

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

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

4 (b) A physician or ~~[preferred]~~ provider must submit a claim
 5 to an insurer not later than the 95th day after the date the
 6 physician or provider provides the medical care or health care
 7 services for which the claim is made. An insurer shall accept as
 8 proof of timely filing a claim filed in compliance with Subsection
 9 (c) of this section or information from another insurer showing
 10 that the physician or provider submitted the claim to the insurer in
 11 compliance with Subsection (c) of this section. If a physician or
 12 provider fails to submit a claim in compliance with this
 13 subsection, the physician or provider forfeits the right to payment
 14 unless the failure to submit the claim in compliance with this
 15 subsection is a result of a catastrophic event that substantially
 16 interferes with the normal business operations of the physician or
 17 provider. The period for submitting a claim under this subsection
 18 may be extended by contract. A physician or provider may not submit
 19 a duplicate claim for payment before the 46th day after the date the
 20 original claim was submitted. The commissioner shall adopt rules
 21 under which an insurer may determine whether a claim is a duplicate
 22 claim ~~[for medical care or health care services under a health~~
 23 ~~insurance policy may obtain acknowledgment of receipt of a claim~~
 24 ~~for medical care or health care services under a health care plan by~~
 25 ~~submitting the claim by United States mail, return receipt~~
 26 ~~requested. An insurer or the contracted clearinghouse of an~~
 27 ~~insurer that receives a claim electronically shall acknowledge~~

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

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

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

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

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

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

16 (d) If a claim for medical care or health care services
17 provided to a patient is mailed, the claim is presumed to have been
18 received by the insurer on the third day after the date the claim is
19 mailed or, if the claim is mailed using overnight service or return
20 receipt requested, on the date the delivery receipt is signed. If
21 the claim is submitted electronically, the claim is presumed to
22 have been received on the date of the electronic verification of
23 receipt by the insurer or the insurer's clearinghouse. If the
24 insurer or the insurer's clearinghouse does not provide a
25 confirmation within 24 hours of submission by the physician or
26 provider, the physician's or provider's clearinghouse shall provide
27 the confirmation. The physician's or provider's clearinghouse must

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

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

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

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

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

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

1 (1) pay the total amount of the claim; or
2 (2) notify the pharmacy provider of the reasons for
3 denying payment of the claim.

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

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

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

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

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

16 (j) If an insurer needs additional information from a
17 treating preferred provider to determine eligibility for payment,
18 the insurer, not later than the 30th calendar day after the date the
19 insurer receives a clean claim, shall request in writing that the
20 preferred provider provide any attachment to the claim the insurer
21 desires in good faith for clarification of the claim. The request
22 must describe with specificity the clinical information requested
23 and relate only to information the insurer can demonstrate is
24 specific to the claim or the claim's related episode of care. An
25 insurer that requests an attachment under this subsection shall
26 determine whether the claim is eligible for payment on or before the
27 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) ~~[(e)]~~ 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) ~~[(e)]~~ 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

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

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

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

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

13 Sec. 3B. ELEMENTS OF CLEAN CLAIM. (a) A claim by a
14 physician or provider, other than an institutional provider, is a
15 "clean claim" if the claim is submitted using Health Care Financing
16 Administration Form 1500 or a successor to that form developed by
17 the National Uniform Billing Committee or its successor and adopted
18 by the commissioner by rule for the purposes of this subsection that
19 is submitted to an insurer for payment and that contains the
20 information required by the commissioner by rule for the purposes
21 of this subsection entered into the appropriate fields on the form
22 in the manner prescribed.

23 (b) A claim by an institutional provider is a "clean claim"
24 if the claim is submitted using Health Care Financing
25 Administration Form UB-92 or a successor to that form developed by
26 the National Uniform Billing Committee or its successor and adopted
27 by the commissioner by rule for the purposes of this subsection that

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

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

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

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

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

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

23 (2) the physician or provider does not make
24 arrangements for repayment of the requested funds on or before the
25 45th day after the date the physician or provider receives the
26 notice.

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

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

7 (b) An insurer shall provide verification under this
8 section between 6 a.m. and 6 p.m. central standard time Monday
9 through Friday on each day that is not a legal holiday and between 9
10 a.m. and 12 p.m. on Saturday, Sunday, and legal holidays.

