BILL ANALYSIS

Senate Research Center

S.B. 418
By: Nelson
Health and Human Services
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Enrolled

DIGEST AND PURPOSE

Issues related to the prompt payment of physicians' claims by insurers have confronted lawmakers since 1997. Texas physicians contend that insurers are slow to pay or refuse to pay for services rendered to insured patients; insurers contend that providers do not provide complete and accurate billing information. Despite passage of state law in 1999 that was intended to accelerate payments to providers, physicians still claim that insurers have been able to avoid prompt payment of claims. In May of 2000, the Texas Department of Insurance adopted rules to implement the new law requiring payment of a "clean claim" within a specified time period. The rules defined a clean claim as one submitted with documentation reasonably necessary for the insurer to process the claim and included a list of elements based on federal claim forms for Medicare. Under those rules, an insurer could request attachments, such as medical records or operative reports, and the amount paid by any other insurer. Despite the statutory changes and new rules, problems relating to the prompt payment of claims persisted.

The 77th Legislature enacted H.B. 1862 to further revise prompt-payment requirements and establish requirements for submission of a clean claim, but the bill was subsequently vetoed. The Senate Special Interim Committee on Prompt Payment of Health Care Providers was established to evaluate current state law and agency rules, and to recommend ways to improve the process of paying health insurance claims.

S.B. 418 provides for the regulation and prompt payment of health care providers under certain health benefit plans and establishes penalties for penalties for violations of statutory provisions.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 2 (Article 3.70-3C, Section 3A, Insurance Code), SECTION 3 (Article 3.70-3C, Sections 3C and 3I, Insurance Code), SECTION 6 (Section 843.336, Insurance Code), SECTION 7 (Section 843.337, Insurance Code), SECTION 9 (Section 843.3385, Insurance Code), SECTION 11 (Section 843.340, Insurance Code), SECTION 15 (Section 843.342, Insurance Code), SECTION 20 (Article 21.30, Insurance Code), SECTION 21 (Section 5, Insurance Code), and SECTION 22 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by adding Subdivisions (14) and (15), as follows:

(14) Defines "preauthorization."

(15) Defines "verification."

SECTION 3. Amends Section 3A, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, as follows:

Sec. 3A. New Heading: PROMPT PAYMENT OF PROVIDERS. (a) Makes a conforming change related to the addition of Section 3C to this article.

(b) Requires a physician or provider to submit a claim to an insurer not later than the 95th day after the date the physician or provider provides the medical care or health care services for which the claim is made. Requires an insurer to accept as proof of timely filing a claim filed in compliance with Subsection (c) of this section or information from another insurer or health maintenance organization showing that the physician or provider submitted the claim to the insurer or health maintenance organization in compliance with Subsection (c) of this section. Deletes existing text "preferred" as a modifier for provider. Provides that if a physician or provider fails to submit a claim in compliance with this subsection, the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with this subsection is a result of a catastrophic event that substantially interferes with the normal business operations of the physician or provider. Authorizes the period for submitting a claim under this subsection to be extended by contract. Prohibits a physician or provider from submitting a duplicate claim for payment before the 46th day after the date the original claim was submitted. Requires the commissioner of insurance (commissioner) to adopt rules under which an insurer is authorized to determine whether a claim is a duplicate claim. Deletes existing text relating to acknowledgment of receipt of a claim for medical care or medical services.

(c) Authorizes a physician or provider, as appropriate, to take certain actions relating to delivery of the claim, except as provided by Article 21.52Z of this code.

(d) Provides that if a claim for medical care or health care services provided to a patient is mailed, the claim is presumed to have been received by the insurer on the fifth day after the date the claim is mailed or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed. Provides that if the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the insurer's clearinghouse. Requires the physician's or provider's clearinghouse to provide the confirmation, if the insurer's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or provider. Requires the physician's or provider's clearinghouse to be able to verify that the filing contained the correct payor identification of the entity to receive the filing. Provides that is the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. Provides that is the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed.

(e) Requires the insurer, not later than the 45th day after the date the insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date the insurer receives a clean claim from a preferred provider that is electronically submitted, to make a determination of whether the claim is payable and take certain actions related to the amount determined to be paid, except as provided by Subsection (j) of this section.

(f) Requires the insurer to pay the total amount of the claim, not later than the 21st day after the date an insurer affirmatively adjudicates a pharmacy claim that is electronically submitted.

(g) Requires the insurer, if the insurer intends to audit the preferred provider claim, to pay the charges submitted at 100, rather than 85, percent of the contracted rate on the claim by a certain date for electronically received claims and by a certain date for nonelectronically received claims, except as provided by Subsection (j) of this section. Requires the insurer to clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule that the claim is being paid at 100 percent of the contracted rate, subject to the completion of an audit. Requires the insurer to complete the audit on or

before a certain date. Requires the request to describe with specificity the clinical information requested and relate only to information the insurer in good faith can demonstrate is specific to the claim or the claim's related episode of care, if the insurer requests additional information needed to complete the audit. Prohibits the insurer from requesting as part of the audit information that is not contained in, or is not in the process of being incorporated into, the patient's medical billing record maintained by a preferred provider. Authorizes the insurer, if a preferred provider does not supply information reasonably requested by the insurer in connection with the audit, to take certain actions. Deletes existing text related to acknowledging coverage of an insured under the health insurance policy.

