BILL ANALYSIS

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By: Nelson
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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.

As proposed, 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 1 (Article 3.70-3C, Insurance Code), SECTION 2 (Article 3.70-3C, Insurance Code), SECTION 5 (Section 843.336, Insurance Code), SECTION 6 (Section 843.337, Insurance Code), SECTION 8 (Section 843.3385, Insurance Code), SECTION 10 (Section 843.340, Insurance Code), SECTION 13 (Section 843.3411, Insurance Code), SECTION 14 (Section 843.342, Insurance Code), SECTION 19 (Article 21.52Z, Insurance Code), and SECTION 20 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. 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 PHYSICIANS AND PROVIDERS. (a) Makes a conforming change related to the addition of Section 3C to this article.
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> (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. 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 as determined under guidelines established by the commissioner of insurance (commissioner) by rule. Requires the insurer to accept as proof of timely filing information from another health benefit plan issuer showing that the physician or provider submitted the claim to the health benefit plan issuer in compliance with this subsection. Authorizes the period for submitting a claim under this subsection to be extended by contract. Prohibits a 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 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) Requires the insurer to make a determination of whether the claim is eligible for payment and take certain actions relating to that determination, not later than the 45th day after the date that the insurer receives a clean claim submitted by a preferred provider, except as provided by Subsection (e) or (f) of this section.

(d) Requires the insurer to take certain actions relating to payment of a claim, not later than the 21st day after the date an insurer affirmatively adjudicates a pharmacy claim that is electronically submitted. Deletes existing text related to payment of a prescription benefit claim.

(e) 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 and clearly indicate on the explanation of benefits statement in the manner prescribed by the commissioner by rule that the claim is being paid 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 and additional payment due a preferred provider following the audit. Makes a conforming change.

(f) Requires the insurer to request in writing that the preferred provider provide any additional information the insurer desires in good faith for clarification of the claim, not later than the 30th day after the date the insurer receives a claim, if an insurer needs additional information from a treating preferred provider to determine eligibility for 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. Prohibits the insurer from requesting certain information. Provides that if an insurer requests additional information under this subsection, the period for determining whether the claim is eligible for payment is extended by one day for each day after the date the insurer requests the additional information and before the date the insurer receives the additional information. Prohibits the insurer from making more then one request under this subsection in connection with a claim. Deletes existing text related to liability for violations of certain subsections of this section.

(g) Requires the commissioner to adopt rules to identify a submission by a physician or provider to an insurer that includes additional information requested by the insurer.

(h) Requires the insurer's clean claims payment processes to meet certain requirements.

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

(j) Provides that an insurer that violates Subsections (c), (d), (e), or (f) of this section in processing more than two percent of clean claims institutional providers or more than two percent of clean claims submitted to the insurer by preferred providers who are not institutional providers is subject to an administrative penalty under Chapter 84 (Administrative Penalties), rather than Article 1.10E, of this code. Prohibits the penalty, for each day an administrative penalty is imposed under this subsection, from exceeding $1,000 for each claim, rather than each day, that remains unpaid in violation of Subsections (c), (d), (e), or (f) of this section.

(k) Deletes existing text related to copies of certain materials an insurer is required to provide a preferred provider.

(l) Redesignates existing Subsection (m) as (l).

(m) Redesignates existing Subsection (n) as (m). Requires the commissioner to adopt rules as necessary to implement this section.

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

[Deletes existing Subsections (j), (k), and (l). Redesignates existing Subsections (h) and (i) as (j) and (k).]

SECTION 2. 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 10-13, as follows:

Sec. 3C. ELEMENTS OF CLEAN CLAIM. (a) Provides a claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted to an insurer for payment using Centers for Medicare and Medicaid Services Form 1500 or a successor to that form developed by the National Uniform Claim Committee (committee) or its successor and adopted by the commissioner by rule for purposes of this subsection and contains the information required by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form in the manner prescribed.

