

1-1 By: Nelson S.B. No. 418  
1-2 (In the Senate - Filed February 10, 2003; February 17, 2003,  
1-3 read first time and referred to Committee on Health and Human  
1-4 Services; March 17, 2003, reported adversely, with favorable  
1-5 Committee Substitute by the following vote: Yeas 7, Nays 0;  
1-6 March 17, 2003, sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR S.B. No. 418 By: Deuell

1-8 A BILL TO BE ENTITLED  
1-9 AN ACT

1-10 relating to the regulation and prompt payment of health care  
1-11 providers; providing penalties.

1-12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-13 SECTION 1. Section 2, Chapter 397, Acts of the 54th  
1-14 Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas  
1-15 Insurance Code), is amended by adding Subsection (N) to read as  
1-16 follows:

1-17 (N) An individual or group policy of accident and sickness  
1-18 insurance that is delivered, issued for delivery, or renewed in  
1-19 this state, including a policy issued by a company subject to  
1-20 Chapter 842, Insurance Code, and an evidence of coverage issued by a  
1-21 health maintenance organization subject to Chapter 843, Insurance  
1-22 Code, may contain a coordination of payment provision to coordinate  
1-23 payment when a member is covered by more than one policy or evidence  
1-24 of coverage in accordance with rules adopted by the commissioner.

1-25 SECTION 2. Section 1, Article 3.70-3C, Insurance Code, as  
1-26 added by Chapter 1024, Acts of the 75th Legislature, Regular  
1-27 Session, 1997, is amended by adding Subdivisions (14) and (15) to  
1-28 read as follows:

1-29 (14) "Preauthorization" means a determination by an  
1-30 insurer that medical care or health care services proposed to be  
1-31 provided to a patient are medically necessary and appropriate.

1-32 (15) "Verification" means a reliable representation  
1-33 by an insurer to a physician or health care provider that the  
1-34 insurer will pay the physician or provider for proposed medical  
1-35 care or health care services if the physician or provider renders  
1-36 those services to the patient for whom the services are proposed.  
1-37 The term includes precertification, certification,  
1-38 recertification, and any other term that would be a reliable  
1-39 representation by an insurer to a physician or provider.

1-40 SECTION 3. Section 3A, Article 3.70-3C, Insurance Code, as  
1-41 added by Chapter 1024, Acts of the 75th Legislature, Regular  
1-42 Session, 1997, is amended to read as follows:

1-43 Sec. 3A. PROMPT PAYMENT OF [~~PREFERRED~~] PROVIDERS. (a) In  
1-44 this section, "clean claim" means a [~~completed~~] claim that complies  
1-45 with Section 3C of this article [~~, as determined under department~~  
1-46 ~~rules, submitted by a preferred provider for medical care or health~~  
1-47 ~~care services under a health insurance policy].~~

1-48 (b) A physician or [~~preferred~~] provider must submit a claim  
1-49 to an insurer not later than the 95th day after the date the  
1-50 physician or provider provides the medical care or health care  
1-51 services for which the claim is made. An insurer shall accept as  
1-52 proof of timely filing a claim filed in compliance with Subsection  
1-53 (c) of this section or information from another insurer or health  
1-54 maintenance organization showing that the physician or provider  
1-55 submitted the claim to the insurer or health maintenance  
1-56 organization in compliance with Subsection (c) of this section. If  
1-57 a physician or provider fails to submit a claim in compliance with  
1-58 this subsection, the physician or provider forfeits the right to  
1-59 payment unless the failure to submit the claim in compliance with  
1-60 this subsection is a result of a catastrophic event that  
1-61 substantially interferes with the normal business operations of the  
1-62 physician or provider. The period for submitting a claim under this  
1-63 subsection may be extended by contract. A physician or provider may

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

2-13 (c) Except as provided by Article 21.52Z of this code, a  
 2-14 physician or provider may, as appropriate:

2-15 (1) mail a claim by United States mail, first class, or  
 2-16 by overnight delivery service;

2-17 (2) submit the claim electronically;

2-18 (3) fax the claim; or

2-19 (4) hand deliver the claim.

2-20 (d) If a claim for medical care or health care services  
 2-21 provided to a patient is mailed, the claim is presumed to have been  
 2-22 received by the insurer on the fifth day after the date the claim is  
 2-23 mailed or, if the claim is mailed using overnight service or return  
 2-24 receipt requested, on the date the delivery receipt is signed. If  
 2-25 the claim is submitted electronically, the claim is presumed to  
 2-26 have been received on the date of the electronic verification of  
 2-27 receipt by the insurer or the insurer's clearinghouse. If the  
 2-28 insurer or the insurer's clearinghouse does not provide a  
 2-29 confirmation within 24 hours of submission by the physician or  
 2-30 provider, the physician's or provider's clearinghouse shall provide  
 2-31 the confirmation. The physician's or provider's clearinghouse must  
 2-32 be able to verify that the filing contained the correct payor  
 2-33 identification of the entity to receive the filing. If the claim is  
 2-34 faxed, the claim is presumed to have been received on the date of  
 2-35 the transmission acknowledgment. If the claim is hand delivered,  
 2-36 the claim is presumed to have been received on the date the delivery  
 2-37 receipt is signed.

2-38 (e) Except as provided by Subsection (j) of this section,  
 2-39 not [~~Not~~] later than the 45th day after the date [~~that~~] the insurer  
 2-40 receives a clean claim from a preferred provider in a nonelectronic  
 2-41 format or the 30th day after the date the insurer receives a clean  
 2-42 claim from a preferred provider that is electronically submitted,  
 2-43 the insurer shall make a determination of whether the claim is  
 2-44 payable and:

2-45 (1) if the insurer determines the entire claim is  
 2-46 payable, pay the total amount of the claim in accordance with the  
 2-47 contract between the preferred provider and the insurer;

2-48 (2) if the insurer determines a portion of the claim is  
 2-49 payable, pay the portion of the claim that is not in dispute and  
 2-50 notify the preferred provider in writing why the remaining portion  
 2-51 of the claim will not be paid; or

2-52 (3) if the insurer determines that the claim is not  
 2-53 payable, notify the preferred provider in writing why the claim  
 2-54 will not be paid.

2-55 (f) Not later than the 21st day after the date an insurer  
 2-56 affirmatively adjudicates a pharmacy claim that is electronically  
 2-57 submitted, the insurer shall:

2-58 (1) pay the total amount of the claim; or

2-59 (2) notify the pharmacy provider of the reasons for  
 2-60 denying payment of the claim.

2-61 (g) The investigation and determination of payment,  
 2-62 including any coordination of other payments, does not extend the  
 2-63 period for determining whether a claim is payable under Subsection  
 2-64 (e) or (f) of this section or for auditing the claim under  
 2-65 Subsection (h) of this section [~~(d) If a prescription benefit~~  
 2-66 claim is electronically adjudicated and electronically paid, and  
 2-67 the preferred provider or its designated agent authorizes  
 2-68 treatment, the claim must be paid not later than the 21st day after  
 2-69 the treatment is authorized].

3-1 (h) Except as provided by Subsection (j) of this section, if  
 3-2 ~~[(e) If] the insurer [acknowledges coverage of an insured under~~  
 3-3 ~~the health insurance policy but]~~ intends to audit the preferred  
 3-4 provider claim, the insurer shall pay the charges submitted at 100  
 3-5 ~~[85]~~ percent of the contracted rate on the claim not later than the  
 3-6 30th day after the date the insurer receives the claim from the  
 3-7 preferred provider if submitted electronically or if submitted  
 3-8 nonelectronically not later than the 45th day after the date ~~[that]~~  
 3-9 the insurer receives the claim from the preferred provider. The  
 3-10 insurer shall clearly indicate on the explanation of payment  
 3-11 statement in the manner prescribed by the commissioner by rule that  
 3-12 the claim is being paid at 100 percent of the contracted rate,  
 3-13 subject to completion of the audit. If the insurer requests  
 3-14 additional information to complete the audit, the request must  
 3-15 describe with specificity the clinical information requested and  
 3-16 relate only to information the insurer in good faith can  
 3-17 demonstrate is specific to the claim or episode of care. The  
 3-18 insurer may not request as a part of the audit information that is  
 3-19 not contained in, or is not in the process of being incorporated  
 3-20 into, the patient's medical or billing record maintained by a  
 3-21 preferred provider. If the preferred provider does not supply  
 3-22 information reasonably requested by the insurer in connection with  
 3-23 the audit, the insurer may:

3-24 (1) notify the provider in writing that the provider  
 3-25 must provide the information not later than the 45th day after the  
 3-26 date of the notice or forfeit the amount of the claim; and

3-27 (2) if the provider does not provide the information  
 3-28 required by this subsection, recover the amount of the claim.

3-29 (i) The insurer must complete ~~[Following completion of]~~ the  
 3-30 audit on or before the 180th day after the date the clean claim is  
 3-31 received by the insurer, and any additional payment due a preferred  
 3-32 provider or any refund due the insurer shall be made not later than  
 3-33 the 30th day after the completion of the audit. If a preferred  
 3-34 provider disagrees with a refund request made by an insurer based on  
 3-35 the audit, the insurer shall provide the provider with an  
 3-36 opportunity to appeal, and the insurer may not attempt to recover  
 3-37 the payment until all appeal rights are exhausted ~~[later of the date~~  
 3-38 ~~that:~~

3-39 ~~[(1) the preferred provider receives notice of the~~  
 3-40 ~~audit results; or~~

3-41 ~~[(2) any appeal rights of the insured are exhausted].~~

3-42 (j) If an insurer needs additional information from a  
 3-43 treating preferred provider to determine payment, the insurer, not  
 3-44 later than the 30th calendar day after the date the insurer receives  
 3-45 a clean claim, shall request in writing that the preferred provider  
 3-46 provide an attachment to the claim that is relevant and necessary  
 3-47 for clarification of the claim. The request must describe with  
 3-48 specificity the clinical information requested and relate only to  
 3-49 information the insurer can demonstrate is specific to the claim or  
 3-50 the claim's related episode of care. The preferred provider is not  
 3-51 required to provide an attachment that is not contained in, or is  
 3-52 not in the process of being incorporated into, the patient's  
 3-53 medical or billing record maintained by a preferred provider. An  
 3-54 insurer that requests an attachment under this subsection shall  
 3-55 determine whether the claim is payable on or before the later of the  
 3-56 15th day after the date the insurer receives the requested  
 3-57 attachment or the latest date for determining whether the claim is  
 3-58 payable under Subsection (e) or (f) of this section. An insurer may  
 3-59 not make more than one request under this subsection in connection  
 3-60 with a claim. Subsections (c) and (d) of this section apply to a  
 3-61 request for and submission of an attachment under this subsection.

