Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy
Division 1. Utilization Reviews
28 TAC §19.1703

Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage
28 TAC §19.2003

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §19.1703 and §19.2003, concerning utilization reviews for health care. The §19.1703 amendments are adopted without changes, and the §19.2003 amendments are adopted with nonsubstantive changes to the proposed text published in the August 22, 2025, issue of the *Texas Register* (50 TexReg 5423).

REASONED JUSTIFICATION. The amendments are necessary to update the definition of "person" in §19.1703(b)(22) and replace the term "mental retardation" with "intellectual disability" in §19.2003(b)(25), in alignment with House Bill 446, 88th Legislature, 2023, which updated the definition of "person" in Insurance Code §1305.004.

In a separate rulemaking, as part of the implementation of HB 446, TDI proposed amendments to 28 TAC §3.3052, concerning standards for termination of insurance provision, to similarly update references to the term "mental retardation." The proposed amendments to Chapter 3 were also published in the August 22, 2025, issue of the *Texas Register* (50 TexReg 5422), and the adopted Chapter 3 amendments are also published in this issue of the *Texas Register*.

In addition, the amendments to §19.1703 and §19.2003 include nonsubstantive rule drafting and formatting changes to conform the sections to the agency's current style and to improve the rules' clarity.

In §19.1703, these changes include inserting the titles of cited Insurance Code provisions in subsections (a), (b)(5), (b)(6)(A), (b)(14), (b)(22), and (b)(24)(A) and related punctuation updates in subsection (b)(22); removing a comma from subsection (b)(11); inserting the title of a cited Government Code provision in subsection (b)(17)(A); italicizing *Diagnostic and Statistical Manual of Mental Disorders* in subsection (b)(21); changing "prior to" to "before" in subsection (b)(26)(A) - (C) for plain language purposes; and changing "re-certification" to "recertification" in subsection (b)(35).

In §19.2003, these changes include inserting the titles of cited Insurance Code provisions in subsections (a), (b)(5), (b)(7)(A), (b)(25), (b)(39), and (b)(43); inserting the titles of cited Labor Code provisions in subsections (b)(2), (b)(6), and (b)(40); adding a comma in subsection (b)(2); inserting the title of a cited Government Code provision in subsection (b)(16)(A); italicizing *Diagnostic and Statistical Manual of Mental Disorders* in subsection (b)(22); inserting necessary punctuation updates related to the change in subsection (b)(25); changing "prior to" to "before" in subsection (b)(28)(A) - (C) for plain language purposes; and removing an incorrect comma in subsection (b)(30). The text of subsection (b)(25) as proposed has been changed to correct punctuation by replacing commas with semicolons.

SUMMARY OF COMMENTS. TDI provided an opportunity for public comment on the rule proposal for a period that ended on September 22, 2025. TDI did not receive any comments on the proposed amendments.

Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy
Division 1. Utilization Reviews
28 TAC §19.1703

STATUTORY AUTHORITY. The commissioner adopts amended §19.1703 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§19.1703. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201, concerning Utilization Review Agents, 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, concerning Definitions.

(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, concerning Complaint as Appeal; 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, concerning Definitions.

(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), concerning Dates and Descriptions of Holidays;

(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*.

(22) Person--Any individual; partnership; association; corporation; organization; trust; hospital district; community mental health center; intellectual disability center; mental health and intellectual disability center; limited liability company; limited liability partnership; the statewide rural health care system under Insurance Code Chapter 845, concerning Statewide Rural Health Care System; 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, concerning Preferred Provider Benefit Plans.

(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 before issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day before issuing a prospective utilization review adverse determination;

(B) no less than five working days before issuing a retrospective utilization review adverse determination; or

(C) before 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, recertification, 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, recertification, or representation includes the requirements of §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

Subchapter U. Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage
28 TAC §19.2003

STATUTORY AUTHORITY. The commissioner adopts amended §19.2003 under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the commissioner may adopt rules as necessary to implement Insurance Code Chapter 1305.

Insurance Code §4201.003 provides that the commissioner may adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§19.2003. Definitions.

(a) The words and terms defined in Insurance Code Chapter 4201, concerning Utilization Review Agents, 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, concerning Workers' Compensation, 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, concerning Definitions.

(6) Compensable injury--As defined in Labor Code §401.011, concerning General Definitions.

(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, concerning Complaint as Appeal; 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), concerning Dates and Descriptions of Holidays;

(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; intellectual disability center; mental health and intellectual disability center; limited liability company; limited

liability partnership; a political subdivision of this state; the statewide rural health care system under Insurance Code Chapter 845, concerning Statewide Rural Health Care System; 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 before issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day before issuing a prospective utilization review adverse determination;

(B) no less than five working days before issuing a retrospective utilization review adverse determination; or

(C) before 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, concerning Definitions.

(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), concerning Election.

(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, concerning Workers' Compensation Health Care Networks.

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

Issued at Austin, Texas, on October 29, 2025.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §19.1703 and §19.2003 are adopted.

Signed by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2025-9575