(b) Provides that a claim by an institutional provider is a "clean claim" if the claim is submitted to an insurer for payment using Centers for Medicare and Medicaid Services Form UB-92 or a successor to that form developed by the committee or its successor and adopted by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form in the manner prescribed.

(c) Prohibits the commissioner from requiring any data element for electronically filed claims that is not required to comply with federal law.

(d) Authorizes an insurer and a physician or provider to agree by contract that a claim that uses fewer elements than those required by the commissioner is a clean claim for the purposes of this article.

(e) Provides that a 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.

(f) Prohibits the provisions of this section from being waved, voided, or nullified by contract, except as provided by this section.

Sec. 3D. OVERPAYMENT. (a) Authorizes an insurer, except as provided by Subsection (b) of this section, to deduct the amount of an overpayment from any amount owed by the insurer to the physician or provider, or otherwise recover the amount of overpayment, if certain requirements are met.

(b) Prohibits the insurer from recovering the amount overpaid until the physician's or provider's right of appeal is exhausted, if a physician or provider exercises a right of appeal available under the physician's or provider's contract with the insurer with respect to an alleged overpayment.

Sec. 3E. AVAILABILITY OF CODING GUIDELINES. (a) Requires a preferred provider contract between an insurer and a physician or provider to include certain provisions related to coding guidelines, fee schedules, and contract termination.

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

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

(d) Authorizes nothing in this section to be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. Requires the insurer to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services provided to insureds.

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

Sec. 3F. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) Defines "preauthorization."

(b) 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 working day after the date a request is made, a list of certain services.

(c) 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.

(d) Requires the insurer to review and issue by mail or otherwise a determination indicating whether the proposed services are preauthorized, not later than the third day after the date an insurer receives a request form a preferred provider.

(e) Requires the insurer to review and issue a length of stay for the admission into a health care facility based on the insurer's written medically accepted screening criteria and review procedures, considering the recommendation of the patient's physician or health care provider, if the proposed medical care or health care services involve inpatient care and the insurer requires preauthorization as a condition of payment. Requires the insurer to review and issue a determination indicating whether proposed services are preauthorized on or before the calendar day after the date of request by the physician, if the proposed medical or health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed.

(f) 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 calendar day after the date the call is received.

(g) 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.

(h) 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.

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

Sec. 3G. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (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 insurer to inform the physician or provider without delay whether the service, if provided to that patient, is eligible for payment from the insurer to the physician or provider and whether a certificate of creditable coverage for the patient has been provided to the insurer by the group policyholder under Section 11 of this article, on the request of a physician or provider for verification of the eligibility for payment of a particular medial care or health care service the physician or provider proposes to provide to a particular patient.

(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 calendar day after the date the call is received.

(d) 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.

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

(f) Authorizes an insurer to establish a specific period during which the verification is valid.

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

Sec. 3H. COORDINATION OF PAYMENT. (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 claim form.

(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(c), (d), (e), or (f) of this article.

(c) Requires a physician or provider who submits a claim for particular medical care or 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 a claim for the same medial care or health care services is being filed. Authorizes the commissioner, by rule, to require claim elements under Section 3C of this article that facilitate coordination of payment. Requires a claim electronically submitted by the preferred provider for covered services or benefits for which there is other coverage that contains a coordination of benefits provision to include certain information related to the primary plan. Provides that the information is required for the claim submitted to the secondary plan to be a clean claim. Authorizes a preferred provider to file a claim with the secondary plan only after the preferred provider has received notice of the disposition of the claim by the primary plan.

(d) Requires an insurer processing an electronic claim as a secondary plan to rely on the primary plan information submitted on the claim by the preferred provider. Authorizes the insurer to ask for additional information from any source available, including certain persons and entities, subject to Section 3A of this article, if the secondary plan cannot determine liability based on the information provided by the physician or provider. Authorizes primary plan information to be submitted electronically by the primary plan to the secondary payor.

