

By: Nelson

S.B. No. 418

A BILL TO BE ENTITLED

AN ACT

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

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

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

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

(b) A physician or [preferred] provider must submit a claim to an insurer not later than the 95th day after the date the physician or provider provides the medical care or health care services for which the claim is made. If a physician or provider fails to submit a claim in compliance with this subsection, the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with this subsection is a result of a catastrophic event that substantially interferes with the normal business operations of the physician or provider as determined under guidelines established by the commissioner by rule. An insurer shall accept as proof of timely filing information

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

18 (c) Except as provided by Subsection (e) or (f) of this  
19 section, not [~~Not~~] later than the 45th day after the date that the  
20 insurer receives a clean claim submitted by [~~from~~] a preferred  
21 provider, the insurer shall make a determination of whether the  
22 claim is eligible for payment and:

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

27 (2) if the insurer determines a portion of the claim is

1 eligible for payment, pay the portion of the claim that is not in  
2 dispute and notify the preferred provider in writing why the  
3 remaining portion of the claim will not be paid; or

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

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

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

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

17 (e) Except as provided by Subsection (f) of this section, if  
18 [~~If]~~ the insurer [~~acknowledges coverage of an insured under the~~  
19 ~~health insurance policy but]~~ intends to audit the preferred  
20 provider claim, the insurer shall pay the charges submitted at 100  
21 [~~85~~] percent of the contracted rate on the claim not later than the  
22 45th day after the date that the insurer receives the claim from the  
23 preferred provider and shall clearly indicate on the explanation of  
24 benefits statement in the manner prescribed by the commissioner by  
25 rule that the claim is being paid subject to the completion of an  
26 audit. The insurer must complete the audit on or before the 180th  
27 day after the date the insurer receives the claim. If the insurer

1 requests additional information needed to complete the audit, the  
2 request must describe with specificity the clinical information  
3 requested and relate only to information the insurer in good faith  
4 can demonstrate is specific to the claim or the claim's related  
5 episode of care. The insurer may not request as part of the audit  
6 information that is not contained in, or is not in the process of  
7 being incorporated into, the patient's medical or billing record  
8 maintained by a preferred provider. If a preferred provider does  
9 not supply information reasonably requested by the insurer in  
10 connection with 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 as required by Subdivision (1) of this subsection, recover the  
16 amount of the claim under Section 3D of this article and reasonable  
17 attorney's fees and court costs in any action to recover payment  
18 under that section. [~~Following completion of the audit, any~~  
19 ~~additional payment due a preferred provider or any refund due the~~  
20 ~~insurer shall be made not later than the 30th day after the later of~~  
21 ~~the date that:~~

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

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

25 (f) If an insurer needs additional information from a  
26 treating preferred provider to determine eligibility for payment,  
27 the insurer, not later than the 30th day after the date the insurer

1 receives a clean claim, shall request in writing that the preferred  
2 provider provide any additional information the insurer desires in  
3 good faith for clarification of the claim. The request must  
4 describe with specificity the clinical information requested and  
5 relate only to information the insurer can demonstrate is specific  
6 to the claim or the claim's related episode of care. The insurer  
7 may not request information that is not contained in, or is not in  
8 the process of being incorporated into, the patient's medical or  
9 billing record maintained by the preferred provider. If an insurer  
10 requests additional information under this subsection, the period  
11 for determining whether the claim is eligible for payment is  
12 extended by one day for each day after the date the insurer requests  
13 the additional information and before the date the insurer receives  
14 the additional information. An insurer may not make more than one  
15 request under this subsection in connection with a claim. [~~An~~  
16 ~~insurer that violates Subsection (c) or (e) of this section is~~  
17 ~~liable to a preferred provider for the full amount of billed charges~~  
18 ~~submitted on the claim or the amount payable under the contracted~~  
19 ~~penalty rate, less any amount previously paid or any charge for a~~  
20 ~~service that is not covered by the health insurance policy.]~~

21 (g) The commissioner shall adopt rules to identify a  
22 submission by a physician or provider to an insurer that includes  
23 additional information requested by the insurer.

24 (h) The insurer's clean claims payment processes must:

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

1           (2) be consistent with the nationally recognized,  
2 noncommercial system of bundling edits and logic known as the  
3 National Correct Coding Initiative and available from the National  
4 Technical Information Service.

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

8           (j) [(h)] In addition to any other penalty or remedy  
9 authorized by this code or another insurance law of this state, an  
10 insurer that violates Subsection (c), (d), ~~or~~ (e), or (f) of this  
11 section in processing more than two percent of clean claims  
12 submitted to the insurer by preferred providers who are  
13 institutional providers or more than two percent of clean claims  
14 submitted to the insurer by preferred providers who are not  
15 institutional providers is subject to an administrative penalty  
16 under Chapter 84 [Article 1.10E] of this code. For each day an  
17 ~~The~~ administrative penalty is imposed under this subsection, the  
18 penalty ~~[that article]~~ may not exceed \$1,000 for each ~~day the~~  
19 claim that remains unpaid in violation of Subsection (c), (d), ~~or~~  
20 (e), or (f) of this section.

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

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

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

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

8           (1) ~~[(m)]~~ This section applies to a person with whom an  
9 insurer contracts to process claims or to obtain the services of  
10 preferred providers to provide medical care or health care to  
11 insureds under a health insurance policy.

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

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

17           SECTION 2. Article 3.70-3C, Insurance Code, as added by  
18 Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997,  
19 is amended by adding Sections 3C-3J and 10-13 to read as follows:

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

1 subsection entered into the appropriate fields on the form in the  
2 manner prescribed.

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

11 (c) The commissioner may not require any data element for  
12 electronically filed claims that is not required to comply with  
13 federal law.

14 (d) An insurer and a physician or provider may agree by  
15 contract that a claim that uses fewer elements than those required  
16 by the commissioner is a clean claim for the purposes of this  
17 article.

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

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

24 Sec. 3D. OVERPAYMENT. (a) Except as provided by Subsection  
25 (b) of this section, an insurer may deduct the amount of an  
26 overpayment from any amount owed by the insurer to the physician or  
27 provider, or may otherwise recover the amount of overpayment, if:



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

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

10          (b) If a physician or provider exercises a right of appeal  
11 available under the physician's or provider's contract with the  
12 insurer with respect to an alleged overpayment, the insurer may not  
13 recover the amount overpaid until the physician's or provider's  
14 right of appeal is exhausted.

