By: Nelson S.B. No. 418

(In the Senate - Filed February 10, 2003; February 17, 2003, read first time and referred to Committee on Health and Human Services; March 17, 2003, reported adversely, with favorable Committee Substitute by the following vote: Yeas 7, Nays 0; March 17, 2003, sent to printer.)

COMMITTEE SUBSTITUTE FOR S.B. No. 418 By: Deuell

A BILL TO BE ENTITLED
AN ACT

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) submit the claim electronically;

(3) fax the claim; or

(4) hand deliver the claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the insurer may recover any overpayment under Section 3D of this article.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

successor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If proposed medical care or health care services require

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

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

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

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

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

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

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

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

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

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

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

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

(b) A physician or provider who receives information under

Subsection (a) of this section may only:

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

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

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

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

Sec. 3I. VIOLATION OF CLAIMS PAYMENT REQUIREMENTS; PENALTY. (a) Except as provided by this section, if a clean claim submitted to an insurer is payable and the insurer does not determine under Section 3A of this article that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay the physician or provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of:

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

(2) $100,000.

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

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

(2) $200,000.

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

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

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

(2) $100,000.

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

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

(2) $200,000.

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

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

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

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

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

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

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

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

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

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

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

(1) process claims;

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

(3) issue verifications or preauthorizations.

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

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

(2) provides to an insured:

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

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

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

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

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

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

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

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

organization to an enrollee must:

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

(2) display:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) submit the claim electronically;

(3) fax the claim; or

(4) hand deliver the claim.

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

identification of the entity to receive the filing. If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed [~~for health care services under a health care plan may obtain acknowledgment of receipt of a claim for health care services under a health care plan by submitting the claim by United States mail, return receipt requested.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) $100,000.

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

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

(2) $200,000.

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

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

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

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

(2) $100,000.

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

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

(2) $200,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) process claims; [~~or~~]

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

(3) issue verifications or preauthorizations.

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

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

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

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

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

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

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

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

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

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

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

patient, will be paid by the health maintenance organization.

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

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

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

Sec. 843.348. PREAUTHORIZATION OF HEALTH CARE SERVICES. (a) In this section, "preauthorization" means a determination by a health maintenance organization that health care services proposed to be provided to a patient are medically necessary and appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) provides to an enrollee:

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

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

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

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

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

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

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

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

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

(e) Members of the advisory committee serve without

compensation.

Art. 21.52Z. ELECTRONIC HEALTH CARE TRANSACTIONS

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

(1) an insurance company;

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

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

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

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

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

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

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

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

(b) The term includes:

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

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

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

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

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

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

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

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

(2) the operation of small physician practices;

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

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

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

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

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

(g) This section expires September 1, 2007.

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

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

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

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

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

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

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

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