

By: Nelson, et al.

S.B. No. 418

A BILL TO BE ENTITLED

AN ACT

relating to the regulation and prompt payment of health care providers; providing penalties.

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

SECTION 1. Section 2, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), is amended by adding Subsection (N) to read as follows:

(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 842, Insurance Code, and an evidence of coverage issued by a health maintenance organization subject to Chapter 843, Insurance Code, may contain a coordination of payment provision to coordinate payment when a member is covered by more than one policy or evidence of coverage in accordance with rules adopted by the commissioner.

SECTION 2. Section 1, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, is amended by adding Subdivisions (14) and (15) to read as follows:

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

(15) "Verification" means a reliable representation

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

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

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

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

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

17 (c) Except as provided by Article 21.52Z of this code, a
18 physician or provider may, as appropriate:

- 19 (1) mail a claim by United States mail, first class, or
20 by overnight delivery service;
21 (2) submit the claim electronically;
22 (3) fax the claim; or
23 (4) hand deliver the claim.

24 (d) If a claim for medical care or health care services
25 provided to a patient is mailed, the claim is presumed to have been
26 received by the insurer on the fifth day after the date the claim is
27 mailed or, if the claim is mailed using overnight service or return

1 receipt requested, on the date the delivery receipt is signed. If
2 the claim is submitted electronically, the claim is presumed to
3 have been received on the date of the electronic verification of
4 receipt by the insurer or the insurer's clearinghouse. If the
5 insurer or the insurer's clearinghouse does not provide a
6 confirmation within 24 hours of submission by the physician or
7 provider, the physician's or provider's clearinghouse shall provide
8 the confirmation. The physician's or provider's clearinghouse must
9 be able to verify that the filing contained the correct payor
10 identification of the entity to receive the filing. If the claim is
11 faxed, the claim is presumed to have been received on the date of
12 the transmission acknowledgment. If the claim is hand delivered,
13 the claim is presumed to have been received on the date the delivery
14 receipt is signed.

15 (e) Except as provided by Subsection (i) of this section,
16 not [~~Not~~] later than the 45th day after the date [~~that~~] the insurer
17 receives a clean claim from a preferred provider in a nonelectronic
18 format or the 30th day after the date the insurer receives a clean
19 claim from a preferred provider that is electronically submitted,
20 the insurer shall make a determination of whether the claim is
21 payable and:

22 (1) if the insurer determines the entire claim is
23 payable, pay the total amount of the claim in accordance with the
24 contract between the preferred provider and the insurer;

25 (2) if the insurer determines a portion of the claim is
26 payable, pay the portion of the claim that is not in dispute and
27 notify the preferred provider in writing why the remaining portion

1 of the claim will not be paid; or

2 (3) if the insurer determines that the claim is not
3 payable, notify the preferred provider in writing why the claim
4 will not be paid.

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

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

9 (2) notify the pharmacy provider of the reasons for
10 denying payment of the claim [~~(d) If a prescription benefit claim~~
11 ~~is electronically adjudicated and electronically paid, and the~~
12 ~~preferred provider or its designated agent authorizes treatment,~~
13 ~~the claim must be paid not later than the 21st day after the~~
14 ~~treatment is authorized].~~

15 (g) Except as provided by Subsection (i) of this section, if
16 [~~(e) If~~] the insurer [~~acknowledges coverage of an insured under~~
17 ~~the health insurance policy but~~] intends to audit the preferred
18 provider claim, the insurer shall pay the charges submitted at 100
19 [85] percent of the contracted rate on the claim not later than the
20 30th day after the date the insurer receives the clean claim from
21 the preferred provider if submitted electronically or if submitted
22 nonelectronically not later than the 45th day after the date [~~that~~
23 the insurer receives the clean claim from the preferred provider.
24 The insurer shall clearly indicate on the explanation of payment
25 statement in the manner prescribed by the commissioner by rule that
26 the clean claim is being paid at 100 percent of the contracted rate,
27 subject to completion of the audit. If the insurer requests

1 additional information to complete the audit, the request must
2 describe with specificity the clinical information requested and
3 relate only to information the insurer in good faith can
4 demonstrate is specific to the claim or episode of care. The
5 insurer may not request as a part of the audit information that is
6 not contained in, or is not in the process of being incorporated
7 into, the patient's medical or billing record maintained by a
8 preferred provider. If the preferred provider does not supply
9 information reasonably requested by the insurer in connection with
10 the audit, the insurer may:

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

14 (2) if the provider does not provide the information
15 required by this subsection, recover the amount of the claim.

16 (h) The insurer must complete [~~Following completion of~~] the
17 audit on or before the 180th day after the date the clean claim is
18 received by the insurer, and any additional payment due a preferred
19 provider or any refund due the insurer shall be made not later than
20 the 30th day after the completion of the audit. If a preferred
21 provider disagrees with a refund request made by an insurer based on
22 the audit, the insurer shall provide the provider with an
23 opportunity to appeal, and the insurer may not attempt to recover
24 the payment until all appeal rights are exhausted [~~later of the date~~
25 that:

26 ~~(1) the preferred provider receives notice of the~~
27 ~~audit results, or~~

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

2 (i) If an insurer needs additional information from a
3 treating preferred provider to determine payment, the insurer, not
4 later than the 30th calendar day after the date the insurer receives
5 a clean claim, shall request in writing that the preferred provider
6 provide an attachment to the claim that is relevant and necessary
7 for clarification of the claim. The request must describe with
8 specificity the clinical information requested and relate only to
9 information the insurer can demonstrate is specific to the claim or
10 the claim's related episode of care. The preferred provider is not
11 required to provide an attachment that is not contained in, or is
12 not in the process of being incorporated into, the patient's
13 medical or billing record maintained by a preferred provider. An
14 insurer that requests an attachment under this subsection shall
15 determine whether the claim is payable on or before the later of the
16 15th day after the date the insurer receives the requested
17 attachment or the latest date for determining whether the claim is
18 payable under Subsection (e) or (f) of this section. An insurer may
19 not make more than one request under this subsection in connection
20 with a claim. Subsections (c) and (d) of this section apply to a
21 request for and submission of an attachment under this subsection.

22 (j) If an insurer requests an attachment or other
23 information from a person other than the preferred provider who
24 submitted the claim, the insurer shall provide a copy of the request
25 to the preferred provider who submitted the claim. The insurer may
26 not withhold payment pending receipt of an attachment or
27 information requested under this subsection. If on receiving an

1 attachment or information requested under this subsection the
2 insurer determines that there was an error in payment of the claim,
3 the insurer may recover any overpayment under Section 3D of this
4 article.

