

By: Miller

H.B. No. 2405

A BILL TO BE ENTITLED

1 AN ACT

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

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

5 SECTION 1. Section 3A, Article 3.70-3C, Insurance Code, as
6 added by Chapter 1024, Acts of the 75th Legislature, Regular
7 Session, 1997, is amended to read as follows:

8 Sec. 3A. PROMPT PAYMENT OF PREFERRED PROVIDERS. (a) In
9 this section, "clean claim" means a ~~[completed]~~ claim that complies
10 with section 3C of this article~~[, as determined under department~~
11 ~~rules, submitted by a preferred provider for medical care or health~~
12 ~~care services under a health insurance policy]~~.

13 (b) A physician or [preferred] provider must submit a claim
14 to an insurer not later than the 95th day after the date the
15 physician or provider provides the medical care or health care
16 services for which the claim is made. If a physician or provider
17 fails to submit a claim in compliance with this subsection, the
18 physician or provider forfeits the right to payment unless the
19 failure to submit the claim in compliance with this subsection is a
20 result of a catastrophic event that substantially interferes with
21 the normal business operations of the physician or provider as
22 determined under guidelines established by the commissioner by
23 rule. The period for submitting a claim under this subsection may
24 be extended by contract. A physician or provider may not submit a

1 duplicate claim for payment before the 46th day after the date the
2 original claim was submitted. The commissioner may adopt rules
3 under which an insurer may determine whether a claim is a duplicate
4 claim [~~for medical care or health care services under a health~~
5 ~~insurance policy may obtain acknowledgment of receipt of a claim~~
6 ~~for medical care or health care services under a health care plan by~~
7 ~~submitting the claim by United States mail, return receipt~~
8 ~~requested. An insurer or the contracted clearinghouse of an~~
9 ~~insurer that receives a claim electronically shall acknowledge~~
10 ~~receipt of the claim by an electronic transmission to the preferred~~
11 ~~provider and is not required to acknowledge receipt of the claim by~~
12 ~~the insurer in writing].~~

13 (c) Except as provided by subsection (e) or (f) of this
14 section, not [~~Not~~] later than the 45th day after the date that the
15 insurer receives a clean claim submitted by [~~from~~] a preferred
16 provider, the insurer shall:

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

19 (2) pay the portion of the claim that is not in dispute
20 and notify the preferred provider in writing why the remaining
21 portion of the claim will not be paid; or

22 (3) notify the preferred provider in writing why the
23 claim will not be paid.

24 (d) If a prescription benefit claim is electronically
25 adjudicated and electronically paid, and the preferred provider or
26 its designated agent authorizes treatment, the claim must be paid
27 not later than 21st day after the treatment is authorized.

1 (e) Except as provided by subsection (f) of this section, if
2 ~~[If]~~ the insurer ~~[acknowledges coverage of an insured under the~~
3 ~~health insurance policy but]~~ intends to audit the preferred
4 provider claim, the insurer shall pay the charges submitted at 100
5 ~~[85]~~ percent of the contracted rate on the claim not later than the
6 45th day after the date that the insurer receives the clean claim
7 from the preferred provider. If the insurer requests additional
8 information needed to complete the audit, the request must describe
9 with specificity the information requested and relate only to
10 information the insurer in good faith needs to adjudicate the
11 claim. The insurer may only request information from the preferred
12 provider that is contained in, or is in the process of being
13 incorporated into, the patient's medical or billing record
14 maintained by the preferred provider. If a preferred provider does
15 not supply information reasonably requested by the insurer in
16 connection with the audit, the insurer may:

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

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

27 ~~[(1) the preferred provider receives notice of the~~

1 ~~audit results, or~~

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

3 (f) If an insurer needs additional information from a
4 preferred provider to process a clean claim, the insurer shall
5 request in writing that the preferred provider provide any
6 additional information the insurer desires in good faith for
7 clarification of the claim. The insurer must request the
8 additional information not later than the 30th day after the date
9 the insurer receives the clean claim. The request must describe
10 with specificity the information requested and relate only to
11 information the insurer in good faith needs to adjudicate the
12 claim. The insurer may only request information from the preferred
13 provider that is contained in, or is in the process of being
14 incorporated into, the patient's medical or billing record
15 maintained by the preferred provider. An insurer that requests
16 additional information shall pay, deny, or audit the claim on or
17 before the 45th day after the date the initial clean claim is
18 received, excluding the day the insurer requests the additional
19 information and each day after the date the additional information
20 is requested and before the date the insurer receives the
21 additional information. ~~[An insurer that violates Subsection (c) or~~
22 ~~(e) of this section is liable to a preferred provider for the full~~
23 ~~amount of billed charges submitted on the claim or the amount~~
24 ~~payable under the contracted penalty rate, less any amount~~
25 ~~previously paid or any charge for a service that is not covered by~~
26 ~~the health insurance policy.]~~

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

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

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

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

10 (j) [~~(h)~~] In addition to any other penalty or remedy
11 authorized by this code or another insurance law of this state, an
12 insurer that violates subsection (c), [~~or~~] (d), or (e) of this
13 section is subject to an administrative penalty under Chapter 84
14 [~~Article 1.10E~~] of this code. For each day an [~~The~~] administrative
15 penalty is imposed under this subsection, the penalty [~~that~~
16 ~~article~~] may not exceed \$1,000 for each [~~day the~~] claim that remains
17 unpaid or violation of Subsection (c), [~~or~~] (d), or (e) of this
18 section. An insurer is not subject to an administrative penalty if
19 the commissioner finds that the insurer has paid, denied or audited
20 at least ninety-five (95) percent of all clean claims received from
21 preferred providers within the statutory time frames during a
22 calendar year. The commissioner may establish standards under
23 which the commissioner may impose sanctions on or assess penalties
24 against an insurer under Chapter 82 or 84 of this code if the
25 commissioner finds that an insurer has violated subsection (c),
26 (d), or (e) of this section in processing less than ninety-five (95)
27 percent of clean claims submitted to the insurer by preferred

1 providers within the statutory time frames.

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

7 (l) [(j)] An insurer may, by contact with a preferred
8 provider, add or change the data elements that must be submitted
9 with the preferred provider claim.

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

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

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

18 contracts to process claims or to obtain the services of preferred

19 providers to provide medical care or health care to insureds under a

20 health insurance policy.

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

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

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

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

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

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

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

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

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

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

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

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

25 (2) the physician or provider does not make
26 arrangements for repayment of the requested funds on or before the
27 45th day after the date the physician or provider receives the

1 notice.

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

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

8 Sec. 3E. AVAILABILITY OF CODING GUIDELINES. (a) The
9 commissioner by rule shall require a contract between an insurer
10 and a preferred physician or preferred provider to provide that:

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

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

19 (3) the insurer will provide notice of changes to the
20 coding guidelines and fee schedules that will result in a change of
21 payment to a physician or provider not later than the 60th day
22 before the date the changes take effect and will not make
23 retroactive revisions to the coding guidelines and fee schedules;
24 and

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

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

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

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

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

11 (c) The insurer shall, on request of a physician or
12 provider, provide the name, edition, and model version of the
13 software that the insurer uses to determine bundling and unbundling
14 of claims.

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

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

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

1 preferred physician or preferred provider the contracted rate owed
2 by the insurer for the claim, less amounts previously paid, plus a
3 penalty in the amount of fifty (50) percent of the difference
4 between the billed charge and the contracted rate. A penalty under
5 this subsection shall not exceed one hundred thousand dollars
6 (\$100,000). No penalty shall be paid on clean claims not covered by
7 the health insurance policy. This penalty shall apply to clean
8 claims paid forty-five (45) days or less after the statutory claims
9 payment deadline, subject to Sec. 3A(f).

10 (c) An insurer that fails to pay a clean claim in accordance
11 with sections 3A(c), (d) or (e) of this article shall pay to the
12 preferred physician or preferred provider the contracted rate owed
13 by the insurer for the claim, less amounts previously paid, plus a
14 penalty in the amount of one hundred (100) percent of the difference
15 between the billed charge and the contracted rate. A penalty under
16 this subsection shall not exceed two hundred thousand dollars
17 (\$200,000). No penalty shall be paid on clean claims not covered by
18 the health insurance policy. This penalty shall apply to clean
19 claims paid forty-six (46) days or more after the statutory claims
20 payment deadline, subject to Sec. 3A(f).