(h) Requires the insurer to complete the audit on or before the 180th day after the date the clean claim is received by the insurer, and any additional payment due a preferred provider or any refund due the insurer to be made not later than the 30th day after the completion of the audit. Requires the insurer, if a preferred provider disagrees with a refund request made by an insurer based on the audit, to provide the provider with an opportunity to appeal, and prohibits the insurer from attempting to recover the payment until all appeal rights are exhausted. Makes nonsubstantive changes.

(i) Provides that the investigation and determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Subsection (e) or (f) of this section or for auditing a claim under Subsection (g) of this section.

(j) Requires the insurer, not later than the 30th calendar day after the date the insurer receives a clean claim, to request in writing that the preferred provider provide an attachment to the claim that is relevant and necessary for clarification of a claim, if an insurer needs additional information from a treating preferred provider to determine payment. Requires the request to describe with specificity the clinical information requested and relate only to information the insurer can demonstrate is specific to the claim or the claim's related episode of care. Provides that the preferred provider is not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a preferred provider. Requires an insurer that requests an attachment under this subsection to determine whether the claim is payable on or before the later of the 15th day after the date the insurer receives the requested attachment or the latest date for determining whether the claim is payable under Subsection (e) or (f) of this section. Prohibits an insurer from making more than one request under this subsection in connection with a claim. Provides that Subsections (c) and (d) of this section apply to a request for and submission of an attachment under this subsection.

(k) Requires the insurer to provide notice containing the name of the physician or provider from whom the insurer is requesting information to the preferred provider who submitted the claim. Prohibits the insurer from withholding payment pending receipt of an attachment or information requested under this subsection. Authorizes the insurer, if on receiving an attachment or information requested under this subsection the insurer determines that there was an error in payment of the claim, to recover any overpayment under Section 3D of this article. Deletes existing Subsection (k) related to written notice of the addition or change to each preferred provider.

(l) Requires the commissioner to adopt rules under which an insurer can easily identify attachments or other information submitted by a physician or provider under Subsection (j) or (k) of this section. Deletes existing Subsection (l) related to application of this section to a claim made by a preferred provider who is a member of the legislature.

(m) Requires insurer's claims payment process to meet certain standards. Deletes existing Subsection (m) related to application of this section to a person whom an insurer contract for certain activities.

(n) Authorizes a preferred provider to recover reasonable attorney's fees and court costs in an action to recover payment under this section.

(o) Requires the insurer to provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures. Deletes existing Subsection (o) related to administrative penalties for violation of certain subsections.

(p) Authorizes the commissioner to adopt rules as necessary to implement this section.

(q) Prohibits the provisions of this section from being waived, voided, or nullified by contract, except as provided by Subsection (b) of this section.

SECTION 3. Amends Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by adding Sections 3C-3J and 10-12, as follow:

Sec. 3C. ELEMENTS OF CLEAN CLAIM. (a) Provides that a nonelectronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is submitted using a certain form, or if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. Provides that an electronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is submitted using a certain format, or if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(b) Provides that a nonelectronic claim by an institutional provider, is a clean claim if the claim is submitted using a certain form, or if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. Provides that an electronic claim by an institutional provider, is a clean claim if the claim is submitted using a certain format, or if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(c) Authorizes the commissioner to adopt rules that specify the information that is required to be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(d) Prohibits the commissioner from requiring any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(e) Authorizes an insurer and a physician or provider to agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(f) Provides that an otherwise clean claim submitted by a physician or provider that includes certain information not required under this section is considered to be a clean claim for the purposes of this article.

(g) Prohibits the provisions of this section from being waived, voided, or nullified by contract, except as provided by Subsection (e) of this section.

Sec. 3D. OVERPAYMENT. (a) Authorizes an insurer to recover an overpayment to a physician or provider if certain conditions are met.

(b) Requires the insurer, if a physician or provider disagrees with a request for recovery of an overpayment, to provide the physician or provider with an opportunity to appeal, and prohibits the insurer from attempting to recover the over payment until all appeal rights are exhausted.

Sec. 3E. VERIFICATION. (a) Provides that in this section, "verification" includes preauthorization only when preauthorization is a condition for verification.

(b) Requires the insurer, on request of a referred provider for verification of a particular medical care or health care service the preferred provider proposes to provide to a particular patient, to inform the preferred provider without delay whether the service, if provided to the patient, will be paid by the insurer and to specify any deductibles, copayments, or coinsurance for which the insured is responsible.

(c) Requires an insurer to have appropriate personnel reasonably available to a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central standard time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central standard time on Saturday, Sunday, and legal holidays. Requires an insurer to have a telephone system capable of accepting or recording incoming phone calls for preauthorization after 6 p.m. central standard time Monday through Friday and after noon central standard time on Saturday, Sunday, and legal holidays and have the capability to respond to each call on or before the second calendar day after the date the call is received.

