By: Miller H.B. No. 2405

A BILL TO BE ENTITLED

AN ACT

relating to the prompt payment of claims to physicians and providers by insurers and health maintenance organizations.

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

SECTION 1. 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 3C 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. If a physician or provider fails to submit a claim in compliance with this subsection, the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with this subsection is a result of a catastrophic event that substantially interferes with the normal business operations of the physician or provider as determined under guidelines established by the commissioner by rule. 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 may 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) Except as provided by subsection (e) or (f) of this section, not [~~Not~~] later than the 45th day after the date that the insurer receives a clean claim submitted by [~~from~~] a preferred provider, the insurer shall:

(1) pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) 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) notify the preferred provider in writing why the claim will not be paid.

(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 21st day after the treatment is authorized.

(e) Except as provided by subsection (f) of this section, if [~~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 100 [~~85~~] percent of the contracted rate on the claim not later than the 45th day after the date that the insurer receives the clean claim from the preferred provider. If the insurer requests additional information needed to complete the audit, the request must describe with specificity the information requested and relate only to information the insurer in good faith needs to adjudicate the claim. The insurer may only request information from the preferred provider that is contained in, or is in the process of being incorporated into, the patient's medical or billing record maintained by the preferred provider. If a preferred provider does not supply information reasonably requested by the insurer in connection with the audit, the insurer may:

(1) notify the provider in writing that the provider must provide the information not later than the 45th day after the date of the notice of forfeit the amount of the claim; and

(2) if the provider does not provide the information as required by subsection (1), recover the amount of the claim and reasonable attorney's fees and court costs in an action to recover payment under this subsection [~~Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the 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~~].

(f) If an insurer needs additional information from a preferred provider to process a clean claim, the insurer shall request in writing that the preferred provider provide any additional information the insurer desires in good faith for clarification of the claim. The insurer must request the additional information not later than the 30th day after the date the insurer receives the clean claim. The request must describe with specificity the information requested and relate only to information the insurer in good faith needs to adjudicate the claim. The insurer may only request information from the preferred provider that is contained in, or is in the process of being incorporated into, the patient's medical or billing record maintained by the preferred provider. An insurer that requests additional information shall pay, deny, or audit the claim on or before the 45th day after the date the initial clean claim is received, excluding the day the insurer requests the additional information and each day after the date the additional information is requested and before the date the insurer receives the additional information. [~~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.~~]

(g) The commissioner shall adopt rules to identify a filing

by a physician or provider to an insurer that includes additional information requested by the insurer.

(h) The insurer's clean claims payment processes shall be consistent with, if available, nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers.

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

(j) [~~(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 (c), [~~or~~] (d), or (e) of this section is subject to an administrative penalty under Chapter 84 [~~Article 1.10E~~] of this code. For each day an [~~The~~] administrative penalty is imposed under this subsection, the penalty [~~that article~~] may not exceed $1,000 for each [~~day the~~] claim that remains unpaid or violation of Subsection (c), [~~or~~] (d), or (e) of this section. An insurer is not subject to an administrative penalty if the commissioner finds that the insurer has paid, denied or audited at least ninety-five (95) percent of all clean claims received from preferred providers within the statutory time frames during a calendar year. The commissioner may establish standards under which the commissioner may impose sanctions on or assess penalties against an insurer under Chapter 82 or 84 of this code if the commissioner finds that an insurer has violated subsection (c), (d), or (e) of this section in processing less than ninety-five (95) percent of clean claims submitted to the insurer by preferred

providers within the statutory time frames.

(k) [~~(i)~~] Upon written request, [~~T~~] the insurer shall provide a preferred provider with summaries [~~copies~~] of all applicable utilization review policies and claim processing policies or procedures[~~, including required data elements and claim formats~~].

(l) [~~(j) An insurer may, by contact 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.

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

(n) Except as provided by subsections (b) and (h) of this section, the provisions of this section 3A may not be waived, voided, or nullified by contract.