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

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

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

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

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

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

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

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

11 Sec. 3J. AUTHORITY OF ATTORNEY GENERAL. (a) If the
12 attorney general has good cause to believe that a physician or
13 provider has failed in good faith to repay an insurer under section
14 3D of this article, the attorney general may:

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

17 (2) on the finding of a court that the physician or
18 provider has violated section 3D, recover a civil penalty of not
19 more than the greater of \$1,000 or two times the amount in dispute
20 for each violation; and

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

22 (b) If the attorney general has good cause to believe that a
23 physician or provider has improperly used or disclosed information
24 received by the physician or provider under section 3E of this
25 article, the attorney general may:

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

1 information;

2 (2) on the finding of a court that the physician or
3 provider has violated section 3E, recover a civil penalty of not
4 more than \$1,000 for each negligent violation or \$10,000 for each
5 intentional violation; and

6 (3) recover court costs and attorneys' fees.

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

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

12 (2) on the finding of a court that the physician or
13 provider has violated section 3A, recover a civil penalty of not
14 more than \$1,000 for each negligent violation or \$10,000 for each
15 intentional violation; and

16 (3) recover court costs and attorneys' fees.

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

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

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

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

1 1500 or a successor to that form developed by the National Uniform
2 Billing Committee or its successor and adopted by the commissioner
3 by rule for the purposes of this subsection that is submitted to a
4 health maintenance organization for payment and that contains the
5 information required by the commissioner by rule for the purposes
6 of this subsection entered into the appropriate fields on the form.

7 (c) A claim by an institutional provider is a "clean claim"
8 if the claim is submitted using Centers for Medicare and Medicaid
9 Services Form UB-92 or a successor to that form developed by the
10 National Uniform Billing Committee or its successor and adopted by
11 the commissioner by rule for the purposes of this subsection that is
12 submitted to a health maintenance organization for payment and that
13 contains the information required by the commissioner by rule for
14 the purposes of this subsection entered into the appropriate fields
15 on the form.

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

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

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

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

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

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

13 Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE
14 CLAIMS [ACKNOWLEDGMENT OF RECEIPT OF CLAIM]. (a) A physician or
15 provider must submit a claim to a health maintenance organization
16 not later than the 95th day after the date the physician or provider
17 provides the medical care or health care services for which the
18 claim is made [A physician or provider for health care services
19 under a health care plan may obtain acknowledgment of receipt of a
20 claim for health care services under a health care plan by
21 submitting the claim by United States mail, return receipt
22 requested]. If a physician or provider fails to submit a claim in
23 compliance with this subsection, the physician or provider forfeits
24 the right to payment unless the failure to submit the claim in
25 compliance with this subsection is a result of a catastrophic event
26 that substantially interferes with the normal business operations
27 of the physician or provider as determined under guidelines

1 established by the commissioner by rule.

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

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

7 (d) The commissioner may adopt rules under which a health
8 maintenance organization may determine whether a claim is a
9 duplicate claim [~~A health maintenance organization or the~~
10 ~~contracted clearinghouse of the health maintenance organization~~
11 ~~that receives a claim electronically shall acknowledge receipt of~~
12 ~~the claim by an electronic transmission to the physician or~~
13 ~~provider and is not required to acknowledge receipt of the claim in~~
14 ~~writing)].~~

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

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

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

25 (2) pay the portion of the claim that is not in dispute
26 and notify the physician or provider in writing why the remaining
27 portion of the claim will not be paid; or

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

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

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

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

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

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

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

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

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

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

18 Sec. 843.340. AUDITED CLAIMS. Except as provided by
19 section 843.3385, if a [A] health maintenance organization [that
20 acknowledges coverage of an enrollee under a health care plan but]
21 intends to audit a claim submitted by a physician or provider, the
22 health maintenance organization shall pay the charges submitted at
23 100 [85] percent of the contracted rate on the claim not later than
24 the 45th day after the date on which the health maintenance
25 organization receives the clean claim from a physician or provider.
26 If the health maintenance organization requests additional
27 information needed to complete the audit, the request must describe