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

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

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

26           (3) the insurer or the insurer's agent will provide  
27 notice of changes to the coding guidelines and fee schedules that

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

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

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

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

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

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

21 (d) Nothing in this section may be construed to require an  
22 insurer to provide specific information that would violate any  
23 applicable copyright law or licensing agreement. However, the  
24 insurer must supply, in lieu of any information withheld on the  
25 basis of copyright law or a licensing agreement, a summary of  
26 information that will allow a reasonable person with sufficient  
27 training, experience, and competence in claims processing to

1 determine the payment to be made under the terms of the contract for  
2 covered services provided to insureds.

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

5 Sec. 3F. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE  
6 SERVICES. (a) In this section, "preauthorization" means a  
7 determination by the insurer that the medical care or health care  
8 services proposed to be provided to a patient are medically  
9 necessary and appropriate.

10 (b) An insurer that uses a preauthorization process for  
11 medical care and health care services shall provide to each  
12 preferred provider, not later than the 10th working day after the  
13 date a request is made, a list of medical care and health care  
14 services that require preauthorization and information concerning  
15 the preauthorization process.

16 (c) If proposed medical care or health care services require  
17 preauthorization as a condition of the insurer's payment to a  
18 preferred provider under a health insurance policy, the insurer  
19 shall determine whether the medical care or health care services  
20 proposed to be provided to the insured are medically necessary and  
21 appropriate.

22 (d) Not later than the third day after the date an insurer  
23 receives a request from a preferred provider for preauthorization,  
24 the insurer shall review and issue by mail or otherwise a  
25 determination indicating whether the proposed services are  
26 preauthorized.

27 (e) If the proposed medical care or health care services

1 involve inpatient care and the insurer requires preauthorization as  
2 a condition of payment, the insurer shall review and issue a length  
3 of stay for the admission into a health care facility based on the  
4 insurer's written medically accepted screening criteria and review  
5 procedures, considering the recommendation of the patient's  
6 physician or health care provider. If the proposed medical or  
7 health care services are to be provided to a patient who is an  
8 inpatient in a health care facility at the time the services are  
9 proposed, the insurer shall review and issue a determination  
10 indicating whether proposed services are preauthorized on or before  
11 the calendar day after the date of request by the physician or  
12 health care provider.

13 (f) An insurer shall have appropriate personnel reasonably  
14 available at a toll-free telephone number to respond to requests  
15 for a preauthorization between 6 a.m. and 6 p.m. central standard  
16 time Monday through Friday on each day that is not a legal holiday  
17 and between 9 a.m. and noon central standard time on Saturday,  
18 Sunday, and legal holidays. An insurer must have a telephone system  
19 capable of accepting or recording incoming phone calls for  
20 preauthorizations after 6 p.m. central standard time Monday through  
21 Friday and after noon central standard time on Saturday, Sunday,  
22 and legal holidays and have the capability to respond to each call  
23 on or before the calendar day after the date the call is received.

24 (g) If an insurer has preauthorized medical care or health  
25 care services, the insurer may not deny or reduce payment to the  
26 physician or provider for those services based on medical necessity  
27 or appropriateness of care unless the physician or provider has

1 materially misrepresented the proposed medical or health care  
2 services or has substantially failed to perform the proposed  
3 medical or health care services.

4 (h) This section applies to an agent or other person with  
5 whom an insurer contracts to perform, or to whom the insurer  
6 delegates the performance of, preauthorization of proposed medical  
7 or health care services.

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

10 Sec. 3G. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) In  
11 this section, "verification" means a reliable representation by an  
12 insurer to a physician or provider that the insurer will pay the  
13 physician or provider for proposed medical care or health care  
14 services if the physician or provider renders those services to the  
15 patient for whom the services are proposed. The term includes  
16 precertification, certification, recertification, and any other  
17 term that would be a reliable representation by an insurer to a  
18 physician or provider.

19 (b) On the request of a physician or provider for  
20 verification of the eligibility for payment of a particular medical  
21 care or health care service the physician or provider proposes to  
22 provide to a particular patient, the insurer shall inform the  
23 physician or provider without delay whether the service, if  
24 provided to that patient, is eligible for payment from the insurer  
25 to the physician or provider and whether a certificate of  
26 creditable coverage for the patient has been provided to the  
27 insurer by the group policyholder under Section 11 of this article.

1       (c) An insurer shall have appropriate personnel reasonably  
2 available at a toll-free telephone number to provide a verification  
3 under this section between 6 a.m. and 6 p.m. central standard time  
4 Monday through Friday on each day that is not a legal holiday and  
5 between 9 a.m. and noon central standard time on Saturday, Sunday,  
6 and legal holidays. An insurer must have a telephone system capable  
7 of accepting or recording incoming phone calls for verifications  
8 after 6 p.m. central standard time Monday through Friday and after  
9 noon central standard time on Saturday, Sunday, and legal holidays  
10 and have the capability to respond to each call on or before the  
11 second calendar day after the date the call is received.

12       (d) If an insurer has provided a verification for medical  
13 care or health care services, the insurer may not deny or reduce  
14 payment to the physician or provider for those medical care or  
15 health care services if those services are provided to the insured  
16 during the calendar month in which the verification was provided  
17 unless the physician or provider has materially misrepresented the  
18 proposed medical or health care services or has substantially  
19 failed to perform the proposed medical or health care services.

20       (e) An insurer may decline to determine eligibility for  
21 payment if the insurer notifies the physician or provider who  
22 requested the verification of the specific reason the determination  
23 was not made.

24       (f) An insurer may establish a specific period during which  
25 the verification is valid.

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

1       Sec. 3H. COORDINATION OF PAYMENT. (a) An insurer may  
2 require a physician or provider to retain in the physician's or  
3 provider's records updated information concerning other health  
4 benefit plan coverage and to provide the information to the insurer  
5 on the applicable claim form. Except as provided by this  
6 subsection, an insurer may not require a physician or provider to  
7 investigate coordination of other health benefit plan coverage.

8       (b) Coordination of payment under this section does not  
9 extend the period for determining whether a service is eligible for  
10 payment under Section 3A(c), (d), (e), or (f) of this article.

