



September 20, 2021

Cassie Brown
Commissioner
Texas Department of Insurance
Austin, Texas 78744-9104

Via email: LHLcomments@tdi.texas.gov

Re: TDI Request for information to use in implementation of House Bill 3459

Dear Commissioner Brown:

On behalf of our collectively more than 55,000 physician and medical student members, the Texas Medical Association (TMA), Texas Orthopaedic Association, Texas Society for Gastroenterology and Endoscopy, Texas Society of Anesthesiologists, Texas Chapter of the American College of Physicians, Texas Academy of Family Physicians, Texas Chapter, American College of Cardiology, Texas Dermatological Society, Texas Pediatric Society, Texas College of Emergency Physicians, Texas Radiological Society, Texas Society of Pathologists, Texas Osteopathic Medical Association, and Federation of Texas Psychiatry (hereinafter the "Associations") appreciate the opportunity to submit these comments on the Texas Department of Insurance's (TDI)'s "Request for information to use in implementation of House Bill 3459."

As TDI is aware, our organizations have a well-demonstrated interest in reducing the burdens and increasing the transparency of health plan preauthorization requirements. Accordingly, we strongly supported HB 3459 last regular legislative session. We appreciate TDI's efforts to implement this important legislation. In response to the specific questions posed, we offer the comments, below.

Texas administrative medical licenses

1. Insurance Code Section 4201.206(a) requires that before an adverse determination is issued, the ordering health care provider be given the opportunity to discuss the treatment plan with a licensed physician. Please provide input on TDI's consideration of a rule providing that an Administrative Medical License could satisfy the requirements of Section 4201.206(a).

In response to the first question posed by TDI, the Associations are opposed to TDI's consideration of a rule providing that an Administrative Medical License could satisfy the requirements of Section 4201.206(a) of the Texas Insurance Code regarding the "peer-to-peer" call prior to an adverse determination.

The Associations are concerned that the: (1) limitations placed on this type of Texas license make the license ill-suited for the functions performed by the Texas-licensed physician who conducts the peer-to-peer call; and (2) use of a limited license for the practice of administrative medicine is inconsistent with the statutory intent of HB 3459.

More specifically, under Section 155.009 of the Texas Occupation Code and 22 Tex. Admin. Code § 172.17, the Texas Medical Board (TMB) is authorized to issue a license that is limited to administrative medicine. "Administrative medicine" is defined under the rule as "administration or management utilizing the medical and clinical knowledge, skill, and judgment of a licensed physician, and capable of affecting the health and safety of the public and any person." However, the rule continues by stating that "[a]n administrative license *does not include the authority to practice clinical medicine, prescribe dangerous drugs or controlled substances, or delegate medical acts or prescriptive authority.*" (emphasis added).

We are concerned with these administrative medical licensure limitations regarding clinical practice, given that under the applicable Insurance Code provision (Section 4201.206), the physician reviewer would be performing very clinically driven functions. For example, the physician would be discussing the patient's treatment plan and the clinical basis for the agent's determination concerning the medical necessity, appropriateness or the experimental or investigational nature of a health care service. Thus, for the functions performed by the physician to truly be "peer-to-peer," the reviewing physician must have full authority to practice clinical medicine in this state.

Peer reviews (in other medical contexts) are traditionally performed by individuals who have the authority to engage in the same type of practice as the physician or health care professional being reviewed. TMA policy [225.019](#) acknowledges this and, therefore, expressly provides that:

[t]he Texas Medical Association advocates that physicians who conduct review for health care decisions in Texas should (1) be in an active practice; (2) possess a nonrestricted license to practice in Texas; and (3) be experienced in the procedures or treatment under review. (For example, not all orthopedic surgeons perform spinal surgery.)

In the context of conducting utilization reviews, maintaining full regular licensure to practice medicine in Texas as a requirement is equally important. While the physician is not being peer reviewed for disciplinary purposes under Section 4201.206, the physician reviewer can significantly impact the enrollee/patient's care. Thus, TMA policy [160.107](#) provides, in part, that "... adverse utilization review determinations [should] be made only by physicians who are *fully licensed* by the Texas Medical Board" (emphasis added).

