TX House Bill 3459 - Preauthorization Exemptions

Frequently Asked Questions

What is Texas HB 3459?

House Bill 3459, passed in 2021, specifies that an HMO or insurer that uses a Preauthorization process for healthcare services may not require a physician or provider to obtain Preauthorization for a particular healthcare service that requires Preauthorization if, in the most recent six-month evaluation period, the HMO 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 healthcare service. Preauthorization Exemptions ("Exemptions") are evaluated based on the National Provider Identifier (NPI) for the requesting provider.

Who does the law apply to?

The law applies to licensed Texas physicians/providers providing healthcare services to commercial, fully-insured members. The law is not applicable to Self-funded plans (Level Funded Premium (LFP) or Administrative Services Only (ASO)), Medicare, Medicaid, or TriCare.

When is the new law pertaining to Preauthorization Exemptions effective?

Texas HB 3459 (the law) was effective January 1, 2022; however, regulations adopted by the Texas Department of Insurance delayed implementation of provisions of the law until October 1, 2022.

When will a granted Preauthorization Exemption begin to apply to a Texas Physician/Provider?

A Preauthorization Exemption granted to a Texas Physician/Provider began on October 1, 2022 for the initial evaluation period. For subsequent evaluation periods, Exemptions will begin on the date the notice is issued, approximately two months after the evaluation period ends.

What is the Preauthorization Exemption criteria?

A Texas physician/provider is required to submit at least 5 eligible Preauthorization requests for a particular health care service during the most recent evaluation period and the health plan approves (or would have approved) at least 90% of the Preauthorization requests submitted by the Texas physician/provider for that service during the most recent evaluation period.

What is an Evaluation Period?

The Evaluation Period is a six month period as defined by Texas law for which Health Plans analyze Preauthorization data to determine Preauthorization Exemption eligibility. Data is analyzed according to the Preauthorization Exemption criteria defined above (See *"What is the*

Preauthorization Exemption criteria?"). Evaluation Periods are specified as January 1 – June 30 and July 1 – December 31 each year. The Evaluation Period for initial implementation ran from January 1, 2022 – July 30, 2022.

If I have a Preauthorization Exemption, do I still need to obtain Preauthorization for services for which I do not have an Exemption?

Yes. Services not covered by a Preauthorization Exemption ("Non-Exempt Services") remain subject to plan rules, including any preauthorization requirements. If any Non-Exempt Services are covered by the member's plan, and performed without obtaining the necessary preauthorization, the Provider may not balance bill the member for an amount other than the member's applicable copayment, coinsurance, and/or deductible responsibilities in accordance with the reimbursement terms outlined in the member's plan documents.

Is the provider notified if they meet the criteria for Preauthorization Exemption status?

Texas physicians/providers that submitted at least five eligible preauthorization requests for a particular health care service during the most recent evaluation period will be issued a notice of a Preauthorization Exemption or denial. Preauthorization Exemptions are effective the date the notice is issued. For the initial evaluation period of January 1, 2022 through June 30, 2022, Exemptions were effective October 1, 2022.

Can a provider dispute a Preauthorization denial determination?

Humana's letter informing the provider of a denied Preauthorization Exemption includes information on how to dispute our Preauthorization Exemption determination.

What if a provider does not receive a notification / letter?

If a notification is not sent to the provider/physician, the provider did not meet the Preauthorization Exemption criteria as defined above (See "*What is the Preauthorization Exemption criteria?")*.

How long is the provider's Exemption status effective?

The Preauthorization Exemption is valid for a minimum period of six months from the effective date. The Preauthorization Exemption remains in effect until Humana notifies the Provider of its intent to rescind the Preauthorization Exemption.

Can a granted Preauthorization Exemption be removed for a provider?

Yes. Texas regulation permits the health plan to retrospectively review a random sample of not fewer than 5 and no more than 20 claims submitted by the provider/physician during the most recent evaluation period. A Preauthorization Exemption can be rescinded if less than 90% of reviewed claims met the medical necessity criteria used by the health plan during the relevant evaluation period. The health plan must notify the provider not less than 25 days before the proposed rescission is to take effect. The provider has the right to appeal this decision.

What if I am providing services ordered by an exempted provider, but I don't have a Preauthorization Exemption?

For care ordered by a Treating Provider or provider that has a Preauthorization Exemption that is then rendered by a provider that does not have an Exemption, the Treating Provider must include the name and NPI of the ordering physician on the claim in:

- Fields 17 and 17B of CMS Form 1500;
- Fields 76 -79 or another appropriate field in Form UB094; or
- Corresponding fields for electronic claims using the ASC X12N 837 format.