that is certified or registered before the effective date of this rule must submit an updated application to TDI to comply with this subchapter within 90 calendar days after the effective date of this rule. However, the submission of an updated application does not change the URA's existing renewal date, and this section still governs the URA's renewal process.

§19.2005. General Standards of Utilization Review.

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

(b) Special circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require

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

(c) Screening criteria. Each URA must utilize written screening criteria that are evidence-based, scientifically valid, outcome-focused, and that comply with the requirements in Insurance Code §4201.153. 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 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, 413.011, and 413.014, 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. Adverse determinations must be referred to and may only be determined by a physician, doctor, or other health care provider with appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement) and §19.2006 of this title (relating to Requirements and Prohibitions Relating to Personnel). Physicians and doctors

performing utilization review must also comply with Labor Code §§408.0043, 408.0044, and 408.0045.

(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, 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. 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, 408.0044, and 408.0045. 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 (relating to Chiropractors), or Texas Board of Chiropractic Examiners rules. Individuals licensed by the Texas Medical Board are subject to 22 TAC Chapter 190, regarding disciplinary guidelines.

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

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

disqualifying association. A physician, doctor, or other health care provider who conducts utilization review must not have any disqualifying associations with the:

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

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

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

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

(e) Physician direction requirement. Utilization review conducted by a URA must be under the direction of a physician currently licensed without restriction to practice medicine in Texas. The physician must be employed by or under contract with the URA.

§19.2007. URA Contact with and Receipt of Information from Health Care Providers.

(a) If a URA must reimburse health care providers for providing medical information under Insurance Code §4201.207, reimbursement is limited to the

reasonable costs for providing medical records relevant to the utilization review that were requested by the URA in writing. A health care provider's charge for providing medical information to a URA must comply with §134.120 of this title (relating to Reimbursement for Medical Documentation) and may not include any costs that are recouped as a part of the charge for health care. Nothing in this subsection removes the health care provider's requirement to provide information to substantiate the medical necessity of health care requested under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments) or to submit required documentation when submitting a medical bill under Chapter 133 of this title (relating to General Medical Provisions).

(b) When conducting utilization review, a URA must request all relevant and updated information and medical records to complete the review.

(1) This information may include identifying information about the injured employee; the claim; the treating physician, doctor, or other health care provider; and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the injured employee and the medical history of the injured employee relevant to the diagnoses and the compensable injury, the injured employee's prognosis, and the plan of treatment prescribed by the provider of record, along with the provider of record's justification for the plan of treatment. The required information should be requested from the appropriate sources.

(2) A URA must not routinely request copies of all medical records on injured employees reviewed. During utilization review, copies of the necessary or

pertinent sections of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate or experimental or investigational in nature.

(c) The URA must share among its various divisions all clinical and demographic information on individual injured employees to avoid duplicate requests for information from injured employees, physicians, doctors, and other health care providers.

(d) A URA may not require as a condition of approval of a health care service, or for any other reason, the observation of a psychotherapy session or 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 injured employee'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 the URA from requiring submission of:

(1) an injured employee's mental health medical record summary; or

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

§19.2008. On-Site Review by a URA.

(a) Identification of URAs. If a URA's staff member is conducting an on-site or off-site review, each staff member must provide his or her name, the name of his or her organization, photo identification, and a URA identification card with the certification or

registration number assigned by TDI when requested by an individual, including an injured employee or health care provider.

(b) On-site review. For on-site review conducted at a health care facility, a URA:

(1) must ensure that on-site review staff:

(A) register with the appropriate contact individual, if available, prior to requesting any clinical information or assistance from health care facility staff; and

(B) wear appropriate health care facility supplied identification tags while on the health care facility premises;

(2) must agree, if so requested, that the medical records remain available in the designated areas during the on-site review and that reasonable health care facility administrative procedures will be followed by on-site review staff to avoid disrupting health care facility operations or injured employee care. The procedures, however, should not obstruct or limit the ability of the URA to efficiently conduct the necessary review.

§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 Code of Federal Regulations §162.1102 (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction) based on the type of service in the preauthorization request.

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

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

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

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

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

(6) a description of the URA's appeal process, as required by §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determination) and a statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination by an IRO and is not required to comply with procedures for an internal review of the adverse determination by the URA for prospective and concurrent utilization review;

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

(8) for workers' compensation non-network coverage, a description of treatment guidelines used under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b) 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 prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician, dentist, or chiropractor. If the health care services in question are dental services, then a dentist may conduct the discussion if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may conduct the discussion if the services in question are within the scope of the chiropractor's license to practice chiropractic. The discussion must include, at a

minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

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

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

§19.2011. Written Procedures for Appeal of Adverse Determinations.