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

9 (1) The insurer's claims payment processes shall:

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

13 (2) be consistent with nationally recognized,
14 noncommercial system of bundling edits and logic, if available
15 ~~[(f) An insurer that violates Subsection (c) or (e) of this~~
16 ~~section is liable to a preferred provider for the full amount of~~
17 ~~billed charges submitted on the claim or the amount payable under~~
18 ~~the contracted penalty rate, less any amount previously paid or any~~
19 ~~charge for a service that is not covered by the health insurance~~
20 ~~policy].~~

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

24 (n) [(h) In addition to any other penalty or remedy
25 authorized by this code or another insurance law of this state, an
26 insurer that violates Subsection (c) or (e) of this section is
27 subject to an administrative penalty under Article 1.10E of this

1 ~~code. The administrative penalty imposed under that article may~~
2 ~~not exceed \$1,000 for each day the claim remains unpaid in violation~~
3 ~~of Subsection (c) or (e) of this section.~~

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

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

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

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

18 ~~[(m) This section applies to a person with whom an insurer~~
19 ~~contracts to process claims or to obtain the services of preferred~~
20 ~~providers to provide medical care or health care to insureds under a~~
21 ~~health insurance policy.~~

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

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

27 SECTION 4. Article 3.70-3C, Insurance Code, as added by

1 Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997,
2 is amended by adding Sections 3C through 3J, 10, 11, and 12 to read
3 as follows:

4 Sec. 3C. ELEMENTS OF CLEAN CLAIM. (a) A nonelectronic
5 claim by a physician or provider, other than an institutional
6 provider, is a "clean claim" if the claim is submitted using the
7 Centers for Medicare and Medicaid Services Form 1500 or, if adopted
8 by the commissioner by rule, a successor to that form developed by
9 the National Uniform Claim Committee or its successor. An
10 electronic claim by a physician or provider, other than an
11 institutional provider, is a "clean claim" if the claim is
12 submitted using the Professional 837 (ASC X12N 837) format or, if
13 adopted by the commissioner by rule, a successor to that format
14 adopted by the Centers for Medicare and Medicaid Services or its
15 successor.

16 (b) A nonelectronic claim by an institutional provider is a
17 "clean claim" if the claim is submitted using the Centers for
18 Medicare and Medicaid Services Form UB-92 or, if adopted by the
19 commissioner by rule, a successor to that form developed by the
20 National Uniform Billing Committee or its successor. An electronic
21 claim by an institutional provider is a "clean claim" if the claim
22 is submitted using the Institutional 837 (ASC X12N 837) format or,
23 if adopted by the commissioner by rule, a successor to that format
24 adopted by the Centers for Medicare and Medicaid Services or its
25 successor.

26 (c) The commissioner may adopt rules that specify the
27 information that must be entered into the appropriate fields on the

1 applicable claim form for a claim to be a clean claim.

2 (d) The commissioner may not require any data element for an
3 electronic claim that is not required in an electronic transaction
4 set needed to comply with federal law.

5 (e) An insurer and a physician or provider may agree by
6 contract to use fewer data elements than are required in an
7 electronic transaction set needed to comply with federal law.

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

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

15 Sec. 3D. OVERPAYMENT. (a) An insurer may recover an
16 overpayment to a physician or provider if:

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

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

26 (b) If a physician or provider disagrees with a request for
27 recovery of an overpayment, the insurer shall provide the physician

1 or provider with an opportunity to appeal, and the insurer may not
2 attempt to recover the overpayment until all appeal rights are
3 exhausted.

4 Sec. 3E. VERIFICATION. (a) In this section, "verification"
5 includes preauthorization only when preauthorization is a
6 condition for the verification.

7 (b) On the request of a preferred provider for verification
8 of a particular medical care or health care service the preferred
9 provider proposes to provide to a particular patient, the insurer
10 shall inform the preferred provider without delay whether the
11 service, if provided to that patient, will be paid by the insurer.

12 (c) An insurer shall have appropriate personnel reasonably
13 available at a toll-free telephone number to provide a verification
14 under this section between 6 a.m. and 6 p.m. central time Monday
15 through Friday on each day that is not a legal holiday and between 9
16 a.m. and noon central time on Saturday, Sunday, and legal holidays.
17 An insurer must have a telephone system capable of accepting or
18 recording incoming phone calls for verifications after 6 p.m.
19 central time Monday through Friday and after noon central time on
20 Saturday, Sunday, and legal holidays and responding to each of
21 those calls on or before the second calendar day after the date the
22 call is received.

23 (d) An insurer may decline to determine eligibility for
24 payment if the insurer notifies the physician or preferred provider
25 who requested the verification of the specific reason the
26 determination was not made.

27 (e) An insurer may establish a specific period during which

1 the verification is valid of not less than 30 days.

2 (f) An insurer that declines to provide a verification shall
3 notify the physician or provider who requested the verification of
4 the specific reason the verification was not provided.

5 (g) If an insurer has provided a verification for proposed
6 medical care or health care services, the insurer may not deny or
7 reduce payment to the physician or provider for those medical care
8 or health care services if provided to the insured on or before the
9 30th day after the date the verification was provided unless the
10 physician or provider has materially misrepresented the proposed
11 medical or health care services or has substantially failed to
12 perform the proposed medical or health care services.

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

15 Sec. 3F. COORDINATION OF PAYMENTS. (a) An insurer may
16 require a physician or provider to retain in the physician's or
17 provider's records updated information concerning other sources of
18 payment and to provide the information to the insurer on the
19 applicable form described by Section 3C of this article. Except as
20 provided by this subsection, an insurer may not require a physician
21 or provider to investigate coordination of payment.

22 (b) Coordination of payment under this section does not
23 extend the period for determining whether a claim is payable under
24 Section 3A(e) or (f) of this article or for auditing a claim under
25 Section 3A(g) of this article.

26 (c) A preferred provider who submits a claim for a
27 particular medical care or health care service to more than one

1 health maintenance organization or insurer shall provide notice on
2 the claim submitted to each health maintenance organization or
3 insurer with which a claim for the same medical care or health care
4 service will be filed. For the purposes of Sections 3C(a) and (b)
5 of this article, the commissioner by rule may require claim
6 elements to be submitted that would facilitate coordination of
7 payment. A claim electronically submitted by the preferred
8 provider for covered services or benefits for which there is other
9 coverage that contains a coordination of benefits provision shall
10 include the name of the primary payor, adjustment code group,
11 claims adjustment reason, and amount paid as a covered claim by the
12 primary payor. That information is considered to be essential
13 elements of a clean claim for purposes of the secondary payor's
14 processing of the claim. A preferred provider may only file a claim
15 under this section with the secondary payor after the preferred
16 provider has received notice of the disposition of the claim by the
17 primary payor.

18 (d) An insurer processing an electronic claim as a secondary
19 payor shall rely on the primary payor information submitted on the
20 claim by the preferred provider. If the secondary payor cannot
21 determine liability based on the information provided by the
22 physician or provider, the payor may ask for additional information
23 from any source available, including the physician or provider, the
24 primary payor, or the insured, subject to the requirements for
25 timely payment imposed under Section 3A of this article. Primary
26 payor information may be submitted electronically by the primary
27 payor to the secondary payor.

1 (e) If an insurer is a secondary payor and pays a portion of
2 a claim that should have been paid by the insurer or health
3 maintenance organization that is the primary payor, the overpayment
4 must first be pursued from the primary payor. The secondary payor
5 may collect from the preferred provider if:

6 (1) on or before the 180th day after the date the
7 provider receives the overpayment, the secondary payor provides
8 written notice to the provider of the overpayment and that the
9 overpayment will be pursued from the primary payor; and

10 (2) the provider does not make arrangements for
11 repayment of the requested funds on or before the 45th day after the
12 date the provider receives notice that the secondary payor is
13 unable to collect from the primary payor.

