By: Eiland H.B. No. 720

A BILL TO BE ENTITLED

AN ACT

relating to the regulation and prompt payment of health care providers under certain health benefit plans; providing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

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

(14) "Preauthorization" means a determination by the insurer that the medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

(15) "Verification" means a reliable representation by an insurer to a physician or health care provider that the insurer will pay the physician or provider for proposed medical care or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other term that would be a reliable representation by an insurer to a physician or provider.

SECTION 2. Section 3A, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, is amended to read as follows:

Sec. 3A. PROMPT PAYMENT OF PREFERRED PROVIDERS. (a) In this section, "clean claim" means a [~~completed~~] claim that complies

with Section 3B of this article[~~, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy~~].

(b) A physician or [~~preferred~~] provider must 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. An insurer shall accept as proof of timely filing a claim filed in compliance with Subsection (c) of this section or information from another insurer showing that the physician or provider submitted the claim to the insurer in compliance with Subsection (c) of this section. 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. The period for submitting a claim under this subsection may be extended by contract. A physician or provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted. The commissioner shall adopt rules under which an insurer may determine whether a claim is a duplicate claim [~~for medical care or health care services under a health insurance policy may obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim by United States mail, return receipt requested. An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge~~

~~receipt of the claim by an electronic transmission to the preferred provider and is not required to acknowledge receipt of the claim by the insurer in writing~~].

(c) A physician or provider shall, as appropriate:

(1) mail a claim by United States mail, first class, or by overnight delivery service, and maintain a log of mailed claims and include a copy of the log with the relevant mailed claim, and fax a copy of the log to the insurer and maintain a copy of the fax verification;

(2) submit the claim electronically and maintain a log of electronically submitted claims;

(3) fax the claim and maintain a log of all faxed claims; or

(4) hand deliver the claim and maintain a log of all hand-delivered claims.

(d) 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 third 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. 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 or the insurer's clearinghouse. If the insurer or the insurer's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or provider, the physician's or provider's clearinghouse shall provide the confirmation. The physician's or provider's clearinghouse must

be able to verify that the filing contained the correct payor identification of the entity to receive the filing. If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed. The commissioner shall promulgate a form to be submitted by the physician or provider that easily identifies all claims included in each filing and that can be used by a physician or provider as the physician's or provider's log.

(e) Not later than the 45th day after the date that the insurer receives a clean claim from a preferred provider, the insurer shall make a determination of whether the claim is eligible for payment and:

(1) if the insurer determines the entire claim is eligible for payment, pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) if the insurer determines a portion of the claim is eligible for payment, pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not eligible for payment, notify the preferred provider in writing why the claim will not be paid.

(f) Not later than the 21st day after the date an insurer affirmatively adjudicates a pharmacy claim that is electronically submitted, the insurer shall:

(1) pay the total amount of the claim; or

(2) notify the pharmacy provider of the reasons for denying payment of the claim.

(g) An insurer that determines under Subsection (e) of this section that a claim is eligible for payment and does not pay the claim on or before the 45th day after the date the insurer receives a clean claim shall pay the physician or provider making the claim the lesser of the full amount of billed charges submitted on the claim and interest on the billed charges at a rate of 15 percent annually or two times the contracted rate and interest on that amount at a rate of 15 percent annually. If the provider submits the claim using a form described by Section 3B(a) of this article, billed charges shall be established under a fee schedule provided by the preferred provider to the insurer on or before the 30th day after the date the physician or provider enters into a preferred provider contract with the insurer. The preferred provider may modify the fee schedule if the provider notifies the insurer of the modification on or before the 90th day before the date the modification takes effect.

(h) The investigation and determination of eligibility for payment, including any coordination of other payments, does not extend the period for determining whether a claim is eligible for payment under Subsection (e) of this section [~~(d) If a prescription benefit claim is electronically adjudicated and electronically paid, and the preferred provider or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized~~].