3-62 (k) If an insurer requests an attachment or other  
 3-63 information from a person other than the preferred provider who  
 3-64 submitted the claim, the insurer shall provide a copy of the request  
 3-65 to the preferred provider who submitted the claim. The insurer may  
 3-66 not withhold payment pending receipt of an attachment or  
 3-67 information requested under this subsection. If on receiving an  
 3-68 attachment or information requested under this subsection the  
 3-69 insurer determines that there was an error in payment of the claim,

4-1 the insurer may recover any overpayment under Section 3D of this  
4-2 article.

4-3 (l) The commissioner shall adopt rules under which an  
4-4 insurer can easily identify attachments or other information  
4-5 submitted by a physician or provider under Subsection (j) or (k) of  
4-6 this section.

4-7 (m) The insurer's claims payment processes shall:

4-8 (1) use nationally recognized, generally accepted  
4-9 Current Procedural Terminology codes, notes, and guidelines,  
4-10 including all relevant modifiers; and

4-11 (2) be consistent with the nationally recognized,  
4-12 noncommercial system of bundling edits and logic known as the  
4-13 National Correct Coding Initiative and available from the National  
4-14 Technical Information Service or a successor to that system adopted  
4-15 by the commissioner by rule for the purposes of this subsection

4-16 ~~[(f) An insurer that violates Subsection (c) or (e) of this~~  
4-17 ~~section is liable to a preferred provider for the full amount of~~  
4-18 ~~billed charges submitted on the claim or the amount payable under~~  
4-19 ~~the contracted penalty rate, less any amount previously paid or any~~  
4-20 ~~charge for a service that is not covered by the health insurance~~  
4-21 ~~policy].~~

4-22 (n) [(g)] A preferred provider may recover reasonable  
4-23 attorney's fees and court costs in an action to recover payment  
4-24 under this section.

4-25 ~~(o) [(h) In addition to any other penalty or remedy~~  
4-26 ~~authorized by this code or another insurance law of this state, an~~  
4-27 ~~insurer that violates Subsection (c) or (e) of this section is~~  
4-28 ~~subject to an administrative penalty under Article 1.10E of this~~  
4-29 ~~code. The administrative penalty imposed under that article may~~  
4-30 ~~not exceed \$1,000 for each day the claim remains unpaid in violation~~  
4-31 ~~of Subsection (c) or (e) of this section.~~

4-32 ~~[(i)] The insurer shall provide a preferred provider with~~  
4-33 ~~copies of all applicable utilization review policies and claim~~  
4-34 ~~processing policies or procedures[, including required data~~  
4-35 ~~elements and claim formats].~~

4-36 ~~(p) [(j) An insurer may, by contract with a preferred~~  
4-37 ~~provider, add or change the data elements that must be submitted~~  
4-38 ~~with the preferred provider claim.~~

4-39 ~~[(k) Not later than the 60th day before the date of an~~  
4-40 ~~addition or change in the data elements that must be submitted with~~  
4-41 ~~a claim or any other change in an insurer's claim processing and~~  
4-42 ~~payment procedures, the insurer shall provide written notice of the~~  
4-43 ~~addition or change to each preferred provider.~~

4-44 ~~[(l) This section does not apply to a claim made by a~~  
4-45 ~~preferred provider who is a member of the legislature.~~

4-46 ~~[(m) This section applies to a person with whom an insurer~~  
4-47 ~~contracts to process claims or to obtain the services of preferred~~  
4-48 ~~providers to provide medical care or health care to insureds under a~~  
4-49 ~~health insurance policy.~~

4-50 ~~[(n)] The commissioner of insurance may adopt rules as~~  
4-51 ~~necessary to implement this section.~~

4-52 (q) Except as provided by Subsection (b) of this section,  
4-53 the provisions of this section may not be waived, voided, or  
4-54 nullified by contract.

4-55 SECTION 4. Article 3.70-3C, Insurance Code, as added by  
4-56 Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997,  
4-57 is amended by adding Sections 3C through 3J, 10, 11, and 12 to read  
4-58 as follows:

4-59 Sec. 3C. ELEMENTS OF CLEAN CLAIM. (a) A nonelectronic  
4-60 claim by a physician or provider, other than an institutional  
4-61 provider, is a "clean claim" if the claim is submitted using the  
4-62 Centers for Medicare and Medicaid Services Form 1500 or, if adopted  
4-63 by the commissioner by rule, a successor to that form developed by  
4-64 the National Uniform Claim Committee or its successor. An  
4-65 electronic claim by a physician or provider, other than an  
4-66 institutional provider, is a "clean claim" if the claim is  
4-67 submitted using the Professional 837 (ASC X12N 837) format or, if  
4-68 adopted by the commissioner by rule, a successor to that format  
4-69 adopted by the Centers for Medicare and Medicaid Services or its

5-1 successor.

5-2 (b) A nonelectronic claim by an institutional provider is a  
 5-3 "clean claim" if the claim is submitted using the Centers for  
 5-4 Medicare and Medicaid Services Form UB-92 or, if adopted by the  
 5-5 commissioner by rule, a successor to that form developed by the  
 5-6 National Uniform Billing Committee or its successor. An electronic  
 5-7 claim by an institutional provider is a "clean claim" if the claim  
 5-8 is submitted using the Institutional 837 (ASC X12N 837) format or,  
 5-9 if adopted by the commissioner by rule, a successor to that format  
 5-10 adopted by the Centers for Medicare and Medicaid Services or its  
 5-11 successor.

5-12 (c) The commissioner may adopt rules that specify the  
 5-13 information that must be entered into the appropriate fields on the  
 5-14 applicable claim form for a claim to be a clean claim.

5-15 (d) The commissioner may not require any data element that  
 5-16 is not required in an electronic transaction set needed to comply  
 5-17 with federal law.

5-18 (e) An insurer and a physician or provider may agree by  
 5-19 contract to use fewer data elements than are required in an  
 5-20 electronic transaction set needed to comply with federal law.

5-21 (f) A claim submitted by a physician or provider that  
 5-22 includes additional fields, data elements, attachments, or other  
 5-23 information not required under this section is considered to be a  
 5-24 clean claim for the purposes of this article.

5-25 (g) Except as provided by Subsection (e) of this section,  
 5-26 the provisions of this section may not be waived, voided, or  
 5-27 nullified by contract.

5-28 Sec. 3D. OVERPAYMENT. (a) An insurer may recover an  
 5-29 overpayment to a physician or provider if:

5-30 (1) not later than the 180th day after the date the  
 5-31 physician or provider receives the payment, the insurer provides  
 5-32 written notice of the overpayment to the physician or provider that  
 5-33 includes the basis and specific reasons for the request for  
 5-34 recovery of funds; and

5-35 (2) the physician or provider does not make  
 5-36 arrangements for repayment of the requested funds on or before the  
 5-37 45th day after the date the physician or provider receives the  
 5-38 notice.

5-39 (b) If a physician or provider disagrees with a request for  
 5-40 recovery of an overpayment, the insurer shall provide the physician  
 5-41 or provider with an opportunity to appeal, and the insurer may not  
 5-42 attempt to recover the overpayment until all appeal rights are  
 5-43 exhausted.

5-44 Sec. 3E. VERIFICATION. (a) In this section, "verification"  
 5-45 includes preauthorization only when preauthorization is a  
 5-46 condition for the verification.

5-47 (b) On the request of a preferred provider for verification  
 5-48 of a particular medical care or health care service the preferred  
 5-49 provider proposes to provide to a particular patient, the insurer  
 5-50 shall inform the preferred provider without delay whether the  
 5-51 service, if provided to that patient, will be paid by the insurer.

5-52 (c) An insurer shall have appropriate personnel reasonably  
 5-53 available at a toll-free telephone number to provide a verification  
 5-54 under this section between 6 a.m. and 6 p.m. central time Monday  
 5-55 through Friday on each day that is not a legal holiday and between 9  
 5-56 a.m. and noon central time on Saturday, Sunday, and legal holidays.  
 5-57 An insurer must have a telephone system capable of accepting or  
 5-58 recording incoming phone calls for verifications after 6 p.m.  
 5-59 central time Monday through Friday and after noon central time on  
 5-60 Saturday, Sunday, and legal holidays and responding to each of  
 5-61 those calls on or before the second calendar day after the date the  
 5-62 call is received.

5-63 (d) An insurer that declines to provide a verification shall  
 5-64 notify the physician or provider who requested the verification of  
 5-65 the specific reason the verification was not provided.

5-66 (e) If an insurer has provided a verification for proposed  
 5-67 medical care or health care services, the insurer may not deny or  
 5-68 reduce payment to the physician or provider for those medical care  
 5-69 or health care services if provided to the insured on or before the

6-1 30th day after the date the verification was provided unless the  
 6-2 physician or provider has materially misrepresented the proposed  
 6-3 medical or health care services or has substantially failed to  
 6-4 perform the proposed medical or health care services.

6-5 (f) The provisions of this section may not be waived,  
 6-6 voided, or nullified by contract.

6-7 Sec. 3F. COORDINATION OF PAYMENTS. (a) An insurer may  
 6-8 require a physician or provider to retain in the physician's or  
 6-9 provider's records updated information concerning other sources of  
 6-10 payment and to provide the information to the insurer on the  
 6-11 applicable form described by Section 3C of this article. Except as  
 6-12 provided by this subsection, an insurer may not require a physician  
 6-13 or provider to investigate coordination of payment.

6-14 (b) Coordination of payment under this section does not  
 6-15 extend the period for determining whether a claim is payable under  
 6-16 Section 3A(e) or (f) of this article or for auditing a claim under  
 6-17 Section 3A(h) of this article.

