FAQs on Preauthorization Exemptions ("Gold Card" Act)

The Texas Hospital Association offers answers to member hospitals' questions about the Texas Department of Insurance's (TDI) new rules for certain health plans to implement House Bill 3459, 87th Legislature, 2021. HB 3459 amended Chapter 4201 of the Texas Insurance Code adding a new Subchapter N to require certain insurers provide preauthorization exemptions – known informally as a "gold card" – for particular health care services.

1. **Where can I find the new rules?**

   The preauthorization exemption rules begin here. Rules on independent review of preauthorization exemptions may be accessed here.

2. **Who can receive a preauthorization exemption?**

   Physicians and/or providers.

   The statute defines providers as persons who are licensed in Texas to provide health care services including physicians, chiropractors, registered nurses, pharmacists, optometrists, acupuncturists, pharmacies, and ***hospitals*****.** Providers also include persons wholly owned or controlled by an individual provider or group of providers who are licensed or otherwise authorized to provide the same health care services or persons who are wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

3. **Who must comply with the new preauthorization exemption rules?**

   The rules apply to state-regulated health plans: health maintenance organizations operating under chapter 843, Insurance Code; preferred provider benefit plans and exclusive provider benefit plans operating under chapter 1301, Insurance Code; and plans issued under the Texas Employees Group Benefits Act (chapter 1551, Insurance Code), the Texas Public School Retired Employees Benefits Act (chapter 1575, Insurance Code), and the Texas School Employees Uniform Group Health Coverage Act (chapter 1579, Insurance Code). These include the Employee Retirement System and the Teacher Retirement System of Texas. Federally administrated health plans, such as employee welfare benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), Medicaid and the Children's Health Insurance Program, are not subject to Chapter 4201 and thus not required to issue preauthorization exemptions. Collectively the entities that must comply are known as "issuers" under the new rules.

4. **Do the rules apply to Medicaid plans?**

   No. Only commercial plans regulated by TDI.

5. **Do the rules apply to ERISA plans?**

   No.

6. **How do I identify a physician or provider?**

   Physicians or providers must be identified using the National Provider Identifier (NPI) of the physician or provider used to make preauthorization requests.

7. **How does a physician or provider receive a preauthorization exemption?**

   Issuers must conduct an evaluation of all the preauthorization requests submitted by the physician or provider during an evaluation period. The evaluation must be based on no fewer than ***five*** eligible preauthorization requests.

   Once the evaluation is completed, an issuer must provide notice within five days from the completion date to the physician or provider granting or denying the preauthorization exemption. A physician or provider does not qualify for a preauthorization exemption if they received approval for fewer than 90% of the eligible preauthorization requests for a particular health care service during an evaluation period.

8. **If a physician or provider has submitted less than five eligible preauthorization requests for a particular health care service during an evaluation period, can the physician or provider receive an exemption for that service?**

   No. Only physicians or providers that have submitted at least five eligible preauthorization requests are eligible for the exemption for a health care service.

9. **Does a physician or provider have to request an evaluation by the issuer for any health care service?**

   No. Issuers are required by law to provide preauthorization exemptions for qualifying physicians or providers for particular health care services that are subject to preauthorization as listed on an issuer's website.

10. **Does "health care service" include prescription drugs?**

    Yes.

11. **How long is a preauthorization exemption in effect?**

    Preauthorization exemptions, once granted, are effective from the notice issuance date of the notice granting the exemption and must remain in place for six months before they can be rescinded.

12. **Can a hospital rely on a physician or provider's preauthorization exemption for a particular health care service?**

    Yes, if the health care service is ***ordered*** by a "treating physician or provider" that has the preauthorization exemption, and the hospital serves as the ***rendering*** provider and does not have an exemption. In other words, a physician or provider's preauthorization exemption follows them to the hospital. Hospitals are

also allowed to have their own preauthorization exemption for a particular health care service. TDI clarified that evaluations on continued eligibility for an exemption can be based on claims submitted by *or in connection with* a physician or provider for a particular health care service.