SECTION 2. Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 7th Legislature, Regular Session, 1997,

is amended by adding sections 3C-3E, 3I, 3J, and 10 to read as follows:

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

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

(c) For electronically filed claims, the commissioner shall require any data element that is required in an electronic transaction set needed to comply with federal law.

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

(f) A claim by a physician, provider or institutional provider is not a clean claim if the insurer reasonably and in good faith believes that it might have been submitted fraudulently. An insurer may take appropriate measures to detect, investigate, prevent payment of, and report as required by law, claims that an insurer in good faith reasonably suspects may be fraudulent in nature. Claims that in good faith of the insurer fall under reasonable suspicion of having been submitted fraudulently are not subject to the other provisions of this section 3C and must be treated in accordance with the insurer's established anti-fraud procedures and with state and/or federal laws and regulations pertaining to the investigation and reporting of suspected insurance fraud.

Sec. 3D. OVERPAYMENT. (a) Except as provided by subsection (b), an insurer may deduct the amount of an overpayment from any amount owed by the insurer to the physician or provider, or may otherwise recover the amount of overpayment, 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.

(b) If a physician or provider exercises a right of appeal available under the physician's or provider's contract with the insurer, the insurer may not recover the amount overpaid until the physician's or provider's right of appeal is exhausted.

(c) The insurer may modify the provisions of this section 3D by contract if agreed by the physician or provider.

Sec. 3E. AVAILABILITY OF CODING GUIDELINES. (a) The commissioner by rule shall require a contract between an insurer and a preferred physician or preferred provider to 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 provide 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 changes to the coding guidelines and fee schedules that will result in a change of payment to a physician or provider not later than the 60th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) after a physician or provider receives information under this subsection, the contract may be terminated by the physician or provider, without penalty or discrimination in

participation in contracts with the insurer, on or after the 60th day after the date the physician or provider provides the insurer written notice of intent to terminate the contract, unless modified by contract.

(b) A physician or provider who receives information under subsection (a) of this section may only:

(1) use or disclose the information for the purpose of practice management or billing activities; and

(2) disclose the information to a government agency involved in the regulation of health care or insurance.

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

Sec. 3I. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; PENALTY. (a) This section applies only to a clean claim.

(b) An insurer that fails to pay a clean claim in accordance with sections 3A(c), (d), or (e) of this article shall pay to the

preferred physician or preferred provider the contracted rate owed by the insurer for the claim, less amounts previously paid, plus a penalty in the amount of fifty (50) percent of the difference between the billed charge and the contracted rate. A penalty under this subsection shall not exceed one hundred thousand dollars ($100,000). No penalty shall be paid on clean claims not covered by the health insurance policy. This penalty shall apply to clean claims paid forty-five (45) days or less after the statutory claims payment deadline, subject to Sec. 3A(f).

(c) An insurer that fails to pay a clean claim in accordance with sections 3A(c), (d) or (e) of this article shall pay to the preferred physician or preferred provider the contracted rate owed by the insurer for the claim, less amounts previously paid, plus a penalty in the amount of one hundred (100) percent of the difference between the billed charge and the contracted rate. A penalty under this subsection shall not exceed two hundred thousand dollars ($200,000). No penalty shall be paid on clean claims not covered by the health insurance policy. This penalty shall apply to clean claims paid forty-six (46) days or more after the statutory claims payment deadline, subject to Sec. 3A(f).

(d) An insurer that fails to pay the contracted rate owed by the insurer for a clean claim in accordance with sections 3A(c), (d) or (e) of this article shall pay to the preferred physician or preferred provider a penalty in the amount of fifty (50) percent of the underpaid amount. A penalty under this subsection may not exceed one hundred thousand dollars ($100,000) or the difference between the billed charges and the contracted rate whichever is

less. This penalty shall apply if the insurer pays the balance of the contracted rate to the preferred physician or preferred provider within forty-five (45) days of receipt of written notice of the underpayment from the preferred physician or preferred provider.