11       (c) A physician or provider who submits a claim for  
12 particular medical care or health care services to more than one  
13 health maintenance organization or insurer shall provide written  
14 notice on the claim submitted to each health maintenance  
15 organization or insurer of the identity of each other health  
16 maintenance organization or insurer with which a claim for the same  
17 medical care or health care services is being filed. The  
18 commissioner by rule may require claim elements under Section 3C of  
19 this article that facilitate coordination of payment. A claim  
20 electronically submitted by the preferred provider for covered  
21 services or benefits for which there is other coverage that  
22 contains a coordination of benefits provision must include the name  
23 of the primary plan, adjustment code group, claims adjustment  
24 reason, and amount paid as a covered claim by the primary plan.  
25 That information is required for the claim submitted to the  
26 secondary plan to be a clean claim. A preferred provider may file a  
27 claim with the secondary plan only after the preferred provider has

1 received notice of the disposition of the claim by the primary plan.

2 (d) An insurer processing an electronic claim as a secondary  
3 plan shall rely on the primary plan information submitted on the  
4 claim by the preferred provider. If the secondary plan cannot  
5 determine liability based on the information provided by the  
6 physician or provider, the insurer may ask for additional  
7 information from any source available, including the physician or  
8 provider, the primary payor, or the insured, subject to Section 3A  
9 of this article. Primary plan information may be submitted  
10 electronically by the primary plan to the secondary payor.

11 (e) If an insurer is a secondary payor and pays a portion of  
12 the claim that should have been paid by the insurer or health  
13 maintenance organization that is the primary payor, the secondary  
14 payor must first pursue recovery of the amount of the overpayment  
15 from the primary payor. The secondary payor shall provide notice to  
16 the preferred provider of the overpayment and that recovery of the  
17 overpayment will be pursued from the primary payor. If the  
18 secondary payor is unable to collect the amount of the overpayment  
19 from the primary payor, the secondary payor may collect the amount  
20 of the overpayment from the preferred provider under Section 3D of  
21 this article. The time allowed to recover an overpayment from a  
22 preferred provider under this subsection in accordance with Section  
23 3D of this article begins on the date the secondary payor notifies  
24 the preferred provider that recovery is being pursued from the  
25 primary payor.

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



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

4       (b) An insurer that pays a clean claim after the date the  
5 insurer is required to pay the claim in accordance with Section 3A  
6 of this article and before the 46th day after that date shall pay to  
7 the physician or provider the contracted rate owed by the insurer  
8 for the claim plus a penalty in the amount of the lesser of:

9           (1) 50 percent of the difference between the billed  
10 charge and the contracted rate; or

11           (2) \$100,000.

12       (c) An insurer that pays a clean claim on or after the 46th  
13 day after the date the insurer is required to pay the claim in  
14 accordance with Section 3A of this article and before the 91st day  
15 after that date shall pay to the physician or provider the  
16 contracted rate owed by the insurer for the claim plus a penalty in  
17 the amount of the lesser of:

18           (1) 100 percent of the difference between the billed  
19 charge and the contracted rate; or

20           (2) \$200,000.

21       (d) An insurer that pays a clean claim on or after the 91st  
22 day after the date the insurer is required to pay the claim in  
23 accordance with Section 3A of this article shall pay to the  
24 physician or provider the contracted rate owed by the insurer for  
25 the claim plus a penalty in the amount of the lesser of:

26           (1) 100 percent of the difference between the billed  
27 charge and the contracted rate plus simple interest on the amount of

1 that difference and the amount of the contracted rate at a rate of  
2 18 percent annually, computed beginning on the 91st day after the  
3 date the insurer is required to pay the claim and ending on the date  
4 the payment is made; or

5 (2) \$200,000.

6 (e) An insurer that pays only a portion of the amount of a  
7 clean claim on or before the date the insurer is required to pay the  
8 claim in accordance with Section 3A of this article and pays any  
9 portion of the balance of the contracted rate owed by the insurer  
10 for the claim before the 46th day after that date shall pay to the  
11 physician or provider, in addition to the contracted rate owed by  
12 the insurer for the claim, a penalty in the amount of 50 percent of  
13 the amount paid after the date the insurer is required to pay the  
14 claim and before the 46th day after that date. A penalty under this  
15 subsection may not exceed \$100,000.

16 (f) An insurer that pays only a portion of the amount of a  
17 clean claim on or before the date the insurer is required to pay the  
18 claim in accordance with Section 3A of this article and pays any  
19 portion of the balance of the contracted rate owed by the insurer  
20 for the claim on or after the 46th day after that date and before the  
21 91st day after that date shall pay to the physician or provider, in  
22 addition to the contracted rate owed by the insurer for the claim, a  
23 penalty in the amount of 100 percent of the amount paid after the  
24 date the insurer is required to pay the claim and before the 91st  
25 day after that date. A penalty under this subsection may not exceed  
26 \$200,000.

27 (g) An insurer that pays only a portion of the amount of a

1 clean claim on or before the date the insurer is required to pay the  
2 claim in accordance with Section 3A of this article and does not pay  
3 the balance of the contracted rate owed by the insurer for the claim  
4 before the 91st day after that date shall pay to the physician or  
5 provider, in addition to the contracted rate owed by the insurer for  
6 the claim, a penalty in the amount of 100 percent of the amount that  
7 remains unpaid on the 91st day after the date the insurer is  
8 required to pay the claim plus simple interest on the amount of that  
9 difference and the amount of the contracted rate at a rate of 18  
10 percent annually, computed beginning on the 91st day after the date  
11 the insurer is required to pay the claim and ending on the date of  
12 payment. A penalty under this subsection may not exceed \$300,000.

13 (h) An insurer is not liable for a penalty under this  
14 section if:

15 (1) in the case of an underpayment, the physician or  
16 provider fails to notify the insurer of the underpayment not later  
17 than the 180th day after the date the underpayment is received; or

18 (2) the failure to pay the claim in accordance with  
19 Section 3A of this article is a result of a catastrophic event that  
20 substantially interferes with the business operations of the  
21 insurer as determined under guidelines established by the  
22 commissioner by rule.

23 (i) An insurer that pays a penalty under this section shall  
24 clearly indicate on the explanation of benefits statement or other  
25 written documentation in the manner prescribed by the commissioner  
26 by rule the amount of the contracted rate paid and the amount paid  
27 as a penalty.