6-18 (c) A preferred provider who submits a claim for a  
 6-19 particular medical care or health care service to more than one  
 6-20 health maintenance organization or insurer shall provide notice on  
 6-21 the claim submitted to each health maintenance organization or  
 6-22 insurer with which a claim for the same medical care or health care  
 6-23 service will be filed. For the purposes of Sections 3C(a) and (b)  
 6-24 of this article, the commissioner by rule may require claim  
 6-25 elements to be submitted that would facilitate coordination of  
 6-26 payment. A claim electronically submitted by the preferred  
 6-27 provider for covered services or benefits for which there is other  
 6-28 coverage that contains a coordination of benefits provision shall  
 6-29 include the name of the primary payor, adjustment code group,  
 6-30 claims adjustment reason, and amount paid as a covered claim by the  
 6-31 primary payor. That information is considered to be essential  
 6-32 elements of a clean claim for purposes of the secondary payor's  
 6-33 processing of the claim. A preferred provider may only file a claim  
 6-34 under this section with the secondary payor after the preferred  
 6-35 provider has received notice of the disposition of the claim by the  
 6-36 primary payor.

6-37 (d) An insurer processing an electronic claim as a secondary  
 6-38 payor shall rely on the primary payor information submitted on the  
 6-39 claim by the preferred provider. If the secondary payor cannot  
 6-40 determine liability based on the information provided by the  
 6-41 physician or provider, the payor may ask for additional information  
 6-42 from any source available, including the physician or provider, the  
 6-43 primary payor, or the insured, subject to the requirements for  
 6-44 timely payment imposed under Section 3A of this article. Primary  
 6-45 payor information may be submitted electronically by the primary  
 6-46 payor to the secondary payor.

6-47 (e) If an insurer is a secondary payor and pays a portion of  
 6-48 a claim that should have been paid by the insurer or health  
 6-49 maintenance organization that is the primary payor, the overpayment  
 6-50 must first be pursued from the primary payor. The secondary payor  
 6-51 may collect from the preferred provider if:

6-52 (1) on or before the 180th day after the date the  
 6-53 provider receives the overpayment, the secondary payor provides  
 6-54 written notice to the provider of the overpayment and that the  
 6-55 overpayment will be pursued from the primary payor; and

6-56 (2) the provider does not make arrangements for  
 6-57 repayment of the requested funds on or before the 45th day after the  
 6-58 date the provider receives notice that the secondary payor is  
 6-59 unable to collect from the primary payor.

6-60 (f) The provisions of this section may not be waived,  
 6-61 voided, or nullified by contract.

6-62 Sec. 3G. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE  
 6-63 SERVICES. (a) An insurer that uses a preauthorization process for  
 6-64 medical care and health care services shall provide to each  
 6-65 preferred provider, not later than the 10th business day after the  
 6-66 date a request is made, a list of medical care and health care  
 6-67 services that require preauthorization and information concerning  
 6-68 the preauthorization process.

6-69 (b) If proposed medical care or health care services require

7-1 preauthorization as a condition of the insurer's payment to a  
 7-2 preferred provider under a health insurance policy, the insurer  
 7-3 shall determine whether the medical care or health care services  
 7-4 proposed to be provided to the insured are medically necessary and  
 7-5 appropriate.

7-6 (c) On receipt of a request from a preferred provider for  
 7-7 preauthorization, the insurer shall review and issue a  
 7-8 determination indicating whether the proposed medical or health  
 7-9 care services are preauthorized. The determination must be mailed  
 7-10 or otherwise transmitted not later than the third calendar day  
 7-11 after the date the request is received by the insurer.

7-12 (d) If the proposed medical care or health care services  
 7-13 involve inpatient care and the insurer requires preauthorization as  
 7-14 a condition of payment, the insurer shall review the request and  
 7-15 issue a length of stay for the admission into a health care facility  
 7-16 based on the recommendation of the patient's physician or provider  
 7-17 and the insurer's written medically accepted screening criteria and  
 7-18 review procedures. If the proposed medical or health care services  
 7-19 are to be provided to a patient who is an inpatient in a health care  
 7-20 facility at the time the services are proposed, the insurer shall  
 7-21 review the request and issue a determination indicating whether  
 7-22 proposed services are preauthorized within 24 hours of the request  
 7-23 by the physician or provider.

7-24 (e) An insurer shall have appropriate personnel reasonably  
 7-25 available at a toll-free telephone number to respond to requests  
 7-26 for a preauthorization between 6 a.m. and 6 p.m. central time Monday  
 7-27 through Friday on each day that is not a legal holiday and between 9  
 7-28 a.m. and noon central time on Saturday, Sunday, and legal holidays.  
 7-29 An insurer must have a telephone system capable of accepting or  
 7-30 recording incoming phone calls for preauthorizations after 6 p.m.  
 7-31 central time Monday through Friday and after noon central time on  
 7-32 Saturday, Sunday, and legal holidays and responding to each of  
 7-33 those calls not later than 24 hours after the call is received.

7-34 (f) If an insurer has preauthorized medical care or health  
 7-35 care services, the insurer may not deny or reduce payment to the  
 7-36 physician or provider for those services based on medical necessity  
 7-37 or appropriateness of care unless the physician or provider has  
 7-38 materially misrepresented the proposed medical or health care  
 7-39 services or has substantially failed to perform the proposed  
 7-40 medical or health care services.

7-41 (g) This section applies to an agent or other person with  
 7-42 whom an insurer contracts to perform, or to whom the insurer  
 7-43 delegates the performance of, preauthorization of proposed medical  
 7-44 or health care services.

7-45 (h) The provisions of this section may not be waived,  
 7-46 voided, or nullified by contract.

7-47 Sec. 3H. AVAILABILITY OF CODING GUIDELINES. (a) A  
 7-48 contract between an insurer and a physician or provider must  
 7-49 provide that:

7-50 (1) the physician or provider may request a  
 7-51 description and copy of the coding guidelines, including any  
 7-52 underlying bundling, recoding, or other payment process and fee  
 7-53 schedules applicable to specific procedures that the physician or  
 7-54 provider will receive under the contract;

7-55 (2) the insurer or the insurer's agent will provide the  
 7-56 coding guidelines and fee schedules not later than the 30th day  
 7-57 after the date the insurer receives the request;

7-58 (3) the insurer or the insurer's agent will provide  
 7-59 notice of changes to the coding guidelines and fee schedules that  
 7-60 will result in a change of payment to the physician or provider not  
 7-61 later than the 90th day before the date the changes take effect and  
 7-62 will not make retroactive revisions to the coding guidelines and  
 7-63 fee schedules; and

7-64 (4) the contract may be terminated by the physician or  
 7-65 provider on or before the 30th day after the date the physician or  
 7-66 provider receives information requested under this subsection  
 7-67 without penalty or discrimination in participation in other health  
 7-68 care products or plans.

7-69 (b) A physician or provider who receives information under

8-1 Subsection (a) of this section may only:

8-2 (1) use or disclose the information for the purpose of  
8-3 practice management, billing activities, and other business  
8-4 operations; and

8-5 (2) disclose the information to a governmental agency  
8-6 involved in the regulation of health care or insurance.

8-7 (c) The insurer shall, on request of the physician or  
8-8 provider, provide the name, edition, and model version of the  
8-9 software that the insurer uses to determine bundling and unbundling  
8-10 of claims.

8-11 (d) The provisions of this section may not be waived,  
8-12 voided, or nullified by contract.

8-13 Sec. 3I. VIOLATION OF CLAIMS PAYMENT REQUIREMENTS; PENALTY.

8-14 (a) Except as provided by this section, if a clean claim submitted  
8-15 to an insurer is payable and the insurer does not determine under  
8-16 Section 3A of this article that the claim is payable and pay the  
8-17 claim on or before the date the insurer is required to make a  
8-18 determination or adjudication of the claim, the insurer shall pay  
8-19 the physician or provider making the claim the contracted rate owed  
8-20 on the claim plus a penalty in the amount of the lesser of:

8-21 (1) 50 percent of the difference between the billed  
8-22 charges, as submitted on the claim, and the contracted rate; or

8-23 (2) \$100,000.

8-24 (b) If the claim is paid on or after the 46th day and before  
8-25 the 91st day after the date the insurer is required to make a  
8-26 determination or adjudication of the claim, the insurer shall pay a  
8-27 penalty in the amount of the lesser of:

8-28 (1) 100 percent of the difference between the billed  
8-29 charges, as submitted on the claim, and the contracted rate; or

8-30 (2) \$200,000.

8-31 (c) If the claim is paid on or after the 91st day after the  
8-32 date the insurer is required to make a determination or  
8-33 adjudication of the claim, the insurer shall pay a penalty computed  
8-34 under Subsection (b) of this section plus 18 percent annual  
8-35 interest on that amount. Interest under this subsection accrues  
8-36 beginning on the date the insurer was required to pay the claim and  
8-37 ending on the date the claim and the penalty are paid in full.

8-38 (d) Except as provided by this section, an insurer that  
8-39 determines under Section 3A of this article that a claim is payable,  
8-40 pays only a portion of the amount of the claim on or before the date  
8-41 the insurer is required to make a determination or adjudication of  
8-42 the claim, and pays the balance of the contracted rate owed for the  
8-43 claim after that date shall pay to the physician or provider, in  
8-44 addition to the contracted amount owed, a penalty on the amount not  
8-45 timely paid in the amount of the lesser of:

8-46 (1) 50 percent of the difference between the billed  
8-47 charges for the amount not timely paid, as submitted on the claim,  
8-48 and the contracted rate for the amount not timely paid; or

8-49 (2) \$100,000.

8-50 (e) If the balance of the claim is paid on or after the 46th  
8-51 day and before the 91st day after the date the insurer is required  
8-52 to make a determination or adjudication of the claim, the insurer  
8-53 shall pay a penalty on the balance of the claim in the amount of the  
8-54 lesser of:

8-55 (1) 100 percent of the difference between the billed  
8-56 charges for the balance of the claim, as submitted on the claim, and  
8-57 the contracted rate for the balance of the claim; or

8-58 (2) \$200,000.