For a reviewing physician on a peer-to-peer call to recommend denying coverage to an enrollee/patient based upon a determination that a drug being prescribed is medically unnecessary when that physician has no authority to prescribe that drug himself or herself makes little sense from either a clinical or a public policy perspective. And, if an adverse determination is issued due to this disconnect in clinical authority, it is likely to cause unnecessary delay in the patient's care, as the ordering physician would then have to appeal the determination. **Time is of the essence for many patients who are seeking preauthorization for medical services. Injecting further delay into the system is wasteful, at best, but harmful to patient care, at worst.**

Furthermore, the use of a limited administrative medicine license is inconsistent with the statutory intent of HB 3459. HB 3459 was designed to ensure that physicians who perform peer-to-peer calls are: (1) accountable to the Texas Medical Board; and (2) the most familiar with the standard of care/delivery of care in this state. A limited license to practice administrative medicine in Texas might aid, to a limited extent, in promoting the first goal. But it does not support the second goal (and certainly does not to the extent that a regular full Texas medical license would).

The bill author's/sponsor's [statement of intent](#) expressly provides that:

[t]here are concerns that the preauthorization and utilization review processes for health care benefit plan coverage may be burdensome to physicians and providers and may have the potential to prevent patients from receiving the care they need. *H.B. 3459 seeks to address this issue by ensuring that physicians who are the most familiar with the delivery of health care in Texas are involved in utilization reviews for health benefit plan coverage.* (emphasis added).

Put simply, requiring physicians who perform peer-to-peer calls under Section 4201.206 to have a full Texas medical license is much more aligned with legislative intent in adding the Texas licensure requirement to the peer-to-peer requirements under the law. The Legislature's goal in amending Section 4201.206 was not to reduce the licensure requirements under prior law (i.e., to move it from a full license in one state to an administrative medicine only license in another), but to make it a *Texas-specific full* licensure requirement. The Associations urge TDI to act consistently with this intent, which will promote access to timely, medically appropriate patient care.

We also note that the Texas Association of Health Plan (TAHP) representatives have stated in [news articles](#) that "[h]ealth plans are often the only ones with a 360-degree view of a patient's treatment, and safety edits can help stop dangerous interactions for care or prescriptions supplied by multiple providers." If this statement were true, then we argue that the health plans should be supportive of having a physician with the

most appropriate training, experience and licensure (which would include being authorized to prescribe the reviewed drugs in this state) performing the peer-to-peer calls for utilization reviews.

Additionally, if TDI is considering an administrative medicine only license out of concern that it may be difficult to find fully-licensed Texas physicians to perform the peer-to-peer calls, then it is important for TDI to be aware that, based upon data received from the TMB, it is our understanding that Texas licensed 5,304 new physicians in fiscal year 2021. This is the highest annual number since we began collecting these data in 1981 and likely in the state's history. Therefore, any supply concern may be unfounded in light of this substantial new physician licensure increase.

Further, with the passage of [HB 1616](#) (the Interstate Medical Licensure Compact), these numbers should continue to grow. We expect expedited access to a full medical license to be greatly facilitated through use of the Compact. Also, we note that the process and criteria for obtaining a full medical license under Texas' normal licensure process are largely the same as for an administrative medicine license (with the exception of the active practice of medicine requirements). Thus, it is not much more burdensome for a physician to obtain a full medical license, rather than a limited administrative medicine license. The number of administrative medicine only licenses also is likely nominal compared to the number of fully-licensed physicians in Texas, so expanding the licensure requirement to permit the use of administrative medicine only licenses would do little to address any supply concern that TDI may have.

For all the foregoing reasons, we strongly urge TDI to require a full license to practice medicine in Texas for a physician performing the peer-to-peer call under Section 4201.206, Texas Insurance Code.

Preauthorization requests

2. Insurance Code Section 4201.653(a) exempts physicians and other health providers from preauthorization requirements for certain services if the HMO or health plan "has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service."

- a. When determining a provider's approval rate for preauthorization requests, should requests for a certain quantity (such as five days of inpatient care) be counted as a single request or multiple requests? What is the approval rate if, using the inpatient care example, three days were approved and two days were denied.**

Prior authorizations are generally reviewed on a Current Procedural Terminology (CPT®) code basis, either the specific CPT code or groups of CPT codes within the same family (i.e., inpatient E/M codes). Therefore, it makes sense to review on the basis of the primary CPT code. The Associations also urge TDI to ensure that any method TDI selects to address the questions in RFI No. 2 is fully transparent to all stakeholders.

b. How should approval rates be calculated for preauthorization requests for a treatment regimen (such as three-drug regimen) where some services within the request may be approved and others denied or approved with changes?