1       Sec. 3J. AUTHORITY OF ATTORNEY GENERAL. (a) In addition to  
2 any other remedy available for a violation of this article, the  
3 attorney general may take action and seek remedies available under  
4 Section 15, Article 21.21, of this code and Sections 17.58, 17.60,  
5 17.61, and 17.62, Business & Commerce Code, for a violation of  
6 Section 3A or 7 of this article.

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

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

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

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

17       (c) If the attorney general has good cause to believe that a  
18 physician or provider has improperly used or disclosed information  
19 received by the physician or provider under Section 3E of this  
20 article, the attorney general may:

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

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

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

2           Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH  
3 CARE PROVIDERS. The provisions of this article relating to prompt  
4 payment by an insurer of a physician or health care provider and to  
5 verification of medical care or health care services apply to a  
6 physician or health care provider who:

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

9           (2) provides to an insured:

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

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

16           Sec. 11. TERMS OF ENROLLEE ELIGIBILITY. A contract between  
17 an insurer and a group policyholder must provide that:

18           (1) the group policyholder will provide the insurer  
19 with a copy of an insured's certificate of creditable coverage, if  
20 applicable, at the time the insured becomes eligible for coverage  
21 under the policy;

22           (2) the group policyholder is liable for an individual  
23 insured's premiums for the month in which the policyholder notifies  
24 the insurer that the individual is no longer part of the group  
25 eligible for coverage under the policy; and

26           (3) the individual remains covered under the policy  
27 during that month.

1       Sec. 12. PROOF OF COVERAGE. A card or other similar  
2 document issued to an individual insured as proof of coverage must:

3           (1) indicate that the issuer of the coverage is  
4 regulated under this code and subject to the prompt payment  
5 provisions of this article; and

6           (2) display:

7               (A) the first date on which the individual's  
8 coverage became effective; or

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

11       Sec. 13. CONFLICT WITH OTHER LAW. To the extent of any  
12 conflict between this article and Article 21.52C or Article 21.58A  
13 of this code, this article controls.

14       SECTION 3. Subchapter F, Chapter 843, Insurance Code, as  
15 effective June 1, 2003, is amended by adding Sections 843.209 and  
16 843.210 to read as follows:

17       Sec. 843.209. TERMS OF ENROLLEE ELIGIBILITY. A contract  
18 between a health maintenance organization and a group contract  
19 holder must provide that:

20           (1) the group contract holder will provide the health  
21 maintenance organization with a copy of an enrollee's certificate  
22 of creditable coverage, if applicable, at the time the enrollee  
23 becomes eligible for coverage under the contract;

24           (2) the group contract holder is liable for an  
25 enrollee's premiums for the month in which the contract holder  
26 notifies the health maintenance organization that the enrollee is  
27 no longer part of the group eligible for coverage by the contract;

1 and

2 (3) the enrollee remains covered by the contract  
3 during that month.

4 Sec. 843.210. PROOF OF COVERAGE. A card or other similar  
5 document issued to an enrollee as proof of coverage must:

6 (1) indicate that the health maintenance organization  
7 is regulated under this code and subject to the prompt payment  
8 provisions of Subchapter J; and

9 (2) display:

10 (A) the first date on which the enrollee's  
11 coverage became effective; or

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

14 SECTION 4. Subchapter I, Chapter 843, Insurance Code, as  
15 effective June 1, 2003, is amended by adding Section 843.319 to read  
16 as follows:

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

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

25 (2) the health maintenance organization or the health  
26 maintenance organization's agent will provide the coding  
27 guidelines and fee schedules not later than the 30th day after the

1 date the health maintenance organization receives the request;

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

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

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

16 (1) use or disclose the information for the purpose of  
17 practice management, billing activities, or other business  
18 operations; and

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

21 (c) The health maintenance organization shall, on request  
22 of the physician or provider, provide the name, edition, and model  
23 version of the software that the health maintenance organization  
24 uses to determine bundling and unbundling of claims.

25 (d) Nothing in this section may be construed to require a  
26 health maintenance organization to provide specific information  
27 that would violate any applicable copyright law or licensing



1 agreement. However, the health maintenance organization must  
2 supply, in lieu of any information withheld on the basis of  
3 copyright law or a licensing agreement, a summary of information  
4 that will allow a reasonable person with sufficient training,  
5 experience, and competence in claims processing to determine the  
6 payment to be made under the terms of the contract for covered  
7 services provided to enrollees.

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

10 SECTION 5. Section 843.336, Insurance Code, as effective  
11 June 1, 2003, is amended to read as follows:

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

17 (b) A claim by a physician or provider, other than an  
18 institutional provider, is a "clean claim" if the claim is  
19 submitted using Centers for Medicare and Medicaid Services Form  
20 1500 or a successor to that form developed by the National Uniform  
21 Claim Committee or its successor and adopted by the commissioner by  
22 rule for the purposes of this subsection and contains the  
23 information required by the commissioner by rule for the purposes  
24 of this subsection entered into the appropriate fields on the form  
25 in the manner prescribed.

26 (c) A claim by an institutional provider is a "clean claim"  
27 if the claim is submitted using Centers for Medicare and Medicaid

1 Services Form UB-92 or a successor to that form developed by the  
2 National Uniform Billing Committee or its successor and adopted by  
3 the commissioner by rule for the purposes of this subsection and  
4 contains the information required by the commissioner by rule for  
5 the purposes of this subsection entered into the appropriate fields  
6 on the form in the manner prescribed.

7 (d) The commissioner may not require any data element for  
8 electronically filed claims that is not required to comply with  
9 federal law.

10 (e) A health maintenance organization and a physician or  
11 provider may agree by contract that a claim that uses fewer elements  
12 than those required by the commissioner is a clean claim for  
13 purposes of this section.