13. **What must a hospital include on claim forms to confirm reliance on a preauthorization exemption?**

    Hospitals must ensure that the name and NPI of the ordering physician or provider with the preauthorization exemption is included on the claim in fields 17 and 17B of the CMS Form 1500, in fields 76-79 or another field in Form UB-04, or in the corresponding fields for electronic claims using the ASC X12N 837 format. The rules allow the issuers to provide coding guidance to physicians and providers so hospitals should be proactive in looking out for or seeking coding guidance from issuers.

14. **Who is considered a "treating physician or provider"?**

    The physician or other provider who is primarily responsible for a patient's health and medical care. A treating physician or provider can also be the rendering physician or provider or a referring or ordering physician or provider.

15. **Can a nurse or physician's assistant rely on a supervising physician's preauthorization exemption?**

    Yes, so long as the nurse or physician's assistant practices under the supervision of a physician and appropriately orders care and routinely requests preauthorization under the supervising physician's NPI.

16. **When is reliance on a physician or provider's preauthorization exemption prohibited?**

    A treating physician or provider who does not have a preauthorization exemption cannot rely on another physician's or provider's preauthorization exemption. TDI clarified that "exemption[s] and [their] protections do not extend to care that is not ordered, referred, or provided by the physician or provider who qualifies for the exemption."

    Example:

    Dr. G, an attending physician at ABC Hospital, is primarily responsible for Patient Y's medical care. Dr. G orders an MRI for Patient Y. Patient Y has XYZ Insurance. XYZ Insurance requires prior authorization for MRIs. XYZ Insurance has not granted Dr. G or ABC Hospital a preauthorization exemption for MRIs. Dr. B is a physician who works in the same group practice as Dr. G and has privileges to practice at ABC Hospital. Dr. B has a preauthorization exemption for MRIs from XYZ Insurance. Neither Dr. G or ABC Hospital can rely on Dr. B's preauthorization exemption to bypass XYZ's preauthorization requirements for MRIs because Dr. B is not the "treating physician or provider."

17. **Is the issuer required to notify a physician or provider when they have denied a preauthorization exemption for a particular health care service?**

    Yes. The notice must include actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate why the physician or provider does not meet the criteria for a preauthorization exemption; a description on how to appeal the denial using the issuer's complaints and appeals process; and how to file a complaint with TDI.

18. **If a physician or provider is denied a preauthorization exemption can the physician or provider appeal that decision?**

    Yes.

19. **What is an evaluation?**

    When a preauthorization exemption has not been granted:

    A review of the outcomes of eligible preauthorization requests submitted by a physician or provider during the most recent evaluation period to determine the percentage of requests that were approved.

    When a preauthorization exemption has been granted:

    A retrospective review of a random sample of payable claims submitted by or in connection with the physician or provider during the most recent evaluation period to determine the claims percentage that would have been approved, based on meeting the issuer's medical necessity criteria at the time the service was provided.

20. **When does the evaluation period begin?**

    The initial evaluation period is **Jan. 1–June 30, 2022**. Issuers must provide notices to physicians or providers granting or denying preauthorization exemptions for particular health care services for which they require preauthorization no later than **Oct. 1, 2022**.

    Following the initial period, evaluation periods are the subsequent six-month periods from July 1-Dec. 31 and Jan. 1–June 30 that follow each year.

21. **What constitutes an eligible preauthorization request?**

    Requests that were submitted by a physician or provider and finalized by the health plan during the evaluation period, are not pending appeal, and whose outcomes were either approval or an adverse determination for the particular health care service. Modified preauthorization requests accepted by physicians or providers are also included. Issuers must count each health care service separately when a preauthorization request includes more than one particular health care service.

22. **Once a preauthorization exemption has been granted for a particular health care service, is an issuer required to conduct subsequent evaluations to determine whether an exemption should be rescinded?**

    No, it is not required, but issuers are allowed to conduct such evaluations to determine if a physician or provider still qualifies for an exemption. The statute allows for an issuer to continue an exemption without conducting an evaluation.