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

16 Sec. 3G. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE
17 SERVICES. (a) An insurer that uses a preauthorization process for
18 medical care and health care services shall provide to each
19 preferred provider, not later than the 10th business day after the
20 date a request is made, a list of medical care and health care
21 services that require preauthorization and information concerning
22 the preauthorization process.

23 (b) If proposed medical care or health care services require
24 preauthorization as a condition of the insurer's payment to a
25 preferred provider under a health insurance policy, the insurer
26 shall determine whether the medical care or health care services
27 proposed to be provided to the insured are medically necessary and

1 appropriate.

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

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

20 (e) An insurer shall have appropriate personnel reasonably
21 available at a toll-free telephone number to respond to requests
22 for a preauthorization between 6 a.m. and 6 p.m. central time Monday
23 through Friday on each day that is not a legal holiday and between 9
24 a.m. and noon central time on Saturday, Sunday, and legal holidays.
25 An insurer must have a telephone system capable of accepting or
26 recording incoming phone calls for preauthorizations after 6 p.m.
27 central time Monday through Friday and after noon central time on

1 Saturday, Sunday, and legal holidays and responding to each of
2 those calls not later than 24 hours after the call is received.

3 (f) If an insurer has preauthorized medical care or health
4 care services, the insurer may not deny or reduce payment to the
5 physician or provider for those services based on medical necessity
6 or appropriateness of care unless the physician or provider has
7 materially misrepresented the proposed medical or health care
8 services or has substantially failed to perform the proposed
9 medical or health care services.

10 (g) This section applies to an agent or other person with
11 whom an insurer contracts to perform, or to whom the insurer
12 delegates the performance of, preauthorization of proposed medical
13 or health care services.

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

16 Sec. 3H. AVAILABILITY OF CODING GUIDELINES. (a) A
17 contract between an insurer and a physician or provider must
18 provide that:

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

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

27 (3) the insurer or the insurer's agent will provide

1 notice of changes to the coding guidelines and fee schedules that
2 will result in a change of payment to the physician or provider not
3 later than the 90th day before the date the changes take effect and
4 will not make retroactive revisions to the coding guidelines and
5 fee schedules; and

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

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

13 (1) use or disclose the information for the purpose of
14 practice management, billing activities, and other business
15 operations; and

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

18 (c) The insurer shall, on request of the physician or
19 provider, provide the name, edition, and model version of the
20 software that the insurer uses to determine bundling and unbundling
21 of claims.

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

24 Sec. 3I. VIOLATION OF CLAIMS PAYMENT REQUIREMENTS; PENALTY.

25 (a) Except as provided by this section, if a clean claim submitted
26 to an insurer is payable and the insurer does not determine under
27 Section 3A of this article that the claim is payable and pay the

1 claim on or before the date the insurer is required to make a
2 determination or adjudication of the claim, the insurer shall pay
3 the physician or provider making the claim the contracted rate owed
4 on the claim plus a penalty in the amount of the lesser of:

5 (1) 50 percent of the difference between the billed
6 charges, as submitted on the claim, and the contracted rate; or

7 (2) \$100,000.

8 (b) If the claim is paid on or after the 46th day and before
9 the 91st day after the date the insurer is required to make a
10 determination or adjudication of the claim, the insurer shall pay a
11 penalty in the amount of the lesser of:

12 (1) 100 percent of the difference between the billed
13 charges, as submitted on the claim, and the contracted rate; or

14 (2) \$200,000.

15 (c) If the claim is paid on or after the 91st day after the
16 date the insurer is required to make a determination or
17 adjudication of the claim, the insurer shall pay a penalty computed
18 under Subsection (b) of this section plus 18 percent annual
19 interest on that amount. Interest under this subsection accrues
20 beginning on the date the insurer was required to pay the claim and
21 ending on the date the claim and the penalty are paid in full.

22 (d) Except as provided by this section, an insurer that
23 determines under Section 3A of this article that a claim is payable,
24 pays only a portion of the amount of the claim on or before the date
25 the insurer is required to make a determination or adjudication of
26 the claim, and pays the balance of the contracted rate owed for the
27 claim after that date shall pay to the physician or provider, in

1 addition to the contracted amount owed, a penalty on the amount not
2 timely paid in the amount of the lesser of:

3 (1) 50 percent of the underpaid amount; or

4 (2) \$100,000.

5 (e) If the balance of the claim is paid on or after the 46th
6 day and before the 91st day after the date the insurer is required
7 to make a determination or adjudication of the claim, the insurer
8 shall pay a penalty on the balance of the claim in the amount of the
9 lesser of:

10 (1) 100 percent of the underpaid amount; or

11 (2) \$200,000.

12 (f) If the balance of the claim is paid on or after the 91st
13 day after the date the insurer is required to make a determination
14 or adjudication of the claim, the insurer shall pay a penalty on the
15 balance of the claim computed under Subsection (e) of this section
16 plus 18 percent annual interest on that amount. Interest under this
17 subsection accrues beginning on the date the insurer was required
18 to pay the claim and ending on the date the claim and the penalty are
19 paid in full.

20 (g) An insurer is not liable for a penalty under this
21 section:

22 (1) if the failure to pay the claim in accordance with
23 Section 3A of this article is a result of a catastrophic event that
24 substantially interferes with the normal business operations of the
25 insurer; or

26 (2) if the claim was paid in accordance with Section 3A
27 of this article, but for less than the contracted rate, and:

1 (A) the physician or provider notifies the
2 insurer of the underpayment after the 180th day after the date the
3 underpayment was received; and

4 (B) the insurer pays the balance of the claim on
5 or before the 45th day after the date the insurer receives the
6 notice.

7 (h) Subsection (g) of this section does not relieve the
8 insurer of the obligation to pay the remaining unpaid contracted
9 rate owed the physician or provider.

10 (i) An insurer that pays a penalty under this section shall
11 clearly indicate on the explanation of payment statement in the
12 manner prescribed by the commissioner by rule the amount of the
13 contracted rate paid and the amount paid as a penalty.

14 (j) In addition to any other penalty or remedy authorized by
15 this code, an insurer that violates Section 3A(e), (f), or (g) of
16 this article in processing more than two percent of clean claims
17 submitted to the insurer is subject to an administrative penalty
18 under Chapter 84 of this code. For each day an administrative
19 penalty is imposed under this subsection, the penalty may not
20 exceed \$1,000 for each claim that remains unpaid in violation of
21 Section 3A (e), (f), or (g) of this article. In determining whether
22 an insurer has processed physician and provider claims in
23 compliance with Section 3A(e), (f), or (g) of this article, the
24 commissioner shall consider paid claims, other than claims that
25 have been paid under Section 3A(g) of this article, and shall
26 compute a compliance percentage for physician and provider claims,
27 other than institutional provider claims, and a compliance

1 percentage for institutional provider claims.

2 Sec. 3J. APPLICABILITY OF ARTICLE TO ENTITIES CONTRACTING
3 WITH INSURER. Sections 3A-3I of this article apply to a person with
4 whom an insurer contracts to:

5 (1) process claims;

6 (2) obtain the services of physicians and providers to
7 provide health care services to insureds; or

8 (3) issue verifications or preauthorizations.