- i. Should each distinct service be counted as a separate request?**

For the three-drug treatment regimen, referenced above, we would support each drug being treated separately.

ii. ii. Should a preauthorization request for a drug be treated as the same particular health care service if the prescribed dosage or other dispensing details are different?

The Associations contend that for drug approvals, the drug should be the basis for the preauthorization exemption determination (rather than the dosage). Although medications may have different indications for different dosages and there may be different dosages used for different conditions, dosing will be more difficult to parse and apply in the context of this bill. Dosing issues will also be addressed by the standard of care, which is enforceable through other mechanisms outside of preauthorization (e.g., the Texas Medical Board and medical professional liability). Use of a drug in the context of a general medical condition could also be considered (rather than the dosage).

Preauthorization exemptions

3. Under Insurance Code Sections 4201.655(a)(2) and 4201.656(d), the issuer must make a determination by evaluating a random sample of at least five claims from the most recent six-month evaluation period. Please provide input on how an exemption should be considered when there are four or fewer claims for the particular health care service in the most recent six-month evaluation period.

For this question, it may be helpful to separate this issue by denials and recissions, because the Associations believe this question is answered by the express language of the law. For denial of an exemption when there are four or fewer claims, Section 4201.655(c) states:

(c) A health maintenance organization or insurer may deny an exemption from preauthorization requirements under Section 4201.653 only if:

(1) the physician or provider does not have the exemption at the time of the relevant evaluation period; and

(2) the health maintenance organization or insurer provides the physician or provider with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider does not meet the criteria for an exemption from preauthorization requirements for the particular health care service under Section 4201.653.

In relevant part, Section 4201.653 states:

(a) A health maintenance organization or an insurer that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service if, in the most recent six-month evaluation period, as described

by Subsection (b), the health maintenance organization or insurer has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service.

So in order to grant or deny an exemption for a particular health care service for which the physician has submitted four or fewer claims, the law states that the general 90 percent approval threshold from Section 4201.653(a), Texas Insurance Code would apply. To clarify further, the initial preauthorization exemption for a particular health care service is not based upon a random sample of claims. For example, if a physician had four claims and all were approved for that particular service, the physician would receive a preauthorization exemption for that service from the HMO or insurer, because the physician would have a 100 percent approval rate for those claims.

Alternatively, under the bill, the random sampling of claims comes into play when an HMO or insurer is attempting to rescind a preauthorization exemption that has already been granted. More specifically, Section 4201.654 provides that an HMO or insurer may rescind an exemption from preauthorization requirements under Section 4201.653 *only if* certain requirements are met. One of those requirements is that the HMO or insurer must have made a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted by the physician or provider during the most recent evaluation period, that less than 90 percent of the claims for the particular health care service met the medical necessity criteria that would have been used for the service.

If there are four or fewer claims, *ipso facto*, this rescission criterion cannot be satisfied and the physician or provider's gold card exemption continues for that particular service. This is made clear through the language in Section 4201.654, which provides that "[i]f a health maintenance organization or insurer does not finalize a rescission determination as specified in Subsection (a) [which is an impossibility given the inadequate sampling number in cases of 4 or fewer claims], then the physician or provider is considered to have met the criteria under Section 4201.653 to continue to qualify for the exemption."

The bill's default status of a continuation of an exemption (when four or fewer claims are submitted in a six-month evaluation period) makes sense from a policy perspective, because the physician has already had a history of submitting claims that met the 90 percent approval threshold for that particular service and there are too few claims to present a waste or abuse concern. (Note that fraud should not be a concern either, because even with an exemption in place, there is a separate provision designed to address fraud under the law (i.e., Section 4201.659).

4. Under Insurance Code Section 4201.653(d), a physician or provider is not required to request an exemption to qualify. Under Section 4201.653(c), an issuer may grant an exemption without evaluating whether the physician or provider qualifies. Please provide input on TDI's consideration of rules that would require physicians or providers to be automatically granted an exemption by an issuer at the end of the first six-month evaluation period, unless the insurer shows that the 90% threshold was not met during the evaluation period.

The Associations support automatically granting of an exemption by an issuer at the end of the first six-month evaluation period, unless the issuer shows that the 90 percent threshold was not met during the evaluation period. This would present the least amount of burden in terms of a review for an issuer and defaults to granting an exemption (presuming high approval as authorized under Section 4201.653(c)) which is appropriate.