(i) Except as provided by Subsection (j) of this section, if [~~(c) If~~] the insurer [~~acknowledges coverage of an insured under the health insurance policy but~~] intends to audit the preferred provider claim, the insurer shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the insurer receives the claim from the preferred provider. The insurer must complete [~~Following completion of~~] the audit, and any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 90th [~~30th~~] day after the receipt of a claim or 45 days after receipt of a requested attachment from the preferred provider, whichever is later [~~of the date that:~~

[~~(1) the preferred provider receives notice of the audit results; or~~

[~~(2) any appeal rights of the insured are exhausted~~].

(j) If an insurer needs additional information from a treating preferred provider to determine eligibility for payment, the insurer, not later than the 30th calendar day after the date the insurer receives a clean claim, shall request in writing that the preferred provider provide any attachment to the claim the insurer desires in good faith for clarification of the claim. The request must 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. An insurer that requests an attachment under this subsection shall determine whether the claim is eligible for payment 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 eligible for payment under Subsection (e) of this section. An insurer may not make more than one request under this subsection in connection with a claim. Subsections (c) and (d) of this section apply to a request for and submission of an attachment under this subsection.

(k) If an insurer requests an attachment or other information from a person other than the preferred provider who submitted the claim, the insurer shall provide a copy of the request to the preferred provider who submitted the claim. The insurer may not withhold payment pending receipt of an attachment or information requested under this subsection. If on receiving an attachment or information requested under this subsection the insurer determines an error in payment of the claim, the insurer may recover under Section 3C of this article.

(l) The commissioner shall adopt rules under which an insurer can easily identify attachments or information submitted by a physician or provider under Subsection (j) or (k) of this section.

(m) The insurer's claims payment processes shall:

(1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines including all relevant modifiers; and

(2) be consistent with nationally recognized, generally accepted bundling logic and edits [~~(f) An insurer that violates Subsection (c) or (e) of this section is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty~~

~~rate, less any amount previously paid or any charge for a service that is not covered by the health insurance policy~~].

(n) [~~(g)~~] A preferred provider may recover reasonable attorney's fees and court costs in an action to recover payment under this section.

(o) [~~(h)~~] In addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Subsection (e) [~~(c)~~] or (i) [~~(e)~~] of this section is subject to an administrative penalty under Article 1.10E of this code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of Subsection (e) [~~(c)~~] or (i) [~~(e)~~] of this section.

(p) [~~(i)~~] The insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures[~~, including required data elements and claim formats~~].

(q) [~~(j) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with the preferred provider claim.~~

[~~(k) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider.~~

[~~(l) This section does not apply to a claim made by a preferred provider who is a member of the legislature.~~

[~~(m)~~] This section applies to a person with whom an insurer

contracts to process claims or to obtain the services of preferred providers to provide medical care or health care to insureds under a health insurance policy.

(r) [~~(n)~~] The commissioner of insurance may adopt rules as necessary to implement this section.

(s) Except as provided by Subsection (b) of this section, the provisions of this section may not be waived, voided, or nullified by contract.

SECTION 3. Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, is amended by adding Sections 3B-3I, 10, 11, and 12 to read as follows:

Sec. 3B. ELEMENTS OF CLEAN CLAIM. (a) A claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using Health Care Financing Administration Form 1500 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 that is submitted to an insurer for payment and that 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) A claim by an institutional provider is a "clean claim" if the claim is submitted using Health Care Financing Administration 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 that

is submitted to an insurer for payment and that contains the information required by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form.

(c) An insurer may require any data element that is required in an electronic transaction set needed to comply with federal law. An insurer may not require a physician or provider to provide information other than information for a data field included on the form used for a clean claim under Subsection (a) or (b) of this section, as applicable.

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

(e) Except as provided by this section, the provisions of this section may not be waived, voided, or nullified by contract.

Sec. 3C. OVERPAYMENT. An insurer may recover an overpayment to a physician or provider if:

(1) not later than the 180th day after the date the physician or provider receives the payment, the insurer provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds; and

(2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the notice.