9 Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND
10 PROVIDERS. The provisions of this article relating to prompt
11 payment by an insurer of a physician or provider and to verification
12 of medical care or health care services apply to a physician or
13 provider who:

14 (1) is not a preferred provider included in the
15 preferred provider network; and

16 (2) provides to an insured:

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

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

23 Sec. 11. IDENTIFICATION CARD. An identification card or
24 other similar document issued by an insurer regulated by this code
25 and subject to this article to an individual insured must display:

26 (1) the first date on which the individual became
27 insured under the plan; or

1 (2) a toll-free number a physician or provider may use
2 to obtain that date.

3 Sec. 12. CONFLICT WITH OTHER LAW. To the extent of any
4 conflict between this article and Article 21.52C of this code, this
5 article controls.

6 SECTION 5. Subchapter F, Chapter 843, Insurance Code, as
7 effective June 1, 2003, is amended by adding Section 843.209 to read
8 as follows:

9 Sec. 843.209. IDENTIFICATION CARD. An identification card
10 or other similar document issued by a health maintenance
11 organization to an enrollee must:

12 (1) indicate that the health maintenance organization
13 is regulated under this code and subject to the provisions of
14 Subchapter J; and

15 (2) display:

16 (A) the first date on which the enrollee became
17 enrolled; or

18 (B) a toll-free number a physician or provider
19 may use to obtain that date.

20 SECTION 6. Subchapter I, Chapter 843, Insurance Code, as
21 effective June 1, 2003, is amended by adding Section 843.319 to read
22 as follows:

23 Sec. 843.319. AVAILABILITY OF CODING GUIDELINES. (a) A
24 contract between a health maintenance organization and a physician
25 or provider must provide that:

26 (1) the physician or provider may request a
27 description and copy of the coding guidelines, including any

1 underlying bundling, recoding, or other payment process and fee
2 schedules applicable to specific procedures that the physician or
3 provider will receive under the contract;

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

8 (3) the health maintenance organization or the health
9 maintenance organization's agent will provide notice of changes to
10 the coding guidelines and fee schedules that will result in a change
11 of payment to the physician or provider not later than the 90th day
12 before the date the changes take effect and will not make
13 retroactive revisions to the coding guidelines and fee schedules;
14 and

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

20 (b) A physician or provider who receives information under
21 Subsection (a) may only:

22 (1) use or disclose the information for the purpose of
23 practice management, billing activities, and other business
24 operations; and

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

27 (c) The health maintenance organization shall, on request

1 of the physician or provider, provide the name, edition, and model
2 version of the software that the health maintenance organization
3 uses to determine bundling and unbundling of claims.

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

6 SECTION 7. Section 843.336, Insurance Code, as effective
7 June 1, 2003, is amended to read as follows:

8 Sec. 843.336. CLEAN CLAIM [DEFINITION]. (a) In this
9 subchapter, "clean claim" means a [completed] claim that complies
10 with this section~~[, as determined under department rules, submitted~~
11 ~~by a physician or provider for health care services under a health~~
12 ~~care plan].~~

13 (b) A nonelectronic claim by a physician or provider, other
14 than an institutional provider, is a clean claim if the claim is
15 submitted using the Centers for Medicare and Medicaid Services Form
16 1500 or, if adopted by the commissioner by rule, a successor to that
17 form developed by the National Uniform Claim Committee or its
18 successor. An electronic claim by a physician or provider, other
19 than an institutional provider, is a clean claim if the claim is
20 submitted using the Professional 837 (ASC X12N 837) format or, if
21 adopted by the commissioner by rule, a successor to that format
22 adopted by the Centers for Medicare and Medicaid Services or its
23 successor.

24 (c) A nonelectronic claim by an institutional provider is a
25 clean claim if the claim is submitted using the Centers for Medicare
26 and Medicaid Services Form UB-92 or, if adopted by the commissioner
27 by rule, a successor to that form developed by the National Uniform

1 Billing Committee or its successor. An electronic claim by an
2 institutional provider is a clean claim if the claim is submitted
3 using the Institutional 837 (ASC X12N 837) format or, if adopted by
4 the commissioner by rule, a successor to that format adopted by the
5 Centers for Medicare and Medicaid Services or its successor.

6 (d) The commissioner may adopt rules that specify the
7 information that must be entered into the appropriate fields on the
8 applicable claim form for a claim to be a clean claim.

9 (e) The commissioner may not require any data element for an
10 electronic claim that is not required in an electronic transaction
11 set needed to comply with federal law.

12 (f) A health maintenance organization and a physician or
13 provider may agree by contract to use fewer data elements than are
14 required in an electronic transaction set needed to comply with
15 federal law.

16 (g) An otherwise clean claim submitted by a physician or
17 provider that includes additional fields, data elements,
18 attachments, or other information not required under this section
19 is considered to be a clean claim for the purposes of this section.

20 SECTION 8. Section 843.337, Insurance Code, as effective
21 June 1, 2003, is amended to read as follows:

22 Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE
23 CLAIMS; ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A physician or
24 provider must submit a claim to a health maintenance organization
25 not later than the 95th day after the date the physician or provider
26 provides the health care services for which the claim is made. A
27 health maintenance organization shall accept as proof of timely

1 filing a claim filed in compliance with Subsection (e) or
2 information from another health maintenance organization or
3 insurer showing that the physician or provider submitted the claim
4 to the health maintenance organization or insurer in compliance
5 with Subsection (e).

6 (b) If a physician or provider fails to submit a claim in
7 compliance with this section, the physician or provider forfeits
8 the right to payment unless the failure to submit the claim in
9 compliance with this section is a result of a catastrophic event
10 that substantially interferes with the normal business operations
11 of the physician or provider.

12 (c) The period for submitting a claim under this section may
13 be extended by contract.

14 (d) A physician or provider may not submit a duplicate claim
15 for payment before the 46th day after the date the original claim
16 was submitted. The commissioner shall adopt rules under which a
17 health maintenance organization may determine whether a claim is a
18 duplicate claim.

19 (e) Except as provided by Article 21.52Z, a physician or
20 provider may, as appropriate:

21 (1) mail a claim by United States mail, first class, or
22 by overnight delivery service;

23 (2) submit the claim electronically;

24 (3) fax the claim; or

25 (4) hand deliver the claim.

26 (f) If a claim for health care services provided to a
27 patient is mailed, the claim is presumed to have been received by

1 the health maintenance organization on the fifth day after the date
2 the claim is mailed or, if the claim is mailed using overnight
3 service or return receipt requested, on the date the delivery
4 receipt is signed. If the claim is submitted electronically, the
5 claim is presumed to have been received on the date of the
6 electronic verification of receipt by the health maintenance
7 organization or the health maintenance organization's
8 clearinghouse. If the health maintenance organization or the
9 health maintenance organization's clearinghouse does not provide a
10 confirmation within 24 hours of submission by the physician or
11 provider, the physician's or provider's clearinghouse shall provide
12 the confirmation. The physician's or provider's clearinghouse must
13 be able to verify that the filing contained the correct payor
14 identification of the entity to receive the filing. If the claim is
15 faxed, the claim is presumed to have been received on the date of
16 the transmission acknowledgment. If the claim is hand delivered,
17 the claim is presumed to have been received on the date the delivery
18 receipt is signed ~~[for health care services under a health care plan~~
19 ~~may obtain acknowledgment of receipt of a claim for health care~~
20 ~~services under a health care plan by submitting the claim by United~~
21 ~~States mail, return receipt requested.~~

