SUBCHAPTER W. COVERAGE FOR ACQUIRED BRAIN INJURY
28 TAC §§21.3101 – 21.3107

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC §§21.3101 – 21.3107, concerning mandatory coverage for acquired brain injury. The amendments are adopted with changes to the proposed text published in the February 20, 2015, issue of the *Texas Register* (40 TexReg 772).

REASONED JUSTIFICATION. The amendments are necessary to update the rules to conform with Insurance Code Chapter 1352 as amended by HB 2929, 83rd Legislature, Regular Session (2013). TDI also makes nonsubstantive editorial changes throughout §§21.3101 – 21.3107.

Insurance Code Chapter 1352 requires health benefit plans to provide coverage for treatment of acquired brain injury. HB 2929 made substantial amendments to Chapter 1352, including prohibiting a health benefit plan from including any post-acute-care treatment covered under the plan in any annual limitation on the number of days of acute-care treatment covered; removing a provision requiring any limitation on post-acute-care treatment to be separately stated in the plan; prohibiting a plan from limiting the number of days of covered postacute care or the number of days of covered inpatient care for medically necessary treatment of acquired brain injury; and clarifying that a plan must include the same amount of limitations, deductibles, copayments, and coinsurance factors for required coverage for an acquired brain injury as are applicable to other medical conditions for which coverage is provided under the plan.

The amendments to §21.3103 address changes made by HB 2929 to required coverage for health benefit plans other than small employer health benefit plans. TDI amends §21.3103(d)(1) to clarify that a plan must include the same dollar amount and number of visit limitations, deductibles, copayments, and coinsurance factors for required brain injury coverage as are applicable to other medical conditions for which coverage is provided under the plan, rather than those applicable to "similar coverage" provided under the plan as the rule currently provides. Similarly, adopted §21.3103(g) clarifies that a plan may deny coverage or apply a

limitation or exclusion for a required service if the service is prescribed for an acquired brain injury sustained in an activity or occurrence that is limited or excluded for other medical conditions under the plan. Amendments to §21.3103(d)(2) prohibit a plan from including any post-acute-care treatment covered under the plan in any annual limitation on the number of days of acute-care treatment covered. TDI further amends §21.3103(d)(3) to remove the requirement that a plan separately state any lifetime limitation on days of post-acute-care treatment and prohibit a plan from limiting the number of days of covered postacute care or the number of days of covered inpatient care for medically necessary treatment of acquired brain injury. The amendments are necessary to align TDI's rules with Insurance Code Chapter 1352 as amended by HB 2929 and to clarify required coverage.

The amendments to §21.3106 address changes made by HB 2929 to required coverage for small employer health benefit plans. TDI amends §21.3106(b) to clarify that coverage of acquired brain injury may be subject to deductibles, copayments, coinsurance, or annual or maximum dollar amount or number of visit limits consistent with those applicable to other medical conditions for which coverage is provided under the small employer health benefit plan. Amendments to §21.3106(f) likewise clarify that a plan may deny coverage or apply a limitation or exclusion for a required service if it is prescribed for an acquired brain injury sustained in an activity or occurrence for which coverage for other medical conditions under the plan is limited or excluded. The amendments are necessary to align TDI's rules with Insurance Code Chapter 1352 as amended by HB 2929 and to clarify required coverage.

TDI adopts the rule with two changes to the proposed text. In response to a comment on the published proposal, TDI adds the words "when the services are medically necessary" to the notice to insureds and enrollees required by §21.3107(a). The change is needed to clarify that the listed services are covered when they are medically necessary, as provided in Insurance Code §1352.003(c-1). Carriers may exhaust any existing supply of printed notices containing the previous language before updating the notice to reflect the changes. TDI also removes the definition of "other similar coverage" from §21.3102 and renumbers the rest of the definitions accordingly. The definition is unnecessary because it is no longer used in the rule. These

changes do not introduce new subject matter, create additional costs, or affect persons other than those previously on notice from the proposal.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Comment: A commenter expresses concern about the use of the word "degenerative" as excluding language in the rule's definition of acquired brain injury at §21.3102(1). The commenter states that the word may be misleading as additional research is conducted in the field and that it might be used as a means to curtail appropriate services in the future.
Agency Response: TDI declines to make a change to the definition at this time. The word "degenerative" is used in the definition to exclude degenerative brain diseases such as Alzheimer's disease and Parkinson's disease and not conditions resulting from a brain injury that may be considered degenerative. This is consistent with the generally accepted meaning of the term "acquired brain injury" in the field. If the definition in the rule is used to curtail appropriate services in the future, TDI will revisit the wording of the definition at that time.