Sec. 3D. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) On

the request of a preferred provider for verification of the eligibility for payment of a particular medical care or health care service the preferred provider proposes to provide to a particular patient, the insurer shall inform the preferred provider whether the service, if provided to that patient, is eligible for payment from the insurer to the preferred provider.

(b) An insurer shall provide 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 12 p.m. on Saturday, Sunday, and legal holidays.

(c) Verification under this section shall be made in good faith and without delay.

(d) In this section, "verification" includes preauthorization only when preauthorization is a condition for the determination of eligibility for payment.

(e) An insurer that declines to provide a verification of eligibility for payment shall notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(f) An insurer may establish a time certain for the validity of verification.

(g) If an insurer has verified medical care or health care services, the insurer may not deny or reduce payment to a physician or health care provider for those services unless:

(1) 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; or

(2) the insurer certifies in writing:

(A) that the physician or provider is not contractually obligated to provide the services to the patient because the patient's enrollment in the health plan was terminated;

(B) the insurer was notified on or before the 30th day after the date the patient's enrollment ended; and

(C) the physician or provider was notified that the patient's enrollment ended on or before the 30th day after the date of verification under this section.

(h) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 3E. COORDINATION OF PAYMENT. (a) An insurer may 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 3B of this article. Except as provided in this subsection, an insurer may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of payment under this section does not extend the period for determining whether a service is eligible for payment under Section 3A(e) of this article.

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

(e) 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, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary insurer was also paid by the primary health maintenance organization or insurer, the secondary insurer may recover the amount of overpayment under Section 3C of this article from the physician or provider who received the payment.

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

(h) The provisions of this section may not be waived, voided, or nullified by contract.

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

services that require preauthorization and information concerning the preauthorization process.

(b) 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, the insurer shall determine whether the medical care or health care services proposed to be provided to the insured are medically necessary and appropriate.

(c) On receipt of a request from a preferred provider for preauthorization, the insurer shall review and issue a determination indicating whether the proposed services are preauthorized. The determination must be mailed or otherwise transmitted not later than the third calendar day after the date the request is received by the insurer.

(d) If the proposed medical care or health care services involve inpatient care and the insurer requires preauthorization as a condition of payment, the insurer shall 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 health care provider and the insurer's written medically accepted screening criteria and review procedures. 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, the insurer shall review and issue a determination indicating whether proposed services are preauthorized within one calendar day of the request by the physician or health care provider.

(e) If an insurer has preauthorized medical care or health

care services, the insurer may not deny or reduce 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.

(f) 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.

(g) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 3G. AVAILABILITY OF CODING GUIDELINES. (a) A preferred provider contract between an insurer and a physician or provider must provide that:

(1) the physician or provider may request a description of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the physician or provider will receive under the contract;

(2) the insurer or the insurer's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the insurer receives the request;

(3) the insurer will provide notice of material changes to the coding guidelines and fee schedules not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee

schedules; and

(4) the contract may be terminated by the physician or provider on or before the 30th day after the date the physician or provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A physician or provider who receives information under Subsection (a) of this section may use or disclose the information only for the purpose of practice management, billing activities, or other business operations.

(c) Nothing in this section shall be interpreted to require an insurer to violate copyright or other law by disclosing proprietary software that the insurer has licensed. In addition to the above, the insurer shall, on request of a physician or provider, provide the name, edition, and model version of the software that the insurer uses to determine bundling and unbundling of claims.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 3I. AUTHORITY OF ATTORNEY GENERAL. (a) In addition to any other remedy available for a violation of this article, the attorney general may take action and seek remedies available under Section 15, Article 21.21 of this code, and Sections 17.58, 17.60, 17.61, and 17.62, Business & Commerce Code, for a violation of Section 3A or 7 of this article.