(e) Requires the secondary payor to first pursue recovery of the amount of the overpayment from the primary payor, if an insurer is a secondary payor and pays a portion of the claim that should have been paid by the insurer or health maintenance organization that is the primary payor. Requires the secondary payor to provide notice to the preferred provider of the overpayment and that recovery of the overpayment will be pursued from the primary payor. Authorizes the secondary payor to collect the amount of the overpayment from the preferred provider under Section 3D of this article, if the secondary payor is unable to collect the amount of the overpayment from

the primary payor. Provides that the time allowed to recover an overpayment from a preferred provider under this subsection in accordance with Section 3D of this article begins on the date the secondary payor notifies the preferred provider that recovery is being pursued from the primary payor.

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

Sec. 3I. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; PENALTY. (a) Provides that this section applies only to a clean claim eligible for payment.

(b) Requires an insurer that pays a clean claim after the date the insurer is required to pay the claim in accordance with Section 3A of this article and before the 46th day after that date to pay to the physician or provider the contracted rate owed by the insurer for the claim plus a penalty in the amount of the lesser of two certain amounts.

(c) Requires an insurer that pays a clean claim on or after the 46th day after the date the insurer is required to pay the claim in accordance with Section 3A of this article and before the 91st day after that date to pay to the physician or provider the contracted rate owed by the insurer for the claim plus a penalty in the amount of the lesser of two certain amounts.

(d) Requires an insurer that pays a clean claim on or after the 91st day after the date the insurer is required to pay the claim in accordance with Section 3A of this article to pay to the physician or provider the contracted rate owed by the insurer for the claim plus a penalty in the amount of the lesser of two certain amounts.

(e) Requires an insurer that pays only a portion os the amount of a clean claim on or before the date the insurer is required to pay the claim in accordance with Section 3A of this article and pays any portion of the balance of the contracted rate owed by the insurer for the claim before the 46th day after that date to pay to the physician or provider, in addition to the contracted rate owed by the insurer for the claim, a penalty in the amount of 50 percent of the amount paid after the date the insurer is required to pay the claim and before the 46th day after that date. Prohibits the penalty under this subsection from exceeding $100,000.

(f) Requires an insurer that pays only a portion os the amount of a clean claim on or before the date the insurer is required to pay the claim in accordance with Section 3A of this article and pays any portion of the balance of the contracted rate owed by the insurer for the claim before the 46th day after that date and before the 91st day after that date to pay to the physician or provider, in addition to the contracted rate owed by the insurer for the claim, a penalty in the amount of 100 percent of the amount paid after the date the insurer is required to pay the claim and before the 91st day after that date. Prohibits the penalty under this subsection from exceeding $200,000.

(g) Requires an insurer that pays only a portion of the amount of a clean claim on or before the date the insurer is required to pay the claim in accordance with Section 3A of this article and does not pay the balance of the contracted rate owed by the insurer for the claim before the 91st day after that date to pay to the physician or provider, in addition to the contracted rate owed by the insurer for the claim, a penalty in the amount of 100 percent of the amount that remains unpaid on the 91st day after the date the insurer is required to pay the claim plus simple interest on the amount of that difference and the amount of the contracted rate at a rate of 18 percent annually, computed beginning on the 91st day after the date the insurer is required to pay the claim and ending on the date of payment. Prohibits the penalty under this subsection

from exceeding $300,000.

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

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

Sec. 3J. AUTHORITY OF ATTORNEY GENERAL. (a) Authorizes the attorney general to take action and seek remedies available under Section 15, Article 21.21, of this code, and Sections 17.58 (Voluntary Compliance), 17.60 (Reports and Examinations), 17.61 (Civil Investigative Demand), and 17.62 (Penalties), Business and Commerce Code, in addition to any other remedy available for a violation of this article, for a violation of Section 3A or 7 of this article.

(b) Authorizes the attorney general, if the attorney general has good cause to believe that a physician or provider has failed in good faith to repay an insurer under Section 3D of this article, to take certain actions related to a repayment violation.