22 ~~[(b) A health maintenance organization or the contracted~~
23 ~~clearinghouse of the health maintenance organization that receives~~
24 ~~a claim electronically shall acknowledge receipt of the claim by an~~
25 ~~electronic transmission to the physician or provider and is not~~
26 ~~required to acknowledge receipt of the claim in writing].~~

27 SECTION 9. Section 843.338, Insurance Code, as effective

1 June 1, 2003, is amended to read as follows:

2 Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except
3 as provided by Section 843.3385, not [~~Not~~] later than the 45th day
4 after the date on which a health maintenance organization receives
5 a clean claim from a participating physician or provider in a
6 nonelectronic format or the 30th day after the date the health
7 maintenance organization receives a clean claim from a
8 participating physician or provider that is electronically
9 submitted, the health maintenance organization shall make a
10 determination of whether the claim is payable and:

11 (1) if the health maintenance organization determines
12 the entire claim is payable, pay the total amount of the claim in
13 accordance with the contract between the physician or provider and
14 the health maintenance organization;

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

19 (3) if the health maintenance organization determines
20 that the claim is not payable, notify the physician or provider in
21 writing why the claim will not be paid.

22 SECTION 10. Subchapter J, Chapter 843, Insurance Code, as
23 effective June 1, 2003, is amended by adding Section 843.3385 to
24 read as follows:

25 Sec. 843.3385. ADDITIONAL INFORMATION. (a) If a health
26 maintenance organization needs additional information from a
27 treating participating physician or provider to determine payment,

1 the health maintenance organization, not later than the 30th
2 calendar day after the date the health maintenance organization
3 receives a clean claim, shall request in writing that the physician
4 or provider provide an attachment to the claim that is relevant and
5 necessary for clarification of the claim.

6 (b) The request must describe with specificity the clinical
7 information requested and relate only to information the health
8 maintenance organization can demonstrate is specific to the claim
9 or the claim's related episode of care. The participating
10 physician or provider is not required to provide an attachment that
11 is not contained in, or is not in the process of being incorporated
12 into, the patient's medical or billing record maintained by a
13 participating physician or provider.

14 (c) A health maintenance organization that requests an
15 attachment under this section shall determine whether the claim is
16 payable on or before the later of the 15th day after the date the
17 health maintenance organization receives the requested attachment
18 or the latest date for determining whether the claim is payable
19 under Section 843.338 or 843.339.

20 (d) A health maintenance organization may not make more than
21 one request under this section in connection with a claim. Sections
22 843.337(e) and (f) apply to a request for and submission of an
23 attachment under Subsection (a).

24 (e) If a health maintenance organization requests an
25 attachment or other information from a person other than the
26 participating physician or provider who submitted the claim, the
27 health maintenance organization shall provide a copy of the request

1 to the physician or provider who submitted the claim. The health
2 maintenance organization may not withhold payment pending receipt
3 of an attachment or information requested under this subsection.
4 If on receiving an attachment or information requested under this
5 subsection the health maintenance organization determines that
6 there was an error in payment of the claim, the health maintenance
7 organization may recover any overpayment under Section 843.350.

8 (f) The commissioner shall adopt rules under which a health
9 maintenance organization can easily identify an attachment or other
10 information submitted by a physician or provider under this
11 section.

12 SECTION 11. Section 843.339, Insurance Code, as effective
13 June 1, 2003, is amended to read as follows:

14 Sec. 843.339. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION
15 ~~[BENEFIT]~~ CLAIMS. Not later than the 21st day after the date a
16 health maintenance organization affirmatively adjudicates a
17 pharmacy claim that is electronically submitted, the health
18 maintenance organization shall:

- 19 (1) pay the total amount of the claim; or
20 (2) notify the pharmacy provider of the reasons for
21 denying payment of the claim [~~If a health maintenance organization~~
22 ~~or its designated agent authorizes treatment, a prescription~~
23 ~~benefit claim that is electronically adjudicated and~~
24 ~~electronically paid shall be paid not later than the 21st day after~~
25 ~~the date on which the treatment is authorized].~~

26 SECTION 12. Section 843.340, Insurance Code, as effective
27 June 1, 2003, is amended to read as follows:

1 Sec. 843.340. AUDITED CLAIMS. (a) Except as provided by
2 Section 843.3385, if a [A] health maintenance organization [that
3 acknowledges coverage of an enrollee under a health care plan but]
4 intends to audit a claim submitted by a participating physician or
5 provider, the health maintenance organization shall pay the charges
6 submitted at 100 [85] percent of the contracted rate on the claim
7 not later than the 30th day after the date the health maintenance
8 organization receives the clean claim from the participating
9 physician or provider if submitted electronically or if submitted
10 nonelectronically not later than the 45th day after the date on
11 which the health maintenance organization receives the clean claim
12 from a participating physician or provider. The health maintenance
13 organization shall clearly indicate on the explanation of payment
14 statement in the manner prescribed by the commissioner by rule that
15 the clean claim is being paid at 100 percent of the contracted rate,
16 subject to completion of the audit.

17 (b) If the health maintenance organization requests
18 additional information to complete the audit, the request must
19 describe with specificity the clinical information requested and
20 relate only to information the health maintenance organization in
21 good faith can demonstrate is specific to the claim or episode of
22 care. The health maintenance organization may not request as a part
23 of the audit information that is not contained in, or is not in the
24 process of being incorporated into, the patient's medical or
25 billing record maintained by a participating physician or provider.

26 (c) If the participating physician or provider does not
27 supply information reasonably requested by the health maintenance

1 organization in connection with the audit, the health maintenance
2 organization may:

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

7 (2) if the physician or provider does not provide the
8 information required by this section, recover the amount of the
9 claim.

10 (d) The health maintenance organization must complete
11 [Following completion of] the audit on or before the 180th day after
12 the date the clean claim is received by the health maintenance
13 organization, and any additional payment due a participating
14 physician or provider or any refund due the health maintenance
15 organization shall be made not later than the 30th day after the
16 completion of the audit.

17 (e) If a participating physician or provider disagrees with
18 a refund request made by a health maintenance organization based on
19 the audit, the health maintenance organization shall provide the
20 physician or provider with an opportunity to appeal, and the health
21 maintenance organization may not attempt to recover the payment
22 until all appeal rights are exhausted [later of the date that:

23 (1) the physician or provider receives notice of the
24 audit results; or

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

26 SECTION 13. Section 843.341, Insurance Code, as effective
27 June 1, 2003, is amended to read as follows:

1 Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) A health
2 maintenance organization shall provide a participating physician
3 or provider with copies of all applicable utilization review
4 policies and claim processing policies or procedures[~~, including~~
5 ~~required data elements and claim formats~~].

6 (b) A health maintenance organization's claims payment
7 processes shall:

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

11 (2) be consistent with nationally recognized,
12 noncommercial system of bundling edits and logic, if available
13 ~~[organization may, by contract with a participating physician or~~
14 ~~provider, add or change the data elements that must be submitted~~
15 ~~with a claim from the physician or provider.~~

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

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

24 Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT
25 PROVISIONS; PENALTIES [~~ADMINISTRATIVE PENALTY~~]. (a) Except as
26 provided by this section, if a clean claim submitted to a health
27 maintenance organization is payable and the health maintenance

1 organization does not determine under this subchapter that the
2 claim is payable and pay the claim on or before the date the health
3 maintenance organization is required to make a determination or
4 adjudication of the claim, the health maintenance organization
5 shall pay the physician or provider making the claim the contracted
6 rate owed on the claim plus a penalty in the amount of the lesser of:

7 (1) 50 percent of the difference between the billed
8 charges, as submitted on the claim, and the contracted rate; or

9 (2) \$100,000.