8-59 (f) If the balance of the claim is paid on or after the 91st  
8-60 day after the date the insurer is required to make a determination  
8-61 or adjudication of the claim, the insurer shall pay a penalty on the  
8-62 balance of the claim computed under Subsection (e) of this section  
8-63 plus 18 percent annual interest on that amount. Interest under this  
8-64 subsection accrues beginning on the date the insurer was required  
8-65 to pay the claim and ending on the date the claim and the penalty are  
8-66 paid in full.

8-67 (g) An insurer is not liable for a penalty under this  
8-68 section:

8-69 (1) if the failure to pay the claim in accordance with

9-1 Section 3A of this article is a result of a catastrophic event that  
 9-2 substantially interferes with the normal business operations of the  
 9-3 insurer; or

9-4 (2) if the claim was paid in accordance with Section 3A  
 9-5 of this article, but for less than the contracted rate, and:

9-6 (A) the physician or provider notifies the  
 9-7 insurer of the underpayment after the 180th day after the date the  
 9-8 underpayment was received; and

9-9 (B) the insurer pays the balance of the claim on  
 9-10 or before the 45th day after the date the insurer receives the  
 9-11 notice.

9-12 (h) Subsection (g) of this section does not relieve the  
 9-13 insurer of the obligation to pay the remaining unpaid contracted  
 9-14 rate owed the physician or provider.

9-15 (i) An insurer that pays a penalty under this section shall  
 9-16 clearly indicate on the explanation of payment statement in the  
 9-17 manner prescribed by the commissioner by rule the amount of the  
 9-18 contracted rate paid and the amount paid as a penalty.

9-19 (j) In addition to any other penalty or remedy authorized by  
 9-20 this code, an insurer that violates Section 3A(e), (f), or (h) of  
 9-21 this article in processing more than two percent of clean claims  
 9-22 submitted to the insurer is subject to an administrative penalty  
 9-23 under Chapter 84 of this code. For each day an administrative  
 9-24 penalty is imposed under this subsection, the penalty may not  
 9-25 exceed \$1,000 for each claim that remains unpaid in violation of  
 9-26 Section 3A (e), (f), or (h) of this article. In determining whether  
 9-27 an insurer has processed physician and provider claims in  
 9-28 compliance with Section 3A(e), (f), or (h) of this article, the  
 9-29 commissioner shall consider paid claims, other than claims that  
 9-30 have been paid under Section 3A(h) of this article, and shall  
 9-31 compute a compliance percentage for physician and provider claims,  
 9-32 other than institutional provider claims, and a compliance  
 9-33 percentage for institutional provider claims.

9-34 Sec. 3J. APPLICABILITY OF ARTICLE TO ENTITIES CONTRACTING  
 9-35 WITH INSURER. Sections 3A-3I of this article apply to a person with  
 9-36 whom an insurer contracts to:

9-37 (1) process claims;

9-38 (2) obtain the services of physicians and providers to  
 9-39 provide health care services to insureds; or

9-40 (3) issue verifications or preauthorizations.

9-41 Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND  
 9-42 PROVIDERS. The provisions of this article relating to prompt  
 9-43 payment by an insurer of a physician or provider and to verification  
 9-44 of medical care or health care services apply to a physician or  
 9-45 provider who:

9-46 (1) is not a preferred provider included in the  
 9-47 preferred provider network; and

9-48 (2) provides to an insured:

9-49 (A) care related to an emergency or its attendant  
 9-50 episode of care as required by state or federal law; or

9-51 (B) specialty or other medical care or health  
 9-52 care services at the request of the insurer or a preferred provider  
 9-53 because the services are not reasonably available from a preferred  
 9-54 provider who is included in the preferred delivery network.

9-55 Sec. 11. IDENTIFICATION CARD. An identification card or  
 9-56 other similar document issued by an insurer regulated by this code  
 9-57 and subject to this article to an individual insured must display:

9-58 (1) the first date on which the individual became  
 9-59 insured under the plan; or

9-60 (2) a toll-free number a physician or provider may use  
 9-61 to obtain that date.

9-62 Sec. 12. CONFLICT WITH OTHER LAW. To the extent of any  
 9-63 conflict between this article and Article 21.52C or 21.58A of this  
 9-64 code, this article controls.

9-65 SECTION 5. Subchapter F, Chapter 843, Insurance Code, as  
 9-66 effective June 1, 2003, is amended by adding Section 843.209 to read  
 9-67 as follows:

9-68 Sec. 843.209. IDENTIFICATION CARD. An identification card  
 9-69 or other similar document issued by a health maintenance

10-1 organization to an enrollee must:

10-2 (1) indicate that the health maintenance organization  
 10-3 is regulated under this code and subject to the provisions of  
 10-4 Subchapter J; and

10-5 (2) display:

10-6 (A) the first date on which the enrollee became  
 10-7 enrolled; or

10-8 (B) a toll-free number a physician or provider  
 10-9 may use to obtain that date.

10-10 SECTION 6. Subchapter I, Chapter 843, Insurance Code, as  
 10-11 effective June 1, 2003, is amended by adding Section 843.319 to read  
 10-12 as follows:

10-13 Sec. 843.319. AVAILABILITY OF CODING GUIDELINES. (a) A  
 10-14 contract between a health maintenance organization and a physician  
 10-15 or provider must provide that:

10-16 (1) the physician or provider may request a  
 10-17 description and copy of the coding guidelines, including any  
 10-18 underlying bundling, recoding, or other payment process and fee  
 10-19 schedules applicable to specific procedures that the physician or  
 10-20 provider will receive under the contract;

10-21 (2) the health maintenance organization or the health  
 10-22 maintenance organization's agent will provide the coding  
 10-23 guidelines and fee schedules not later than the 30th day after the  
 10-24 date the health maintenance organization receives the request;

10-25 (3) the health maintenance organization or the health  
 10-26 maintenance organization's agent will provide notice of changes to  
 10-27 the coding guidelines and fee schedules that will result in a change  
 10-28 of payment to the physician or provider not later than the 90th day  
 10-29 before the date the changes take effect and will not make  
 10-30 retroactive revisions to the coding guidelines and fee schedules;  
 10-31 and

10-32 (4) the contract may be terminated by the physician or  
 10-33 provider on or before the 30th day after the date the physician or  
 10-34 provider receives information requested under this subsection  
 10-35 without penalty or discrimination in participation in other health  
 10-36 care products or plans.

10-37 (b) A physician or provider who receives information under  
 10-38 Subsection (a) may only:

10-39 (1) use or disclose the information for the purpose of  
 10-40 practice management, billing activities, and other business  
 10-41 operations; and

10-42 (2) disclose the information to a governmental agency  
 10-43 involved in the regulation of health care or insurance.

10-44 (c) The health maintenance organization shall, on request  
 10-45 of the physician or provider, provide the name, edition, and model  
 10-46 version of the software that the health maintenance organization  
 10-47 uses to determine bundling and unbundling of claims.

10-48 (d) The provisions of this section may not be waived,  
 10-49 voided, or nullified by contract.

10-50 SECTION 7. Section 843.336, Insurance Code, as effective  
 10-51 June 1, 2003, is amended to read as follows:

10-52 Sec. 843.336. CLEAN CLAIM [DEFINITION]. (a) In this  
 10-53 subchapter, "clean claim" means a [completed] claim that complies  
 10-54 with this section[, as determined under department rules, submitted  
 10-55 by a physician or provider for health care services under a health  
 10-56 care plan].

10-57 (b) A nonelectronic claim by a physician or provider, other  
 10-58 than an institutional provider, is a clean claim if the claim is  
 10-59 submitted using the Centers for Medicare and Medicaid Services Form  
 10-60 1500 or, if adopted by the commissioner by rule, a successor to that  
 10-61 form developed by the National Uniform Claim Committee or its  
 10-62 successor. An electronic claim by a physician or provider, other  
 10-63 than an institutional provider, is a clean claim if the claim is  
 10-64 submitted using the Professional 837 (ASC X12N 837) format or, if  
 10-65 adopted by the commissioner by rule, a successor to that format  
 10-66 adopted by the Centers for Medicare and Medicaid Services or its  
 10-67 successor.

10-68 (c) A nonelectronic claim by an institutional provider is a  
 10-69 clean claim if the claim is submitted using the Centers for Medicare

11-1 and Medicaid Services Form UB-92 or, if adopted by the commissioner  
 11-2 by rule, a successor to that form developed by the National Uniform  
 11-3 Billing Committee or its successor. An electronic claim by an  
 11-4 institutional provider is a clean claim if the claim is submitted  
 11-5 using the Institutional 837 (ASC X12N 837) format or, if adopted by  
 11-6 the commissioner by rule, a successor to that format adopted by the  
 11-7 Centers for Medicare and Medicaid Services or its successor.

11-8 (d) The commissioner may adopt rules that specify the  
 11-9 information that must be entered into the appropriate fields on the  
 11-10 applicable claim form for a claim to be a clean claim.

11-11 (e) The commissioner may not require any data element that  
 11-12 is not required in an electronic transaction set needed to comply  
 11-13 with federal law.

11-14 (f) A health maintenance organization and a physician or  
 11-15 provider may agree by contract to use fewer data elements than are  
 11-16 required in an electronic transaction set needed to comply with  
 11-17 federal law.

11-18 (g) A claim submitted by a physician or provider that  
 11-19 includes additional fields, data elements, attachments, or other  
 11-20 information not required under this section is considered to be a  
 11-21 clean claim for the purposes of this section.

11-22 SECTION 8. Section 843.337, Insurance Code, as effective  
 11-23 June 1, 2003, is amended to read as follows:

11-24 Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE  
 11-25 CLAIMS; ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A physician or  
 11-26 provider must submit a claim to a health maintenance organization  
 11-27 not later than the 95th day after the date the physician or provider  
 11-28 provides the health care services for which the claim is made. A  
 11-29 health maintenance organization shall accept as proof of timely  
 11-30 filing a claim filed in compliance with Subsection (e) or  
 11-31 information from another health maintenance organization or  
 11-32 insurer showing that the physician or provider submitted the claim  
 11-33 to the health maintenance organization or insurer in compliance  
 11-34 with Subsection (e).