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

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

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

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

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

25 (1) the physician or provider has materially
26 misrepresented the proposed medical or health care services or has
27 substantially failed to perform the proposed medical or health care

1 services; or

2 (2) the insurer certifies in writing:

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

6 (B) the insurer was notified on or before the
7 30th day after the date the patient's enrollment ended; and

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

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

13 Sec. 3E. COORDINATION OF PAYMENT. (a) An insurer may
14 require a physician or provider to retain in the physician's or
15 provider's records updated information concerning other health
16 benefit plan coverage and to provide the information to the insurer
17 on the applicable form described by Section 3B of this article.
18 Except as provided in this subsection, an insurer may not require a
19 physician or provider to investigate coordination of other health
20 benefit plan coverage.

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

24 (c) A physician or provider who submits a claim for
25 particular medical care or health care services to more than one
26 health maintenance organization or insurer shall provide written
27 notice on the claim submitted to each health maintenance

1 organization or insurer of the identity of each other health
2 maintenance organization or insurer with which the same claim is
3 being filed.

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

8 (e) If an insurer is a secondary payor and pays a portion of
9 a claim that should have been paid by the insurer or health
10 maintenance organization that is the primary payor, the overpayment
11 may only be recovered from the health maintenance organization or
12 insurer that is primarily responsible for that amount.

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

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

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

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

1 services that require preauthorization and information concerning
2 the preauthorization process.

3 (b) If proposed medical care or health care services require
4 preauthorization as a condition of the insurer's payment to a
5 preferred provider under a health insurance policy, the insurer
6 shall determine whether the medical care or health care services
7 proposed to be provided to the insured are medically necessary and
8 appropriate.

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

15 (d) If the proposed medical care or health care services
16 involve inpatient care and the insurer requires preauthorization as
17 a condition of payment, the insurer shall review and issue a length
18 of stay for the admission into a health care facility based on the
19 recommendation of the patient's physician or health care provider
20 and the insurer's written medically accepted screening criteria and
21 review procedures. If the proposed medical or health care services
22 are to be provided to a patient who is an inpatient in a health care
23 facility at the time the services are proposed, the insurer shall
24 review and issue a determination indicating whether proposed
25 services are preauthorized within one calendar day of the request
26 by the physician or health care provider.

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

1 care services, the insurer may not deny or reduce payment to the
2 physician or provider for those services based on medical necessity
3 or appropriateness of care unless the physician or provider has
4 materially misrepresented the proposed medical or health care
5 services or has substantially failed to perform the proposed
6 medical or health care services.

7 (f) This section applies to an agent or other person with
8 whom an insurer contracts to perform, or to whom the insurer
9 delegates the performance of, preauthorization of proposed medical
10 or health care services.

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

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

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

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

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

1 schedules; and

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

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

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

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

19 Sec. 3I. AUTHORITY OF ATTORNEY GENERAL. (a) In addition to
20 any other remedy available for a violation of this article, the
21 attorney general may take action and seek remedies available under
22 Section 15, Article 21.21 of this code, and Sections 17.58, 17.60,
23 17.61, and 17.62, Business & Commerce Code, for a violation of
24 Section 3A or 7 of this article.

25 (b) If the attorney general has good cause to believe that a
26 physician or provider has failed in good faith to repay an insurer
27 under Section 3C of this article, the attorney general may:

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

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

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

8 (c) If the attorney general has good cause to believe that a
9 physician or provider is or has improperly used or disclosed
10 information received by the physician or provider under Section 3G
11 of this article, the attorney general may:

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

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

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

20 Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH
21 CARE PROVIDERS. The provisions of this article relating to prompt
22 payment by an insurer of a physician or health care provider and to
23 verification of medical care or health care services apply to a
24 physician or health care provider who:

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

27 (2) provides to an insured:

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

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

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

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

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

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

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

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

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

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

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

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

16 (b) A physician or provider must submit a claim under this
 17 section to a health maintenance organization not later than the
 18 95th day after the date the physician or provider provides the
 19 medical care or health care services for which the claim is made. A
 20 health maintenance organization shall accept as proof of timely
 21 filing a claim filed in compliance with Subsection (c) of this
 22 section or information from another health maintenance
 23 organization showing that the physician or provider submitted the
 24 claim to the health maintenance organization in compliance with
 25 Subsection (c) of this section. If a physician or provider fails to
 26 submit a claim in compliance with this subsection, the physician or
 27 provider forfeits the right to payment unless the failure to submit