(e) An insurer that fails to pay the contracted rate owed by the insurer for a clean claim in accordance with sections 3A(c), (d) or (e) of this article shall pay to the preferred physician or preferred provider a penalty in the amount of one hundred (100) percent of the underpaid amount. A penalty under this subsection may not exceed two hundred thousand dollars ($200,000) or the difference between the billed charges and the contracted rate whichever is less. This penalty shall apply if the insurer pays the balance of the contracted rate to the preferred physician or preferred provider forty-six (46) days or more after receipt of written notice of the underpayment from the preferred physician or preferred provider.

(f) An insurer is not liable for a penalty under subsection (d) or (e) of this section if the insurer corrects the underpayment within thirty (30) days of receipt of written notice from the preferred physician or preferred provider. An insurer is not liable for a penalty under subsection (d) or (e) of this section unless the physician or provider notifies the insurer of the underpayment not later than the 180th day after the date the underpayment is received.

(g) An insurer that pays a penalty under this section shall clearly indicate on the explanation of benefits or other statement

in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(h) An insurer is not liable for any penalties under this Section 3I or regulatory penalties under section 3A(j) if the failure to comply is a result of a catastrophic event that substantially interferes with the normal business operations of the insurer as determined under guidelines established by the commissioner by rule.

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

Sec. 3J. AUTHORITY OF ATTORNEY GENERAL. (a) If the attorney general has good cause to believe that a physician or provider has failed in good faith to repay an insurer under section 3D of this article, 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 3D, recover 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.

(b) If the attorney general has good cause to believe that a physician or provider has improperly used or disclosed information received by the physician or provider under section 3E of this article, 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 3E, recover 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 attorneys' fees.

(c) If the attorney general has good cause to believe that a physician or provider has failed to comply with section 3A of this article, the attorney general may:

(1) bring an action seeking an injunction against the physician or provider to enforce compliance;

(2) on the finding of a court that the physician or provider has violated section 3A, recover 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 attorneys' fees.

Sec. 10. CONFLICT WITH OTHER LAW. To the extent of any conflict between this article and Article 21.52C of this code, this article controls.

SECTION 3. Section 843.336, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.336. CLEAN CLAIM [~~DEFINITION~~]. (a) In this subchapter, "clean claim" means a [~~completed~~] claim that complies with this section.

(b) A claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using Centers for Medicare and Medicaid Services Form

1500 or a successor to that form developed by the National Uniform 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 claim by an institutional provider is a "clean claim" if the claim is submitted using Centers for Medicare and medicaid Services Form UB-92 or a successor to that form developed by the National Uniform Billing Committee or its successor and adopted by the commissioner by rule for the purposes of this subsection 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.

(d) For electronically filed claims, the commissioner shall require any data element that is required in an electronic transaction set needed to comply with federal law.

(e) A clean 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.

(f) The commissioner may require any data element that is required in an electronic transaction set needed to comply with federal law.

(g) A claim by a physician, provider or institutional provider is not a clean claim if the insurer reasonably and in good

faith believes that it might have been submitted fraudulently. An insurer may take appropriate measures to detect, investigate prevent payment of, and report as required by law, claims that an insurer in good faith reasonably suspects may be fraudulent in nature. Claims that in good faith of the insurer fall under reasonable suspicion of having been submitted fraudulently are not subject to the other provisions of this chapter and must be treated in accordance with the insurer's established anti-fraud procedures and with state and/or federal laws and regulations pertaining to the investigation and reporting of suspected insurance fraud.