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

18 SECTION 6. Section 843.337, Insurance Code, as effective  
19 June 1, 2003, is amended to read as follows:

20 Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE  
21 CLAIMS [ACKNOWLEDGMENT OF RECEIPT OF CLAIM]. (a) A physician or  
22 provider must submit a claim under this subchapter to a health  
23 maintenance organization not later than the 95th day after the date  
24 the physician or provider provides the medical care or health care  
25 services for which the claim is made. [A physician or provider for  
26 health care services under a health care plan may obtain  
27 acknowledgment of receipt of a claim for health care services under

1 ~~a health care plan by submitting the claim by United States mail,~~  
2 ~~return receipt requested.]~~

3 (b) If a physician or provider fails to submit a claim in  
4 compliance with Subsection (a), the physician or provider forfeits  
5 the right to payment unless the failure to submit the claim in  
6 compliance with Subsection (a) is a result of a catastrophic event  
7 that substantially interferes with the normal business operations  
8 of the physician or provider as determined under guidelines  
9 established by the commissioner by rule.

10 (c) A health maintenance organization shall accept as proof  
11 of timely filing information from another health benefit plan  
12 issuer showing that the physician or provider submitted the claim  
13 to the health benefit plan issuer in compliance with Subsection  
14 (a).

15 (d) The period for submitting a claim under this section may  
16 be extended by contract.

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

20 (f) The commissioner shall adopt rules under which a health  
21 maintenance organization may determine whether a claim is a  
22 duplicate claim. [A health maintenance organization or the  
23 contracted clearinghouse of the health maintenance organization  
24 that receives a claim electronically shall acknowledge receipt of  
25 the claim by an electronic transmission to the physician or  
26 provider and is not required to acknowledge receipt of the claim in  
27 writing.]

1 SECTION 7. Section 843.338, Insurance Code, as effective  
2 June 1, 2003, is amended to read as follows:

3 Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except  
4 as provided by Section 843.3385 or 843.340, not [~~Not~~] later than the  
5 45th day after the date on which a health maintenance organization  
6 receives a clean claim submitted by [~~from~~] a physician or provider,  
7 the health maintenance organization shall make a determination of  
8 whether the claim is eligible for payment and:

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

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

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

21 SECTION 8. Subchapter J, Chapter 843, Insurance Code, as  
22 effective June 1, 2003, is amended by adding Section 843.3385 to  
23 read as follows:

24 Sec. 843.3385. ADDITIONAL INFORMATION. (a) If a health  
25 maintenance organization needs additional information from a  
26 treating physician or provider to determine eligibility for  
27 payment, the health maintenance organization, not later than the

1 30th day after the date the health maintenance organization  
2 receives a clean claim, shall request in writing that the physician  
3 or provider provide any additional information the health  
4 maintenance organization desires in good faith for clarification of  
5 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.

10 (c) The health maintenance organization may not request  
11 information that is not contained in, or is not in the process of  
12 being incorporated into, the patient's medical or billing record  
13 maintained by the physician or provider.

14 (d) If a health maintenance organization requests  
15 additional information under this section, the period for  
16 determining whether the claim is eligible for payment is extended  
17 by one day for each day after the date the health maintenance  
18 organization requests the additional information and before the  
19 date the health maintenance organization receives the additional  
20 information.

21 (e) A health maintenance organization may not make more than  
22 one request under this section in connection with a claim.

23 (f) The commissioner shall adopt rules to identify a  
24 submission by a physician or provider that includes additional  
25 information requested by the health maintenance organization.

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

1           Sec. 843.339. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION  
2 BENEFIT CLAIMS. Not later than the 21st day after the date a health  
3 maintenance organization affirmatively adjudicates a pharmacy  
4 claim that is electronically submitted, the health maintenance  
5 organization shall:

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

7                   (2) notify the pharmacy provider of the reasons for  
8 denying payment of the claim. [~~If a health maintenance organization~~  
9 ~~or its designated agent authorizes treatment, a prescription~~  
10 ~~benefit claim that is electronically adjudicated and~~  
11 ~~electronically paid shall be paid not later than the 21st day after~~  
12 ~~the date on which the treatment is authorized.]~~

13           SECTION 10. Section 843.340, Insurance Code, as effective  
14 June 1, 2003, is amended to read as follows:

15           Sec. 843.340. AUDITED CLAIMS. (a) Except as provided by  
16 Section 843.3385, if a [A] health maintenance organization [that  
17 ~~acknowledges coverage of an enrollee under a health care plan but]~~  
18 intends to audit a claim submitted by a physician or provider, the  
19 health maintenance organization shall pay the charges submitted at  
20 100 [85] percent of the contracted rate on the claim not later than  
21 the 45th day after the date on which the health maintenance  
22 organization receives the claim from a physician or provider and  
23 shall clearly indicate on the explanation of benefits statement in  
24 the manner prescribed by the commissioner by rule that the claim is  
25 being paid subject to the completion of an audit.

26                   (b) The health maintenance organization must complete the  
27 audit on or before the 180th day after the date the health

1 maintenance organization receives the claim.

2 (c) If the health maintenance organization requests  
3 additional information needed to complete the audit, the request  
4 must describe with specificity the clinical information requested  
5 and relate only to information the health maintenance organization  
6 in good faith can demonstrate is specific to the claim or the  
7 claim's related episode of care.

8 (d) The health maintenance organization may not request as  
9 part of the audit information that is not contained in, or is not in  
10 the process of being incorporated into, the patient's medical or  
11 billing record maintained by a physician or provider.

12 (e) If a physician or provider does not supply information  
13 reasonably requested by the health maintenance organization in  
14 connection with the audit, the health maintenance organization may:

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

19 (2) if the physician or provider does not provide the  
20 information as required by Subdivision (1), recover the amount of  
21 the claim under Section 843.3401 and reasonable attorney's fees and  
22 court costs in any action to recover payment under that section.

23 ~~[Following completion of the audit, any additional payment due a~~  
24 ~~physician or provider or any refund due the health maintenance~~  
25 ~~organization shall be made not later than the 30th day after the~~  
26 ~~later of the date that:~~

27 ~~[(1) the physician or provider receives notice of the~~

1 ~~audit results, or~~

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

3 SECTION 11. Subchapter J, Chapter 843, Insurance Code, as  
4 effective June 1, 2003, is amended by adding Sections 843.3401,  
5 843.3404, and 843.3405 to read as follows:

6 Sec. 843.3401. OVERPAYMENT. (a) Except as provided by  
7 Subsection (b), a health maintenance organization may deduct the  
8 amount of an overpayment from any amount owed by the health  
9 maintenance organization to the physician or provider, or may  
10 otherwise recover the amount of overpayment if:

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

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

20 (b) If a physician or provider exercises a right of appeal  
21 available under the physician's or provider's contract with the  
22 health maintenance organization with respect to an alleged  
23 overpayment, the health maintenance organization may not recover  
24 the amount overpaid until the physician's or provider's right of  
25 appeal is exhausted.