1 the claim in compliance with this subsection is a result of a
2 catastrophic event that substantially interferes with the normal
3 business operations of the physician or provider. The period for
4 submitting a claim under this subsection may be extended by
5 contract. A physician or provider may not submit a duplicate claim
6 for payment before the 46th day after the date the original claim
7 was submitted. The commissioner shall adopt rules under which a
8 health maintenance organization may determine whether a claim is a
9 duplicate claim. ~~[A physician or provider for medical care or~~
10 ~~health care services under a health care plan may obtain~~
11 ~~acknowledgment of receipt of a claim for medical care or health care~~
12 ~~services under a health care plan by submitting the claim by United~~
13 ~~States mail, return receipt requested. A health maintenance~~
14 ~~organization or the contracted clearinghouse of the health~~
15 ~~maintenance organization that receives a claim electronically~~
16 ~~shall acknowledge receipt of the claim by an electronic~~
17 ~~transmission to the physician or provider and is not required to~~
18 ~~acknowledge receipt of the claim by the health maintenance~~
19 ~~organization in writing.]~~

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

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

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

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

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

5 (d) If a claim for medical care or health care services
6 provided to a patient is mailed, the claim is presumed to have been
7 received by the health maintenance organization on the third day
8 after the date the claim is mailed or, if the claim is mailed using
9 overnight service or return receipt requested, on the date the
10 delivery receipt is signed. If the claim is submitted
11 electronically, the claim is presumed to have been received on the
12 date of the electronic verification of receipt by the health
13 maintenance organization or the health maintenance organization's
14 clearinghouse. If the health maintenance organization or the
15 health maintenance organization's clearinghouse does not provide a
16 confirmation within 24 hours of submission by the physician or
17 provider, the physician's or provider's clearinghouse shall provide
18 the confirmation. The physician's or provider's clearinghouse must
19 be able to verify that the filing contained the correct payor
20 identification of the entity to receive the filing. If the claim is
21 faxed, the claim is presumed to have been received on the date of
22 the transmission acknowledgment. If the claim is hand delivered,
23 the claim is presumed to have been received on the date the delivery
24 receipt is signed. The commissioner shall promulgate a form to be
25 submitted by the physician or provider which easily identifies all
26 claims included in each filing which can be utilized by the
27 physician or provider as their log.

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

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

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

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

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

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

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

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

1 and does not pay the claim on or before the 45th day after the date
 2 the health maintenance organization receives a clean claim shall
 3 pay the physician or provider making the claim the lesser of the
 4 full amount of billed charges submitted on the claim and interest on
 5 the billed charges at a rate of 15 percent annually or two times the
 6 contracted rate and interest on that amount at a rate of 15 percent
 7 annually. If the physician or provider submits the claim using a
 8 form described by Section 18D(a) of this Act, billed charges shall
 9 be established under a fee schedule provided by the physician or
 10 provider to the health maintenance organization on or before the
 11 30th day after the date the physician or provider enters into the
 12 contract with the health maintenance organization. The physician
 13 or provider may modify the fee schedule if the physician or provider
 14 notifies the health maintenance organization of the modification on
 15 or before the 90th day before the date the modification takes
 16 effect.

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

25 (i) Except as provided by Subsection (j) of this section, if
 26 [~~(e) If~~] the health maintenance organization [acknowledges
 27 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

1 payment on or before the later of the 15th day after the date the
2 health maintenance organization receives the requested attachment
3 or the latest date for determining whether the claim is eligible for
4 payment under Subsection (e) of this section. A health maintenance
5 organization may not make more than one request under this
6 subsection in connection with a claim. Subsections (c) and (d) of
7 this section apply to a request for and submission of an attachment
8 under this subsection.

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

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

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

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

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

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

12 (o) [~~(h)~~] In addition to any other penalty or remedy
 13 authorized by the Insurance Code or another insurance law of this
 14 state, a health maintenance organization that violates Subsection
 15 (e) [~~(e)~~] or (i) [~~(e)~~] of this section is subject to an
 16 administrative penalty under Article 1.10E, Insurance Code. The
 17 administrative penalty imposed under that article may not exceed
 18 \$1,000 for each day the claim remains unpaid in violation of
 19 Subsection (e) [~~(e)~~] or (i) [~~(e)~~] of this section.

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

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

27 ~~[(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.~~

~~[(1) 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.