11-35 (b) If a physician or provider fails to submit a claim in  
 11-36 compliance with this section, the physician or provider forfeits  
 11-37 the right to payment unless the failure to submit the claim in  
 11-38 compliance with this section is a result of a catastrophic event  
 11-39 that substantially interferes with the normal business operations  
 11-40 of the physician or provider.

11-41 (c) The period for submitting a claim under this section may  
 11-42 be extended by contract.

11-43 (d) A physician or provider may not submit a duplicate claim  
 11-44 for payment before the 46th day after the date the original claim  
 11-45 was submitted. The commissioner shall adopt rules under which a  
 11-46 health maintenance organization may determine whether a claim is a  
 11-47 duplicate claim.

11-48 (e) Except as provided by Article 21.52Z, a physician or  
 11-49 provider may, as appropriate:

11-50 (1) mail a claim by United States mail, first class, or  
 11-51 by overnight delivery service;

11-52 (2) submit the claim electronically;

11-53 (3) fax the claim; or

11-54 (4) hand deliver the claim.

11-55 (f) If a claim for health care services provided to a  
 11-56 patient is mailed, the claim is presumed to have been received by  
 11-57 the health maintenance organization on the fifth day after the date  
 11-58 the claim is mailed or, if the claim is mailed using overnight  
 11-59 service or return receipt requested, on the date the delivery  
 11-60 receipt is signed. If the claim is submitted electronically, the  
 11-61 claim is presumed to have been received on the date of the  
 11-62 electronic verification of receipt by the health maintenance  
 11-63 organization or the health maintenance organization's  
 11-64 clearinghouse. If the health maintenance organization or the  
 11-65 health maintenance organization's clearinghouse does not provide a  
 11-66 confirmation within 24 hours of submission by the physician or  
 11-67 provider, the physician's or provider's clearinghouse shall provide  
 11-68 the confirmation. The physician's or provider's clearinghouse must  
 11-69 be able to verify that the filing contained the correct payor

12-1 identification of the entity to receive the filing. If the claim is  
 12-2 faxed, the claim is presumed to have been received on the date of  
 12-3 the transmission acknowledgment. If the claim is hand delivered,  
 12-4 the claim is presumed to have been received on the date the delivery  
 12-5 receipt is signed [for health care services under a health care plan  
 12-6 may obtain acknowledgment of receipt of a claim for health care  
 12-7 services under a health care plan by submitting the claim by United  
 12-8 States mail, return receipt requested.

12-9 [(b) A health maintenance organization or the contracted  
 12-10 clearinghouse of the health maintenance organization that receives  
 12-11 a claim electronically shall acknowledge receipt of the claim by an  
 12-12 electronic transmission to the physician or provider and is not  
 12-13 required to acknowledge receipt of the claim in writing].

12-14 SECTION 9. Section 843.338, Insurance Code, as effective  
 12-15 June 1, 2003, is amended to read as follows:

12-16 Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except  
 12-17 as provided by Section 843.3385, not [Not] later than the 45th day  
 12-18 after the date on which a health maintenance organization receives  
 12-19 a clean claim from a participating physician or provider in a  
 12-20 nonelectronic format or the 30th day after the date the health  
 12-21 maintenance organization receives a clean claim from a  
 12-22 participating physician or provider that is electronically  
 12-23 submitted, the health maintenance organization shall make a  
 12-24 determination of whether the claim is payable and:

12-25 (1) if the health maintenance organization determines  
 12-26 the entire claim is payable, pay the total amount of the claim in  
 12-27 accordance with the contract between the physician or provider and  
 12-28 the health maintenance organization;

12-29 (2) if the health maintenance organization determines  
 12-30 a portion of the claim is payable, pay the portion of the claim that  
 12-31 is not in dispute and notify the physician or provider in writing  
 12-32 why the remaining portion of the claim will not be paid; or

12-33 (3) if the health maintenance organization determines  
 12-34 that the claim is not payable, notify the physician or provider in  
 12-35 writing why the claim will not be paid.

12-36 SECTION 10. Subchapter J, Chapter 843, Insurance Code, as  
 12-37 effective June 1, 2003, is amended by adding Section 843.3385 to  
 12-38 read as follows:

12-39 Sec. 843.3385. ADDITIONAL INFORMATION. (a) If a health  
 12-40 maintenance organization needs additional information from a  
 12-41 treating participating physician or provider to determine payment,  
 12-42 the health maintenance organization, not later than the 30th  
 12-43 calendar day after the date the health maintenance organization  
 12-44 receives a clean claim, shall request in writing that the physician  
 12-45 or provider provide an attachment to the claim that is relevant and  
 12-46 necessary for clarification of the claim.

12-47 (b) The request must describe with specificity the clinical  
 12-48 information requested and relate only to information the health  
 12-49 maintenance organization can demonstrate is specific to the claim  
 12-50 or the claim's related episode of care. The participating  
 12-51 physician or provider is not required to provide an attachment that  
 12-52 is not contained in, or is not in the process of being incorporated  
 12-53 into, the patient's medical or billing record maintained by a  
 12-54 participating physician or provider.

12-55 (c) A health maintenance organization that requests an  
 12-56 attachment under this section shall determine whether the claim is  
 12-57 payable on or before the later of the 15th day after the date the  
 12-58 health maintenance organization receives the requested attachment  
 12-59 or the latest date for determining whether the claim is payable  
 12-60 under Section 843.338 or 843.339.

12-61 (d) A health maintenance organization may not make more than  
 12-62 one request under this section in connection with a claim. Sections  
 12-63 843.337(e) and (f) apply to a request for and submission of an  
 12-64 attachment under Subsection (a).

12-65 (e) If a health maintenance organization requests an  
 12-66 attachment or other information from a person other than the  
 12-67 participating physician or provider who submitted the claim, the  
 12-68 health maintenance organization shall provide a copy of the request  
 12-69 to the physician or provider who submitted the claim. The health

13-1 maintenance organization may not withhold payment pending receipt  
 13-2 of an attachment or information requested under this subsection.  
 13-3 If on receiving an attachment or information requested under this  
 13-4 subsection the health maintenance organization determines that  
 13-5 there was an error in payment of the claim, the health maintenance  
 13-6 organization may recover any overpayment under Section 843.350.

13-7 (f) The commissioner shall adopt rules under which a health  
 13-8 maintenance organization can easily identify an attachment or other  
 13-9 information submitted by a physician or provider under this  
 13-10 section.

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

13-13 Sec. 843.339. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION  
 13-14 [~~BENEFIT~~] CLAIMS. Not later than the 21st day after the date a  
 13-15 health maintenance organization affirmatively adjudicates a  
 13-16 pharmacy claim that is electronically submitted, the health  
 13-17 maintenance organization shall:

13-18 (1) pay the total amount of the claim; or  
 13-19 (2) notify the pharmacy provider of the reasons for  
 13-20 denying payment of the claim [~~If a health maintenance organization  
 13-21 or its designated agent authorizes treatment, a prescription  
 13-22 benefit claim that is electronically adjudicated and  
 13-23 electronically paid shall be paid not later than the 21st day after  
 13-24 the date on which the treatment is authorized].~~

13-25 SECTION 12. Subchapter J, Chapter 843, Insurance Code, as  
 13-26 effective June 1, 2003, is amended by adding Section 843.3395 to  
 13-27 read as follows:

13-28 Sec. 843.3395. INVESTIGATION AND DETERMINATION OF PAYMENT.  
 13-29 The investigation and determination of payment, including any  
 13-30 coordination of other payments, does not extend the period for  
 13-31 determining whether a claim is payable under Section 843.338 or  
 13-32 843.339 or for auditing a claim under Section 843.340.

13-33 SECTION 13. Section 843.340, Insurance Code, as effective  
 13-34 June 1, 2003, is amended to read as follows:

13-35 Sec. 843.340. AUDITED CLAIMS. (a) Except as provided by  
 13-36 Section 843.3385, if a [A] health maintenance organization [~~that  
 13-37 acknowledges coverage of an enrollee under a health care plan but~~]  
 13-38 intends to audit a claim submitted by a participating physician or  
 13-39 provider, the health maintenance organization shall pay the charges  
 13-40 submitted at 100 [85] percent of the contracted rate on the claim  
 13-41 not later than the 30th day after the date the health maintenance  
 13-42 organization receives the claim from the participating physician or  
 13-43 provider if submitted electronically or if submitted  
 13-44 nonelectronically not later than the 45th day after the date on  
 13-45 which the health maintenance organization receives the claim from a  
 13-46 participating physician or provider. The health maintenance  
 13-47 organization shall clearly indicate on the explanation of payment  
 13-48 statement in the manner prescribed by the commissioner by rule that  
 13-49 the claim is being paid at 100 percent of the contracted rate,  
 13-50 subject to completion of the audit.

13-51 (b) If the health maintenance organization requests  
 13-52 additional information to complete the audit, the request must  
 13-53 describe with specificity the clinical information requested and  
 13-54 relate only to information the health maintenance organization in  
 13-55 good faith can demonstrate is specific to the claim or episode of  
 13-56 care. The health maintenance organization may not request as a part  
 13-57 of the audit information that is not contained in, or is not in the  
 13-58 process of being incorporated into, the patient's medical or  
 13-59 billing record maintained by a participating physician or provider.

13-60 (c) If the participating physician or provider does not  
 13-61 supply information reasonably requested by the health maintenance  
 13-62 organization in connection with the audit, the health maintenance  
 13-63 organization may:

13-64 (1) notify the physician or provider in writing that  
 13-65 the physician or provider must provide the information not later  
 13-66 than the 45th day after the date of the notice or forfeit the amount  
 13-67 of the claim; and

13-68 (2) if the physician or provider does not provide the  
 13-69 information required by this section, recover the amount of the

14-1 claim.

14-2 (d) The health maintenance organization must complete  
 14-3 [Following completion of] the audit on or before the 180th day after  
 14-4 the date the clean claim is received by the health maintenance  
 14-5 organization, and any additional payment due a participating  
 14-6 physician or provider or any refund due the health maintenance  
 14-7 organization shall be made not later than the 30th day after the  
 14-8 completion of the audit.