SECTION 4. Section 843.337, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE CLAIMS [~~ACKNOWLEDGMENT OF RECEIPT OF CLAIM~~]. (a) A physician or provider must submit a claim 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 physician or provider for health care services under a health care plan may obtain acknowledgment of receipt of a claim for health care services under a health care plan by submitting the claim by United States mail, return receipt requested~~]. If a physician or provider fails to submit a claim in compliance with this subsection, the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with this subsection is a result of a catastrophic event that substantially interferes with the normal business operations of the physician or provider as determined under guidelines

established by the commissioner by rule.

(b) The period for submitting a claim under this subsection may be extended by contract.

(c) A physician or provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted.

(d) The commissioner may adopt rules under which a health maintenance organization may determine whether a claim is a duplicate claim [~~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 in writing~~].

SECTION 5. Section 843.338, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by sections 843.3385 and 843.340, not [~~Not~~] later than the 45th day after the date on which a health maintenance organization receives a clean claim submitted by a physician or provider, the health maintenance organization shall:

(1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) 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) notify the physician or provider in writing why the claim will not be paid.

SECTION 6. Subchapter J, Chapter 843, Insurance Code, as effective June 1, 2003, is amended by adding section 843.3385 to read as follows:

Sec. 843.3385. ADDITIONAL INFORMATION. (a) If a health maintenance organization needs additional information from a physician or provider to process claim, the health maintenance organization shall request in writing that the physician or provider provide any additional information the health maintenance organization desires in good faith for clarification of the claim. The health maintenance organization must request the additional information not later than the 30th day after the date the health maintenance organization receives the clean claim. The health maintenance organization may only request information that is contained in, or is in the process of being incorporated into, the patient's medical or billing record maintained by the physician or provider.

(b) The request must describe with specificity the information requested and relate only to information the health maintenance organization in good faith needs to adjudicate the claim.

(c) A health maintenance organization that requests additional information under this section shall pay, deny, or audit the claim on or before the 45th day after the date the initial clean claim is received, excluding the day the health maintenance organization requests the additional information or each day after

the date the additional information is requested and before the date that the health maintenance organization receives the additional information.

(d) The commissioner shall adopt rules under which a health maintenance organization can easily identify a filing by a physician or provider that includes additional information requested by the health maintenance organization.

SECTION 7. Section 843.339, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.339. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION BENEFIT CLAIMS. If a health maintenance organization or its designated agent authorizes treatment, a prescription benefit claim that is electronically adjudicated and electronically paid shall be paid not later than the 21st day after the date on which the treatment is authorized.

SECTION 8. Section 843.340, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.340. AUDITED CLAIMS. Except as provided by section 843.3385, if a [~~A~~] health maintenance organization [~~that acknowledges coverage of an enrollee under a health care plan but~~] intends to audit a claim submitted by a physician or provider, the health maintenance organization shall pay the charges submitted at 100 [~~85~~] percent of the contracted rate on the claim not later than the 45th day after the date on which the health maintenance organization receives the clean claim from a physician or provider. If the health maintenance organization requests additional information needed to complete the audit, the request must describe

with specificity the information requested and relate only to information the health maintenance organization in good faith needs to adjudicate the claim. The health maintenance organization may only request information from the preferred provider that is contained in, or is in the process of being incorporated into, the patient's medical or billing record maintained by the physician or provider. If a physician or provider does not supply information reasonably requested by the health maintenance organization in connection with the audit, the health maintenance organization may:

(1) notify the physician or provider in writing that the physician or provider must provide the information not later than the 45th day after the date of the notice; or forfeit the amount of the claim; and

(2) if the physician or provider does not provide the information as required by Subdivision (1), recover the amount of the claim and reasonable attorney's fees and court costs in an action to recover payment under this subsection. [~~Following completion of the audit, any additional payment due a physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the 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~~].