23. **How can an issuer rescind a preauthorization exemption for a particular health care service?**

Recissions can only occur during January or June of each year. Issuers must follow the following process:

a) The issuer must conduct the evaluation outlined in Question 19 when a preauthorization exemption has already been granted. The random sample of eligible preauthorization requests must include at least five but no more than 20 claims submitted during the most recent evaluation period. The selected claims must be made without method or conscious decision (i.e., random).
b) If an issuer determines it is going to rescind an exemption, it must notify the physician or provider only in January or June of each year and not less than 25 days before the recission is to take effect.

24. **When does the recission take effect?**

Thirty days after the issuer notifies the physician or provider of its determination to rescind an exemption, if the physician or provider does not appeal the determination.

25. **What is required to be included in a recission notice?**

- Identification of the particular health care service;
- Issuance date of the notice;
- Rescission effective date;
- A plain-language explanation of how the physician or provider may appeal and seek an independent review of the determination;
- The company's address and contact information for returning the appeal form by mail or electronic means;
- The total number of payable claims submitted that were eligible for evaluation;
- The number of claims included in the random sample;
- The sample information used to make the determination including claim identification and whether each claim met the issuer's screening criteria;
- For claims determined not to have met the criteria the notice must include for each claim:
    - Principal reasons the claim did not meet the screening criteria, including, if applicable, a statement that the determination was based on a failure to submit specific medical records;
    - Clinical basis under which the claim did not meet the screening criteria;
    - Description of the screening criteria sources;
    - The professional specialty of the physician, doctor, or other health care provider who made the determination;
- Space for a physician or provider to include the name, address, contact information, and identification number of the physician or provider requesting an independent review, whether the physician or provider is requesting an independent review organization (IRO) review the same sample or review a new sample; and the date an appeal is requested;
- Instructions on how to return the form before the rescission date and to include applicable medical records for any determination that was based on a failure to provide medical records.

26. **Has TDI created a sample rescission notification form?**

    Yes. A sample form can be found here.

27. **Can an issuer request medical records or other documents when conducting a retrospective review of a preauthorization exemption for a health care service?**

    Yes, issuers can request medical records but must allow physicians and providers 30 days to submit the requested records. Medical records requests must comply with 28 TAC §19.1701 (URA Contact With and Receipt of Information from Health Care Providers).

28. **Can an issuer rescind a preauthorization exemption based on a failure to provide requested medical records?**

    Yes.

29. **Can a physician or provider request an IRO review of the recission of a preauthorization exemption?**

    Yes. Physicians and providers can request an IRO review of the recissions by submitting the request on the notification form provided by the issuer as outlined in Question 25. If they want to continue with the recission, issuers must submit the request to TDI for assignment to an IRO.

30. **Can a physician or provider request that an IRO review a different random sample of eligible claims?**

    Yes, but only if at least five additional claims were eligible for review *but not included* in the original random sample of claims reviewed. The issuer must include a sufficiently detailed list to the IRO of all payable claims that were eligible for evaluation but not included in the original sample.

31. **Does a physician or provider have to pay costs for an appeal or IRO review**?

    No. Insurers bear the cost of an appeal or IRO review.

32. **How long does an IRO have to complete its review?**

    IROs must complete their review within 30 days from the date the physician or provider files the request for the review. IROs must provide timely notice to an insurer regarding its determination consistent with this time frame, but the statute does not require a specific deadline for notification.

33. **What happens if the IRO overturns the recission decision?**

    A physician or provider's preauthorization exemption for the health care service continues for at least another 6 months and an insurer cannot rescind the exemption unless they comply with the evaluation process again during the next evaluation period. Issuers are bound by the decisions made by the IROs.

34. **What happens if the IRO affirms the recission decision?**

The recission becomes effective on the fifth day after the IRO affirms the recission determination. Physicians or providers will once again have to comply with the issuer's preauthorization requirements for the particular health care service(s) for which they were previously exempt.

35. **Can an issuer retroactively deny claims for the particular health care service based on a recission of a preauthorization exemption?**

No. The law expressly prohibits this practice by issuers.

Contact a member of THA's advocacy & legal teams for additional information:

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