(c) Authorizes the attorney general, if the attorney general has good cause to believe that a physician or provider has improperly used or disclosed information received by the physician or provider under Section 3E of this article, to take certain actions related to a disclosure violation.

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

Sec. 11. TERMS OF ENROLLEE ELIGIBILITY. Requires a contract between an insurer and a group policyholder to provide certain information relating to the contract.

Sec. 12. PROOF OF COVERAGE. Requires a card or other similar document issued to an individual insured as proof of coverage to include certain information relating to specifics of the individuals coverage.

Sec. 13. CONFLICT WITH OTHER LAW. Provides that to the extent of any conflict between this article and Article 21.52C or Article 21.58A of this code, this article controls.

SECTION 3. Amends Chapter 843F, Insurance Code, as effective June 1, 2003, by adding Sections 843.209 and 843.210, as follows:

Sec. 843.209. TERMS OF ENROLLEE ELIGIBILITY. Requires a contract between a health maintenance organization and a group contract holder to provide certain information on the contract.

Sec. 843.210. PROOF OF COVERAGE. Requires a card or other similar document issued to an individual insured as proof of coverage to include certain information relating to specifics of the individual's coverage.

SECTION 4. Amends Chapter 843I, 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) Provides that nothing in this section may be construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. Requires the health maintenance organization to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services provided to enrollees.

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

SECTION 5. Amends Section 843.336, Insurance Code, as effective June 1, 2003, as follows:

Sec. 843.336. New heading: CLEAN CLAIM. (a) Defines "clean claim."

(b) Provides that a claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using Centers for Medicare and Medicaid Services Form 1500 or a successor to that form developed by the National Uniform Claim Committee or its successor and adopted by the commissioner by rule for the purposes of this subsection and contains the information required by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form in the manner prescribed.

(c) Provides that a claim by an institutional provider is a "clean claim" if the claim is submitted using Centers for Medicare or Medicaid Services Form UB-92 or a successor to that form developed by the National Uniform Billing Committee or its successor and adopted by the commissioner by rule for the purposes of this subsection and contains the information required by the commissioner by rule for the purpose of this subsection entered into the appropriate fields on the form in the manner prescribed.

(d) Prohibits the commissioner from requiring any data element for electronically filed claims that is not required to comply with federal law.

(e) Authorizes a health maintenance organization and a physician or provider to agree by contract that a claim that uses fewer elements than those required by the commissioner is a clean claim for the purposes of this section.

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

SECTION 6. 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. (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. Deletes existing text related to acknowledgment of receipt of a claim.

(b) Provides that if a physician or provider fails to submit a claim in compliance with Subsection (a), the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with Subsection (a) 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) Requires a health maintenance organization to accept as proof of timely filing information from another health benefit plan issuer showing that the physician or provider submitted the claim to the health benefit plan issuer in compliance with Subsection (a).

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

(e) Prohibits a physician or provider from submitting a duplicate claim for payment before the 46th day after the date the original claim was submitted.

(f) Requires the commissioner to adopt rules under which a health maintenance organization is authorized to determine whether a claim is a duplicate claim. Deletes existing text related to acknowledgment by a health maintenance organization of receipt of a claim electronically.

SECTION 7. Amends Section 843.338, Insurance Code, as effective June 1, 2003, to make a conforming change related to the addition of Sections 843.3385 and 843.340. Requires the health maintenance organization, not later than the 45th day after the date on which a health maintenance organization receives a clean claim submitted by, rather than from, a physician or provider, to make a determination of whether the claim is eligible for payment and certain actions related to the health maintenance organization determining the entire claim is eligible for payment.

SECTION 8. Amends Chapter 843J, 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 eligibility for payment, to request in writing that the physician or provider provide any additional information the health maintenance organization desires in good faith for clarification of the claim, not later than the 30th 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.

(c) Prohibits the health maintenance organization from requesting 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 the physician or provider.

(d) Provides that if the health maintenance organization requests additional information under this section, the period for determining whether the claim is eligible for payment is

extended by one day for each day after the date the health maintenance organization requests the additional information and before the date the health maintenance organization receives the additional information.