SECTION 9. Subchapter J, Chapter 843, Insurance code, as effective June 1, 2003, is amended by adding section 843.3401 to read as follows:

Sec. 843.3401. OVERPAYMENT. (a) Except as provided by subsection (b), a health maintenance organization may deduct the amount of an overpayment from any amount owed by the health maintenance organization to the physician or provider, or may otherwise recover the amount of overpayment 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;

(b) if a physician or provider exercises a right of appeal available under the physician's or providers' contract with the health maintenance organization, the health maintenance organization may not recover the amount overpaid until the physician's or provider's right of appeal is exhausted;

(4) The health maintenance organization may modify the provisions of Sec. 843.3401 by contract if agreed by the physician or provider.

SECTION 10. Subchapter J, Chapter 843, Insurance Code, as effective June 1, 2003, is amended by adding section 843.3402 to read as follows:

AVAILABILITY OF CODING GUIDELINES. (a) The commissioner by rule shall require a contract between a health maintenance

organization and a physician or provider to 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 provide under the contract;

(2) the health maintenance organization or the health maintenance organization's agent 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 changes to the coding guidelines and fee schedules that will result in a change of payment to a physician or provider not later than the 60th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) after a physician or provider receives information under this subsection, the contract may be terminated by the physician or provider, without penalty or discrimination in participation in other contracts with the health maintenance organization, on or after the 60th day after the date the physician or provider provides the insurer written notice of intent to terminate the contract, unless modified by contract.

(b) A physician or provider who receives information under subsection (a) of this section may only:

(1) use or disclose the information for the purpose of practice management or billing activities; and

(2) disclose the information to a government agency involved in the regulation of health care or insurance.

(c) The health maintenance organization 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) Nothing in this section may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer must supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services provided to enrollees.

(e) Except for (a)(4), the provisions of this section may not be waived, voided, or nullified by contract.

SECTION 11. Section 843.341, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) Upon written request, a health maintenance organization shall provide a participating physician or provider with [~~copies~~] summaries of all applicable utilization review policies and claim processing policies or procedures[~~, including required data elements and claim formats~~].

(b) A health maintenance organization's claims payment processes shall be consistent with, if available, nationally

recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers. [~~A health maintenance organization may, by contract with a participating physician or provider, add or change the data elements that must be submitted with a claim from the physician or provider.~~]

[~~(c) 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.~~]

SECTION 12. Section 843.342, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; PENALTIES [~~ADMINISTRATIVE PENALTY~~].

(a) This section applies only to a clean claim.

(b) A health maintenance organization that fails to pay a clean claim in accordance with sections 843.338, 843.339 or 843.340 of this article shall pay to the physician or provider the contracted rate owed by the health maintenance organization for the claim, less amounts previously paid, plus a penalty in the amount of the fifty (50) percent of the difference between the billed charge and the contracted rate. A penalty under this subsection shall not exceed one hundred thousand dollars ($100,000). No penalty shall be paid on clean claims not covered by the health insurance policy. This penalty shall apply to clean claims paid forty-five (45) days

or less after the statutory claims payment deadline, subject to Sec. 843.342.

(c) A health maintenance organization that fails to pay a clean claim in accordance with sections 843.338, 843.339 or 843.340 of this article shall pay to the physician or provider the contracted rate owed by the health maintenance organization for the claim, less amounts previously paid, plus a penalty in the amount of one hundred (100) percent of the difference between the billed charge and the contracted rate. A penalty under this subsection shall not exceed two hundred thousand dollars ($200,000). No penalty shall be paid on clean claims not covered by the health insurance policy. This penalty shall apply to clean claims paid forty-six (46) days or more after the statutory claims payment deadline, subject to Sec. 843.342.

(d) A health maintenance organization that fails to pay the contracted rate owed by the health maintenance organization for a clean claim in accordance with sections 843.338, 843.339 or 843.340 of this article shall pay to the physician or provider a penalty in the amount of fifty (50) percent of the underpaid amount. A penalty under this subsection may not exceed one hundred thousand dollars ($100,000) or the difference between the billed charges and the contracted rate, whichever is less. This penalty shall apply if the health maintenance organization pays the balance of the contracted rate to the physician or provider within forty-five (45) days of receipt of written notice of the underpayment from the physician or provider.