14-9 (e) If a participating physician or provider disagrees with  
 14-10 a refund request made by a health maintenance organization based on  
 14-11 the audit, the health maintenance organization shall provide the  
 14-12 physician or provider with an opportunity to appeal, and the health  
 14-13 maintenance organization may not attempt to recover the payment  
 14-14 until all appeal rights are exhausted [later of the date that:

14-15 ~~(1) the physician or provider receives notice of the~~  
 14-16 ~~audit results; or~~

14-17 ~~(2) any appeal rights of the enrollee are exhausted].~~

14-18 SECTION 14. Section 843.341, Insurance Code, as effective  
 14-19 June 1, 2003, is amended to read as follows:

14-20 Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) A health  
 14-21 maintenance organization shall provide a participating physician  
 14-22 or provider with copies of all applicable utilization review  
 14-23 policies and claim processing policies or procedures [, including  
 14-24 required data elements and claim formats].

14-25 (b) A health maintenance organization's claims payment  
 14-26 processes shall:

14-27 (1) use nationally recognized, generally accepted  
 14-28 Current Procedural Terminology codes, notes, and guidelines,  
 14-29 including all relevant modifiers; and

14-30 (2) be consistent with the nationally recognized,  
 14-31 noncommercial system of bundling edits and logic known as the  
 14-32 National Correct Coding Initiative and available from the National  
 14-33 Technical Information Service or a successor to that system adopted  
 14-34 by the commissioner by rule for the purposes of this subsection  
 14-35 [organization may, by contract with a participating physician or  
 14-36 provider, add or change the data elements that must be submitted  
 14-37 with a claim from the physician or provider.

14-38 ~~[(c) Not later than the 60th day before the date of an~~  
 14-39 ~~addition or change in the data elements that must be submitted~~  
 14-40 ~~with a claim or any other change in a health maintenance organization's~~  
 14-41 ~~claim processing and payment procedures, the health maintenance~~  
 14-42 ~~organization shall provide written notice of the addition or change~~  
 14-43 ~~to each participating physician or provider].~~

14-44 SECTION 15. Section 843.342, Insurance Code, as effective  
 14-45 June 1, 2003, is amended to read as follows:

14-46 Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT  
 14-47 PROVISIONS; PENALTIES [ADMINISTRATIVE PENALTY]. (a) Except as  
 14-48 provided by this section, if a clean claim submitted to a health  
 14-49 maintenance organization is payable and the health maintenance  
 14-50 organization does not determine under this subchapter that the  
 14-51 claim is payable and pay the claim on or before the date the health  
 14-52 maintenance organization is required to make a determination or  
 14-53 adjudication of the claim, the health maintenance organization  
 14-54 shall pay the physician or provider making the claim the contracted  
 14-55 rate owed on the claim plus a penalty in the amount of the lesser of:

14-56 (1) 50 percent of the difference between the billed  
 14-57 charges, as submitted on the claim, and the contracted rate; or

14-58 (2) \$100,000.

14-59 (b) If the claim is paid on or after the 46th day and before  
 14-60 the 91st day after the date the health maintenance organization is  
 14-61 required to make a determination or adjudication of the claim, the  
 14-62 health maintenance organization shall pay a penalty in the amount  
 14-63 of the lesser of:

14-64 (1) 100 percent of the difference between the billed  
 14-65 charges, as submitted on the claim, and the contracted rate; or

14-66 (2) \$200,000.

14-67 (c) If the claim is paid on or after the 91st day after the  
 14-68 date the health maintenance organization is required to make a  
 14-69 determination or adjudication of the claim, the health maintenance

15-1 organization shall pay a penalty computed under Subsection (b) plus  
 15-2 18 percent annual interest on that amount. Interest under this  
 15-3 subsection accrues beginning on the date the health maintenance  
 15-4 organization was required to pay the claim and ending on the date  
 15-5 the claim and the penalty are paid in full.

15-6 (d) Except as provided by this section, a health maintenance  
 15-7 organization that determines under this subchapter that a claim is  
 15-8 payable, pays only a portion of the amount of the claim on or before  
 15-9 the date the health maintenance organization is required to make a  
 15-10 determination or adjudication of the claim, and pays the balance of  
 15-11 the contracted rate owed for the claim after that date shall pay to  
 15-12 the physician or provider, in addition to the contracted amount  
 15-13 owed, a penalty on the amount not timely paid in the amount of the  
 15-14 lesser of:

15-15 (1) 50 percent of the difference between the billed  
 15-16 charges for the amount not timely paid, as submitted on the claim,  
 15-17 and the contracted rate for the amount not timely paid; or

15-18 (2) \$100,000.

15-19 (e) If the balance of the claim is paid on or after the 46th  
 15-20 day and before the 91st day after the date the health maintenance  
 15-21 organization is required to make a determination or adjudication of  
 15-22 the claim, the health maintenance organization shall pay a penalty  
 15-23 on the balance of the claim in the amount of the lesser of:

15-24 (1) 100 percent of the difference between the billed  
 15-25 charges for the balance of the claim, as submitted on the claim, and  
 15-26 the contracted rate for the balance of the claim; or

15-27 (2) \$200,000.

15-28 (f) If the balance of the claim is paid on or after the 91st  
 15-29 day after the date the health maintenance organization is required  
 15-30 to make a determination or adjudication of the claim, the health  
 15-31 maintenance organization shall pay a penalty on the balance of the  
 15-32 claim computed under Subsection (e) plus 18 percent annual interest  
 15-33 on that amount. Interest under this subsection accrues beginning  
 15-34 on the date the health maintenance organization was required to pay  
 15-35 the claim and ending on the date the claim and the penalty are paid  
 15-36 in full.

15-37 (g) A health maintenance organization is not liable for a  
 15-38 penalty under this section:

15-39 (1) if the failure to pay the claim in accordance with  
 15-40 this subchapter is a result of a catastrophic event that  
 15-41 substantially interferes with the normal business operations of the  
 15-42 health maintenance organization; or

15-43 (2) if the claim was paid in accordance with this  
 15-44 subchapter, but for less than the contracted rate, and:

15-45 (A) the physician or provider notifies the health  
 15-46 maintenance organization of the underpayment after the 180th day  
 15-47 after the date the underpayment was received; and

15-48 (B) the health maintenance organization pays the  
 15-49 balance of the claim on or before the 45th day after the date the  
 15-50 health maintenance organization receives the notice.

15-51 (h) Subsection (g) does not relieve the health maintenance  
 15-52 organization of the obligation to pay the remaining unpaid  
 15-53 contracted rate owed the physician or provider.

15-54 (i) A health maintenance organization that pays a penalty  
 15-55 under this section shall clearly indicate on the explanation of  
 15-56 payment statement in the manner prescribed by the commissioner by  
 15-57 rule the amount of the contracted rate paid and the amount paid as a  
 15-58 penalty.

15-59 ~~(j) [A health maintenance organization that violates~~  
 15-60 ~~Section 843.338 or 843.340 is liable to a physician or provider for~~  
 15-61 ~~the full amount of billed charges submitted on the claim or the~~  
 15-62 ~~amount payable under the contracted penalty rate, less any amount~~  
 15-63 ~~previously paid or any charge for a service that is not covered by~~  
 15-64 ~~the health care plan.~~

15-65 ~~[(b)]~~ In addition to any other penalty or remedy authorized  
 15-66 by this code, a health maintenance organization that violates  
 15-67 Section 843.338, 843.339, or 843.340 in processing more than two  
 15-68 percent of clean claims submitted to the health maintenance  
 15-69 organization is subject to an administrative penalty under Chapter

16-1 84. For each day an [The] administrative penalty is imposed under  
 16-2 this subsection, the penalty [that chapter] may not exceed \$1,000  
 16-3 for each [day the] claim that remains unpaid in violation of Section  
 16-4 843.338, 843.339, or 843.340.

16-5 (k) In determining whether a health maintenance  
 16-6 organization has processed physician and provider claims in  
 16-7 compliance with Section 843.338, 843.339, or 843.340, the  
 16-8 commissioner shall consider paid claims, other than claims that  
 16-9 have been paid under Section 843.340, and shall compute a  
 16-10 compliance percentage for physician and provider claims, other than  
 16-11 institutional provider claims, and a compliance percentage for  
 16-12 institutional provider claims.

16-13 SECTION 16. Section 843.343, Insurance Code, as effective  
 16-14 June 1, 2003, is amended to read as follows:

16-15 Sec. 843.343. ATTORNEY'S FEES. A physician or provider may  
 16-16 recover reasonable attorney's fees and court costs in an action to  
 16-17 recover payment under this subchapter ~~[Section 843.342]~~.

16-18 SECTION 17. Section 843.344, Insurance Code, as effective  
 16-19 June 1, 2003, is amended to read as follows:

16-20 Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES  
 16-21 CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter  
 16-22 applies [Sections 843.336-843.343 apply] to a person with whom a  
 16-23 health maintenance organization contracts to:

- 16-24 (1) process claims; ~~[or]~~  
 16-25 (2) obtain the services of physicians and providers to  
 16-26 provide health care services to enrollees; or  
 16-27 (3) issue verifications or preauthorizations.

16-28 SECTION 18. Section 843.345, Insurance Code, as effective  
 16-29 June 1, 2003, is amended to read as follows:

16-30 Sec. 843.345. EXCEPTION [EXCEPTIONS]. This subchapter does  
 16-31 [Sections 843.336-843.344 do] not apply to[+]

16-32 ~~[(1)]~~ a capitated payment required to be made to a  
 16-33 physician or provider under an agreement to provide health care  
 16-34 services ~~[, including medical care, under a health care plan; or~~

16-35 ~~[(2)] a claim submitted by a physician or provider who~~  
 16-36 ~~is a member of the legislature].~~

16-37 SECTION 19. Section 843.346, Insurance Code, as effective  
 16-38 June 1, 2003, is amended to read as follows:

16-39 Sec. 843.346. PAYMENT OF CLAIMS. Except as provided by this  
 16-40 subchapter [Subject to Sections 843.336-843.345], a health  
 16-41 maintenance organization shall pay a physician or provider for  
 16-42 health care services and benefits provided to an enrollee [under  
 16-43 the evidence of coverage and to which the enrollee is entitled under  
 16-44 the terms of the evidence of coverage] not later than:

16-45 (1) the 45th day after the date on which a claim for  
 16-46 payment is received with the documentation reasonably necessary to  
 16-47 process the claim; or

16-48 (2) if applicable, within the number of calendar days  
 16-49 specified by written agreement between the physician or provider  
 16-50 and the health maintenance organization.