(e) Prohibits a health maintenance organization from making more than one request under this section in connection with a claim.

(f) Requires the commissioner to adopt rules to identify a submission by a physician or provider that includes additional information requested by the health maintenance organization.

SECTION 9. Amends Section 843.339, Insurance Code, as effective June 1, 2003, to require 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 or notify the pharmacy provider of the reasons for denying payment of the claim. Deletes existing text related to related to an electronically adjudicated and paid prescription benefit claim.

SECTION 10. 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 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 and clearly indicate on the explanation of benefits statement in the manner prescribed by the commissioner by rule that the claim is being paid subject to the completion of an audit.

(b) Requires the health maintenance organization to complete the audit on or before the 180th day after the date the health maintenance organization receives the claim.

(c) 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.

(d) Prohibits the health maintenance organization 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 or billing record maintained by a physician or provider.

(e) Authorizes the health maintenance organization, if a physician or provider does not supply information reasonably requested by the health maintenance organization in connection with the audit, to take certain actions related to the amount of the claim. Deletes existing text related to additional payments or refunds due after the completion of the audit.

SECTION 11. Amends Chapter 843J, Insurance Code, as effective June 1, 2003, by adding Sections 843.3401, 843.3404, and 843.3405, as follows:

Sec. 843.3401. OVERPAYMENT. (a) Authorizes a health maintenance organization, except as provided by Subsection (b), to deduct the amount of an overpayment from any amount owed by the health maintenance organization to the physician or provider, or otherwise recover the amount of overpayment if certain conditions related to repayment are met.

(b) Authorizes the health maintenance organization, if a physician or provider exercises

a right of appeal available under the physician's or provider's contract with the health maintenance organization with respect to an alleged overpayment, to recover the amount overpaid until the physician's or provider's right of appeal is exhausted.

Sec. 843.3404. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) Defines "verification." Provides that the term includes certain terms that would be a reliable representation by a health maintenance organization to a physician or provider.

(b) Requires the health maintenance organization, on the request of a physician or provider for verification of the payment eligibility of a particular health care service the physician or provider proposes to provide to a particular patient, to inform the physician or provider without delay whether the service, if provided to that patient, is eligible for payment from the health maintenance organization to the physician or provider and whether a certificate of creditable coverage for the patient has been provided to the health maintenance organization by the group contract holder under Section 843.209.

(c) Requires a health maintenance organization to have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section 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 verifications 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 calender day after the date the call is received.

(d) Authorizes a health maintenance organization to decline to determine eligibility for payment if the health maintenance organization notifies the physician or 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.

(f) Prohibits a health maintenance organization, if the health maintenance organization has provided a verification for health care services, from denying or reducing payment to the physician or provider for those health care services if those services are provided to the enrollee during the calender month in which 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. 843.3405. PREAUTHORIZATION OF HEALTH CARE SERVICES. (a) Defines "preauthorization."

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

(c) Requires the health maintenance organization, if proposed health care services require preauthorization as a condition of the health maintenance organization's payment to a participating physician or provider, to determine whether the health care services proposed to be provided to the enrollee are medically necessary and

appropriate.

(d) Requires the health maintenance organization, not later than the third day after the date a health maintenance organization receives a request from a participating physician or provider for preauthorization, to review and issue by mail or otherwise a determination indicating whether the proposed services are preauthorized.

(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 health maintenance organization's written medically accepted screening criteria and review procedures, considering the recommendation of the patient's physician and provider. Requires the health maintenance organization, if the proposed health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, to review and issue a determination indicating whether proposed services are preauthorized on or before the calender day after the date of the request by the physician or provider.

(f) Requires a health maintenance organization to have appropriate personnel reasonably available at a toll-free telephone number to respond to a request 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 verifications 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 calender day after the date the call is received.