(d) Authorizes an insurer to decline to determine eligibility for payment if the insurer notifies the physician or preferred provided who requested the verification of the specific reason the determination was not made.

(e) Authorizes an insurer to establish a specific period during which the verification is valid of not less than 30 days.

(f) Requires an insurer that declines to provide a verification to notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(g) Prohibits the insurer from denying or reducing payment to the physician or provider for those medical care or health care services if provided to the insured on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services, if an insurer has provided a verification for proposed medical care or health care services.

(h) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 3F. COORDINATION OF PAYMENTS. (a) Authorizes an insurer to require a physician or provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the insurer on the applicable form described by Section 3C of this article. Prohibits an insurer from requiring a physician or provider to investigate coordination of other health benefit plan coverage, except as provided by this subsection.

(b) Provides that coordination of payment under this section does not extend the period for determining whether a service is eligible for payment under Section 3A(e) or (f) of this article or for auditing a claim under Section 3A(g) of this article.

(c) Requires a physician or provider who submits a claim for a particular medical care or health care service to more than one health maintenance organization or insurer to provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) Requires an insurer, on receipt of notice under Subsection (c) of this section, to coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or provider.

(e) Authorizes the overpayment, if an insurer is a secondary payor and pays a portion of a claim that should have been paid by the insurer or health maintenance organization that is the primary payor, to only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount, except as provided by Subsection (f) of this section.

(f) Authorizes the secondary insurer, if the portion of the claim overpaid by the secondary insurer was also paid by the primary health maintenance organization or insurer, to recover the amount of overpayment under Section 3D of this article from the physician or provider who received the payment. Requires an insurer processing an electronic claim as a secondary payor to rely on the primary payor information submitted on the claim by the physician or provider. Authorizes primary payor information to be submitted electronically by the primary payor to the secondary payor.

(g) Authorizes an insurer to share information with a health maintenance organization or another insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

(h) Prohibits the provisions of this section from being waived, voided, or nullified.

Sec. 3G. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) Requires an insurer that uses a preauthorization process for medical care and health care services to provide to each preferred provider, not later than the 10th business day after the date a request is made, a list of certain services.

(b) Requires the insurer to determine whether the medical care or health care services proposed to be provided to the insured are medically necessary and appropriate, if proposed medical care or health care services require preauthorization as a condition of the insurer's payment to a preferred provider under a health insurance policy.

(c) Requires the insurer, on receipt of a request from a preferred provider for preauthorization, to review and issue a determination indicating whether the proposed medical or health care services are preauthorized. Requires the determination to be issued or transmitted not later than the third calendar day after the date the request is received by the insurer.

(d) Requires the insurer to review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the patient's physician or provider and the insurer's written medically accepted screening criteria and review procedures. Requires the insurer to review the request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the physician or provider.

(e) Requires an insurer to have appropriate personnel reasonably available to a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central standard time Monday through Friday on each day that is

not a legal holiday and between 9 a.m. and noon central standard time on Saturday, Sunday, and legal holidays. Requires an insurer to have a telephone system capable of accepting or recording incoming phone calls for preauthorization after 6 p.m. central standard time Monday through Friday and after noon central standard time on Saturday, Sunday, and legal holidays and have the capability to respond to each of those calls not later than 24 hours after the call is received.

(f) Prohibits the insurer from denying or reducing payment to the physician or provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services, if an insurer has preauthorized medical care or health care services.

(g) Provides that this section applies to an agent or other person with whom an insurer contracts to perform, or to whom the insurer delegates the performance of, preauthorization of proposed medical or health care services.

(h) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 3H. AVAILABILITY OF CODING GUIDELINES. (a) Requires a contract between an insurer and a physician or provider to provide certain stipulations.

(b) Authorizes a physician or provider who receives information under Subsection (a) of this section to only use that information incertain instances.

(c) Requires the insurer, on request of the preferred provider, to provide certain information that the insurer used to determine bundling and unbundling of claims.

(d) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 3I. VIOLATION OF CLAIMS PAYMENT REQUIREMENTS; PENALTY. (a) Requires the insurer, if a clean claim submitted to an insurer is payable and the insurer does not determine under Section 3A of this article that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or adjudication of the claim, to pay the preferred provider making the claim the contracted rate owed the physician or provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of two certain amounts.

(b) Requires the insurer, if the claim is paid on or after the 46th day and before the 91st day after the date the insurer is required to make a determination or adjudication of the claim, to pay a penalty in the amount of the lesser of two certain amounts.

(c) Requires the insurer, if the claim is paid on or after the 91st day after the date the insurer is required to make a determination or adjudication of the claim, to pay a penalty computed under Subsection (b) of this section plus 18 percent annual interest on that amount. Provides that interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(d) Requires an insurer that determines under Section 3A of this article that a claim is payable, pays only a portion of the amount of the claim on or before the date the insurer is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date to pay to the physician or provider, in addition to the contracted amount owed, a

penalty on the amount not timely paid in the amount of the lesser of two certain amounts, except as provided by this section.