10 (b) If the claim is paid on or after the 46th day and before
11 the 91st day after the date the health maintenance organization is
12 required to make a determination or adjudication of the claim, the
13 health maintenance organization shall pay a penalty in the amount
14 of the lesser of:

15 (1) 100 percent of the difference between the billed
16 charges, as submitted on the claim, and the contracted rate; or

17 (2) \$200,000.

18 (c) If the claim is paid on or after the 91st day after the
19 date the health maintenance organization is required to make a
20 determination or adjudication of the claim, the health maintenance
21 organization shall pay a penalty computed under Subsection (b) plus
22 18 percent annual interest on that amount. Interest under this
23 subsection accrues beginning on the date the health maintenance
24 organization was required to pay the claim and ending on the date
25 the claim and the penalty are paid in full.

26 (d) Except as provided by this section, a health maintenance
27 organization that determines under this subchapter that a claim is

1 payable, pays only a portion of the amount of the claim on or before
2 the date the health maintenance organization is required to make a
3 determination or adjudication of the claim, and pays the balance of
4 the contracted rate owed for the claim after that date shall pay to
5 the physician or provider, in addition to the contracted amount
6 owed, a penalty on the amount not timely paid in the amount of the
7 lesser of:

8 (1) 50 percent of the underpaid amount; or

9 (2) \$100,000.

10 (e) If the balance of the claim is paid on or after the 46th
11 day and before the 91st day after the date the health maintenance
12 organization is required to make a determination or adjudication of
13 the claim, the health maintenance organization shall pay a penalty
14 on the balance of the claim in the amount of the lesser of:

15 (1) 100 percent of the underpaid amount; or

16 (2) \$200,000.

17 (f) If the balance of the claim is paid on or after the 91st
18 day after the date the health maintenance organization is required
19 to make a determination or adjudication of the claim, the health
20 maintenance organization shall pay a penalty on the balance of the
21 claim computed under Subsection (e) plus 18 percent annual interest
22 on that amount. Interest under this subsection accrues beginning
23 on the date the health maintenance organization was required to pay
24 the claim and ending on the date the claim and the penalty are paid
25 in full.

26 (g) A health maintenance organization is not liable for a
27 penalty under this section:

1 (1) if the failure to pay the claim in accordance with
2 this subchapter is a result of a catastrophic event that
3 substantially interferes with the normal business operations of the
4 health maintenance organization; or

5 (2) if the claim was paid in accordance with this
6 subchapter, but for less than the contracted rate, and:

7 (A) the physician or provider notifies the health
8 maintenance organization of the underpayment after the 180th day
9 after the date the underpayment was received; and

10 (B) the health maintenance organization pays the
11 balance of the claim on or before the 45th day after the date the
12 health maintenance organization receives the notice.

13 (h) Subsection (g) does not relieve the health maintenance
14 organization of the obligation to pay the remaining unpaid
15 contracted rate owed the physician or provider.

16 (i) A health maintenance organization that pays a penalty
17 under this section shall clearly indicate on the explanation of
18 payment statement in the manner prescribed by the commissioner by
19 rule the amount of the contracted rate paid and the amount paid as a
20 penalty.

21 ~~(j) [A health maintenance organization that violates~~
22 ~~Section 843.338 or 843.340 is liable to a physician or provider for~~
23 ~~the full amount of billed charges submitted on the claim or the~~
24 ~~amount 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 care plan.~~

27 ~~(b)~~ In addition to any other penalty or remedy authorized

1 by this code, a health maintenance organization that violates
2 Section 843.338, 843.339, or 843.340 in processing more than two
3 percent of clean claims submitted to the health maintenance
4 organization is subject to an administrative penalty under Chapter
5 84. For each day an [~~The~~] administrative penalty is imposed under
6 this subsection, the penalty [~~that chapter~~] may not exceed \$1,000
7 for each [~~day the~~] claim that remains unpaid in violation of Section
8 843.338, 843.339, or 843.340.

9 (k) In determining whether a health maintenance
10 organization has processed physician and provider claims in
11 compliance with Section 843.338, 843.339, or 843.340, the
12 commissioner shall consider paid claims, other than claims that
13 have been paid under Section 843.340, and shall compute a
14 compliance percentage for physician and provider claims, other than
15 institutional provider claims, and a compliance percentage for
16 institutional provider claims.

17 SECTION 15. Section 843.343, Insurance Code, as effective
18 June 1, 2003, is amended to read as follows:

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

22 SECTION 16. Section 843.344, Insurance Code, as effective
23 June 1, 2003, is amended to read as follows:

24 Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES
25 CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter
26 applies [~~Sections 843.336-843.343 apply~~] to a person with whom a
27 health maintenance organization contracts to:

- 1 (1) process claims; ~~[or]~~
- 2 (2) obtain the services of physicians and providers to
3 provide health care services to enrollees; or
- 4 (3) issue verifications or preauthorizations.

5 SECTION 17. Section 843.345, Insurance Code, as effective
6 June 1, 2003, is amended to read as follows:

7 Sec. 843.345. EXCEPTION ~~[EXCEPTIONS]~~. This subchapter does
8 ~~[Sections 843.336-843.344 do]~~ not apply to~~+~~

- 9 ~~[(1)]~~ a capitated payment required to be made to a
10 physician or provider under an agreement to provide health care
11 services~~[, including medical care, under a health care plan; or~~
- 12 ~~[(2)]~~ a claim submitted by a physician or provider who
13 ~~is a member of the legislature]~~.

14 SECTION 18. Section 843.346, Insurance Code, as effective
15 June 1, 2003, is amended to read as follows:

16 Sec. 843.346. PAYMENT OF CLAIMS. Except as provided by this
17 subchapter ~~[Subject to Sections 843.336-843.345]~~, a health
18 maintenance organization shall pay a physician or provider for
19 health care services and benefits provided to an enrollee ~~[under~~
20 ~~the evidence of coverage and to which the enrollee is entitled under~~
21 ~~the terms of the evidence of coverage]~~ not later than:

- 22 (1) the 45th day after the date on which a claim for
23 payment is received with the documentation reasonably necessary to
24 process the claim; or
- 25 (2) if applicable, within the number of calendar days
26 specified by written agreement between the physician or provider
27 and the health maintenance organization.

1 SECTION 19. Subchapter J, Chapter 843, Insurance Code, as
2 effective June 1, 2003, is amended by adding Sections 843.347
3 through 843.353 to read as follows:

4 Sec. 843.347. VERIFICATION. (a) In this section,
5 "verification" means a reliable representation by a health
6 maintenance organization to a physician or provider that the health
7 maintenance organization will pay the physician or provider for
8 proposed health care services if the physician or provider renders
9 those services to the patient for whom the services are proposed.
10 The term includes precertification, certification,
11 recertification, and any other term that would be a reliable
12 representation by a health maintenance organization to a physician
13 or provider and includes preauthorization only when
14 preauthorization is a condition for the verification.