The Associations contend, however, that it will be important that: (1) the HMO or insurer complies with the requirements in Section 4201.655(c) regarding the provision of data and statistics to support any denial; and (2) for the appeal rights under the bill to continue in the scenario where an issuer claims that the 90 percent threshold was not met during the evaluation period. And, for transparency, it will be important for the HMO or insurer to provide the exemption qualification notice under Section 4201.659(d), so that a physician knows the scope and duration of the exemption. Physician practices process preauthorization requests from numerous plans (both state-regulated and self-funded). It is important for physicians to be on notice as to which plans and services the preauthorization exemption applies. Otherwise, the physician may be under the mistaken impression that a preauthorization exemption applies to a particular plan for a particular service, fail to submit a preauthorization request for that plan, and have an enrollee's coverage for the service denied. Such a result creates bad public policy because it would unnecessarily punish the physician and the patient. Thus, transparency in process will be key to the proper implementation of the law.

5. Please provide input on TDI's consideration of rules that would require issuers to provide notice of a denial of a preauthorization exemption to a physician or provider for a particular health care service rather than when the exemption is granted.

The Associations are very supportive of TDI's promulgation of rules that would require issuers to provide notice of a denial of a preauthorization exemption to a physician (as this would be important for the physician to know in order to exercise the physician's appeal rights under Section 4201.656). However, we do not think that the denial notice should be in lieu of notice when an exemption is granted. It needs to be a requirement *in addition to* when an exemption is granted. As stated in response to RFI No. 4, transparency in the process will be key to proper implementation of the law.

6. Under Insurance Code Section 4201.655, an issuer may rescind an exemption from preauthorization requirements only during January or June of each year. Under Section 6 of HB 3459, Subchapter N of Chapter 4201 applies only to a request for preauthorization of health care service made on or after January 1, 2022. Please provide input on TDI's consideration of rules that would require issuers to provide an initial notice of exemption or denial of exemption in June 2022, based on an evaluation of preauthorization requests that were submitted on or after January 1, 2022.

The Associations are generally supportive of TDI's stated timeframe for implementation of the law. A conservative reading of the bill would be that the "Subchapter N of Chapter 4201 applies only to a request for preauthorization of health care service made on or after January 1, 2022" includes the claims being reviewed for eligibility for the preauthorization exemption. Under this approach, our assumption is that TDI would require insurers and HMOs to provide initial notices either granting or denying exemptions in June 2022 (based upon a review of claims from January 1, 2022 until June

2022). Any granted exemptions would go into effect immediately after qualifying for the exemption (as the law requires notice to be provided not later than five days after the physician qualifies for the exemption). And any exemption would not be subject to potential rescission until completion of the next six-month evaluation period, consistent with the timeframe (i.e., January 2023) and other requirements set forth in the law. Any denied exemptions would be subject to appeal rights under the law.

Alternatively, we note that a more liberal reading of the bill's timing requirements (under SECTION 6 of the bill and Section 4201.655, Texas Insurance Code) would potentially permit plans to grant preauthorization exemptions based upon a review of requests submitted prior to January 1, 2022, since the status of any preauthorization request would not be impacted until the first exemption is granted. The Associations would be supportive of that approach as well. We would not be supportive of any further delay beyond that included in this RFI.

Rescinding preauthorization exemptions

7. Starting from the date notification is received, how much time should a physician or provider have to request an appeal of the issuer's determination to rescind the exemption?

The Associations contend that the physician should have, at the very least, 30 business days to request an appeal of the issuer's determination to rescind the exemption. We would be supportive of any timeframe greater than that. It will take time for the physician to review the rescission determination, assess whether to appeal, and submit the appeal. Any less time will be insufficient for a physician to make the assessment of a need for an appeal. We also strongly recommend that TDI promulgate rules that require the HMO or insurer to provide any notifications required by the law or TDI rule to the physician using the method and contact information preferred by the physician (e.g., preferred email address) so that the physician is able to ensure proper receipt of any notifications or dedicate an email solely to receiving these notifications to ensure the notifications do not get lost.

8. Under Insurance Code Section 4201.655(a)(2), an issuer seeking to rescind an exemption from preauthorization must make a determination "on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted ... during the most recent evaluation period." Under Insurance Code Section 4201.656(d), a physician or provider may request that the independent review organization (IRO) "consider another random sample of not less than five and no more than 20 claims submitted ... during the relevant evaluation period." Is additional guidance in rules needed to clarify how an issuer or IRO should determine how to select the random sample or the number of claims to consider?