(e) Requires the insurer, if the balance of the claim is paid on or after the 46th day and before the 91st day after the date the insurer is required to make a determination or adjudication of the claim, to pay a penalty on the balance of the claim in the amount of the lesser of two certain amounts.

(f) Requires the insurer, if the balance of the claim is paid on or after the 91st day after the date the insurer is required to make a determination or adjudication of the claim, to pay a penalty computed under Subsection (e) of this section plus 18 percent annual interest on that amount. Provides that interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(g) Provides that for the purposes of Subsections (d) and (e) of this section, the underpaid amount is calculated on the ration of the amount underpaid on the contracted rate to the contracted rate as applied to the billed charges as submitted on the claim.

(h) Provides that an insurer is not liable for a penalty under this section under certain conditions.

(i) Provides that Subsection (h) of this section does not relieve the insurer of the obligation to pay the remaining unpaid contracted rate owed the physician or provider.

(j) Requires an insurer that pays a penalty under this section to clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(j) Provides that an insurer who violates Section 3A(e), (f), or (g) of this article in processing more than two percent of clean claims submitted to the insurer is subject to an administrative penalty under Chapter 84 of this code, in addition to any other penalty or remedy authorized by this code. Prohibits the penalty, for each day an administrative penalty is imposed under this subsection, from exceeding $1,000 for each claim that remains unpaid in violation of Section 3A(e), (g), and (h) of this article. Requires the commissioner, in determining whether an insurer has processed preferred provider claims in compliance with Section 3A(e), (f), or (g) of this article, to consider paid claims, other than claims that have been paid under Section 3A(g) of this article, and to compute a compliance percentage for physician and provider claims, other than institutional provider claims, and a compliance percentage for institutional provider claims.

Sec. 3J. APPLICABILITY OF ARTICLE TO ENTITIES CONTRACTING WITH INSURER. Provides that Sections 3A-3I of this article apply to a person with whom an insurer contracts to do certain activities.

Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. Provides that the provisions of this article relating to prompt payment by an insurer of a physician or provider and to verification of medical care or health care services apply to a physician or provider who meets certain requirements.

Sec. 11. IDENTIFICATION CARD. Requires an identification card or other similar document issued by an insurer regulated by this code and subject to this article to an individual insured to display certain information.

Sec. 12. CONFLICT WITH OTHER LAW. Provides that to the extent of any conflict

between this article and Article 21.52C of this code, this article controls.

SECTION 4. Amends Subchapter F, Chapter 843, Insurance Code, as effective June 1, 2003, by adding Section 843.209, as follows:

Sec. 843.209. IDENTIFICATION CARD. Requires a card or other similar document issued by a health maintenance organization to an enrollee to include certain information relating to specifics of the individual's coverage.

SECTION 5. Amends Subchapter I, Chapter 843, Insurance Code, as effective June 1, 2003, by adding Section 843.319, as follows:

Sec. 843.319. AVAILABILITY OF CODING GUIDELINES. (a) Requires a contract between a health maintenance organization and a physician or provider to provide for certain conditions to be met.

(b) Authorizes a physician or provider who receives information under Subsection (a) to only take certain actions related to the use and disclosure of information.

(c) Requires the health maintenance organization, on request of the physician or provider, to provide certain information related to the software that the health maintenance organization uses to determine bundling and unbundling of claims.

(d) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

SECTION 6. Amends Section 843.336. Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.336. New heading: CLEAN CLAIM. (a) Defines "clean claim." Creates this subsection from existing text.

(b) Provides that a nonelectronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is submitted using a certain form, or if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. Provides that an electronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is submitted using a certain format, or if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(c) Provides that a nonelectronic claim by an institutional provider, is a clean claim if the claim is submitted using a certain form, or if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. Provides that an electronic claim by an institutional provider, is a clean claim if the claim is submitted using a certain format, or if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(d) Authorizes the commissioner to adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(e) Prohibits the commissioner from requiring any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(f) Authorizes a health maintenance organization and a physician or provider to agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(g) Provides that an otherwise clean claim submitted by a physician or provider that includes additional information fields, data elements, attachments, or other information not required under this section is considered to be a clean claim for the purposes of this section.

SECTION 7. Amends Section 843.337, Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.337. New heading: TIME FOR SUBMISSION OF CLAIM; DUPLICATE CLAIMS; ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) Requires a physician or provider to submit a claim under this subchapter to a health maintenance organization not later than the 95th day after the date the physician or provider provides the medical care or health care services for which the claim is made. Requires a health maintenance organization to accept as proof of timely filing a claim filed in compliance with Subsection (e) or information form another health maintenance organization or insurer showing that the physician or provider submitted the claim to the health maintenance organization or insurer in compliance with Subsection (e).

(b) Provides that if a physician or provider fails to submit a claim in compliance with this section, the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with this section is a result of a catastrophic event that substantially interferes with the normal business operations of the physician or provider as determined under guidelines established by the commissioner by rule.

(c) Authorizes the period for submitting a claim under this section to be extended by contract.

(d) Prohibits a physician or provider from submitting a duplicate claim for payment before the 46th day after the date the original claim was submitted. Requires the commissioner to adopt rules under which a health maintenance organization is authorized to determine whether a claim is a duplicate claim.

