By: Shapleigh S.B. No. 351

A BILL TO BE ENTITLED

AN ACT

relating to payment of certain emergency room physicians for services provided to enrollees of managed care health benefit plans; providing an administrative penalty.

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

SECTION 1. Section 843.351, Insurance Code, is amended to read as follows:

Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. (a) 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.

(b) A claim by a physician described by Subsection (a)(1) for care described by Subsection (a)(2)(A) that complies with the

requirements of this subchapter and is payable by the health maintenance organization shall be paid at the lesser of:

(1) the total billed charge; or

(2) the greater of:

(A) the interim payment rate for the billed services established under Section 843.3511; or

(B) an amount equal to the reasonable and customary charge for the billed services.

(c) A physician who submits a claim that is subject to Subsection (b) may not bill the enrollee or another person responsible for the enrollee's medical care for any amount not paid by the health maintenance organization.

SECTION 2. Subchapter J, Chapter 843, Insurance Code, is amended by adding Section 843.3511 to read as follows:

Sec. 843.3511. INTERIM PAYMENT RATE. (a) The commissioner by rule shall adopt interim payment rates for medical care and health care services to be used for the purposes of Section 843.351(b).

(b) The commissioner shall determine the interim payment rate for a medical care or health care service at least annually by:

(1) adjusting the rate for the service applicable under the January 1, 2007, published Medicare rates for the service provided by emergency physicians by region in Texas, to reflect any change in the Medical Care Professional Services component of the annual revised consumer price index for all urban consumers for Texas, as published by the federal Bureau of Labor Statistics, during the period following the most recent adoption of a rate for

the service; or

(2) adopting a rate for the service applicable under a version of Medicare rates for emergency physicians by region in Texas published not more than 12 months before the interim payment rate is adopted.

(c) The commissioner shall adopt an interim payment standard for a new Current Procedural Terminology code recognized for payment by the federal Medicare program not later than the 60th day after the date the code is recognized.

SECTION 3. Section 1301.069, Insurance Code, is amended to read as follows:

Sec. 1301.069. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH CARE PROVIDERS. (a) The provisions of this chapter relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a physician or 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.

(b) A claim by a physician described by Subsection (a)(1) for care described by Subsection (a)(2)(A) that complies with the

requirements of this subchapter and is payable by the preferred provider organization shall be paid at the lesser of:

(1) the total billed charge; or

(2) the greater of:

(A) the interim payment rate for the billed services established under Section 1301.0691; or

(B) an amount equal to the reasonable and customary charge for the billed services.

(c) A physician who submits a claim that is subject to Subsection (b) may not bill the insured for any amount not paid by the preferred provider organization.

SECTION 4. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Section 1301.0691 to read as follows:

Sec. 1301.0691. INTERIM PAYMENT RATE. (a) The commissioner by rule shall adopt interim payment rates for medical care and health care services to be used for the purposes of Section 1301.069(b).

(b) The commissioner shall determine the interim payment rate for a medical care or health care service at least annually by:

(1) adjusting the rate for the service applicable under the January 1, 2007, published Medicare rates for the service provided by emergency physicians by region in Texas, to reflect any change in the Medical Care Professional Services component of the annual revised consumer price index for all urban consumers for Texas, as published by the federal Bureau of Labor Statistics, during the period following the most recent adoption of a rate for the service; or

(2) adopting a rate for the service applicable under a version of Medicare rates for emergency physicians by region in Texas published not more than 12 months before the interim payment rate is adopted.

(c) The commissioner shall adopt an interim payment standard for a new Current Procedural Terminology code recognized for payment by the federal Medicare program not later than the 60th day after the date the code is recognized.

SECTION 5. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1275 to read as follows:

CHAPTER 1275. INDEPENDENT DISPUTE RESOLUTION PROCESS FOR BILLING DISPUTES WITH CERTAIN NONNETWORK PROVIDERS

Sec. 1275.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan" means:

(A) a health maintenance organization contract or evidence of coverage issued under Chapter 843; or

(B) a preferred provider organization benefit plan issued under Chapter 1301.

(2) "Issuer," with respect to a health benefit plan, includes any third-party administrator for the plan.