16-51 SECTION 20. Subchapter J, Chapter 843, Insurance Code, as  
 16-52 effective June 1, 2003, is amended by adding Sections 843.347  
 16-53 through 843.353 to read as follows:

16-54 Sec. 843.347. VERIFICATION. (a) In this section,  
 16-55 "verification" means a reliable representation by a health  
 16-56 maintenance organization to a physician or provider that the health  
 16-57 maintenance organization will pay the physician or provider for  
 16-58 proposed health care services if the physician or provider renders  
 16-59 those services to the patient for whom the services are proposed.  
 16-60 The term includes precertification, certification,  
 16-61 recertification, and any other term that would be a reliable  
 16-62 representation by a health maintenance organization to a physician  
 16-63 or provider and includes preauthorization only when  
 16-64 preauthorization is a condition for the verification.

16-65 (b) On the request of a physician or provider for  
 16-66 verification of a particular health care service the participating  
 16-67 physician or provider proposes to provide to a particular patient,  
 16-68 the health maintenance organization shall inform the physician or  
 16-69 provider without delay whether the service, if provided to that

17-1 patient, will be paid by the health maintenance organization.

17-2 (c) A health maintenance organization shall have  
 17-3 appropriate personnel reasonably available at a toll-free  
 17-4 telephone number to provide a verification under this section  
 17-5 between 6 a.m. and 6 p.m. central time Monday through Friday on each  
 17-6 day that is not a legal holiday and between 9 a.m. and noon central  
 17-7 time on Saturday, Sunday, and legal holidays. A health maintenance  
 17-8 organization must have a telephone system capable of accepting or  
 17-9 recording incoming phone calls for verifications after 6 p.m.  
 17-10 central time Monday through Friday and after noon central time on  
 17-11 Saturday, Sunday, and legal holidays and responding to each of  
 17-12 those calls on or before the second calendar day after the date the  
 17-13 call is received.

17-14 (d) A health maintenance organization that declines to  
 17-15 provide a verification shall notify the physician or provider who  
 17-16 requested the verification of the specific reason the verification  
 17-17 was not provided.

17-18 (e) If a health maintenance organization has provided a  
 17-19 verification for proposed health care services, the health  
 17-20 maintenance organization may not deny or reduce payment to the  
 17-21 physician or provider for those health care services if provided to  
 17-22 the enrollee on or before the 30th day after the date the  
 17-23 verification was provided unless the physician or provider has  
 17-24 materially misrepresented the proposed health care services or has  
 17-25 substantially failed to perform the proposed health care services.

17-26 Sec. 843.348. PREAUTHORIZATION OF HEALTH CARE SERVICES.

17-27 (a) In this section, "preauthorization" means a determination by a  
 17-28 health maintenance organization that health care services proposed  
 17-29 to be provided to a patient are medically necessary and  
 17-30 appropriate.

17-31 (b) A health maintenance organization that uses a  
 17-32 preauthorization process for health care services shall provide  
 17-33 each participating physician or provider, not later than the 10th  
 17-34 business day after the date a request is made, a list of health care  
 17-35 services that do not require preauthorization and information  
 17-36 concerning the preauthorization process.

17-37 (c) If proposed health care services require  
 17-38 preauthorization as a condition of the health maintenance  
 17-39 organization's payment to a participating physician or provider,  
 17-40 the health maintenance organization shall determine whether the  
 17-41 health care services proposed to be provided to the enrollee are  
 17-42 medically necessary and appropriate.

17-43 (d) On receipt of a request from a participating physician  
 17-44 or provider for preauthorization, the health maintenance  
 17-45 organization shall review and issue a determination indicating  
 17-46 whether the health care services are preauthorized. The  
 17-47 determination must be mailed or otherwise transmitted not later  
 17-48 than the third calendar day after the date the request is received  
 17-49 by the health maintenance organization.

17-50 (e) If the proposed health care services involve inpatient  
 17-51 care and the health maintenance organization requires  
 17-52 preauthorization as a condition of payment, the health maintenance  
 17-53 organization shall review the request and issue a length of stay for  
 17-54 the admission into a health care facility based on the  
 17-55 recommendation of the patient's physician or provider and the  
 17-56 health maintenance organization's written medically accepted  
 17-57 screening criteria and review procedures. If the proposed health  
 17-58 care services are to be provided to a patient who is an inpatient in  
 17-59 a health care facility at the time the services are proposed, the  
 17-60 health maintenance organization shall review the request and issue  
 17-61 a determination indicating whether proposed services are  
 17-62 preauthorized within 24 hours of the request by the physician or  
 17-63 provider.

17-64 (f) A health maintenance organization shall have  
 17-65 appropriate personnel reasonably available at a toll-free  
 17-66 telephone number to respond to requests for a preauthorization  
 17-67 between 6 a.m. and 6 p.m. central time Monday through Friday on each  
 17-68 day that is not a legal holiday and between 9 a.m. and noon central  
 17-69 time on Saturday, Sunday, and legal holidays. A health maintenance

18-1 organization must have a telephone system capable of accepting or  
 18-2 recording incoming phone calls for preauthorizations after 6 p.m.  
 18-3 central time Monday through Friday and after noon central time on  
 18-4 Saturday, Sunday, and legal holidays and responding to each of  
 18-5 those calls not later than 24 hours after the call is received.

18-6 (g) If the health maintenance organization has  
 18-7 preauthorized health care services, the health maintenance  
 18-8 organization may not deny or reduce payment to the physician or  
 18-9 provider for those services based on medical necessity or  
 18-10 appropriateness of care unless the physician or provider has  
 18-11 materially misrepresented the proposed health care services or has  
 18-12 substantially failed to perform the proposed health care services.

18-13 (h) This section applies to an agent or other person with  
 18-14 whom a health maintenance organization contracts to perform, or to  
 18-15 whom the health maintenance organization delegates the performance  
 18-16 of, preauthorization of proposed health care services.

18-17 Sec. 843.349. COORDINATION OF PAYMENTS. (a) A health  
 18-18 maintenance organization may require a physician or provider to  
 18-19 retain in the physician's or provider's records updated information  
 18-20 concerning other sources of payment coverage and to provide the  
 18-21 information to the health maintenance organization on the  
 18-22 applicable form described by Section 843.336. Except as provided  
 18-23 by this section, a health maintenance organization may not require  
 18-24 a physician or provider to investigate coordination of other  
 18-25 payment.

18-26 (b) Coordination of other payment under this section does  
 18-27 not extend the period for determining whether a claim is payable  
 18-28 under Section 843.338 or 843.339 or for auditing a claim under  
 18-29 Section 843.340.

18-30 (c) A participating physician or provider who submits a  
 18-31 claim for a particular health care service to more than one health  
 18-32 maintenance organization or insurer shall provide notice on the  
 18-33 claim submitted to each health maintenance organization or insurer  
 18-34 with which a claim for the same health care service will be filed.  
 18-35 For the purposes of Sections 843.336(b) and (c), the commissioner  
 18-36 by rule may require claim elements to be submitted that would  
 18-37 facilitate coordination of payment. A claim electronically  
 18-38 submitted by the participating physician or provider for covered  
 18-39 services or benefits for which there is other coverage that  
 18-40 contains a coordination of benefits provision shall include the  
 18-41 name of the primary payor, adjustment code group, claims adjustment  
 18-42 reason, and amount paid as a covered claim by the primary payor.  
 18-43 That information is considered to be essential elements of a clean  
 18-44 claim for purposes of the secondary payor's processing of the  
 18-45 claim. A participating physician or provider may only file a claim  
 18-46 under this section with the secondary payor after the physician or  
 18-47 provider has received notice of the disposition of the claim by the  
 18-48 primary payor.

18-49 (d) A health maintenance organization processing an  
 18-50 electronic claim as a secondary payor shall rely on the primary  
 18-51 payor information submitted on the claim by the participating  
 18-52 physician or provider. If the secondary payor cannot determine  
 18-53 liability based on the information provided by the physician or  
 18-54 provider, the payor may ask for additional information from any  
 18-55 source available, including the physician or provider, the primary  
 18-56 payor, or the enrollee, subject to the requirements for timely  
 18-57 payment imposed under this subchapter. Primary payor information  
 18-58 may be submitted electronically by the primary payor to the  
 18-59 secondary payor.

18-60 (e) If a health maintenance organization is a secondary  
 18-61 payor and pays a portion of a claim that should have been paid by the  
 18-62 insurer or health maintenance organization that is the primary  
 18-63 payor, the overpayment must first be pursued from the primary  
 18-64 payor. The secondary payor may collect from the participating  
 18-65 provider if:

18-66 (1) on or before the 180th day after the date the  
 18-67 provider receives the overpayment, the secondary payor provides  
 18-68 written notice to the provider of the overpayment and that the  
 18-69 overpayment will be pursued from the primary payor; and

19-1           (2) the provider does not make arrangements for  
 19-2 repayment of the requested funds on or before the 45th day after the  
 19-3 date the provider receives notice that the secondary payor is  
 19-4 unable to collect from the primary payor.

19-5           Sec. 843.350. OVERPAYMENT. (a) A health maintenance  
 19-6 organization may recover an overpayment to a physician or provider  
 19-7 if:

19-8           (1) not later than the 180th day after the date the  
 19-9 physician or provider receives the payment, the health maintenance  
 19-10 organization provides written notice of the overpayment to the  
 19-11 physician or provider that includes the basis and specific reasons  
 19-12 for the request for recovery of funds; and

19-13           (2) the physician or provider does not make  
 19-14 arrangements for repayment of the requested funds on or before the  
 19-15 45th day after the date the physician or provider receives the  
 19-16 notice.