(e) Authorizes a physician or provider, as appropriate, except as provided by Article 21.52Z, to take certain actions related to the delivery of a claim.

(f) Provides that if a claim for health care services provided to a patient is mailed, the claim is presumed to have been received by the health maintenance organization on the fifth day after the date the claim is mailed or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed. Provides that if the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the health maintenance organization or the health maintenance organization's clearinghouse. Requires the health maintenance organization or the health maintenance organization's clearinghouse to provide the confirmation, if the health maintenance organization's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or provider. Requires the health maintenance organization or health maintenance organization's clearinghouse to be able to verify that the filing contained the correct payor identification of the entity to receive the filing. Provides that if the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. Provides that if the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed. Deletes existing text related to receipt of acknowledgment. Deletes existing Subsection (b) related to receipt of acknowledgment of an electronic claim.

SECTION 8. Amends Section 843.338, Insurance Code, as effective June 1, 2003, to make a conforming change related to the addition of Sections 843.3385. Requires the health maintenance organization, not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a participating physician or provider in a

nonelectronic format or the 30th day after the date the health maintenance organization receives a clean claim form a participating physician or provider that is electronically submitted, to make a determination of whether the claim is payable and certain actions related to the health maintenance organization's determination that the entire claim is payable.

SECTION 9. Amends Subchapter J, Chapter 843, Insurance Code, as effective June 1, 2003, by adding Section 843.3385, as follows:

Sec. 843.3385. ADDITIONAL INFORMATION. (a) Requires a health maintenance organization, if a health maintenance organization needs additional information from a treating physician or provider to determine payment, to request in writing that the physician or provider provide an attachment to the claim that is relevant and necessary for clarification of the claim, not later than the 30th calendar day after the date the health maintenance organization receives a clean claim.

(b) Requires the request to describe with specificity the clinical information requested and relate only to information the health maintenance organization can demonstrate is specific to the claim or the claim's related episode of care. Provides that the participating physician or provider is not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a participating physician or provider.

(c) Requires a health maintenance organization that requests an attachment under this section to determine whether the claim is payable on or before the later of the 15th day after the date the health maintenance organization receives the requested attachment or the latest date for determining whether the claim is payable under Section 843.338 or 843.339.

(d) Prohibits a health maintenance organization from making more than one request under this section in connection with a claim. Provides that Section 843.337(e) and (f) apply to a request for and submission of an attachment under Subsection (a).

(e) Requires the health maintenance organization to provide notice containing the name of the physician or provider from whom the health maintenance organization is requesting information to the physician or provider who submitted the claim, if a health maintenance organization requests an attachment or other information from a person other than the participating physician or provider who submitted the claim. Prohibits the health maintenance organization from withholding payment pending receipt of an attachment or information requested under this subsection. Provides that if the health maintenance organization determines that there was an error in payment of the claim, the health maintenance organization is authorized to recover any overpayment under Section 843.350.

(f) Requires the commissioner to adopt rules under which a health maintenance organization can easily identify an attachment or other information submitted by a physician or provider under this section.

SECTION 10. Amends Section 843.339, Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.339. New heading: DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION CLAIMS. Deletes "benefit" as a modifier for "claims" in the title. Requires the health maintenance organization, not later than the 21st day after the date a health maintenance organization affirmatively adjudicates a pharmacy claim that is electronically submitted, to pay the total amount of the claim. Deletes existing text related to related to an electronically adjudicated and paid prescription benefit claim.

SECTION 11. Amends Section 843.340, Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.340. AUDITED CLAIMS. (a) Requires the health maintenance organization, if the health maintenance organization intends to audit a claim submitted by a participating physician or provider, to pay the charges submitted at 100, rather than 85, percent of the contracted rate on the claim by a certain date related to the claim being submitted electronically or nonelectronically and clearly indicate on the explanation of benefits statement in the manner prescribed by the commissioner by rule that the claim is being paid at 100 percent of the contracted rate, subject to the completion of an audit.

(b) Requires the request, if the health maintenance organization requests additional information needed to complete the audit, to describe with specificity the clinical information requested and relate only to information the health maintenance organization in good faith can demonstrate is specific to the claim or the claim's related episode of care. Prohibits the health maintenance organization from requesting as a part of the audit information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a participating physician or provider.

(c) Authorizes the health maintenance organization, if the participating physician or provider does not supply information reasonably requested by the health maintenance organization in connection with the audit, to take certain actions.

(d) Requires the health maintenance organization to complete the audit on or before the 180th day after the date the clean claim is received by the health maintenance organization, and requires any additional payment due a participating physician or provider or any refund due the health maintenance organization to be made not later than the 30th day after the completion of the audit.

(e) Requires the health maintenance organization, if a physician or provider disagrees with a request for recovery of an overpayment, to provide the physician or provider with an opportunity to appeal, and prohibits the health maintenance organization from attempting to recover the over payment until all appeal rights are exhausted.