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

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

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

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

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

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

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

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

11 (2) the physician or provider does not make
12 arrangements for repayment of the requested funds on or before the
13 45th day after the date the physician or provider receives the
14 notice;

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

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

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

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

1 organization and a physician or provider to provide that:

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

7 (2) the health maintenance organization or the health
8 maintenance organization's agent will provide the coding
9 guidelines and fee schedules not later than the 30th day after the
10 date the health maintenance organization receives the request;

11 (3) the health maintenance organization will provide
12 notice of changes to the coding guidelines and fee schedules that
13 will result in a change of payment to a physician or provider not
14 later than the 60th day before the date the changes take effect and
15 will not make retroactive revisions to the coding guidelines and
16 fee schedules; and

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

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

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

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

3 (c) The health maintenance organization shall, on request
4 of a physician or provider, provide the name, edition, and model
5 version of the software that the insurer uses to determine bundling
6 and unbundling of claims.

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

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

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

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

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

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

7 ~~[(c) Not later than the 60th day before the date of an~~
8 ~~addition or change in the data elements that must be submitted with~~
9 ~~a claim or any other change in a health maintenance organization's~~
10 ~~claim processing and payment procedures, the health maintenance~~
11 ~~organization shall provide written notice of the addition or change~~
12 ~~to each participating physician or provider.]~~

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

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

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

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

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

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

15 (d) A health maintenance organization that fails to pay the
16 contracted rate owed by the health maintenance organization for a
17 clean claim in accordance with sections 843.338, 843.339 or 843.340
18 of this article shall pay to the physician or provider a penalty in
19 the amount of fifty (50) percent of the underpaid amount. A penalty
20 under this subsection may not exceed one hundred thousand dollars
21 (\$100,000) or the difference between the billed charges and the
22 contracted rate, whichever is less. This penalty shall apply if the
23 health maintenance organization pays the balance of the contracted
24 rate to the physician or provider within forty-five (45) days of
25 receipt of written notice of the underpayment from the physician or
26 provider.

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

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

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

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

26 (h) [A health maintenance organization that violates
27 Section 843.338 or 843.340 is liable to a physician or provider for

1 ~~the full amount of billed charges submitted on the claim or the~~
2 ~~amount payable under the contracted penalty rate, less any amount~~
3 ~~previously paid or any charge for a service that is not covered by~~
4 ~~the health care plan.~~

5 ~~[(b)]~~ In addition to any other penalty or remedy authorized
6 by this code or another insurance law of this state, a health
7 maintenance organization that violates subsections 843.338,
8 843.339 or 843.340 of this article is subject to an administrative
9 penalty under Chapter 84 ~~[Article 1.10E]~~ of this code. For each day
10 an ~~[The]~~ administrative penalty is imposed under this subsection,
11 the penalty ~~[that article]~~ may not exceed \$1,000 for each ~~[day the]~~
12 claim that remains unpaid or violation of subsections ~~[(c), [or]~~
13 ~~(d)]~~ 843.338, 843.339 or 843.340 of this section. A health
14 maintenance organization is not subject to such administrative
15 penalty if the commissioner finds that the health maintenance
16 organization has paid, denied or audited at least ninety-five (95)
17 percent of all clean claims received from providers and at least
18 ninety-five (95) percent of all clean claims received from
19 providers within the statutory time frames during a calendar year.
20 The commissioner may establish standards under which the
21 commissioner may impose sanctions on or assess penalties against a
22 health maintenance organization under Chapter 82 or 84 of this code
23 if the commissioner finds that a health maintenance organization
24 has violated subsections 843.338, 843.339 or 843.340 of this
25 section in processing less than ninety-five (95) percent of clean
26 claims submitted to the health maintenance organization by
27 providers within the statutory time frames.