(e) A health maintenance organization that fails to pay the

contracted rate owed by the health maintenance organization for a clean claim in accordance with sections 843.338, 843.339 or 843.340 of this article shall pay to the physician or provider a penalty in the amount of one hundred (100) percent of the underpaid amount. A penalty under this subsection may not exceed two hundred thousand dollars ($200,000) or the difference between the billed charges and the contracted rate whichever is less. This penalty shall apply if the health maintenance organization pays the balance of the contracted rate to the physician or provider forty-six (46) days or more after receipt of written notice of the underpayment from the physician or provider.

(f) A health maintenance organization is not liable for a penalty under subsections (d) or (e) of this section if the health maintenance organization corrects the underpayment within thirty (30) days of receipt of written notice from the physician or provider. A health maintenance organization is not liable for a penalty under subsection (d) or (e) unless the physician or provider notifies the health maintenance organization of the underpayment not later than the 180th day after the date the underpayment is received.

(g) A health maintenance organization that pays a penalty under this section shall clearly indicate on the explanation of benefits or other statement, in the manner prescribed by the commissioner by rule, the amount of the contracted rate paid and the amount paid as a penalty.

(h) [~~A health maintenance organization that violates Section 843.338 or 843.340 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.~~

[~~(b)~~] In addition to any other penalty or remedy authorized by this code or another insurance law of this state, a health maintenance organization that violates subsections 843.338, 843.339 or 843.340 of this article is subject to an administrative penalty under Chapter 84 [~~Article 1.10E~~] of this code. For each day an [~~The~~] administrative penalty is imposed under this subsection, the penalty [~~that article~~] may not exceed $1,000 for each [~~day the~~] claim that remains unpaid or violation of subsections [~~(c), [or] (d)~~] 843.338, 843.339 or 843.340 of this section. A health maintenance organization is not subject to such administrative penalty if the commissioner finds that the health maintenance organization has paid, denied or audited at least ninety-five (95) percent of all clean claims received from providers and at least ninety-five (95) percent of all clean claims received from providers within the statutory time frames during a calendar year. The commissioner may establish standards under which the commissioner may impose sanctions on or assess penalties against a health maintenance organization under Chapter 82 or 84 of this code if the commissioner finds that a health maintenance organization has violated subsections 843.338, 843.339 or 843.340 of this section in processing less than ninety-five (95) percent of clean claims submitted to the health maintenance organization by providers within the statutory time frames.

(i) A health maintenance organization is not liable for penalties under this section 843.342 if the failure to comply is a result of a catastrophic event that substantially interferes with the normal business operations of the health maintenance organization as determined under guidelines established by the commissioner by rule.

SECTION 13. Section 843.343, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.343. ATTORNEY'S FEES. A physician or provider may recover reasonable attorney's fees and court costs in an action to recover payment under this subsection [~~Section 843.342~~].

SECTION 14. Section 843.345, Insurance Code, as effective June 1, 2003, is amended to read as follows:

Sec. 843.345. EXCEPTIONS. Sections 843.336-843.344 do not apply to[~~:~~

[~~(1)~~] a capitated payment required to be made to a physician or provider under an agreement to provide health care services, including medical care, under a health care plan[~~; or~~

[~~(2) a claim submitted by a physician or provider who is a member of the legislature~~].

SECTION 15. Subchapter J, Chapter 832, Insurance Code, as effective June 1, 2003, is amended by adding sections 843.347 and 843.348 to read as follows:

Sec. 843.347. CONFLICT WITH OTHER LAW. To the extent of any conflict between this subchapter and Article 21.52C, this subchapter controls.

SECTION 16. Subchapter N, Chapter 843, Insurance Code, as

effective June 1, 2003, is amended by adding section 843.465 to read as follows:

(a) If the attorney general has good cause to believe that a physician or provider has failed in good faith to repay a health maintenance organization under section 843.3401, 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 843.3401, recover 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.