SECTION 12. Amends Subchapter J, Chapter 843, Insurance Code, as effective June 1, 2003, by adding Section 843.338 or 843.339 or for auditing a claim under Section 843.340.

SECTION 13. Amends Section 843.341, Insurance Code, as effective June 1, 2003, to delete copies of required data elements and claim formats from the information a health maintenance organization is required to provide a participating physician or provider. Requires a health maintenance organization's claims payment process to meet certain requirements. Deletes existing text related to adding or changing data elements and written notice of the addition or change to each participating physician or provider within 60 days of the addition or change.

SECTION 14. Amends Section 843.342, Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.342. New heading: VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; PENALTIES. Deletes existing text "ADMINISTRATIVE PENALTY" from heading.

(a) Requires the health maintenance organization, if a clean claim submitted to a health maintenance organization is payable and the health maintenance organization does not determine under this subchapter that the claim is payable and pay the claim on or before the date the health maintenance organization is required to make a determination or adjudication of the claim, to pay the physician or provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of two certain fees, except as provided by this section.

(b) Requires a health maintenance organization, if the claim is paid on or after the

46th day and before the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, to pay a penalty in the amount of the lesser of two certain fees.

(c) Requires the health maintenance organization that pays a clean claim on or after the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, to pay a penalty computed under Subsection (b) plus 18 percent annual interest on that amount. Provides that interest under this subsection accrues beginning on the date the health maintenance organization was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(d) Requires a health maintenance organization that determines under this subchapter that a claim is payable, pays only a portion of the amount of the claim on or before the date the health maintenance organization is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date to pay to the physician or provider, in addition to the contracted amount owed, a penalty on the amount not timely paid in the amount of the lesser of two certain fees.

(e) Requires the health maintenance organization, if the balance of the claim is paid on or after a certain date and before another date, to pay a penalty on the balance of the claim in the amount of the lesser of two certain fees.

(f) Requires the health maintenance organization, if the balance of the claim is paid on or after a certain date, to pay a penalty on the balance of the claim computed under Subsection (e) plus 18 percent annual interest on that amount. Provides that interest under this subsection accrues beginning on a certain date and ending on another date.

(g) Provides that for the purpose of Subsections (d) and (e), the underpaid amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to the billed charges as submitted on the claim.

(h) Provides that a health maintenance organization is not liable for a penalty under this section if certain conditions apply.

(i) Provides that Subsection (h) does not relieve the health maintenance organization of the obligation to pay the remaining unpaid contracted rate owed the physician or provider.

(j) Requires a health maintenance organization that pays a penalty under this section to clearly indicate on the explanation of payment statement or other written documentation in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(k) Provides that a health maintenance organization that violates Section 843.338, 843.339, and 843.340 in processing more than two percent of clean claims submitted to the health maintenance organization by participating physicians or providers who are institutional providers or more than two percent of clean claims submitted to the health maintenance organization by participating physicians or providers who are not institutional providers is subject to an administrative penalty under Chapter 84, in addition to any other penalty or remedy authorized by this code. Prohibits the penalty, for each day an administrative penalty is imposed under this subsection, from exceeding $1,000 for each claim that remains unpaid in violation of Section 843.338, 843.339, and 843.340. Deletes text relating to health maintenance organization's liability for violating Sections 843.338 or 843.340.

(l) Requires the commissioner, in determining whether a health maintenance organization has processed physician and provider claims in compliance with Section 843.338, 843.339, or 843.340, to consider paid claims, other than claims that have been paid under Section 843.340, and to compute a compliance percentage for physician and provider claims, other than institutional provider claims, and a compliance percentage for institutional provider claims.

SECTION 15. Amends Section 843.343, Insurance Code, as effective June 1, 2003, to authorize a physician or provider to recover reasonable attorney's fees and court costs in an action to recover payment under this subchapter.

SECTION 16. Amends Section 843.344, Insurance Code, as effective June 1, 2003, as follow:

Sec. 843.344. New heading: APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. Provides that this subchapter, rather than Sections 843.336-843.343, applies to a person with whom a health maintenance organization contracts to certain activities.

SECTION 17. Amends Section 843.345, Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.345. New heading: EXCEPTION. Deletes existing text relating to medical care under a health care plan and a claim submitted by a physician or provider who is a member of the legislature. Makes conforming and nonsubstantive changes.

SECTION 18. Amends Section 843.346, Insurance Code, as effective June 1, 2003, to make a conforming change. Deletes existing text related to evidence of coverage.

SECTION 19. Amends Subchapter J, Chapter 843, Insurance Code, as effective June 1, 2003, by adding Sections 843.347-843.353, as follows:

Sec. 843.347. VERIFICATION. (a) Defines "verification." Provides that the term includes certain terms that would be a reliable representation by an insurer to a physician or provider.

(b) Requires the health maintenance organization to inform the physician or provider without delay whether the service, if provided to that patient, will be paid by the health maintenance organization and to specify any deductibles, copayments, or coinsurance for which the enrollee is responsible, on the request of a physician or provider for verification particular health care service the participating physician or provider proposes to provide to a particular patient.