The Associations support additional guidance to clarify how a "random sample" must be collected to ensure uniformity in decisions are made. As a guide, we believe that the dictionary definition of "random" is fairly straightforward. For example, according to Merriam Webster, ["random,"](#) may is defined as:

1a: lacking a definite plan, purpose, or pattern

b: made, done, or chosen at random read *random* passages from the book

2a: relating to, having, or being elements or events with definite probability of occurrence
random processes

b: being or relating to a set or to an element of a set each of whose elements has equal probability of occurrence a *random* sample

also : characterized by procedures designed to obtain such sets or elements
random sampling

It is important that, consistent, with general definitions of “random,” the insurer or HMO not exhibit a plan, purpose, or pattern in selecting the samples. Each claim should have an equal probability of being selected. And, at no point should specific metrics be applied by the issuer such as, specific patient cohorts or site of service, which may favor the issuer’s decision-making.

Further, under Section 4201.655, where the law provides that a the rescission determination shall be based on “a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted ... during the most recent evaluation period,” TDI should require the issuer to review the maximum amount of claims available within that range. For example, if only five claims have been submitted during the relevant period for the particular service, that would be sufficient for the determination. If twenty or more claims have been submitted for the particular service during the relevant evaluation period, then the issuer should be required to review twenty claims prior to making the determination. This will promote having that most robust data set within the statutory range reviewed.

Also, when under Insurance Code Section 4201.656(d), a physician or provider is permitted to request that the independent review organization (IRO) "consider another random sample of not less than five and no more than 20 claims submitted ... during the relevant evaluation period,” it is important that TDI clarify that if the same claims are selected in this second random sample, the duplicates only are reviewed once and another claim can be randomly selected (if available). The intent of the law is to review the claims originally reviewed, plus a new sample (as provided expressly in Section 4201.656(d)).

However, TDI should provide that if the physician or provider feels the “random” sample used in either Section 4201.655 or 4201.656 is biased, the physician may request that the identified biased metric, such as specific patient cohorts or site of service, be removed. The physician or provider should also be able to file a complaint with TDI to assess the “randomness” of selection procedures utilized by issuers.

Additional comments

9. Please provide any additional comments or points of clarification that the rule should address.

Additional areas of clarification that would be useful in rulemaking include:

- imposing express requirements on issuers to provide notice of denials of preauthorization exemptions (along with information on how to appeal);
- (as stated above), requiring issuers to solicit the preferred contact method/information for notices provided under the law and rules;

- clarifying that the final preauthorization decision is what is utilized to assess the approval rate (i.e., after all appeals, including any external reviews, are conducted). An initial denial that is subsequently overturned should still count as an approval for preauthorization exemption purposes;
- clarifying that a preauthorization exemption may be granted to both an individual physician and the physician’s practice (consistent with the definition of a “physician” under the law). If a preauthorization exemption is granted to a physician’s practice, then the rule should provide that the exemption would apply to all the physicians in the practice regardless of whether they individually qualify for an exemption. As provided under Subchapter N, Chapter 4201, Texas Insurance Code, terms defined by Section 843.002, including “physician” and “provider” have the meanings assigned by that section. Importantly, the definition of a “physician” under Section 843.002 is not limited to an individual licensed to practice medicine in this state. It also includes, among other things,: (1) a professional association organized under the Texas Professional Association Act; and (2) another person wholly owned by physicians. Thus, the HB 3459 provision authorizing a preauthorization exemption should apply to both individual physicians and their practices that fall within the definition of a “physician.” The definition of “provider” is also broad and should be reflected in the rules accordingly; and
- requiring the physician reviewer (under Section 4201.206(b)’s peer-to-peer utilization review provision and Section 4201.655(b)’s preauthorization exemption review provision) to timely provide the physician who is being reviewed with information concerning the reviewer’s specialty so that the reviewed physician is able to file a complaint with TDI if he or she believes the reviewing physician is not truly of the same or similar specialty.

The Associations thank TDI for the opportunity to comment. If you have any questions, please do not hesitate to contact Kelly Walla, Associate Vice President and Deputy General Counsel of the Texas Medical Association, at kelly.walla@texmed.org

Respectfully,



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