(g) Prohibits the health maintenance organization, if the health maintenance organization has preauthorized health care services, from denying or reducing payment to the physician or provider for those health care services if those services are provided to the enrollee during the calender month in which 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.

SECTION 12. 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 clean 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 13. Amends Chapter 843J, Insurance Code, as effective June 1, 2003, by adding Section 843.3411, as follows:

Sec. 843.3411. 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 other health benefit plan coverage and to provide the information to the health maintenance organization on the applicable claim form. Prohibits health maintenance organization 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 843.338,

843.3385, 843.339, or 843.340.

(c) Requires a physician or provider who submits a claim for particular medical care or 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 with which a claim for the same medical care or health care services is being filed. Authorizes the commissioner, by rule, to require claim elements under Section 843.336 that facilitate coordination of payment. Requires a claim electronically submitted by the physician or provider for covered services or benefits for which there is other coverage that contains a coordination of benefits provision to include certain information as a covered claim by the primary plan. Provides that the information is required for the claim submitted to the secondary plan to be a clean claim. Authorizes a physician or provider to file a claim with the secondary plan only after the physician or provider has received notice of the disposition of the claim by the primary plan.

(d) Requires a health maintenance organization processing an electronic claim as a secondary plan to rely on the primary plan information submitted on the claim by the physician or provider. Authorizes the health maintenance organization, if the secondary plan cannot determine liability based on the information provided by the physician or provider, to ask for additional informaiton from any source available, including certain persons, subject to Sections 843.338, 843.3385, 843.339, and 843.340. Authorizes primary plan information to be submitted electronically by the primary plan to the secondary payor.

(e) Requires the secondary payor, if a health maintenance organization is a secondary payor and pays a portion of the claim that should have been paid by the insurer or health maintenance organization that is the primary payor, to first pursue recovery of the amount of the overpayment from the primary payor. Requires the secondary payor to provide notice to the physician or provider of the overpayment and that recovery of the overpayment will be pursued from the primary payor. Authorizes the secondary payor, if the secondary payor is unable to collect the amount of the overpayment from the primary payor, to collect the amount of the overpayment from the physician or provider under Section 843.3401. Provides that the time allowed to recover an overpayment from a physician or provider under this subsection in accordance with Section 843.3401 begins on the date the secondary payor notifies the physician or provider that recovery is being pursued form the primary payor.

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) Provides that this section applies only to a clean claim eligible for payment.

(b) Requires a health maintenance organization that pays a clean claim after the date the health maintenance organization is required to pay the claim in accordance with this subchapter and before the 46th day after that date to pay to the physician or provider the contracted rate owed by the health maintenance organization for the claim plus a penalty in the amount of the lesser of certain fees.

(c) Requires a health maintenance organization that pays a clean claim on or after the 46th day after the date the health maintenance organization is required to pay the claim in accordance with this subchapter and before the 91st day after that date to pay to the physician or provider the contracted rate owed by the health maintenance organization

for the claim plus a penalty in the amount of the lesser of certain fees.

(d) Requires health maintenance organization that pays a clean claim on or after the 91st day after the date the health maintenance organization is required to pay the claim in accordance with this subchapter to pay the physician or provider the contracted rate owed by the health maintenance organization for the claim plus a penalty in the amount of the lesser of certain fees.

(e) Requires a health maintenance organization that pays only a portion of the amount of a clean claim on or before the date the health maintenance organization is required to pay the claim in accordance with this subchapter and pays any portion of the balance of the contracted rate owed by the health maintenance organization for the claim before the 46th day after that date to pay to the physician or provider, in addition to the contracted rate owed by the health maintenance organization for the claim, a penalty in the amount of 50 percent of the amount paid after the date the health maintenance organization is required to pay the claim and before the 46th day after that date. Prohibits a penalty under this subsection from exceeding $100,000.