(c) Requires a health maintenance organization to have appropriate personnel reasonably available to a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central standard time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central standard time on Saturday, Sunday, and legal holidays. Requires an insurer to have a telephone system capable of accepting or recording incoming phone calls for preauthorization after 6 p.m. central standard time Monday through Friday and after noon central standard time on Saturday, Sunday, and legal holidays and have the capability to respond to each call on or before the second calendar day after the date the call is received.

(d) Authorizes a health maintenance organization to decline to determine eligibility for payment if the insurer notifies the physician or preferred provider who requested the verification of the specific reason the determination was not made.

(e) Authorizes a health maintenance organization to establish a specific period during which the verification is valid of not less than 30 days.

(f) Requires a health maintenance organization that declines to provide a verification to notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(g) Prohibits the health maintenance organization, if a health maintenance organization has provided verification for proposed health care services, from denying or reducing payment to the physician or provider for those health care services if provided to the enrollee on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

Sec. 843.348. PREAUTHORIZATION HEALTH CARE SERVICES. (a) Defines "preauthorization."

(b) Requires a health maintenance organization that uses a preauthorization process for medical care and health care services to provide to each preferred provider, not later than the 10th business day after the date a request is made, a list of certain services that do not require preauthorization and information concerning the preauthorization.

(c) Requires the health maintenance organization to determine whether the health care services proposed to be provided to the enrollee are medically necessary and appropriate, if proposed health care services require preauthorization as a condition of the health maintenance organization's payment to a preferred provider under a health insurance policy.

(d) Requires the health maintenance organization, on receipt of a request from a participating physician or provider for preauthorization, to review and issue a determination indicating whether the health care services are preauthorized. Requires the determination to be issued and transmitted not later than a certain day.

(e) Requires the health maintenance organization, if the proposed health care services involve inpatient care and the health maintenance organization requires preauthorization as a condition of payment, to review and issue a length of stay for the admission into a health care facility based on the recommendation of the patient's physician or provider and the health maintenance organization's written medically accepted screening criteria and review procedures. Requires the health maintenance organization to make a decision on a preauthorization request within 24 hours.

(f) Requires a health maintenance organization to have appropriate personnel reasonably available to a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central standard time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central standard time on Saturday, Sunday, and legal holidays. Requires a health maintenance organization to have a telephone system capable of accepting or recording incoming phone calls for preauthorization after 6 p.m. central standard time Monday through Friday and after noon central standard time on Saturday, Sunday, and legal holidays and responding to each of those calls not later than 24 hours after the call is received.

(g) Prohibits the health maintenance organization from denying or reducing payment to the physician or provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services, if a health maintenance organization has preauthorized medical care or health care services.

(h) Provides that this section applies to an agent or other person with whom a health maintenance organization contracts to perform, or to whom the health maintenance organization delegates the performance of, preauthorization of proposed health care services.

Sec. 843.349. COORDINATION OF PAYMENT. (a) Authorizes a health maintenance organization to require a physician or provider to retain in the physician's or provider's records updated information concerning sources of payment and to provide the information to the health maintenance organization on the applicable claim form described by Section 843.336. Prohibits a health maintenance organization from requiring a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Provides that coordination of payment under this section does not extend the period for determining whether a service is eligible for payment under Section 843.338 or 843.339 or for auditing a claim under Section 843.340.

(c) Requires a participating physician or provider who submits a claim for particular health care services to more than one health maintenance organization or insurer to provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) Requires a health maintenance organization, on receipt of notice under Subsection (c), to coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or provider.

(e) Authorizes the overpayment, if a health maintenance organization is a secondary payor and pays a portion of a claim that should have been paid by the health maintenance organization or insurer that is the primary payor, to only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount, except as provided by Subsection (f).

(f) Authorizes the secondary health maintenance organization, if the portion of the claim overpaid by the secondary health maintenance organization was also paid by the primary health maintenance organization or insurer, to recover the amount of the overpayment under Section 843.350 from the physician or provider who received the payment. Requires a health maintenance organization processing an electronic claim as a secondary payor to rely on the primary payor information submitted on the claim by the physician or provider. Authorizes primary payor information to be submitted electronically by the primary payor to the secondary payor.

(g) Authorizes a health maintenance organization to share information with another health maintenance organization or an insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

Sec. 843.350. OVERPAYMENT. (a) Authorizes a health maintenance organization to recover an overpayment to a physician or provider if certain conditions apply.

(b) Requires the health maintenance organization, if a physician or provider disagrees with a request for recovery of an overpayment, to provide the physician or provider with an opportunity to appeal, and prohibits the health maintenance organization from recovering the overpayment until all appeal rights are exhausted.

Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. Provides that the provisions of this subchapter relating to prompt payment by a health maintenance organization of a physician or provider and to verification of

health care service apply to a physician or provider who meets certain requirements.

Sec. 843.352. CONFLICT WITH OTHER LAW. Provides that to the extent of any conflict between this subchapter and Article 21.52C, this subchapter controls.

Sec. 843.353. WAIVER PROHIBITED. Prohibits the provisions of this subchapter from being waived, voided, or nullified by contract, except as provided by Sections 843.336(f) 843.337(c).