19-17           (b) If a physician or provider disagrees with a request for  
 19-18 recovery of an overpayment, the health maintenance organization  
 19-19 shall provide the physician or provider with an opportunity to  
 19-20 appeal, and the health maintenance organization may not recover the  
 19-21 overpayment until all appeal rights are exhausted.

19-22           Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND  
 19-23 PROVIDERS. The provisions of this subchapter relating to prompt  
 19-24 payment by a health maintenance organization of a physician or  
 19-25 provider and to verification of health care services apply to a  
 19-26 physician or provider who:

19-27           (1) is not included in the health maintenance  
 19-28 organization delivery network; and

19-29           (2) provides to an enrollee:

19-30           (A) care related to an emergency or its attendant  
 19-31 episode of care as required by state or federal law; or

19-32           (B) specialty or other health care services at  
 19-33 the request of the health maintenance organization or a physician  
 19-34 or provider who is included in the health maintenance organization  
 19-35 delivery network because the services are not reasonably available  
 19-36 within the network.

19-37           Sec. 843.352. CONFLICT WITH OTHER LAW. To the extent of  
 19-38 any conflict between this subchapter and Article 21.52C or 21.58A,  
 19-39 this subchapter controls.

19-40           Sec. 843.353. WAIVER PROHIBITED. Except as provided by  
 19-41 Sections 843.336(f) and 843.337(c), the provisions of this  
 19-42 subchapter may not be waived, voided, or nullified by contract.

19-43           SECTION 21. Subchapter E, Chapter 21, Insurance Code, is  
 19-44 amended by adding Articles 21.52Y and 21.52Z to read as follows:

19-45           Art. 21.52Y. TECHNICAL ADVISORY COMMITTEE ON CLAIMS  
 19-46 PROCESSING. (a) The commissioner shall appoint a technical  
 19-47 advisory committee on claims processing by insurers and health  
 19-48 maintenance organizations of claims by physicians and other health  
 19-49 care providers for medical care and health care services provided  
 19-50 to patients.

19-51           (b) The committee shall advise the commissioner on  
 19-52 technical aspects of coding of health care services and claims  
 19-53 development, submission, processing, adjudication, and payment, as  
 19-54 well as the impact on those processes of contractual requirements  
 19-55 and relationships, including relationships among employers, health  
 19-56 benefit plans, insurers, health maintenance organizations,  
 19-57 preferred provider organizations, electronic clearinghouses,  
 19-58 physicians and other health care providers, third-party  
 19-59 administrators, independent physician associations, and medical  
 19-60 groups. The committee shall also advise the commissioner with  
 19-61 respect to the implementation of the standardized coding and  
 19-62 bundling edits and logic.

19-63           (c) The commissioner shall consult the advisory committee  
 19-64 with respect to any rule related to the subjects described by  
 19-65 Subsection (b) of this article before adopting the rule.

19-66           (d) On or before September 1 of each even-numbered year, the  
 19-67 committee shall issue a report to the legislature on the activities  
 19-68 of the committee.

19-69           (e) Members of the advisory committee serve without

20-1 compensation.

20-2 Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

20-3 Sec. 1. HEALTH BENEFIT PLAN DEFINED. (a) In this article,  
 20-4 "health benefit plan" means a plan that provides benefits for  
 20-5 medical, surgical, or other treatment expenses incurred as a result  
 20-6 of a health condition, a mental health condition, an accident,  
 20-7 sickness, or substance abuse, including an individual, group,  
 20-8 blanket, or franchise insurance policy or insurance agreement, a  
 20-9 group hospital service contract, or an individual or group evidence  
 20-10 of coverage or similar coverage document that is offered by:

20-11 (1) an insurance company;

20-12 (2) a group hospital service corporation operating  
 20-13 under Chapter 842 of this code;

20-14 (3) a fraternal benefit society operating under  
 20-15 Chapter 885 of this code;

20-16 (4) a stipulated premium insurance company operating  
 20-17 under Chapter 884 of this code;

20-18 (5) a Lloyd's plan operating under Chapter 941 of this  
 20-19 code;

20-20 (6) an exchange operating under Chapter 942 of this  
 20-21 code;

20-22 (7) a health maintenance organization operating under  
 20-23 Chapter 843 of this code;

20-24 (8) a multiple employer welfare arrangement that holds  
 20-25 a certificate of authority under Chapter 846 of this code; or

20-26 (9) an approved nonprofit health corporation that  
 20-27 holds a certificate of authority under Chapter 844 of this code.

20-28 (b) The term includes:

20-29 (1) a small employer health benefit plan written under  
 20-30 Chapter 26 of this code; and

20-31 (2) a health benefit plan offered under Chapter 1551,  
 20-32 1575, or 1601 of this code or Article 3.50-7 of this code.

20-33 Sec. 2. ELECTRONIC SUBMISSION OF CLAIMS. The issuer of a  
 20-34 health benefit plan by contract shall require that a health care  
 20-35 professional licensed or registered under the Occupations Code or a  
 20-36 health care facility licensed under the Health and Safety Code  
 20-37 submit a health care claim or equivalent encounter information, a  
 20-38 referral certification, or an authorization or eligibility  
 20-39 transaction electronically. The health benefit plan issuer shall  
 20-40 comply with the standards for electronic transactions required by  
 20-41 this section and established by the commissioner by rule.

20-42 Sec. 2A. TEMPORARY PROVISION: ELECTRONIC SUBMISSION OF  
 20-43 CLAIMS. (a) Notwithstanding Section 2 of this article, an issuer  
 20-44 of a health benefit plan is not required to require a health care  
 20-45 professional or facility to comply with the contract provision  
 20-46 required by Section 2 of this article before September 1, 2006.

20-47 (b) An issuer of a health benefit plan by contract may  
 20-48 require that a health care professional licensed or registered  
 20-49 under the Occupations Code or a health care facility licensed under  
 20-50 the Health and Safety Code submit a health care claim or equivalent  
 20-51 encounter information, a referral certification, or an  
 20-52 authorization or eligibility transaction electronically before  
 20-53 September 1, 2006. The health benefit plan issuer shall comply with  
 20-54 the standards for electronic transactions required by this section  
 20-55 and established by the commissioner by rule.

20-56 (c) A contract entered into before September 1, 2006,  
 20-57 between the issuer of a health benefit plan and a health care  
 20-58 professional or health care facility must provide for a waiver of  
 20-59 any requirement for electronic submission established under  
 20-60 Subsection (b) of this section.

20-61 (d) The commissioner shall establish circumstances under  
 20-62 which a waiver is required, including:

20-63 (1) circumstances in which no method is available for  
 20-64 the submission of claims in electronic form;

20-65 (2) the operation of small physician practices;

20-66 (3) the operation of other small health care provider  
 20-67 practices;

20-68 (4) undue hardship, including fiscal or operational  
 20-69 hardship; or

21-1 (5) any other special circumstance that would justify  
21-2 a waiver.

21-3 (e) Any health care professional or health care facility  
21-4 that is denied a waiver by a health benefit plan may appeal the  
21-5 denial to the commissioner. The commissioner shall determine  
21-6 whether a waiver must be granted.

21-7 (f) The issuer of a health benefit plan may not refuse to  
21-8 contract or renew a contract with a health care professional or  
21-9 health care facility based in whole or in part on the professional  
21-10 or facility requesting or receiving a waiver or appealing a waiver  
21-11 determination.

21-12 (g) This section expires September 1, 2007.

21-13 Sec. 3. MODE OF TRANSMISSION. The issuer of a health  
21-14 benefit plan may not by contract limit the mode of electronic  
21-15 transmission that a health care professional or health care  
21-16 facility may use to submit information under this article.

21-17 Sec. 4. CERTAIN CHARGES PROHIBITED. A health benefit plan  
21-18 may not directly or indirectly charge or hold a health care  
21-19 professional, health care facility, or person enrolled in a health  
21-20 benefit plan responsible for a fee for the adjudication of a claim.

21-21 Sec. 5. RULES. The commissioner may adopt rules as  
21-22 necessary to implement this article. The commissioner may not  
21-23 require any data element for electronically filed claims that is  
21-24 not required to comply with federal law.

21-25 SECTION 22. As soon as practicable, but not later than the  
21-26 30th day after the effective date of this Act, the commissioner of  
21-27 insurance shall adopt rules as necessary to implement this Act. The  
21-28 commissioner may use the procedures under Section 2001.034,  
21-29 Government Code, for adopting emergency rules with abbreviated  
21-30 notice and hearing to adopt rules under this section. The  
21-31 commissioner is not required to make the finding described by  
21-32 Subsection (a), Section 2001.034, Government Code, to use the  
21-33 emergency rules procedures.

21-34 SECTION 23. (a) With respect to a contract entered into  
21-35 between an insurer or health maintenance organization and a  
21-36 physician or health care provider, and payment for medical care or  
21-37 health care services under the contract, the changes in law made by  
21-38 this Act apply only to a contract entered into or renewed on or  
21-39 after the 60th day after the effective date of this Act and payment  
21-40 for services under the contract. Such a contract entered into  
21-41 before the 60th day after the effective date of this Act and not  
21-42 renewed or that was last renewed before the 60th day after the  
21-43 effective date of this Act, and payment for medical care or health  
21-44 care services under the contract, are governed by the law in effect  
21-45 immediately before the effective date of this Act, and that law is  
21-46 continued in effect for that purpose.

21-47 (b) With respect to the payment for medical care or health  
21-48 care services provided, but not provided under a contract to which  
21-49 Subsection (a) of this section applies, the changes in law made by  
21-50 this Act apply only to the payment for those services provided on or  
21-51 after the 60th day after the effective date of this Act. Payment  
21-52 for those services provided before the 60th day after the effective  
21-53 date of this Act is governed by the law in effect immediately before  
21-54 the effective date of this Act, and that law is continued in effect  
21-55 for that purpose.

21-56 SECTION 24. This Act takes effect June 1, 2003, if it  
21-57 receives a vote of two-thirds of all the members elected to each  
21-58 house, as provided by Section 39, Article III, Texas Constitution.  
21-59 If this Act does not receive the vote necessary for immediate  
21-60 effect, this Act takes effect September 1, 2003.

21-61 \* \* \* \* \*