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

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

8 (2) the physician or provider does not make
9 arrangements for repayment of the requested funds on or before the
10 45th day after the date the physician or provider receives the
11 notice.

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

20 (b) A health maintenance organization shall provide
21 verification under this section between 6 a.m. and 6 p.m. central
22 standard time Monday through Friday on each day that is not a legal
23 holiday and between 9 a.m. and 12 p.m. on Saturday, Sunday, and
24 legal holidays.

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

27 (d) In this section, "verification" includes

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

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

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

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

13 (1) the physician or provider has materially
14 misrepresented the proposed medical or health care services or has
15 substantially failed to perform the proposed medical or health care
16 services; or

17 (2) the health maintenance organization certifies in
18 writing:

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

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

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

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

3 Sec. 18G. COORDINATION OF PAYMENT BENEFITS. (a) A health
4 maintenance organization may require a physician or provider to
5 retain in the physician's or provider's records updated information
6 concerning other health benefit plan coverage and to provide the
7 information to the health maintenance organization on the
8 applicable form described by Section 18D of this Act. Except as
9 provided by this subsection, a health maintenance organization may
10 not require a physician or provider to investigate coordination of
11 other health benefit plan coverage.

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

15 (c) A physician or provider who submits a claim for
16 particular medical care or health care services to more than one
17 health maintenance organization or insurer shall provide written
18 notice on the claim submitted to each health maintenance
19 organization or insurer of the identity of each other health
20 maintenance organization or insurer with which the same claim is
21 being filed.

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

26 (e) If a health maintenance organization is a secondary
27 payor and pays a portion of a claim that should have been paid by the

1 health maintenance organization or insurer that is the primary
2 payor, the overpayment may only be recovered from the health
3 maintenance organization or insurer that is primarily responsible
4 for that amount.

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

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

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

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

25 (b) If proposed medical care or health care services require
26 preauthorization by a health maintenance organization as a
27 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

1 physician or provider for those services based on medical necessity
2 or appropriateness of care unless the physician or provider has
3 materially misrepresented the proposed medical or health care
4 services or has substantially failed to perform the proposed
5 medical or health care services.

6 (f) This section applies to an agent or other person with
7 whom a health maintenance organization contracts to perform, or to
8 whom the health maintenance organization delegates the performance
9 of, preauthorization of proposed medical care or health care
10 services.

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

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

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

20 (2) provides to an enrollee:

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

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

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

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

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

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

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

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

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

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

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

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

16 (b) If the attorney general has good cause to believe that a
17 physician or provider has failed in good faith to repay a health
18 maintenance organization under Section 18E of this Act, the
19 attorney general may:

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

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

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

27 (c) If the attorney general has good cause to believe that a

1 physician or provider is or has improperly used or disclosed
2 information received by the physician or provider under Section 18J
3 of this Act, the attorney general may:

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

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

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

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

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

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

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

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

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

3 (2) a health benefit plan offered under the Texas
4 Employees Uniform Group Insurance Benefits Act (Article 3.50-2,
5 Vernon's Texas Insurance Code), the Texas State College and
6 University Employees Uniform Insurance Benefits Act (Article
7 3.50-3, Vernon's Texas Insurance Code), or Article 3.50-4 of this
8 code.

9 Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. The issuer of a
10 health benefit plan by contract may require that a health care
11 professional licensed under the Occupations Code or a health care
12 facility licensed under the Health and Safety Code submit a health
13 care claim or equivalent encounter information, a referral
14 certification, or an authorization or eligibility transaction
15 electronically. The health benefit plan issuer shall comply with
16 the standards for electronic transactions required by this article
17 and established by the commissioner by rule.

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

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

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

1 (1) undue hardship;
2 (2) health care professionals in rural areas; or
3 (3) any other special circumstance that would justify
4 a waiver.

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

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

14 Sec. 5. CERTAIN CHARGES PROHIBITED. A health benefit plan
15 may not directly or indirectly charge or hold a health care
16 professional, health care facility, or person enrolled in a health
17 benefit plan responsible for a fee for the adjudication of a claim.

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

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

1 necessary and appropriate [~~for whom the services are proposed~~].

2 The term includes precertification, certification,
3 recertification, or any other activity that involves providing a
4 reliable representation by the issuer of a health benefit plan to a
5 physician or health care provider.

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

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

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

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

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