SECTION 20. Amends Subchapter E, Chapter 21, Insurance Code, by adding Article 21.30, as follows:

Art. 21.30. WAIVER OF CERTAIN PROVISIONS FOR CERTAIN FEDERAL PLANS. Requires the commissioner of insurance, by rule, if the commissioner of insurance, in consultation with the commissioner of health and human services, determines the a provision of Section 3A, 3C-3J, or 10-12, Article 3.70-3C of this code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, Section 843.209 or 843.319 of this Code, Subchapter J, Chapter 843 of this code, or Article 21.52Z of this code will cause a negative fiscal impact on the state with respect to providing benefits or services under Subchapter XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), as amended, or Subchapter XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, to waive the application of that provision to the providing of those benefits or services.

SECTION 21. Amends Subchapter E, Chapter 21, Insurance Code, by adding Articles 21.52Y and 21.52Z, as follows:

Art. 21.52Y. TECHNICAL ADVISORY COMMITTEE ON CLAIMS PROCESSING. (a) Requires the commissioner to appoint a technical advisory committee on claims processing by insurers and health maintenance organizations of claims by physicians and health care providers for medical care and health care services provided to patients.

(b) Requires the committee to advise the commissioner on technical aspects of coding of health care services and certain claims processes, as well as the impact on those processes of contractual requirements and relationships, including relationships among certain persons and entities. Requires the committee to also advise the commissioner with respect to the implementation of the standardized coding and bundling edits and logic.

(c) Requires the commissioner to consult the advisory committee with respect to any rule related to the subjects described by Subsection (b) of this article before adopting the rule.

(d) Requires the committee to issue a report to the legislature on the activities of the committee, on or before September 1 of each even-numbered year.

(e) Provides that members of the advisory committee serve without compensation.

(f) Provides that Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee established under this article.

Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

Sec. 1. HEALTH BENEFIT PLAN DEFINED. Defines "health benefit plan."

Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. (a) Authorizes the issuer of a health benefit plan by contract to require that a health care professional licensed or registered under the Occupations Code or a health care facility licensed under the Health and Safety Code submit a health care claim or equivalent encounter information, a

referral certification, or an authorization or eligibility transaction electronically. Requires the health benefit plan issuer to comply with the standards for electronic transactions required by this section and established by the commissioner by rule.

(b) Requires the issuer of a health benefit plan by contract to establish a default method to submit claims in a nonelectronic format if there is a system failure or failures or a catastrophic event substantially interferes with the normal business operations of the physician, provider, or health benefit plan or its agents. Requires the health benefit plan issuer to comply with the standards for nonelectronic transactions established by the commissioner by rule.

Sec. 2A. ELECTRONIC SUBMISSION OF CLAIMS: WAIVER. (a) Requires a contract between the issuer of a health benefit plan and a health care professional or health care facility to provide for a waiver of any requirement for electronic submission established under this article.

(b) Requires the commissioner to establish certain circumstances under which a waiver is required.

(c) Authorizes any health care professional or health care facility that is denied a waiver by a health benefit plan to appeal the denial to the commissioner. Requires the commissioner to determined whether a waiver must be granted.

(d) Prohibits the issuer of a health benefit plan from refusing to contract or renew a contract with a health care professional or health care facility based in whole or in part on the professional of facility requesting or receiving a waiver or appealing a waiver determination.

Sec. 3. MODE OF TRANSMISSION. Prohibits the issuer of a health benefit plan from limiting, by contract, the mode of electronic transmission that a health care professional or health care facility is authorized to use to submit information under this article.

Sec. 4. CERTAIN CHARGES PROHIBITED. Prohibits a health benefit plan from directly or indirectly charging or holding a health care professional, health care facility, or person enrolled in a health benefit plan responsible for a fee for the adjudication of a claim.

Sec. 5. RULES. Authorizes the commissioner to adopt rules as necessary to implement this article. Prohibits the commissioner from requiring any data element for electronically filed claims that is not required to comply with federal law.

SECTION 22. (a) Requires the commissioner, as soon as practicable, but not later than the 30th day after the effective date of this Act, to appoint the technical advisory committee under Article 2152Y, Insurance Code, as added by this Act.

(b) Requires the commissioner, as soon as practicable, but not later than the 30th day after the effective date of this Act, to adopt rules as necessary to implement this Act. Authorizes the commissioner to use the procedures under Section 2001.034, Government Code (Emergency Rulemaking), for adopting emergency rules with abbreviated notice and hearing to adopt rules under this section. Provides that the commissioner is not required to make the finding described by Section 2001.034(a), Government Code (Emergency Rulemaking), to use the emergency rules procedures.

SECTION 23. (a) Makes applications of this Act with respect to a contract entered into between an insurer or health maintenance organization and a physician or health care provider, and payment for medical care or health care services under the contract, prospective to the 60th day after the effective day of this Act.

(b) Makes application of this Act with respect to the payment for medical care or health

care services provided, but not provided under a contract to which Subsection (a) of this Section applies, prospective to the 60th day after the effective day of this Act.

SECTION 24. Effective date: June 1, 2003, or September 1, 2003.