

TEXAS PRIOR AUTHORIZATION EXEMPTION LEGISLATION

For Health Care Providers

September 2023

Texas House Bill 3459 became effective on January 1, 2022. Under this legislation, prior authorization may not be required for certain health care services if the following thresholds have been met within a six-month evaluation period:

- The provider submitted at least five prior authorization requests for the particular health care service; and,
- Cigna Healthcare has approved at least 90 percent of the prior authorization requests submitted by the provider for the particular health care service.

Note: This legislation only applies to plans regulated by the Texas Department of Insurance (TDI), including fully insured employer plans and those sold on Healthcare.gov. Patients covered by a TDI-regulated plan will have a TDI or department of insurance (DOI) logo on their ID card.

Frequently asked questions

1. How is provider eligibility for a prior authorization exemption determined?

Under Texas House Bill 3459, Cigna Healthcare will begin to review a Texas provider's eligibility for exemption status from services that require prior authorization. Reviews will be done in accordance with the guidelines set forth under Texas Insurance Code 4201.655.

If a provider did not hold exemption for the prior evaluation period, Cigna Healthcare will review all relevant prior authorization determinations that were rendered for the specific health care services and determine whether the approval rate has reached the 90-percent threshold.

If a provider held an exemption for the prior evaluation period, Cigna Healthcare will conduct a review of a random sampling of five to 20 claims and determine whether they continue to meet the exemption threshold for that service.

If a provider is either denied an exemption, or has an exemption rescinded, the appropriate communications will be sent as required by law. Additionally, providers will be notified of the services for which they qualify for an exemption.

2. Will Cigna Healthcare conduct evaluations?

Cigna Healthcare will periodically reassess prior authorization data and claims submissions to determine whether a provider qualifies, or continues to qualify, for exemption status for a particular health care service.

Providers will be notified of their initial or continuing prior authorization exemption status, and letters will be mailed biannually in accordance with the timeline below.

- **March 1:** for an evaluation period of July 1 through December 31
- **September 1:** for an evaluation period of January 1 through June 30

Any exemption status will remain in place for at least six months.

3. Which plans does this mandate apply to?

This mandate applies to medical, behavioral, and pharmacy fully insured, and select non-Employee Retirement Income Security Act Administrative Services Only (non-ERISA ASO*) plans that are not currently administered by Cigna Healthcare.



4. Which services does this mandate apply to?

This mandate applies to any health care service that requires prior authorization from the published listing on the Cigna for Health Care Professionals website (CignaforHCP.com).

5. How do I know if a patient's service is eligible for an exemption from prior authorization?

If the front of the customer's ID card has a DOI logo, the customer has an account that is a fully insured plan and is issued in Texas. If the logo is not present, please verify the customer is a resident of Texas, and covered under a fully insured plan, to ensure this service would qualify for prior authorization exemption consideration.

6. How do I obtain more information about my prior authorization status, or what do I do if I disagree with a prior authorization exemption decision?

If you have questions about your prior authorization status as a result of Texas House Bill 3459, including if you disagree with an exemption decision, please email PriorAuthExemption@Cigna.com.

7. If I am performing an exempt service, do I need to request prior authorization?

If you received an exemption for a particular health care service, you do not need to obtain prior authorization for that service.

8. If I refer the patient to another provider, do they need prior authorization for an exempt service?

No. The service itself has received exemption status based on the review of your prior authorization history. Your exemption would apply when you order the service and prior authorization would not be required as a result.

When referring the patient's services to another provider, your National Provider Identifier (NPI) must be included on the claim. If the name and NPI of the ordering provider is *not* included on the claim, we will *not* be able to pay the claim without a prior authorization. The name and NPI of the ordering provider can be included on the claim form in the following fields:

- Fields 17 and 17B of Centers for Medicare & Medicaid Services (CMS) form 1500
- Fields 76 through 79 (or other appropriate field) of form UB-04
- Corresponding fields for electronic claims using the ASC X12N 837 format

9. What is the authorization process for nonparticipating providers?

All nonparticipating providers, regardless of exemption status, must submit a network adequacy authorization at (CignaforHCP.com) > Resources > Forms Center > Medical Forms > [Medical-Network Adequacy Provision Exception Form](#).

If a nonparticipating provider has achieved exemption status, no separate medical necessity authorization required. Those who do not hold exemption must submit a medical necessity authorization.

10. How do I update my preferred method for receiving communications related to Texas House Bill 3459?

If you would like to update your preferred method for receiving communications related to this legislation, please email PriorAuthExemption@Cigna.com with the following information:

- Requestor's name, title, and phone number
- Provider or facility name and NPI
- Preferred method of communication (mail or email)
- Complete mailing or email address, as applicable, of the provider or facility

11. How do I file a complaint with the TDI?

If you feel we have not complied with this legislation, you may contact the TDI through one of the following methods:

- Online: tdi.texas.gov > Health Providers > Complaints > [Guidelines for filing complaints from providers about health claim payments](#)
- Phone: **800.252.3439**
- Fax: **512.490.1007**
- Mail: Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714



12. How do I request an appeal?

Appeal requests should be directed to PriorAuthExemption@Cigna.com.

13. Where can I learn more about this legislation?

Please visit the TDI website (tdi.texas.gov).

* Requirements of Texas House Bill 3459 apply to Texas Employees Group Benefits, Texas Public School Employees Group Benefits Program, and Texas School Employees Uniform Group Health coverage. Cigna Healthcare does not currently administer this coverage.



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