26 Sec. 843.3404. VERIFICATION OF ELIGIBILITY FOR PAYMENT.

27 (a) In this section, "verification" means a reliable



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

9 (b) On the request of a physician or provider for  
10 verification of the payment eligibility of a particular health care  
11 service the physician or provider proposes to provide to a  
12 particular patient, the health maintenance organization shall  
13 inform the physician or provider without delay whether the service,  
14 if provided to that patient, is eligible for payment from the health  
15 maintenance organization to the physician or provider and whether a  
16 certificate of creditable coverage for the patient has been  
17 provided to the health maintenance organization by the group  
18 contract holder under Section 843.209.

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

1 Friday and after noon central standard time on Saturday, Sunday,  
2 and legal holidays and have the capability to respond to each call  
3 on or before the second calendar day after the date the call is  
4 received.

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

9 (e) A health maintenance organization may establish a  
10 specific period during which the verification is valid.

11 (f) If a health maintenance organization has provided a  
12 verification for health care services, the health maintenance  
13 organization may not deny or reduce payment to the physician or  
14 provider for those health care services if those services are  
15 provided to the enrollee during the calendar month in which the  
16 verification was provided unless the physician or provider has  
17 materially misrepresented the proposed health care services or has  
18 substantially failed to perform the proposed health care services.

19 Sec. 843.3405. PREAUTHORIZATION OF HEALTH CARE SERVICES.

20 (a) In this section, "preauthorization" means a determination by  
21 the health maintenance organization that the health care services  
22 proposed to be provided to a patient are medically necessary and  
23 appropriate.

24 (b) A health maintenance organization that uses a  
25 preauthorization process for health care services shall provide to  
26 each participating physician or provider, not later than the 10th  
27 working day after the date a request is made, a list of health care

1 services that do not require preauthorization and information  
2 concerning the preauthorization process.

3 (c) If proposed health care services require  
4 preauthorization as a condition of the health maintenance  
5 organization's payment to a participating physician or provider,  
6 the health maintenance organization shall determine whether the  
7 health care services proposed to be provided to the enrollee are  
8 medically necessary and appropriate.

9 (d) Not later than the third day after the date a health  
10 maintenance organization receives a request from a participating  
11 physician or provider for preauthorization, the health maintenance  
12 organization shall review and issue by mail or otherwise a  
13 determination indicating whether the proposed services are  
14 preauthorized.

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

1 request by the physician or provider.

2 (f) A health maintenance organization shall have  
3 appropriate personnel reasonably available at a toll-free  
4 telephone number to respond to requests for a preauthorization  
5 between 6 a.m. and 6 p.m. central standard time Monday through  
6 Friday on each day that is not a legal holiday and between 9 a.m. and  
7 noon central standard time on Saturday, Sunday, and legal holidays.  
8 A health maintenance organization must have a telephone system  
9 capable of accepting or recording incoming phone calls for  
10 preauthorizations after 6 p.m. central standard time Monday through  
11 Friday and after noon central standard time on Saturday, Sunday,  
12 and legal holidays and have the capability to respond to each call  
13 on or before the calendar day after the date the call was received.

14 (g) If the health maintenance organization has  
15 preauthorized health care services, the health maintenance  
16 organization may not deny or reduce payment to the physician or  
17 provider for those services based on medical necessity or  
18 appropriateness of care unless the physician or provider has  
19 materially misrepresented the proposed health care services or has  
20 substantially failed to perform the proposed health care services.

21 SECTION 12. Section 843.341, Insurance Code, as effective  
22 June 1, 2003, is amended to read as follows:

23 Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) A health  
24 maintenance organization shall provide a participating physician  
25 or provider with copies of all applicable utilization review  
26 policies and claim processing policies or procedures [~~including~~  
27 ~~required data elements and claim formats~~].

1           (b) A health maintenance organization's clean claims  
2 payment processes must:

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

6                 (2) be consistent with the nationally recognized,  
7 noncommercial system of bundling edits and logic known as the  
8 National Correct Coding Initiative and available from the National  
9 Technical Information Service. [~~A health maintenance organization~~  
10 ~~may, by contract with a participating physician or provider, add or~~  
11 ~~change the data elements that must be submitted with a claim from~~  
12 ~~the physician or provider.~~

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

19           SECTION 13. Subchapter J, Chapter 843, Insurance Code, as  
20 effective June 1, 2003, is amended by adding Section 843.3411 to  
21 read as follows:

22                 Sec. 843.3411. COORDINATION OF PAYMENT. (a) A health  
23 maintenance organization may require a physician or provider to  
24 retain in the physician's or provider's records updated information  
25 concerning other health benefit plan coverage and to provide the  
26 information to the health maintenance organization on the  
27 applicable claim form. Except as provided by this subsection, a

1 health maintenance organization may not require a physician or  
2 provider to investigate coordination of other health benefit plan  
3 coverage.

4 (b) Coordination of payment under this section does not  
5 extend the period for determining whether a service is eligible for  
6 payment under Section 843.338, 843.3385, 843.339, or 843.340.

7 (c) A physician or provider who submits a claim for  
8 particular medical care or health care services to more than one  
9 health maintenance organization or insurer shall provide written  
10 notice on the claim submitted to each health maintenance  
11 organization or insurer of the identity of each other health  
12 maintenance organization or insurer with which a claim for the same  
13 medical care or health care services is being filed. The  
14 commissioner by rule may require claim elements under Section  
15 843.336 that facilitate coordination of payment. A claim  
16 electronically submitted by the physician or provider for covered  
17 services or benefits for which there is other coverage that  
18 contains a coordination of benefits provision must include the name  
19 of the primary plan, adjustment code group, claims adjustment  
20 reason, and amount paid as a covered claim by the primary plan.  
21 That information is required for the claim submitted to the  
22 secondary plan to be a clean claim. A physician or provider may  
23 file a claim with the secondary plan only after the physician or  
24 provider has received notice of the disposition of the claim by the  
25 primary plan.