(a) Appeal of prospective or concurrent review adverse determinations. Each URA must comply with its written procedures for appeals. The written procedures for appeals must comply with Insurance Code Chapter 4201, Subchapter H, concerning Appeal of Adverse Determination, and must include the following provisions:

(1) For workers' compensation network coverage, a URA must include in its written procedures a statement specifying the timeframes for requesting the appeal under Insurance Code §1305.354, which may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination.

(2) For workers' compensation non-network coverage and workers' compensation health plans, a URA must include in its written procedures a statement

specifying that the timeframes for requesting the appeal of the adverse determination must be consistent with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) and Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) An injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing.

(4) Appeal decisions must be made by a physician, dentist, or chiropractor who has not previously reviewed the case, as required by Chapter 180 of this title (relating to Monitoring and Enforcement); Insurance Code §1305.354; and §10.103 of this title (relating to Reconsideration of Adverse Determination). If the health care services in question are dental services, then a dentist may make the appeal decision 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 make the appeal decision if the services in question are within the scope of the chiropractor's license to practice chiropractic.

(5) Subject to the notice requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review), in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician. 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 provision must state that the discussion must include, at a minimum, the clinical basis for the URA's decision.

(6) After the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter explaining the resolution of the appeal to individuals specified in §19.2009(a) of this title (relating to Notice of Determinations Made in Utilization Review).

(7) The response letter required in paragraph (6) of this subsection, for both workers' compensation network coverage and for workers' compensation non-network coverage, must include:

(A) a statement of the specific medical or dental reasons for the resolution;

(B) the clinical basis for the decision;

(C) the professional specialty and Texas license number of the physician, dentist, or chiropractor who made the determination;

(D) notice of the appealing party's right to seek review of the adverse determination by an IRO under §19.2017 of this title (relating to Independent Review of Adverse Determinations), the notice of the independent review process, and 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 or health care provider;

(E) procedures for filing a complaint as described in §19.2005(f) of this title (relating to General Standards of Utilization Review);

(F) for workers' compensation network coverage only, a description or the source of the screening criteria that were utilized in making the determination, including a description of the network adopted treatment guidelines, if any; and

(G) for workers' compensation non-network coverage only, a description of treatment guidelines utilized under Chapter 137 of this title (relating to Disability Management) or Labor Code §504.054(b) in making a determination;

(8) Timeframes required for written notifications to the appealing party of the determination of the appeal:

(A) must be resolved as specified in §10.103 of this title for workers' compensation network coverage; and

(B) must be resolved as specified in §134.600 of this title for workers' compensation non-network coverage.

(9) In a circumstance involving an injured employee's life-threatening condition, or involving a request for a medical interlocutory order under §134.550 of this title (Medical Interlocutory Order), the injured employee is entitled to an immediate review by an IRO of the adverse determination and is not required to comply with procedures for an appeal of the adverse determination by the URA.

(b) Appeal of retrospective review adverse determinations. A URA must maintain and make available a written description of appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with §19.2009 of this title for retrospective utilization review adverse determination appeals and Insurance Code §4201.359. The written procedures for appeals must specify that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing.

(1) Workers' compensation network coverage. For workers' compensation network coverage, appeal procedures must comply with the requirements in Insurance Code Chapter 1305, §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements), and §133.250 of this title (relating to Reconsideration for Payment of Medical Bills).

(2) Workers' compensation non-network coverage. For workers' compensation non-network coverage, the appeal procedures must comply with the requirements of §133.250 of this title.

§19.2012. URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care.

(a) A URA must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central Time and Mountain Time, to discuss an injured employee's care and to respond to telephone review requests.

(b) A URA must have procedures that the URA will implement when responding to requests for:

(1) drugs that require preauthorization, in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency; and

(2) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment, as requested by the treating physician or provider of record.

§19.2013. Confidentiality.

(a) Confidentiality requirements. To ensure confidentiality, a URA must, when contacting a physician's, doctor's, or other health care provider's office, provide its certification number, name, and professional qualifications.

(1) If requested by the physician, doctor, or other health care provider, the URA must present written documentation that it is acting as an agent of the insurance carrier for the relevant injured employee.

(2) Medical records and injured employee specific information must be maintained by a URA in a secure area with access limited to essential personnel only.

(3) A URA must retain information generated and obtained by the URA in the course of utilization review for at least four years.

(4) A URA's charges for providing a copy of recorded personal information to individuals may not exceed 10 cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(b) Written procedures on confidentiality.