Comment: A commenter encourages the restatement of portions of Insurance Code §1352.003(c-1) and §1352.007 in the rule.
Agency Response: Restating the statute in the rule is not necessary as it would not add to or clarify the subject matter. TDI declines to make the suggested change.

Comment: Two commenters suggest that transitional postacute services be added to the list of services for which certain limitations are prohibited under §21.3103(d)(3).
Agency Response: TDI declines to make the suggested change. Limitations on the number of days of covered transitional postacute services are already prohibited by the express inclusion of transitional postacute services in Insurance Code §1352.003(b) and by reference in §21.3103(d)(3) to Insurance Code §1352.003(b).

Comment: A commenter urges that medical necessity language used in Insurance Code §1352.003(c-1) be included in the notice sent out to insureds and enrollees under §21.3107.
Agency Response: TDI agrees and adds "when the services are medically necessary" to the notice in §21.3107.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with changes: Texas Traumatic Brain Injury Advisory Council and Texas Alliance of Brain Injury Providers.

STATUTORY AUTHORITY. TDI adopts the amendments under Insurance Code §§1352.003(g), 1352.0035(c), 1352.007(f), and 36.001(a). Section 1352.003(g) authorizes the commissioner to adopt rules as necessary to implement Chapter 1352, relating to coverage for acquired brain injury by health benefit plans. Section 1352.0035(c) authorizes the commissioner to adopt rules as necessary to implement required coverage for acquired brain injury by small employer health benefit plans. Section 1352.007(f) authorizes the commissioner to require that a licensed assisted living facility providing covered postacute care for acquired brain injury other than custodial care hold a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury. Section 36.001(a) provides the commissioner's general rulemaking authority to adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

TEXT.

SUBCHAPTER W. COVERAGE FOR ACQUIRED BRAIN INJURY

§21.3101. General Provisions.

(a) Purpose. The purposes of this subchapter are to:

(1) ensure that enrollees in health benefit plans receive coverage for certain services for acquired brain injury and to facilitate the recovery and progressive rehabilitation of

survivors of acquired brain injuries to the extent possible to their preinjury condition by making available therapies that are medically necessary, clinically proven, goal-oriented, efficacious, based on individualized treatment plans, and provided by, or ordered and provided under, the direction of a licensed healthcare practitioner with the goal of returning the individual to, or maintaining the individual in, the most integrated living environment appropriate to the individual;

(2) ensure that an issuer provides coverage for services related to an acquired brain injury under the medical and surgical provisions of the health benefit plan; and

(3) require the issuer of a health benefit plan to provide adequate training of individuals responsible for preauthorization of coverage or utilization review under the plan in order to prevent wrongful denial of coverage required under Insurance Code Chapter 1352 and this subchapter, and to avoid confusion of medical and surgical benefits with mental and behavioral health benefits.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter is inconsistent with any statutes of this state, is unconstitutional, or for any other reason is invalid, the remaining provisions remain in full effect. If a court of competent jurisdiction holds that the application of any provision of this subchapter to particular persons, or in particular circumstances, is inconsistent with any statutes of this state, is unconstitutional, or for any other reason is invalid, the provision remains in full effect as to other persons or circumstances.

(c) Applicability. Nothing in this subchapter requires the issuer of a health benefit plan to provide coverage for services that are not: medically necessary; clinically proven; goal-oriented; efficacious; based on an individualized treatment plan; or provided by, or ordered and provided under, the direction of a licensed healthcare practitioner.

§21.3102. Definitions. The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Acquired brain injury--A neurological insult to the brain that is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a

change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

(2) Cognitive communication therapy--Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

(3) Cognitive rehabilitation therapy--Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

(4) Community reintegration services--Services that facilitate the continuum of care as an affected individual transitions into the community.