(b) 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 3C of this article, the attorney general may:

(1) bring an action to compel the physician or provider to repay the insurer;

(2) on the finding of a court that the physician or provider has violated Section 3C, impose a civil penalty of not more than the greater of $1,000 or two times the amount in dispute for each violation; and

(3) recover court costs and attorney's fees.

(c) 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 3G of this article, the attorney general may:

(1) bring an action seeking an injunction against the physician or provider to restrain the improper use or disclosure of information;

(2) on the finding of a court that the physician or provider has violated Section 3G, impose a civil penalty of not more than $1,000 for each negligent violation or $10,000 for each intentional violation; and

(3) recover court costs and attorney's fees.

Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH CARE PROVIDERS. 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:

(1) is not a preferred provider under a preferred provider benefit plan; and

(2) provides to an insured:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network.

Sec. 11. CONFLICT WITH OTHER LAW. To the extent of any conflict between this article and Article 21.52C of this code, this article controls.

Sec. 12. APPLICATION OF CERTAIN PROVISIONS UNDER MEDICAID. A provision of this article may not be interpreted as requiring an insurer, physician, or health care provider, in providing benefits or services under the state Medicaid program, to:

(1) use billing forms or codes that are inconsistent with those required under the state Medicaid program; or

(2) make determinations relating to medical necessity or appropriateness or eligibility for coverage in a manner different than that required under the state Medicaid program.

SECTION 4. Section 2, Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code), is amended by adding Subdivisions (ff) and (gg) to read as follows:

(ff) "Preauthorization" means a determination by the health maintenance organization that the medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

(gg) "Verification" means a reliable representation by a health maintenance organization to a physician or provider

that the health maintenance organization will pay the physician or provider for proposed medical care or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other term that would be a reliable representation by a health maintenance organization to a physician or provider.

SECTION 5. Section 18B, Texas Health Maintenance Organization Act (Section 20A.18B, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 18B. PROMPT PAYMENT OF PHYSICIAN AND PROVIDERS. (a) In this section, "clean claim" means a [~~completed~~] claim that complies with Section 18D of this Act[~~, as determined under Texas Department of Insurance rules, submitted by a physician or provider for medical care or health care services under a health care plan~~].

(b) A physician or provider must submit a claim under this section 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. A health maintenance organization shall accept as proof of timely filing a claim filed in compliance with Subsection (c) of this section or information from another health maintenance organization showing that the physician or provider submitted the claim to the health maintenance organization in compliance with Subsection (c) of this section. 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. The period for submitting a claim under this subsection may be extended by contract. A physician or provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted. The commissioner shall adopt rules under which a health maintenance organization may determine whether a claim is a duplicate claim. [~~A physician or provider for medical care or health care services under a health care plan may obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim by United States mail, return receipt requested. A health maintenance organization or the contracted clearinghouse of the health maintenance organization that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the physician or provider and is not required to acknowledge receipt of the claim by the health maintenance organization in writing.~~]

(c) A physician or provider shall, as appropriate:

(1) mail a claim by United States mail, first class, or by overnight delivery service, and maintain a log of mailed claims and include a copy of the log with the relevant mailed claim, and fax a copy of the log to the health maintenance organization and maintain a copy of the fax verification;

(2) submit the claim electronically and maintain a log of electronically submitted claims;

(3) fax the claim and maintain a log of all faxed claims; or

(4) hand deliver the claim and maintain a log of all hand-delivered claims.

(d) 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 health maintenance organization on the third 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. 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. If the health maintenance organization or the health maintenance organization's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or provider, the physician's or provider's clearinghouse shall provide the confirmation. The physician's or provider's clearinghouse must be able to verify that the filing contained the correct payor identification of the entity to receive the filing. If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed. The commissioner shall promulgate a form to be submitted by the physician or provider which easily identifies all claims included in each filing which can be utilized by the physician or provider as their log.