(1) A URA must specify in writing the procedures the URA will implement pertaining to confidentiality of information received from the injured employee, the injured employee's representative, and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for conducting utilization review. These procedures must specify that:

(A) specific information received from the injured employee, the injured employee's representative, and the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for the

purpose of conducting reviews will be considered confidential, be used by the review agent solely for utilization review, and be shared by the URA with only those third parties who have authority to receive the information, for example, the claim administrator; and

(B) the URA has procedures in place to address confidentiality, and that the URA agrees to abide by any federal and state laws governing the issue of confidentiality.

(2) Summary data which does not provide sufficient information to allow identification of individual injured employees, physicians, doctors, or other health care providers is not considered confidential.

§19.2014. Regulatory Requirements Subsequent to Certification or Registration.

(a) Summary report to TDI. By March 1 of each year, each URA certified or registered under this subchapter must submit to TDI through TDI's Internet website a complete summary report of information related to complaints, adverse determinations, and appeals of adverse determinations.

(b) Contents of summary report. The summary report required by this section must cover reviews performed by the URA during the preceding calendar year and must include:

(1) the total number of written notices of adverse determinations;

(2) a listing of adverse determinations for preauthorization, by the medical condition and treatment using the physical diagnosis or DSM-IV (mental health

diagnosis) coding that is in effect at the time, or successor codes and modifiers, and CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure;

(3) the classification of the party requesting review, for example, a health care provider; injured employee; or their representative;

(4) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level within the internal utilization review process; and

(5) the subject matter of any complaint filed with the URA.

(c) Complaints included in summary report. Complaints listed in the summary report under subsection (b)(5) of this section must be categorized as follows:

(1) administration, for example, copies of medical records not paid for, too many calls or written requests for information from provider, and too much information requested from provider;

(2) qualifications of URA's personnel; or

(3) appeal or complaint process, for example, a treating physician unable to discuss the plan of treatment with a utilization review physician; no notice of adverse determination; no notice of clinical basis for adverse determination; or written procedures for appeal not provided.

(d) Complaints to TDI. Complaints received by TDI against a URA must be processed under TDI's established procedures for investigation and resolution of complaints.

(e) TDI inquiries. TDI may address inquiries to a URA related to any matter connected with URA transactions TDI considers necessary for the public good or for the proper discharge of TDI's duties. Under Insurance Code §38.001, a URA that receives an inquiry from TDI must respond to the inquiry in writing not later than the 10th calendar day after the date the inquiry is received.

(f) TDI-DWC inquiries. This section does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5, Insurance Code, or applicable TDI-DWC rules.

(g) On-site review by TDI. For scheduled and unscheduled on-site reviews, TDI may make a complete on-site review of the operations of each URA at the principal place of business for each agent as often as is deemed necessary. An on-site review will only be conducted during working days and normal business hours. A URA must make available all records relating to its operation during any scheduled or unscheduled on-site reviews.

(1) Scheduled on-site reviews. A URA will be notified of any scheduled on-site review by letter, which will specify, at a minimum, the identity of TDI's designated representative and the expected arrival date and time.

(2) Unscheduled on-site reviews. At a minimum, notice of an on-site review of a URA will be in writing and be presented by TDI's designated representative on arrival.

§19.2015. Administrative Violations.

(a) A fraudulent or deceptive act or omission in obtaining, attempting to obtain, or use of certification or registration as a URA is a violation of Insurance Code Chapter 4201.

(b) The commissioner's authority under this subchapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law, including remedies under Insurance Code Chapter 4201, Subchapter M, concerning Enforcement.

(c) This section does not limit the ability of the commissioner of workers' compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of Labor Code Title 5 or TDI-DWC rules. Nothing in this section prohibits joint enforcement actions by TDI and TDI-DWC or delegations of authority between TDI and TDI-DWC to enforce relevant statutes or rules.

§19.2016. Specialty URA.

(a) Application. To be certified or registered as a specialty URA, an applicant must submit to TDI the application, information, and fee required in §19.2004 of this title (Certification or Registration of URAs).

(b) Same specialty required. A specialty URA must conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. To conduct utilization review, a specialty URA must be of the same specialty as the health care provider who ordered the service. For example, when conducting utilization review of prescription drugs prescribed by a physician with a specialty in neurological surgery, the specialty URA must be a physician with a specialty in neurological surgery.

(c) Rule requirements. A specialty URA is subject to the requirements of this subchapter, except for the following provisions:

(1) §19.2005(a) of this title (relating to General Standards of Utilization Review);

(2) §19.2006(a), (c), (d), and (e) of this title (relating to Requirements and Prohibitions Relating to Personnel);

(3) §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination); and

(4) §19.2011(a)(4) and (5) of this title (relating to Written Procedures for Appeal of Adverse Determination).