(5) Enrollee--A person covered by a health benefit plan.

(6) Health benefit plan--As described in Insurance Code §1352.001 and §1352.002.

(7) Issuer--Those entities identified in Insurance Code §1352.001.

(8) Neurobehavioral testing--An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

(9) Neurobehavioral treatment--Interventions that focus on behavior and the variables that control behavior.

(10) Neurocognitive rehabilitation--Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

(11) Neurocognitive therapy--Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

(12) Neurofeedback therapy--Services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and are designed to result in improved mental performance and behavior, and stabilized mood.

(13) Neurophysiological testing--An evaluation of the functions of the nervous system.

(14) Neurophysiological treatment--Interventions that focus on the functions of the nervous system.

(15) Neuropsychological testing--The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

(16) Neuropsychological treatment--Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

(17) Outpatient day treatment services--Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.

(18) Post-acute-care treatment services--Services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

(19) Postacute transition services--Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

(20) Psychophysiological testing--An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

(21) Psychophysiological treatment--Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

(22) Remediation--The process or processes of restoring or improving a specific function.

(23) Services--The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

(24) Therapy--The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

§21.3103. Coverage for Services.

(a) Required Coverage. Under Insurance Code Chapter 1352, a health benefit plan must include coverage for services specified in §1352.003, including cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, remediation, and postacute transition services, community reintegration services, including outpatient day treatment services, or other post-acute-care treatment services, if such services are necessary as a result of and related to an acquired brain injury.

(b) Medically Necessary and Appropriate.

(1) For purposes of Insurance Code §1352.003 and this subchapter, the word "necessary" means "medically necessary."

(2) Under Insurance Code §1352.007(a), a health benefit plan may not deny benefits for the coverage required under Insurance Code Chapter 1352 based solely on the fact that the treatment or services are provided at a facility other than a hospital. Medically necessary treatment and services for an acquired brain injury must be provided under the coverage required by Chapter 1352 at a facility where appropriate services may be provided, including:

(A) a hospital regulated under the Health and Safety Code Chapter 241, including an acute or postacute rehabilitation hospital; and

(B) an assisted living facility regulated under the Health and Safety Code Chapter 247.

(c) Maintenance, Prevention, and Reevaluation of Care.

(1) Treatment goals for services required by Insurance Code Chapter 1352 may include the maintenance of functioning or the prevention or slowing of further deterioration.

(2) Under Insurance Code §1352.003(e), a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual

covered under the plan who has incurred an acquired brain injury, been unresponsive to treatment, and becomes responsive to treatment at a later date. As provided in Insurance Code §1352.003(f), factors for determining whether reasonable expenses related to periodic reevaluation of care must be covered may include:

(A) cost;

(B) the time that has expired since the previous evaluation;

(C) any difference in the expertise of the physician or practitioner performing the evaluation;

(D) changes in technology; and

(E) advances in medicine.

(d) Lifetime Dollar Amount or Number of Visit Limitations, Deductibles, Copayments, and Coinsurance.

(1) A health benefit plan may not subject the coverage required under Insurance Code Chapter 1352 to dollar amount or number of visit limitations, deductibles, copayments, and coinsurance factors that are more restrictive than dollar amount or number of visit limitations, deductibles, copayments, and coinsurance factors applicable to other medical conditions for which the health benefit plan provides coverage.

(2) A health benefit plan that includes annual or lifetime limitations on coverage required under Insurance Code Chapter 1352 is prohibited from including any post-acute-care treatment for the coverage in any annual or lifetime limitation on the number of days of acute-care treatment covered under the plan.

(3) A health benefit plan may not limit the number of days of covered postacute care, including any therapy, treatment, or rehabilitation, testing, remediation, or other service described in Insurance Code §1352.003(a) and (b), or the number of days of covered inpatient care to the extent that the treatment or care is determined to be medically necessary as a result of and related to an acquired brain injury, as provided in Insurance Code §1352.003(c-1) and §1352.006.