(e) Not later than the 45th day after the date that the health maintenance organization receives a clean claim from a physician or provider, the health maintenance organization shall make a determination of whether the claim is eligible for payment and:

(1) if the health maintenance organization determines the entire claim is eligible for payment, pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) if the health maintenance organization determines a portion of the claim is eligible for payment, pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) if the health maintenance organization determines that the claim is not eligible for payment, notify the physician or provider in writing why the claim will not be paid.

(f) Not later than the 21st day after the date a health maintenance organization or the health maintenance organization's designated agent affirmatively adjudicates a pharmacy claim that is electronically submitted, the health maintenance organization shall:

(1) pay the total amount of the claim; or

(2) notify the pharmacy provider of the reasons for denying payment of the claim.

(g) A health maintenance organization that determines under Subsection (e) of this section that a claim is eligible for payment

and does not pay the claim on or before the 45th day after the date the health maintenance organization receives a clean claim shall pay the physician or provider making the claim the lesser of the full amount of billed charges submitted on the claim and interest on the billed charges at a rate of 15 percent annually or two times the contracted rate and interest on that amount at a rate of 15 percent annually. If the physician or provider submits the claim using a form described by Section 18D(a) of this Act, billed charges shall be established under a fee schedule provided by the physician or provider to the health maintenance organization on or before the 30th day after the date the physician or provider enters into the contract with the health maintenance organization. The physician or provider may modify the fee schedule if the physician or provider notifies the health maintenance organization of the modification on or before the 90th day before the date the modification takes effect.

(h) The investigation and determination of eligibility for payment, including any coordination of other payments, does not extend the period for determining whether a claim is eligible for payment under Subsection (e) of this section [~~(d) If a prescription benefit claim is electronically adjudicated and electronically paid, and the health maintenance organization or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized~~].

(i) Except as provided by Subsection (j) of this section, if [~~(e) If~~] the health maintenance organization [~~acknowledges coverage of an enrollee under the health care plan but~~] intends to

audit the physician or provider claim, the health maintenance organization shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the health maintenance organization receives the claim from the physician or provider. The health maintenance organization shall complete [~~Following completion of~~] the audit, and any additional payment due a physician or provider or any refund due the health maintenance organization shall be made not later than the 90th [~~30th~~] day after the receipt of a claim or 45 days after receipt of a requested attachment from the physician or provider, whichever is later [~~later of the date that:~~

[~~(1) the physician or provider receives notice of the audit results; or~~

[~~(2) any appeal rights of the enrollee are exhausted~~].

(j) If a health maintenance organization needs additional information from a treating physician or provider to determine eligibility for payment, the health maintenance organization, not later than the 30th calendar day after the date the health maintenance organization receives a clean claim, shall request in writing that the physician or provider provide any attachment to the claim the health maintenance organization desires in good faith for clarification of the claim. The request must 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. A health maintenance organization that requests an attachment under this subsection shall determine whether the claim is eligible for

payment 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 eligible for payment under Subsection (e) of this section. A health maintenance organization may not make more than one request under this subsection in connection with a claim. Subsections (c) and (d) of this section apply to a request for and submission of an attachment under this subsection.

(k) If a health maintenance organization requests an attachment or other information from a person other than the physician or provider who submitted the claim, the health maintenance organization shall provide a copy of the request to the physician or provider who submitted the claim. The health maintenance organization may not withhold payment pending receipt of an attachment or information requested under this subsection. If on receiving an attachment or information requested under this subsection the health maintenance organization determines an error in payment of the claim, the health maintenance organization may recover under Section 18E of this Act.

(l) The commissioner shall adopt rules under which a health maintenance organization can easily identify attachments or information submitted by a physician or provider.

(m) A health maintenance organization's claims payment processes must:

(1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers; and

(2) be consistent with nationally recognized, generally accepted bundling logic and edits [~~(f) A health maintenance organization that violates Subsection (c) or (e) of this section is liable to a physician or provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health care plan~~].

(n) [~~(g)~~] A physician or provider may recover reasonable attorney's fees and court costs in an action to recover payment under this section.