(d) Utilization review plan. A specialty URA must have its utilization review plan, including appeal requirements, reviewed by a physician, doctor, or other health care provider of the appropriate specialty, and the plan must be implemented under standards developed with input from a physician, doctor, or other health care provider of the appropriate specialty. The specialty URA must have written procedures to ensure that these requirements are implemented.

(e) Requirements of employed or contracted physicians, doctors, other health care providers, and personnel.

(1) Physicians, doctors, other health care providers, and personnel employed by or under contract with a specialty URA to perform workers' compensation utilization review must be appropriately trained, qualified, and currently licensed as specified in Chapter 180 of this title (relating to Monitoring and Enforcement).

(2) Personnel conducting utilization review must hold an unrestricted license, an administrative license issued by a state licensing board in Texas, or be otherwise authorized to provide health care services in Texas.

(f) Utilization review by a specialty URA. Utilization review conducted by a specialty URA must be under the direction of a physician, doctor, or other health care provider of the same specialty and the physician, doctor, or other health care provider must be currently licensed to provide the specialty health care service in Texas. The physician, doctor, or other health care provider may be employed by or under contract to the URA.

(g) Reasonable opportunity for discussion. In any instance in which a specialty URA questions whether the health care is medically necessary or appropriate, the health care provider that ordered the services must, prior to the issuance of an adverse determination, be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision of the URA with a health care provider of the same specialty as the URA. The discussion must include, at a minimum, the clinical basis for the specialty 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) A specialty URA's telephone number must be provided to the provider of record so that the provider of record may contact the specialty URA to discuss the pending adverse determination.

(2) A specialty 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 specialty URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome. The specialty URA must allow the provider of record five working days to respond orally or in writing.

(h) Appeal. The decision in an appeal of any adverse determination by a specialty URA must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination.

§19.2017. Independent Review of Adverse Determinations.

(a) Life-threatening conditions.

(1) Notification for life-threatening conditions. For life-threatening conditions, notification of an adverse determination by a URA must comply with:

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

(B) Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements) for workers' compensation network coverage; and

(C) Section 19.2009(a)(2) of this title (relating to Notice of Determinations Made in Utilization Review), including notice of the independent review process and the procedure for obtaining a copy of the request for a review by an IRO form. The notice must describe how to obtain independent review of the adverse determination and how TDI assigns a request for independent review to an IRO.

(2) Existence of life-threatening condition. An injured employee, the injured employee's representative, or the injured employee's provider of record must determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition.

(3) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination involving a life-threatening condition is denied by the URA may seek review of the adverse determination by an IRO assigned under Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(b) Independent review involving life-threatening and non life- threatening conditions. A URA, or insurance carrier that made the adverse determination, must notify TDI within one working day from the date a request for an independent review is received. The URA, or insurance carrier that made the adverse determination, must submit the completed request for a review by an IRO form to TDI through TDI's Internet website.

(1) Assignment of IRO. Within one working day of receipt of a complete request for independent review, TDI will randomly assign an IRO to conduct the independent review and notify the URA, the payor, the IRO, the injured employee or the injured employee's representative, injured employee's provider of record and any other providers listed by the URA as having records relevant to the review of the assignment.

(2) Workers' compensation non-network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation non-network coverage review are governed by the Texas Workers'

Compensation Act and TDI-DWC rules, including but not limited to Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) Workers' compensation network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation network coverage review are governed by Insurance Code Chapter 1305, TDI rules, and TDI-DWC rules, including but not limited to Chapter 10, Subchapter F, of this title (relating to Utilization Review and Retrospective Review) and Chapter 133, Subchapter D, of this title.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 28, 2013.

Sara Waitt
General Counsel
Texas Department of Insurance

The commissioner of insurance adopts new §§19.1701 – 19.1719 and new §§19.2001 – 19.2017.

Eleanor Kitzman
Commissioner of Insurance

Commissioner's Order No. 2275
JAN 31 2013

Compensation Act and TDI-DWC rules, including but not limited to Chapter 133, Subchapter D, of this title (relating to Dispute of Medical Bills).

(3) Workers' compensation network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation network coverage review are governed by Insurance Code Chapter 1305, TDI rules, and TDI-DWC rules, including but not limited to Chapter 10, Subchapter F, of this title (relating to Utilization Review and Retrospective Review) and Chapter 133, Subchapter D, of this title.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 28, 2013.

/s/
Sara Waitt
General Counsel
Texas Department of Insurance

The commissioner of insurance adopts new §§19.1701 – 19.1719 and new §§19.2001 – 19.2017.

/s/
Eleanor Kitzman
Commissioner of Insurance

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