(3) "Organization" means the independent dispute resolution organization that contracts with the department under this chapter.

Sec. 1275.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a claim subject to Section 843.351(b) or 1301.069(b).

(b) If the physician who submitted the claim elects to

participate in dispute resolution under this chapter, the health maintenance organization or insurer to which the claim was submitted is required to participate in the dispute resolution process. If the health maintenance organization or insurer to which the claim was submitted elects to participate in dispute resolution under this chapter, the physician is required to participate.

(c) The organization may not make determinations regarding a coverage dispute between a health benefit plan issuer and an enrollee. A dispute that arises as a result of that coverage dispute is not eligible for dispute resolution under this chapter unless the coverage dispute is resolved in favor of the enrollee.

Sec. 1275.003. FEES. The commissioner by rule shall establish a fee schedule to pay for the aggregate cost of processing disputes under this chapter. The fees shall be paid directly to the organization in the manner prescribed by rule by the commissioner.

Sec. 1275.004. INDEPENDENT DISPUTE RESOLUTION ORGANIZATION. (a) In this section:

(1) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(2) "Material financial affiliation" means any financial interest of more than five percent of total annual revenue or total annual income of the organization or individual to which this section applies. The term does not include payment by the health benefit plan issuer to the organization for the services required by this chapter or an expert's participation as a

contracting health benefit plan provider.

(3) "Material professional affiliation" means a physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the organization. The term does not include affiliations that are limited to staff privileges at a health facility.

(b) The department shall contract with an independent dispute resolution organization to administer the independent dispute resolution process under this chapter.

(c) The independent dispute resolution organization must:

(1) be independent of any health benefit plan issuer regulated under this code or any organization of emergency physicians engaging in business in this state;

(2) not be an affiliate or subsidiary of, or in any way owned or controlled by, a health benefit plan issuer regulated under this code, a physician or physician group, or a trade association of health benefit plans, physicians, or physician groups; and

(3) submit to the department the following information on initial application to contract with the department for purposes of this chapter and, except as otherwise provided, annually thereafter on any change to any of the following information:

(A) the names of all stockholders and owners of more than five percent of any stock or options if the organization

is publicly held;

(B) the names of all holders of bonds or notes in excess of $100,000;

(C) the names of all corporations and organizations that the organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business;

(D) the names and biographical sketches of all directors, officers, and executives of the organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health benefit plan issuer, disability insurer, managed care organization, medical or health care provider group, or board or committee of a health benefit plan issuer, managed care organization, or medical or health care provider group;

(E) a description of the dispute resolution process the organization proposes to use, including the method of selecting dispute resolution experts; and

(F) a description of how the organization ensures compliance with the conflict-of-interest requirements of this section.

(d) The independent dispute resolution organization, any expert the organization designates to conduct dispute resolution, or any officer, director, or employee of the organization may not have a material professional, familial, or financial affiliation, as determined by the commissioner with:

(1) a health benefit plan issuer;

(2) an officer, director, or employee of a health benefit plan issuer; or

(3) a physician, a physicians' medical group, or the independent practice association involved in the covered emergency medical service in dispute or any entity that contracts with a physician, a physicians' medical group, or the independent practice association to provide billing services, including coding of claims, determination of the amount that should be paid on claims, billing and collecting fees, or negotiating claims.

(e) The commissioner by rule may adopt additional requirements that the organization must meet, including conflict-of-interest standards not specified in this section.

(f) The department shall provide on request a copy of all nonproprietary information, as determined by the commissioner, filed with the department by an organization seeking to contract with the department under this section. The department may charge a nominal fee for photocopying the information.

Sec. 1275.005. SUBMISSION OF DISPUTE BY PLAN ISSUER. (a) Before submitting a dispute under this chapter, a health benefit plan issuer shall send an electronic or printed notice to the physician who submitted the relevant claim stating:

(1) the plan issuer's intention to submit the claim to the organization for dispute resolution;

(2) the physician's name and identification number;

(3) the enrollee's name and identification number;

(4) a clear description of the disputed item, the date of service, and a clear explanation of the basis on which the plan

issuer believes the claim is inappropriate;

(5) a request for adjustment of the claim or other action; and

(6) an alternative proposed payment for the service provided and the specific methodology and database used to compute the payment.