(o) [~~(h)~~] In addition to any other penalty or remedy authorized by the Insurance Code or another insurance law of this state, a health maintenance organization that violates Subsection (e) [~~(c)~~] or (i) [~~(e)~~] of this section is subject to an administrative penalty under Article 1.10E, Insurance Code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of Subsection (e) [~~(c)~~] or (i) [~~(e)~~] of this section.

(p) [~~(i)~~] The health maintenance organization shall provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures[~~, including required data elements and claim formats~~].

(q) [~~(j) A health maintenance organization may, by contract with a physician or provider, add or change the data elements that must be submitted with the physician or provider claim.~~

[~~(k) Not later than the 60th day before the date of an~~

~~addition or change in the data elements that must be submitted with a claim or any other change in a health maintenance organization's claim processing and payment procedures, the health maintenance organization shall provide written notice of the addition or change to each participating physician or provider.~~

[~~(l) This section does not apply to a claim made by a physician or provider who is a member of the legislature.~~

[~~(m)~~] This section does not apply to a capitation payment required to be made to a physician or provider under an agreement to provide medical care or health care services under a health care plan.

(r) [~~(n)~~] This section applies to a person with whom a health maintenance organization contracts to process claims or to obtain the services of physicians and providers to provide health care services to health care plan enrollees.

(s) [~~(o)~~] The commissioner may adopt rules as necessary to implement this section.

(t) Except as provided by Subsection (b) of this section, the provisions of this section may not be waived, voided, or nullified by contract.

SECTION 6. The Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) is amended by adding Sections 18D-18L, 40, and 41 to read as follows:

Sec. 18D. ELEMENTS OF CLEAN CLAIM. (a) A claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using Health Care Financing Administration Form 1500 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 that is submitted to a health maintenance organization for payment and that 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) A claim by an institutional provider is a "clean claim" if the claim is submitted using Health Care Financing Administration 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 that is submitted to a health maintenance organization for payment and that contains the information required by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form.

(c) A health maintenance organization may require any data element that is required in an electronic transaction set needed to comply with federal law. A health maintenance organization may not require a physician or provider to provide information other than information for a data field included on the form used for a clean claim under Subsection (a) or (b) of this section, as applicable.

(d) A claim submitted by a physician or provider that includes additional 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.

(e) Except as provided by this section, the provisions of this section may not be waived, voided, or nullified by contract.

Sec. 18E. OVERPAYMENT. A health maintenance organization may recover an overpayment to a physician or provider if:

(1) not later than the 180th day after the date the physician or provider receives the payment, the health maintenance organization provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds; and

(2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the notice.

Sec. 18F. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) On the request of a physician or provider for verification of the payment eligibility of a particular medical care or health care service the physician or provider proposes to provide to a particular patient, the health maintenance organization shall inform the physician or provider whether the service, if provided to that patient, is eligible for payment from the health maintenance organization to the physician or provider.

(b) A health maintenance organization shall provide 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 12 p.m. on Saturday, Sunday, and legal holidays.

(c) Verification under this section shall be made in good faith and without delay.

(d) In this section, "verification" includes

preauthorization only when preauthorization is a condition for the determination of eligibility for payment.

(e) A health maintenance organization that declines to provide a verification of eligibility for payment shall notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(f) A health maintenance organization may establish a time certain for the validity of verification.

(g) If a health maintenance organization has verified medical care or health care services, the health maintenance organization may not deny or reduce payment to a physician or health care provider for those services unless:

(1) 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; or

(2) the health maintenance organization certifies in writing:

(A) that the physician or provider is not contractually obligated to provide services to the patient because the patient's enrollment in the health plan was terminated;

(B) the health maintenance organization was notified on or before the 30th day after the date the patient's enrollment ended; and

(C) the physician or provider was notified that the patient's enrollment ended on or before the 30th day after the date of verification under this section.