(e) Other Coverage Limitations. The coverage for services required under Insurance Code Chapter 1352 may be subject to limitations and exclusions that are generally applicable to

other physical illnesses or injuries under the health benefit plan. These types of exclusions or limitations include, but are not limited to, limitations or exclusions for services that may be limited or excluded because they are solely educational in nature, experimental or investigational, not medically necessary, or services for which the enrollee failed to obtain proper preauthorization under the requirements of the health benefit plan.

(f) Permitted Coverage Exclusions. The types of limitations or exclusions permitted under Insurance Code §1352.003(d) do not include limitations or exclusions under a health benefit plan that meet the definition of a therapy or service required under Insurance Code Chapter 1352. For example, if a health benefit plan contains an exclusion for biofeedback therapy, the issuer may deny coverage for biofeedback therapy for any diagnosis except an acquired brain injury diagnosis because biofeedback falls within the definition of "neurofeedback therapy" as defined in §21.3102 of this subchapter, and coverage is required for it under Insurance Code Chapter 1352. However, if the same health benefit plan also contains an exclusion for services that are not authorized prior to service, the issuer may, as allowed by subsection (e) of this subsection, deny coverage based on the prior authorization exclusion.

(g) Permitted Coverage Denials. A health benefit plan may deny coverage or apply a limitation or exclusion in a health benefit plan for a service required under Insurance Code Chapter 1352 if the service is prescribed for a condition that, although a result of, or related to, an acquired brain injury, was sustained in an activity or occurrence for which coverage for other medical conditions under the health benefit plan is limited or excluded (for example, acts of war, participation in a riot, etc.).

(h) Inapplicability of Section to Small Employer Health Benefit Plan. Under Insurance Code §1352.003(h) and §1352.007(b), this section does not apply to a small employer health benefit plan.

§21.3104. Training.

(a) In this section, "preauthorization" has the meaning assigned by Insurance Code §1352.004(a), and includes benefit determinations for proposed medical or health care services.

(b) Each issuer must develop written preauthorization and utilization review policies and procedures for the purpose of identifying services to be covered for acquired brain injury, to be used by any individual responsible for preauthorization of coverage or utilization review. Such policies and procedures must include:

(1) identification of all current Common Procedural Terminology (CPT) codes associated with services for acquired brain injury; and

(2) a means to identify an enrollee initially diagnosed with an acquired brain injury.

(c) Each health benefit plan issuer must ensure that all employees or staff responsible for preauthorization of coverage or utilization review, or any individual performing these processes, receive training to prevent wrongful denial of coverage required under Insurance Code Chapter 1352 and this subchapter, and to avoid confusion of medical and surgical benefits with mental and behavioral health benefits. At a minimum, training must consist of:

(1) identification of services likely to be requested in treating an enrollee with an acquired brain injury;

(2) identification of specific therapies currently used in treating an enrollee with an acquired brain injury;

(3) instruction relating to correctly evaluating requests for services to differentiate between covered medical and surgical benefits versus covered benefits for mental and behavioral health; and

(4) instruction relating to the requirements of Insurance Code Chapter 1352 and this subchapter.

(d) At a minimum, training must be accomplished by attendance at an initial orientation, in-service, or continuing education program relating to acquired brain injuries and their treatments, provided that the training is consistent with the requirements of subsections (a) and (b) of this section.

(1) Documentation and verification of training must be maintained for each employee or staff member responsible for preauthorization of coverage, utilization review, or any individual performing these processes.

(2) On request, any documentation and verification required by paragraph (1) of this subsection must be provided to the issuer with whom the employee, staff member, or individual is employed or contracted.

(3) On request, any documentation and verification required by paragraph (1) of this subsection must be provided to the department for review.

(e) The requirements of this section also apply to any contracted entity of an issuer to the extent the contracted entity is responsible for preauthorization or utilization review.

§21.3105. Provision of CPT Codes. Each issuer of a health benefit plan subject to Insurance Code Chapter 1352 and this subchapter must, on request from the department, submit to the department the list of CPT codes identified by the issuer under §21.3104(b)(1) of this subchapter.

§21.3106. Small Employer Health Benefit Plans.

(a) Required Coverage. Under Insurance Code §1352.0035(a), a small employer health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services, if the services are medically necessary as a result of and related to an acquired brain injury.