15 (b) On the request of a physician or provider for
16 verification of a particular health care service the participating
17 physician or provider proposes to provide to a particular patient,
18 the health maintenance organization shall inform the physician or
19 provider without delay whether the service, if provided to that
20 patient, will be paid by the health maintenance organization.

21 (c) A health maintenance organization shall have
22 appropriate personnel reasonably available at a toll-free
23 telephone number to provide a verification under this section
24 between 6 a.m. and 6 p.m. central time Monday through Friday on each
25 day that is not a legal holiday and between 9 a.m. and noon central
26 time on Saturday, Sunday, and legal holidays. A health maintenance
27 organization must have a telephone system capable of accepting or

1 recording incoming phone calls for verifications after 6 p.m.
2 central time Monday through Friday and after noon central time on
3 Saturday, Sunday, and legal holidays and responding to each of
4 those calls on or before the second calendar day after the date the
5 call is received.

6 (d) A health maintenance organization may decline to
7 determine eligibility for payment if the insurer notifies the
8 physician or preferred provider who requested the verification of
9 the specific reason the determination was not made.

10 (e) A health maintenance organization may establish a
11 specific period during which the verification is valid of not less
12 than 30 days.

13 (f) A health maintenance organization that declines to
14 provide a verification shall notify the physician or provider who
15 requested the verification of the specific reason the verification
16 was not provided.

17 (g) If a health maintenance organization has provided a
18 verification for proposed health care services, the health
19 maintenance organization may not deny or reduce payment to the
20 physician or provider for those health care services if provided to
21 the enrollee on or before the 30th day after the date the
22 verification was provided unless the physician or provider has
23 materially misrepresented the proposed health care services or has
24 substantially failed to perform the proposed health care services.

25 Sec. 843.348. PREAUTHORIZATION OF HEALTH CARE SERVICES.

26 (a) In this section, "preauthorization" means a determination by a
27 health maintenance organization that health care services proposed

1 to be provided to a patient are medically necessary and
2 appropriate.

3 (b) A health maintenance organization that uses a
4 preauthorization process for health care services shall provide
5 each participating physician or provider, not later than the 10th
6 business day after the date a request is made, a list of health care
7 services that do not require preauthorization and information
8 concerning the preauthorization process.

9 (c) If proposed health care services require
10 preauthorization as a condition of the health maintenance
11 organization's payment to a participating physician or provider,
12 the health maintenance organization shall determine whether the
13 health care services proposed to be provided to the enrollee are
14 medically necessary and appropriate.

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

22 (e) If the proposed health care services involve inpatient
23 care and the health maintenance organization requires
24 preauthorization as a condition of payment, the health maintenance
25 organization shall review the request and issue a length of stay for
26 the admission into a health care facility based on the
27 recommendation of the patient's physician or provider and the

1 health maintenance organization's written medically accepted
2 screening criteria and review procedures. If the proposed health
3 care services are to be provided to a patient who is an inpatient in
4 a health care facility at the time the services are proposed, the
5 health maintenance organization shall review the request and issue
6 a determination indicating whether proposed services are
7 preauthorized within 24 hours of the request by the physician or
8 provider.

9 (f) A health maintenance organization shall have
10 appropriate personnel reasonably available at a toll-free
11 telephone number to respond to requests for a preauthorization
12 between 6 a.m. and 6 p.m. central time Monday through Friday on each
13 day that is not a legal holiday and between 9 a.m. and noon central
14 time on Saturday, Sunday, and legal holidays. A health maintenance
15 organization must have a telephone system capable of accepting or
16 recording incoming phone calls for preauthorizations after 6 p.m.
17 central time Monday through Friday and after noon central time on
18 Saturday, Sunday, and legal holidays and responding to each of
19 those calls not later than 24 hours after the call is received.

20 (g) If the health maintenance organization has
21 preauthorized health care services, the health maintenance
22 organization may not deny or reduce payment to the physician or
23 provider for those services based on medical necessity or
24 appropriateness of care unless the physician or provider has
25 materially misrepresented the proposed health care services or has
26 substantially failed to perform the proposed health care services.

27 (h) This section applies to an agent or other person with

1 whom a health maintenance organization contracts to perform, or to
2 whom the health maintenance organization delegates the performance
3 of, preauthorization of proposed health care services.

4 Sec. 843.349. COORDINATION OF PAYMENTS. (a) A health
5 maintenance organization may require a physician or provider to
6 retain in the physician's or provider's records updated information
7 concerning other sources of payment coverage and to provide the
8 information to the health maintenance organization on the
9 applicable form described by Section 843.336. Except as provided
10 by this section, a health maintenance organization may not require
11 a physician or provider to investigate coordination of other
12 payment.

13 (b) Coordination of other payment under this section does
14 not extend the period for determining whether a claim is payable
15 under Section 843.338 or 843.339 or for auditing a claim under
16 Section 843.340.

17 (c) A participating physician or provider who submits a
18 claim for a particular health care service to more than one health
19 maintenance organization or insurer shall provide notice on the
20 claim submitted to each health maintenance organization or insurer
21 with which a claim for the same health care service will be filed.
22 For the purposes of Sections 843.336(b) and (c), the commissioner
23 by rule may require claim elements to be submitted that would
24 facilitate coordination of payment. A claim electronically
25 submitted by the participating physician or provider for covered
26 services or benefits for which there is other coverage that
27 contains a coordination of benefits provision shall include the

1 name of the primary payor, adjustment code group, claims adjustment
2 reason, and amount paid as a covered claim by the primary payor.
3 That information is considered to be essential elements of a clean
4 claim for purposes of the secondary payor's processing of the
5 claim. A participating physician or provider may only file a claim
6 under this section with the secondary payor after the physician or
7 provider has received notice of the disposition of the claim by the
8 primary payor.

9 (d) A health maintenance organization processing an
10 electronic claim as a secondary payor shall rely on the primary
11 payor information submitted on the claim by the participating
12 physician or provider. If the secondary payor cannot determine
13 liability based on the information provided by the physician or
14 provider, the payor may ask for additional information from any
15 source available, including the physician or provider, the primary
16 payor, or the enrollee, subject to the requirements for timely
17 payment imposed under this subchapter. Primary payor information
18 may be submitted electronically by the primary payor to the
19 secondary payor.

20 (e) If a health maintenance organization is a secondary
21 payor and pays a portion of a claim that should have been paid by the
22 insurer or health maintenance organization that is the primary
23 payor, the overpayment must first be pursued from the primary
24 payor. The secondary payor may collect from the participating
25 provider if:

26 (1) on or before the 180th day after the date the
27 provider receives the overpayment, the secondary payor provides

1 written notice to the provider of the overpayment and that the
2 overpayment will be pursued from the primary payor; and

3 (2) the provider does not make arrangements for
4 repayment of the requested funds on or before the 45th day after the
5 date the provider receives notice that the secondary payor is
6 unable to collect from the primary payor.

7 Sec. 843.350. OVERPAYMENT. (a) A health maintenance
8 organization may recover an overpayment to a physician or provider
9 if:

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

15 (2) the physician or provider does not make
16 arrangements for repayment of the requested funds on or before the
17 45th day after the date the physician or provider receives the
18 notice.