(f) Requires health maintenance organization that pays only a portion of the amount of a clean claim on or before the date the health maintenance organization is required to pay the claim in accordance with this subchapter and pays any portion of the balance of the contracted rate owed by the health maintenance organization for the claim on or after the 46th day after that date and before the 91st day after that date to pay to the physician or provider, in addition to the contracted rate owed by the health maintenance organization for the claim, a penalty in the amount of 100 percent of the amount paid after the date the health maintenance organization is required to pay the claim and before the 91st day after that date. Prohibits the penalty under this subsection from exceeding $200,000.

(g) Requires a health maintenance organization that pays only a portion of the amount of a clean claim on or before the date the health maintenance organization is required to pay the claim in accordance with this subchapter and does not pay the balance of the contracted rate owed by the health maintenance organization for the claim before the 91st day after that date to pay to the physician or provider, in addition to the contracted rate owed by the health maintenance organization for the claim, a penalty in the amount of 100 percent of the amount that remains unpaid on the 91st day after the date the health maintenance organization is required to pay the claim plus simple interest on the amount of that difference and the amount of the contracted rate at a rate of 18 percent annually, computed beginning on the 91st day after the date the health maintenance organization is required to pay the claim and ending on the date of payment. Prohibits a penalty under this subsection from exceeding $300,000.

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

(i) Requires a health maintenance organization that pays a penalty under this section to clearly indicate on the explanation of benefits 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.

(j) Provides that a health maintenance organization that violates Section 843.338, 843.3385, 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, 843.3385, 843.339, and 843.340. Deletes text relating to health maintenance organization's liability for violating Sections 843.338 or 843.340.

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 843.345, Insurance Code, as effective June 1, 2003, to delete existing text relating to a claim submitted by a physician or provider who is a member of the legislature. Makes conforming and nonsubstantive changes.

SECTION 17. Amends Chapter 843J, Insurance Code, as effective June 1, 2003, by adding Sections 843.347, 843.348, and 843.349, as follows:

Sec. 843.347. 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 services apply to a physician or provider who meets certain conditions.

Sec. 843.348. CONFLICT WITH OTHER LAW. Provides that to the extent of any conflict between this subchapter and Article 21.52C or Article 21.58A, this subchapter controls.

Sec. 843.349. WAIVER PROHIBITED. Prohibits the provisions of this subchapter from being waived, voided, or nullified by contract, except as provided by Section 843.337(d).

SECTION 18. Amends Chapter 843N, Insurance Code, by adding Section 843.465, as follows:

Sec. 843.465. AUTHORITY OF ATTORNEY GENERAL. (a) Authorizes the attorney general, in addition to any other remedy available for a violations of this chapter, to take action and seek remedies available under Section 15, Article 21.21, and Sections 17.58, 17.60, 17.61, and 17.62, Business and Commerce Code (Deceptive Trade Practices), for a violation of Section 843.281, 843.363, or 843.314, or Subchapter J.

(b) Authorizes the attorney general, if the attorney general has good cause to believe that a physician or provider has failed in good faith to repay a health maintenance organization under Section 843.3401, to take certain actions.

(c) Authorizes the attorney general, if the attorney general has good cause to believe that a physician or provider is or has improperly used or disclosed information received by the physician or provider under Section 843.319, to take certain actions.

SECTION 19. Amends Chapter 21E, 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 feasibility of and factors involved in standardization of 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.

Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

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

Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. Requires 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.

Sec. 2A. TEMPORARY PROVISION: ELECTRONIC SUBMISSION OF CLAIMS. (a) Provides that an issuer of a health benefit plan is not required to require a health care professional or facility to comply with the provision required by Section 2 of this article before September 1, 2006.

(b) Authorizes an 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 before September, 1, 2006. 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.

(c) Requires a contract entered into before September 1, 2006, 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 Subsection (b) of this section.

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

(e) Authorizes any health 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 determine whether a waiver is required to be granted.

(f) Provides that this section expires September 1, 2007.

Sec. 3. 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. 4. 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 20. Requires the commissioner, as soon as possible, 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 21. Makes applications of this Act prospective to the 60th day after the effective day of this Act.

SECTION 22. Effective date: upon passage or September 1, 2003.