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

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

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

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

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

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

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

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

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

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

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

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

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

(2) if the provider does not provide the information as required by Subdivision (1) of this subsection, recover the amount of the claim under Section 3D of this article and reasonable attorney's fees and court costs in any action to recover payment under that section. [~~Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) $100,000.

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

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

(2) $200,000.

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

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

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

(2) $200,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) provides to an insured:

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

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

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

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

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

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

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

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

(2) display:

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

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

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

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

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

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

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

and

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

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

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

(2) display:

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

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

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

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

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

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

date the health maintenance organization receives the request;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If a physician or provider fails to submit a claim in compliance with Subsection (a), the physician or provider forfeits the right to payment unless the failure to submit the claim in compliance with Subsection (a) 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.

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

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

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

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

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

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

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

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

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

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

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

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

(b) The request must describe with specificity the clinical information requested and relate only to information the health maintenance organization can demonstrate is specific to the claim or the claim's related episode of care.

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

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

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

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

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

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

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

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

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

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

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

maintenance organization receives the claim.

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

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

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

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

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

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

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

~~audit results; or~~

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

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

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

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

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

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

Sec. 843.3404. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) In this section, "verification" means a reliable

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

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

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

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

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

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

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

Sec. 843.3405. PREAUTHORIZATION OF HEALTH CARE SERVICES. (a) In this section, "preauthorization" means a determination by the health maintenance organization that the health care services proposed to be provided to a patient are medically necessary and appropriate.

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

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

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

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

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

request by the physician or provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT

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

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

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

(2) $100,000.

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

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

(2) $200,000.

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

a penalty in the amount of the lesser of:

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

(2) $200,000.

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

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

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

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

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

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

underpayment is received; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) provides to an enrollee:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

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

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

(1) an insurance company;

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

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

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

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

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

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

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

(b) The term includes:

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

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

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

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

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

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

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

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

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

(2) the operation of small physician practices;

(3) the operation of other small health care provider practices;

(4) undue hardship, including fiscal or operational hardship; or

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

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

(f) This section expires September 1, 2007.

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

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

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

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

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

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

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