26 (d) A health maintenance organization processing an  
27 electronic claim as a secondary plan shall rely on the primary plan

1 information submitted on the claim by the physician or provider. If  
2 the secondary plan cannot determine liability based on the  
3 information provided by the physician or provider, the health  
4 maintenance organization may ask for additional information from  
5 any source available, including the physician or provider, the  
6 primary payor, or the enrollee, subject to Sections 843.338,  
7 843.3385, 843.339, and 843.340. Primary plan information may be  
8 submitted electronically by the primary plan to the secondary  
9 payor.

10 (e) If a health maintenance organization is a secondary  
11 payor and pays a portion of the claim that should have been paid by  
12 the insurer or health maintenance organization that is the primary  
13 payor, the secondary payor must first pursue recovery of the amount  
14 of the overpayment from the primary payor. The secondary payor  
15 shall provide notice to the physician or provider of the  
16 overpayment and that recovery of the overpayment will be pursued  
17 from the primary payor. If the secondary payor is unable to collect  
18 the amount of the overpayment from the primary payor, the secondary  
19 payor may collect the amount of the overpayment from the physician  
20 or provider under Section 843.3401. The time allowed to recover an  
21 overpayment from a physician or provider under this subsection in  
22 accordance with Section 843.3401 begins on the date the secondary  
23 payor notifies the physician or provider that recovery is being  
24 pursued from the primary payor.

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

27 Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT

1 PROVISIONS; PENALTIES [~~ADMINISTRATIVE PENALTY~~]. (a) This section  
2 applies only to a clean claim eligible for payment.

3 (b) A health maintenance organization that pays a clean  
4 claim after the date the health maintenance organization is  
5 required to pay the claim in accordance with this subchapter and  
6 before the 46th day after that date shall pay to the physician or  
7 provider the contracted rate owed by the health maintenance  
8 organization for the claim plus a penalty in the amount of the  
9 lesser of:

10 (1) 50 percent of the difference between the billed  
11 charge and the contracted rate; or

12 (2) \$100,000.

13 (c) A health maintenance organization that pays a clean  
14 claim on or after the 46th day after the date the health maintenance  
15 organization is required to pay the claim in accordance with this  
16 subchapter and before the 91st day after that date shall pay to the  
17 physician or provider the contracted rate owed by the health  
18 maintenance organization for the claim plus a penalty in the amount  
19 of the lesser of:

20 (1) 100 percent of the difference between the billed  
21 charge and the contracted rate; or

22 (2) \$200,000.

23 (d) A health maintenance organization that pays a clean  
24 claim on or after the 91st day after the date the health maintenance  
25 organization is required to pay the claim in accordance with this  
26 subchapter shall pay to the physician or provider the contracted  
27 rate owed by the health maintenance organization for the claim plus



1 a penalty in the amount of the lesser of:

2 (1) 100 percent of the difference between the billed  
3 charge and the contracted rate plus simple interest on the amount of  
4 that difference and the amount of the contracted rate at a rate of  
5 18 percent annually, computed beginning on the 91st day after the  
6 date the health maintenance organization is required to pay the  
7 claim and ending on the date the payment is made; or

8 (2) \$200,000.

9 (e) A health maintenance organization that pays only a  
10 portion of the amount of a clean claim on or before the date the  
11 health maintenance organization is required to pay the claim in  
12 accordance with this subchapter and pays any portion of the balance  
13 of the contracted rate owed by the health maintenance organization  
14 for the claim before the 46th day after that date shall pay to the  
15 physician or provider, in addition to the contracted rate owed by  
16 the health maintenance organization for the claim, a penalty in the  
17 amount of 50 percent of the amount paid after the date the health  
18 maintenance organization is required to pay the claim and before  
19 the 46th day after that date. A penalty under this subsection may  
20 not exceed \$100,000.

21 (f) A health maintenance organization that pays only a  
22 portion of the amount of a clean claim on or before the date the  
23 health maintenance organization is required to pay the claim in  
24 accordance with this subchapter and pays any portion of the balance  
25 of the contracted rate owed by the health maintenance organization  
26 for the claim on or after the 46th day after that date and before the  
27 91st day after that date shall pay to the physician or provider, in

1 addition to the contracted rate owed by the health maintenance  
2 organization for the claim, a penalty in the amount of 100 percent  
3 of the amount paid after the date the health maintenance  
4 organization is required to pay the claim and before the 91st day  
5 after that date. A penalty under this subsection may not exceed  
6 \$200,000.

7 (g) A health maintenance organization that pays only a  
8 portion of the amount of a clean claim on or before the date the  
9 health maintenance organization is required to pay the claim in  
10 accordance with this subchapter and does not pay the balance of the  
11 contracted rate owed by the health maintenance organization for the  
12 claim before the 91st day after that date shall pay to the physician  
13 or provider, in addition to the contracted rate owed by the health  
14 maintenance organization for the claim, a penalty in the amount of  
15 100 percent of the amount that remains unpaid on the 91st day after  
16 the date the health maintenance organization is required to pay the  
17 claim plus simple interest on the amount of that difference and the  
18 amount of the contracted rate at a rate of 18 percent annually,  
19 computed beginning on the 91st day after the date the health  
20 maintenance organization is required to pay the claim and ending on  
21 the date of payment. A penalty under this subsection may not exceed  
22 \$300,000.

23 (h) A health maintenance organization is not liable for a  
24 penalty under this section if:

25 (1) in the case of an underpayment, the physician or  
26 provider fails to notify the health maintenance organization of the  
27 underpayment not later than the 180th day after the date the

1 underpayment is received; or

2 (2) the failure to pay the claim in accordance with  
3 this subchapter is a result of a catastrophic event that  
4 substantially interferes with the business operations of the health  
5 maintenance organization as determined under guidelines  
6 established by the commissioner by rule.

7 (i) A health maintenance organization that pays a penalty  
8 under this section shall clearly indicate on the explanation of  
9 benefits statement or other written documentation in the manner  
10 prescribed by the commissioner by rule the amount of the contracted  
11 rate paid and the amount paid as a penalty.