(b) Deductibles, Copayments, Coinsurance, and Lifetime Limitations. Under Insurance Code §1352.0035(b), small employer health benefit plan coverage of acquired brain injury may be subject to deductibles, copayments, coinsurance, or annual or maximum dollar amount or number of visit limits consistent with the deductibles, copayments, coinsurance, or annual or maximum dollar amount or number of visit limits applicable to other medical conditions for which coverage is provided under the small employer health benefit plan.

(c) Maintenance and Prevention; Treatment Goals. Treatment goals for services required by Insurance Code §1352.0035 may include the maintenance of functioning or the prevention or slowing of further deterioration.

(d) Other Coverage Limitations. The coverage for services required by Insurance Code §1352.0035 may be subject to limitations and exclusions that are generally applicable to other physical illnesses or injuries under the health benefit plan. These types of exclusions or limitations include, but are not limited to, limitations or exclusions for services that may be limited or excluded because they are solely educational in nature, experimental or investigational, not medically necessary, or services for which the enrollee failed to obtain proper preauthorization under the requirements of the health benefit plan.

(e) Permitted Coverage Exclusions. The types of limitations or exclusions permitted under subsection (d) of this section do not include limitations or exclusions under a health benefit plan that meet the definition of a therapy or service required under subsection (a) of this section. For example, if a health benefit plan contains an exclusion for biofeedback therapy, the issuer may deny coverage for biofeedback therapy for any diagnosis except an acquired brain injury diagnosis because biofeedback falls within the definition of "neurofeedback therapy" as defined in §21.3102 of this subchapter, and coverage is required for it under subsection (a) of this section. However, if the same health benefit plan also contains an exclusion for services that are not authorized prior to service, the issuer may, as allowed by subsection (d) of this subsection, deny coverage based on the prior authorization exclusion.

(f) Permitted Coverage Denials. A small employer health benefit plan may deny coverage or apply a limitation or exclusion in a health benefit plan for a service required under Insurance Code Chapter 1352 if the service is prescribed for a condition that, although a result of, or related to, an acquired brain injury, was sustained in an activity or occurrence for which coverage for other medical conditions under the health benefit plan is limited or excluded (e.g., acts of war, participation in a riot, etc.).

§21.3107. Mandatory Annual Notice to Insureds and Enrollees.

(a) Under Insurance Code §1352.005, health benefit plan issuers must provide to insureds and enrollees the notification specified in this subsection. A representation of this notification is as follows:

Figure: 28 TAC §21.3107(a)

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Postacute transition services and community reintegration services, including outpatient day treatment services or other post-acute-care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or postacute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

(b) The notice required by Insurance Code §1352.005 and subsection (a) of this section is required by Insurance Code §1352.005 to be issued annually to each insured or enrollee under the plan.

(c) The notice must be printed in at least 12-point type and must comply with the following requirements:

(1) The notice must be provided during the policy term for the plan, and no later than the 60th day after enrollment and renewal.

(2) Except as specified in paragraph (6) of this subsection, a health benefit plan issuer must deliver the notice to insureds or enrollees through the U.S. Postal Service.

(3) The notice may be delivered with other health benefit plan documents that are delivered through the U.S. Postal Service as long as the time frames set forth in paragraph (1) of this subsection are met. For example, the notice may be delivered with the policy, certificate, evidence of coverage, or enrollment or insurance card.

(4) If the notice is provided to the primary insured's or enrollee's last known address, the requirements of this section are satisfied with respect to all insureds or enrollees residing at that address.

(5) If the last known address of a covered spouse or dependent is different than the primary insured's or enrollee's last known address, separate notices are required to be provided to the spouse or the dependent at the spouse's or dependent's last known address.

(6) For group health benefit plans, the notice may be provided to the group master contract holder for distribution to insureds or enrollees if the health benefit plan issuer has an agreement with the group master contract holder that the notice will be delivered in compliance with the timelines specified in paragraph (1) of this subsection; however, the health benefit plan issuer must ensure that the notice is provided to the insureds or enrollees.

(d) As provided in Insurance Code §1352.005(a), this section does not apply to a small employer health benefit plan issuer.

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

Issued at Austin, Texas, on May 15, 2015.

Sara Waitt
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to §§21.3101 - 21.3107.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **3968**