(b) If the attorney general has good cause to believe that a physician or provider is or has improperly used or disclosed information received by the physician or provider under section 843.319, 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 843.319, recover a civil penalty of not more than $1,000 for each negligent violation or $10,000 for each intention 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 has failed to comply with section 843.337 of

this article, the attorney general may:

(1) bring an action seeking an injunction against the physician or provider to enforce compliance;

(2) on the finding of a court that the physician or provider has violated section 843.337, recover 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 attorneys' fees.

SECTION 17. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.52Z to read as follows:

Art. 21.52Z. 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 842 of this code;

(3) a fraternal benefit society operating under Chapter 885 of this code;

(4) a stipulated premium insurance company operating under Chapter 884 of this code;

(5) a reciprocal exchange operating under Chapter 942

of this code;

(6) a health maintenance organization operating under Chapter 843 of this code;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 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 Chapter 1551, 1575, or 1601 of this code.

(c) The term does not include:

(1) a hospital indemnity policy

(2) a limited benefit policy;

(3) a specified disease policy;

(4) an indemnity policy issued by an insurer that does not contract, directly or indirectly, with physicians or providers;

(5) workers' compensation insurance coverage;

(6) medical payment insurance issued as part of a motor vehicle policy;

(7) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described in subsection (a) of this section; or

(8) a plan that provides coverage:

a. only for accidental death or dismemberment;

b. for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

c. a supplement to liability insurance.

Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. A health care professional licensed under the Occupations Code or a health care facility licensed under the Health and Safety Code shall submit a health care claim or equivalent encounter information to the issuer of a health benefit plan. The health benefit plan issuer shall comply with the standards for electronic transactions required by this section and established by the commissioner by rule.

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

(b) An 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 before September 1, 2006. The health benefit plan issuer shall comply with the standards for electronic transactions required by this section and established by the commissioner by rule.

(c) Health care professionals or health care facilities must submit health care claims or equivalent encounter information

electronically to the issuer of a health benefit plan by September 1, 2006. If a health care professional or health care facility cannot comply with the provisions of this Article, the health care professional or health care facility must apply for a waiver of any requirement for electronic submission established under subsection (b) of this section to the commissioner.

(d) The commissioner shall establish circumstances under which a waiver is required including:

(1) undue hardship;

(2) health care professionals in rural areas; or

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

(e) Any health professional or health care facility that is denied a waiver for a health benefit plan may appeal the denial to the commissioner. The commissioner shall determine whether a waiver must be granted.

(f) This section expires September 1, 2007.

Sec. 3. RULES. The commissioner may adopt rules as necessary to implement this article.

SECTION 18. Article 3.70-2. Form of Policy. Is amended by adding a new subsection (N) to read as follows:

(a) (N) An individual or group policy of accident and sickness insurance that is delivered, issued for delivery, or renewed in this state, including a policy issued by a company subject to Chapter 20, Texas Insurance Code, evidence of coverage issued by a health maintenance organization subject to the Texas HMO Act (Chapter 20A, Vernon's Tex. Ins. Code) may contain a

coordination of benefits provision to coordinate benefits when a member is covered by more than one policy or evidence of coverage in accordance with regulation promulgated by the Texas Department of Insurance.

(b) This section does not apply to:

(1) a hospital indemnity policy

(2) a limited benefit policy, or

(3) a specified disease policy.

SECTION 18. As soon as practicable, but not later than the 30th day after the effective date of this Act, the commissioner of insurance shall adopt rules as necessary to implement this Act. The commissioner may use the procedures under section 2001.034, Government Code, for adopting emergency rules with abbreviated notice and hearing to adopt rules under this section. The commissioner is not required to make the finding described by section 2001.034(a), Government Code, to use the emergency rules procedures.

SECTION 19. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2003.