12 ~~(j) [A health maintenance organization that violates~~  
13 ~~Section 843.338 or 843.340 is liable to a physician or provider for~~  
14 ~~the full amount of billed charges submitted on the claim or the~~  
15 ~~amount payable under the contracted penalty rate, less any amount~~  
16 ~~previously paid or any charge for a service that is not covered by~~  
17 ~~the health care plan.~~

18 ~~[(b)]~~ In addition to any other penalty or remedy authorized  
19 by this code, a health maintenance organization that violates  
20 Section 843.338, 843.3385, 843.339, or 843.340 in processing more  
21 than two percent of clean claims submitted to the health  
22 maintenance organization by participating physicians or providers  
23 who are institutional providers or more than two percent of clean  
24 claims submitted to the health maintenance organization by  
25 participating physicians or providers who are not institutional  
26 providers is subject to an administrative penalty under Chapter 84.  
27 For each day an [The] administrative penalty is imposed under this

1 subsection, the penalty [~~that chapter~~] may not exceed \$1,000 for  
2 each [~~day the~~] claim that remains unpaid in violation of Section  
3 843.338, 843.3385, 843.339, or 843.340.

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

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

9 SECTION 16. Section 843.345, Insurance Code, as effective  
10 June 1, 2003, is amended to read as follows:

11 Sec. 843.345. EXCEPTIONS. Sections 843.336-843.344 do not  
12 apply to[+]

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

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

18 SECTION 17. Subchapter J, Chapter 843, Insurance Code, as  
19 effective June 1, 2003, is amended by adding Sections 843.347,  
20 843.348, and 843.349 to read as follows:

21 Sec. 843.347. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND  
22 PROVIDERS. The provisions of this subchapter relating to prompt  
23 payment by a health maintenance organization of a physician or  
24 provider and to verification of health care services apply to a  
25 physician or provider who:

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

1           (2) provides to an enrollee:

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

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

9           Sec. 843.348. CONFLICT WITH OTHER LAW. To the extent of any  
10 conflict between this subchapter and Article 21.52C or Article  
11 21.58A, this subchapter controls.

12           Sec. 843.349. WAIVER PROHIBITED. Except as provided by  
13 Section 843.337(d), the provisions of this subchapter may not be  
14 waived, voided, or nullified by contract.

15           SECTION 18. Subchapter N, Chapter 843, Insurance Code, as  
16 effective June 1, 2003, is amended by adding Section 843.465 to read  
17 as follows:

18           Sec. 843.465. AUTHORITY OF ATTORNEY GENERAL. (a) In  
19 addition to any other remedy available for a violation of this  
20 chapter, the attorney general may take action and seek remedies  
21 available under Section 15, Article 21.21, and Sections 17.58,  
22 17.60, 17.61, and 17.62, Business & Commerce Code, for a violation  
23 of Section 843.281, 843.363, or 843.314, or Subchapter J.

24           (b) If the attorney general has good cause to believe that a  
25 physician or provider has failed in good faith to repay a health  
26 maintenance organization under Section 843.3401, the attorney  
27 general may:

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

3           (2) on the finding of a court that the physician or  
4 provider has violated Section 843.3401, recover a civil penalty of  
5 not more than the greater of \$1,000 or two times the amount in  
6 dispute for each violation; and

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

8           (c) If the attorney general has good cause to believe that a  
9 physician or provider is or has improperly used or disclosed  
10 information received by the physician or provider under Section  
11 843.319, the attorney general may:

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

15           (2) on the finding of a court that the physician or  
16 provider has violated Section 843.319, recover a civil penalty of  
17 not more than \$1,000 for each negligent violation or \$10,000 for  
18 each intentional violation; and

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

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

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

1       (b) The committee shall advise the commissioner on  
2 technical aspects of coding of health care services and claims  
3 development, submission, processing, adjudication, and payment, as  
4 well as the impact on those processes of contractual requirements  
5 and relationships, including relationships among employers, health  
6 benefit plans, insurers, health maintenance organizations,  
7 preferred provider organizations, electronic clearinghouses,  
8 physicians and other health care providers, third party  
9 administrators, independent physician associations, and medical  
10 groups. The committee shall also advise the commissioner with  
11 respect to the feasibility of and factors involved in  
12 standardization of coding and bundling edits and logic.

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

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

19       (e) Members of the advisory committee serve without  
20 compensation.

21       Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

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

1 group hospital service contract, or an individual or group evidence  
2 of coverage or similar coverage document that is offered by:

3 (1) an insurance company;

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

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

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

10 (5) an exchange operating under Chapter 942 of this  
11 code;

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

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

16 (8) 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.

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) An issuer of a health benefit plan is not required to  
7 require a health care professional or facility to comply with the  
8 provision required by Section 2 of this article before September 1,  
9 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 professional or health care facility that is  
9 denied a waiver by a health benefit plan may appeal the denial to  
10 the commissioner. The commissioner shall determine whether a  
11 waiver must be granted.

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

13           Sec. 3. CERTAIN CHARGES PROHIBITED. A health benefit plan  
14 may not directly or indirectly charge or hold a health care  
15 professional, health care facility, or person enrolled in a health  
16 benefit plan responsible for a fee for the adjudication of a claim.

17           Sec. 4. RULES. The commissioner may adopt rules as  
18 necessary to implement this article. The commissioner may not  
19 require any data element for electronically filed claims that is  
20 not required to comply with federal law.

21           SECTION 20. As soon as practicable, but not later than the  
22 30th day after the effective date of this Act, the commissioner of  
23 insurance shall adopt rules as necessary to implement this Act. The  
24 commissioner may use the procedures under Section 2001.034,  
25 Government Code, for adopting emergency rules with abbreviated  
26 notice and hearing to adopt rules under this section. The  
27 commissioner is not required to make the finding described by

1 Section 2001.034(a), Government Code, to use the emergency rules  
2 procedures.

3 SECTION 21. (a) Except as provided by this section, the  
4 changes in law made by this Act apply only to services provided by a  
5 physician or health care provider, and payment for those services,  
6 on or after the 60th day after the effective date of this Act.  
7 Services provided before the 60th day after the effective date of  
8 this Act, and payment for those services, are governed by the law in  
9 effect immediately before the effective date of this Act, and that  
10 law is continued in effect for that purpose.

11 (b) The changes in law made by this Act do not apply to  
12 services provided by a physician or health care provider, and  
13 payment for those services, under a contract with an insurer or  
14 health maintenance organization entered into before the 60th day  
15 after the effective date of this Act. Provision of and payment for  
16 those services is governed by the law in effect immediately before  
17 the effective date of this Act, and that law is continued in effect  
18 for that purpose.

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