(h) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 18G. COORDINATION OF PAYMENT BENEFITS. (a) A health maintenance organization may 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 form described by Section 18D of this Act. Except as provided by this subsection, a health maintenance organization may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of other payment under this section does not extend the period for determining whether a service is eligible for payment under Section 18B(e) of this Act.

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

(e) 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, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary health maintenance organization was also paid by the primary health maintenance organization or insurer, the secondary health maintenance organization may recover the amount of the overpayment under Section 18E of this Act from the physician or provider who received the payment.

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

(h) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 18H. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) A health maintenance organization that uses a preauthorization process for medical care and health care services shall provide each participating physician or provider, not later than the 10th working day after the date a request is made, a list of the medical care and health care services that do not require preauthorization and information concerning the preauthorization process.

(b) If proposed medical care or health care services require preauthorization by a health maintenance organization as a condition of the health maintenance organization's payment to a

physician or provider, the health maintenance organization shall determine whether the medical care or health care services proposed to be provided to the enrollee are medically necessary and appropriate.

(c) On receipt of a request from a physician or provider for preauthorization, the health maintenance organization shall review and issue a determination indicating whether the services are preauthorized. The determination must be mailed or otherwise transmitted not later than the third calendar day after the date the request is received by the health maintenance organization.

(d) If the proposed medical care or health care services involve inpatient care and the health maintenance organization requires preauthorization as a condition of payment, the health maintenance organization shall 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 health care provider and the health maintenance organization's written medically accepted screening criteria and review procedures. 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, the health maintenance organization shall review and issue a determination indicating whether proposed services are preauthorized within one calendar day of the request by the physician or health care provider.

(e) If the health maintenance organization has preauthorized medical care or health care services, the health maintenance organization may not deny or reduce 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.

(f) 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 medical care or health care services.

(g) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 18I. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. The provisions of this Act relating to prompt payment by a health maintenance organization of a physician or provider and to verification of medical care or health care services apply to a physician or provider who:

(1) is not included in the health maintenance organization delivery network; and

(2) provides to an enrollee:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the health maintenance organization or a physician or provider who is included in the health maintenance organization delivery network because the services are not reasonably available within the network.

Sec. 18J. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a health maintenance organization and a physician or provider must provide that:

(1) the physician or provider may request a description of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the physician or provider will receive under the contract;

(2) the health maintenance organization will provide the coding guidelines and fee schedules not later than the 30th day after the date the health maintenance organization receives the request;

(3) the health maintenance organization will provide notice of material changes to the coding guidelines and fee schedules not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) the contract may be terminated by the physician or provider on or before the 30th day after the date the physician or provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A physician or provider who receives information under Subsection (a) of this section may use or disclose the information only for the purpose of practice management, billing activities, or other business operations.

(c) Nothing in this section shall be interpreted to require

a health maintenance organization to violate copyright or other law by disclosing proprietary software that the health maintenance organization has licensed. In addition to the above, the health maintenance organization shall, on request of the physician or provider, provide the name, edition, and model version of the software that the health maintenance organization uses to determine bundling and unbundling of claims.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 18L. AUTHORITY OF ATTORNEY GENERAL. (a) In addition to any other remedy available for a violation of this Act, the attorney general may take action and seek remedies available under Section 15, Article 21.21, Insurance Code, and Sections 17.58, 17.60, 17.61, and 17.62, Business & Commerce Code, for a violation of Section 14 or 18B of this Act.

(b) 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 18E of this Act, the attorney general may:

(1) bring an action to compel the physician or provider to repay the health maintenance organization;

(2) on the finding of a court that the physician or provider has violated Section 18E, impose a civil penalty of not more than the greater of $1,000 or two times the amount in dispute for each violation; and

(3) recover court costs and attorney's fees.

(c) 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 18J of this Act, the attorney general may:

(1) bring an action seeking an injunction against the physician or provider to restrain the improper use or disclosure of information;

(2) on the finding of a court that the physician or provider has violated Section 18J, impose a civil penalty of not more than $1,000 for each negligent violation or $10,000 for each intentional violation; and

(3) recover court costs and attorney's fees.