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

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

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

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

14 Sec. 843.345. EXCEPTIONS. Sections 843.336-843.344 do not
15 apply to[+]

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

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

21 SECTION 15. Subchapter J, Chapter 832, Insurance Code, as
22 effective June 1, 2003, is amended by adding sections 843.347 and
23 843.348 to read as follows:

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

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

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

3 (a) If the attorney general has good cause to believe that a
4 physician or provider has failed in good faith to repay a health
5 maintenance organization under section 843.3401, the attorney
6 general may:

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

9 (2) on the finding of a court that the physician or
10 provider has violated section 843.3401, recover a civil penalty of
11 not more than the greater of \$1,000 or two times the amount in
12 dispute for each violation; and

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

14 (b) If the attorney general has good cause to believe that a
15 physician or provider is or has improperly used or disclosed
16 information received by the physician or provider under section
17 843.319, the attorney general may:

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

21 (2) on the finding of a court that the physician or
22 provider has violated section 843.319, recover a civil penalty of
23 not more than \$1,000 for each negligent violation or \$10,000 for
24 each intention violation; and

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

26 (c) If the attorney general has good cause to believe that a
27 physician or provider has failed to comply with section 843.337 of

1 this article, the attorney general may:

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

4 (2) on the finding of a court that the physician or
5 provider has violated section 843.337, recover a civil penalty of
6 not more than \$1,000 for each negligent violation or \$10,000 for
7 each intentional violation; and

8 (3) recover court costs and attorneys' fees.

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

11 Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

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

20 (1) an insurance company;

21 (2) a group hospital service corporation operating
22 under Chapter 842 of this code;

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

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

27 (5) a reciprocal exchange operating under Chapter 942

1 of this code;

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

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

6 (8) an approved nonprofit health corporation that
7 holds a certificate of authority under Chapter 844 of this code.

8 (b) The term includes:

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

11 (2) a health benefit plan offered under Chapter 1551,
12 1575, or 1601 of this code.

13 (c) The term does not include:

14 (1) a hospital indemnity policy

15 (2) a limited benefit policy;

16 (3) a specified disease policy;

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

19 (5) workers' compensation insurance coverage;

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

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

27 (8) a plan that provides coverage:

- 1 a. only for accidental death or dismemberment;
- 2 b. for wages or payments in lieu of wages for a
3 period during which an employee is absent from work because of
4 sickness or injury; or
- 5 c. a supplement to liability insurance.

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

13 Sec. 2A. TEMPORARY PROVISION: ELECTRONIC SUBMISSION OR
14 CLAIMS. (a) An issuer of a health benefit plan is not required to
15 require a health care professional or facility to comply with the
16 provision required by section 2 of this article before September 1,
17 2006.

18 (b) An issuer of a health benefit plan by contract may
19 require that a health care professional licensed under the
20 Occupations Code or a health care facility licensed under the
21 Health and Safety Code submit a health care claim or equivalent
22 encounter information before September 1, 2006. The health benefit
23 plan issuer shall comply with the standards for electronic
24 transactions required by this section and established by the
25 commissioner by rule.

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

1 electronically to the issuer of a health benefit plan by September
2 1, 2006. If a health care professional or health care facility
3 cannot comply with the provisions of this Article, the health care
4 professional or health care facility must apply for a waiver of any
5 requirement for electronic submission established under subsection
6 (b) of this section to the commissioner.

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

9 (1) undue hardship;

10 (2) health care professionals in rural areas; or

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

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

17 (f) This section expires September 1, 2007.

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

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

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

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

5 (b) This section does not apply to:

6 (1) a hospital indemnity policy

7 (2) a limited benefit policy, or

8 (3) a specified disease policy.

9 SECTION 18. As soon as practicable, but not later than the
10 30th day after the effective date of this Act, the commissioner of
11 insurance shall adopt rules as necessary to implement this Act. The
12 commissioner may use the procedures under section 2001.034,
13 Government Code, for adopting emergency rules with abbreviated
14 notice and hearing to adopt rules under this section. The
15 commissioner is not required to make the finding described by
16 section 2001.034(a), Government Code, to use the emergency rules
17 procedures.

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