19 (b) If a physician or provider disagrees with a request for
20 recovery of an overpayment, the health maintenance organization
21 shall provide the physician or provider with an opportunity to
22 appeal, and the health maintenance organization may not recover the
23 overpayment until all appeal rights are exhausted.

24 Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND
25 PROVIDERS. The provisions of this subchapter relating to prompt
26 payment by a health maintenance organization of a physician or
27 provider and to verification of health care services apply to a

1 physician or provider who:

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

4 (2) provides to an enrollee:

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

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

12 Sec. 843.352. CONFLICT WITH OTHER LAW. To the extent of
13 any conflict between this subchapter and Article 21.52C, this
14 subchapter controls.

15 Sec. 843.353. WAIVER PROHIBITED. Except as provided by
16 Sections 843.336(f) and 843.337(c), the provisions of this
17 subchapter may not be waived, voided, or nullified by contract.

18 SECTION 20. Subchapter E, Chapter 21, Insurance Code, is
19 amended by adding Articles 21.52Y and 21.52Z to read as follows:

20 Art. 21.52Y. TECHNICAL ADVISORY COMMITTEE ON CLAIMS
21 PROCESSING. (a) The commissioner shall appoint a technical
22 advisory committee on claims processing by insurers and health
23 maintenance organizations of claims by physicians and other health
24 care providers for medical care and health care services provided
25 to patients.

26 (b) The committee shall advise the commissioner on
27 technical aspects of coding of health care services and claims

1 development, submission, processing, adjudication, and payment, as
2 well as the impact on those processes of contractual requirements
3 and relationships, including relationships among employers, health
4 benefit plans, insurers, health maintenance organizations,
5 preferred provider organizations, electronic clearinghouses,
6 physicians and other health care providers, third-party
7 administrators, independent physician associations, and medical
8 groups. The committee shall also advise the commissioner with
9 respect to the implementation of the standardized coding and
10 bundling edits and logic.

11 (c) The commissioner shall consult the advisory committee
12 with respect to any rule related to the subjects described by
13 Subsection (b) of this article before adopting the rule.

14 (d) On or before September 1 of each even-numbered year, the
15 committee shall issue a report to the legislature on the activities
16 of the committee.

17 (e) Members of the advisory committee serve without
18 compensation.

19 Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

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

- 1 (1) an insurance company;
2 (2) a group hospital service corporation operating
3 under Chapter 842 of this code;
4 (3) a fraternal benefit society operating under
5 Chapter 885 of this code;
6 (4) a stipulated premium insurance company operating
7 under Chapter 884 of this code;
8 (5) a Lloyd's plan operating under Chapter 941 of this
9 code;
10 (6) an exchange operating under Chapter 942 of this
11 code;
12 (7) a health maintenance organization operating under
13 Chapter 843 of this code;
14 (8) a multiple employer welfare arrangement that holds
15 a certificate of authority under Chapter 846 of this code; or
16 (9) an approved nonprofit health corporation that
17 holds a certificate of authority under Chapter 844 of this code.

18 (b) The term includes:

- 19 (1) a small employer health benefit plan written under
20 Chapter 26 of this code; and
21 (2) a health benefit plan offered under Chapter 1551,
22 1575, or 1601 of this code or Article 3.50-7 of this code.

23 Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. The issuer of a
24 health benefit plan by contract shall require that a health care
25 professional licensed or registered under the Occupations Code or a
26 health care facility licensed under the Health and Safety Code
27 submit a health care claim or equivalent encounter information, a

1 referral certification, or an authorization or eligibility
2 transaction electronically. The health benefit plan issuer shall
3 comply with the standards for electronic transactions required by
4 this section and established by the commissioner by rule.

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

10 (b) An issuer of a health benefit plan by contract may
11 require that a health care professional licensed or registered
12 under the Occupations Code or a health care facility licensed under
13 the Health and Safety Code submit a health care claim or equivalent
14 encounter information, a referral certification, or an
15 authorization or eligibility transaction electronically before
16 September 1, 2006. The health benefit plan issuer shall comply with
17 the standards for electronic transactions required by this section
18 and established by the commissioner by rule.

19 (c) A contract entered into before September 1, 2006,
20 between the issuer of a health benefit plan and a health care
21 professional or health care facility must provide for a waiver of
22 any requirement for electronic submission established under
23 Subsection (b) of this section.

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

26 (1) circumstances in which no method is available for
27 the submission of claims in electronic form;

- 1 (2) the operation of small physician practices;
- 2 (3) the operation of other small health care provider
3 practices;
- 4 (4) undue hardship, including fiscal or operational
5 hardship; or
- 6 (5) any other special circumstance that would justify
7 a waiver.

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

12 (f) The issuer of a health benefit plan may not refuse to
13 contract or renew a contract with a health care professional or
14 health care facility based in whole or in part on the professional
15 or facility requesting or receiving a waiver or appealing a waiver
16 determination.

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

18 Sec. 3. MODE OF TRANSMISSION. The issuer of a health
19 benefit plan may not by contract limit the mode of electronic
20 transmission that a health care professional or health care
21 facility may use to submit information under this article.

22 Sec. 4. CERTAIN CHARGES PROHIBITED. A health benefit plan
23 may not directly or indirectly charge or hold a health care
24 professional, health care facility, or person enrolled in a health
25 benefit plan responsible for a fee for the adjudication of a claim.

26 Sec. 5. RULES. The commissioner may adopt rules as
27 necessary to implement this article. The commissioner may not

1 require any data element for electronically filed claims that is
2 not required to comply with federal law.

3 SECTION 21. As soon as practicable, but not later than the
4 30th day after the effective date of this Act, the commissioner of
5 insurance shall adopt rules as necessary to implement this Act. The
6 commissioner may use the procedures under Section 2001.034,
7 Government Code, for adopting emergency rules with abbreviated
8 notice and hearing to adopt rules under this section. The
9 commissioner is not required to make the finding described by
10 Subsection (a), Section 2001.034, Government Code, to use the
11 emergency rules procedures.

12 SECTION 22. (a) With respect to a contract entered into
13 between an insurer or health maintenance organization and a
14 physician or health care provider, and payment for medical care or
15 health care services under the contract, the changes in law made by
16 this Act apply only to a contract entered into or renewed on or
17 after the 60th day after the effective date of this Act and payment
18 for services under the contract. Such a contract entered into
19 before the 60th day after the effective date of this Act and not
20 renewed or that was last renewed before the 60th day after the
21 effective date of this Act, and payment for medical care or health
22 care services under the contract, are governed by the law in effect
23 immediately before the effective date of this Act, and that law is
24 continued in effect for that purpose.

25 (b) With respect to the payment for medical care or health
26 care services provided, but not provided under a contract to which
27 Subsection (a) of this section applies, the changes in law made by

1 this Act apply only to the payment for those services provided on or
2 after the 60th day after the effective date of this Act. Payment
3 for those services provided before the 60th day after the effective
4 date of this Act is governed by the law in effect immediately before
5 the effective date of this Act, and that law is continued in effect
6 for that purpose.

7 SECTION 23. This Act takes effect June 1, 2003, if it
8 receives a vote of two-thirds of all the members elected to each
9 house, as provided by Section 39, Article III, Texas Constitution.
10 If this Act does not receive the vote necessary for immediate
11 effect, this Act takes effect September 1, 2003.