Sec. 40. CONFLICT WITH OTHER LAW. To the extent of any conflict between this Act and Article 21.52C, Insurance Code, this Act controls.

Sec. 41. APPLICATION OF CERTAIN PROVISIONS UNDER MEDICAID. A provision of this Act may not be interpreted as requiring a health maintenance organization, physician, or provider, in providing benefits or services under the state Medicaid program, to:

(1) use billing forms or codes that are inconsistent with those required under the state Medicaid program;

(2) make determinations relating to medical necessity or appropriateness or eligibility for coverage in a manner different than that required under the state Medicaid program; or

(3) reimburse physicians or providers for services rendered to a person who was not eligible to receive benefits for such services under the state Medicaid program.

SECTION 7. Subchapter E, Chapter 21, Insurance Code, is

amended by adding Article 21.52K to read as follows:

Art. 21.52K. ELECTRONIC HEALTH CARE TRANSACTIONS

Sec. 1. HEALTH BENEFIT PLAN DEFINED. (a) In this article, "health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) The term includes:

(1) a small employer health benefit plan written under Chapter 26 of this code; and

(2) a health benefit plan offered under the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code), the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code), or Article 3.50-4 of this code.

Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. The issuer of a health benefit plan by contract may require that a health care professional licensed 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. The health benefit plan issuer shall comply with the standards for electronic transactions required by this article and established by the commissioner by rule.

Sec. 3. TIME FOR IMPLEMENTATION OF ELECTRONIC TRANSACTION REQUIREMENTS. The department shall establish a timetable for compliance with Section 2 of this article.

Sec. 4. WAIVER. (a) Any contract between a health benefit plan defined by this article and a health care professional or health care facility must provide for a waiver of any requirement for electronic submission established under Section 2 of this article.

(b) The commissioner shall establish circumstances under which a waiver is required that include:

(1) undue hardship;

(2) health care professionals in rural areas; or

(3) any other special circumstance that would justify a waiver.

(c) Any health professional or health care facility that is denied a waiver by a health benefit plan may appeal the denial to the commissioner. The commissioner shall determine whether or not a waiver must be included in the contract.

(d) A health benefit plan may not refuse to contract or renew a contract with a health care professional or a health care facility based in whole or in part on the health care professional or health care facility requesting, appealing, or obtaining a waiver under this section.

Sec. 5. CERTAIN CHARGES PROHIBITED. A health benefit plan may not directly or indirectly charge or hold 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.

SECTION 8. (a) Section 3, Article 21.53Q, Insurance Code, as added by House Bill 1676, Acts of the 77th Legislature, Regular Session, 2001, is amended to read as follows:

Sec. 3. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In this section, "preauthorization" means a determination by [~~the provision of a reliable representation to a physician or health care provider of whether~~] the issuer of a health benefit plan that the [~~will pay the physician or provider for proposed~~] medical or health care services proposed to be provided [~~if the physician or provider renders those services~~] to a [~~the~~] patient are medically

necessary and appropriate [~~for whom the services are proposed~~]. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer of a health benefit plan to a physician or health care provider.

(b) The commissioner by rule shall require the issuer of a health benefit plan to provide adequate training to appropriate personnel responsible for preauthorization of coverage, if required under the plan, or utilization review under the plan to prevent wrongful denial of coverage required under this article and to avoid confusion of medical benefits with mental health benefits.

(b) This section takes effect only if House Bill 1676, Acts of the 77th Legislature, Regular Session, 2001, becomes law. If House Bill 1676 does not become law, this section has no effect.

SECTION 9. (a) The changes in law made by this Act relating to payment of a physician or health care provider for medical or health care services apply only to payment for services provided on or after the effective date of this Act.

(b) The changes in law made by this Act relating to a contract between a physician or health care provider and an insurer or health maintenance organization apply only to a contract entered into or renewed on or after January 1, 2002.

SECTION 10. This Act takes effect September 1, 2003.