(b) On or before the 30th day after the date a physician receives a notice under this section, the physician may:

(1) refund to the health benefit plan issuer the difference between the paid amount and the alternative payment proposed in the notice; or

(2) attempt to negotiate an amount with the plan issuer that settles the dispute.

(c) If the physician does not make a refund to the plan issuer and a negotiation under this section is not completed before the later of the 30th day after the date the physician received the notice or a later date agreed on by the parties for completing the negotiation, the physician must participate in the plan issuer's internal dispute resolution process unless the plan issuer waives the use of that process.

(d) If the physician is not satisfied with the outcome of the plan's internal dispute resolution process or use of that process is waived by the plan issuer, the physician must defend the dispute through the dispute resolution process under this chapter. The physician shall notify the plan issuer of the physician's intent to defend the claim under this chapter on or before the 30th day after the date the internal dispute resolution process is

completed or the plan issuer waives the use of that process.

Sec. 1275.006. SUBMISSION OF DISPUTE BY PHYSICIAN. (a) Before submitting a dispute under this chapter, a physician shall send an electronic or printed notice to the health benefit plan issuer stating:

(1) the physician's intention to submit the dispute to the organization;

(2) the physician's name, identification number, and contact information;

(3) the enrollee's name and identification number;

(4) a clear description of the disputed item, the date of service, and a clear explanation of the basis on which the physician believes the claim is inappropriate;

(5) a request for adjustment of the claim or other action; and

(6) an alternative proposed payment for the service provided and the specific methodology and database used to compute the payment.

(b) On or before the 30th day after the date a plan issuer receives a notice under this section, the plan issuer may:

(1) pay the physician the difference between the paid amount and the alternative payment proposed in the notice; or

(2) attempt to negotiate an amount with the physician that settles the dispute.

(c) If the plan issuer does not make a payment under Subsection (b)(1) and a negotiation under Subsection (b)(2) is not completed before the later of the 30th day after the date the plan

issuer received the notice or a later date agreed on by the parties for completing the negotiation, the plan issuer may require the physician to participate in the plan issuer's internal dispute resolution process.

(d) If the plan issuer does not require the physician to participate in the plan's internal dispute resolution process, the plan issuer must defend the dispute through the dispute resolution process under this chapter. The plan issuer shall notify the physician of the plan issuer's intent to defend the claim under this chapter on or before the 30th day after the date the plan issuer makes the determination not to require use of the plan issuer's internal dispute resolution process.

(e) If the physician is not satisfied with the outcome of a plan issuer's internal dispute resolution process required under this section, the physician may submit the dispute to the organization not later than the 30th day after the date the plan issuer's internal dispute resolution process is completed.

Sec. 1275.007. SUBMISSION OF MULTIPLE CLAIMS. A health benefit plan issuer or physician may include up to 50 substantially similar disputes in a single notice under Section 1275.005 or 1275.006, as applicable, if each disputed item is clearly identified and the notice contains the information required by this section. For the purposes of this section, substantially similar disputes are those that involve the same or similar services or codes provided by the same physician.

Sec. 1275.008. DISPUTE RESOLUTION POLICIES AND PROCEDURES; DETERMINATION OF REASONABLE AND CUSTOMARY CHARGE. Subject to the

commissioner's approval, the organization shall establish and publish written policies and procedures for receiving claims for dispute resolution and making determinations regarding disputes under this chapter. The policies and procedures must include a process by which the organization determines the reasonable and customary charge for health care services that are the subject of a claim dispute.

Sec. 1275.009. BILLING AND CODING DETERMINATIONS. (a) A determination issued by the organization must include any necessary determinations regarding related billing issues, including appropriate coding and bundling of services.

(b) The organization or the department shall retain claims documentation or coding experts to assist with questions related to claims documentation and coding.

Sec. 1275.010. ISSUANCE OF DETERMINATION; DETERMINATION OF CHARGE. (a) Not later than the 60th day after the date a claim dispute is submitted to the organization under this chapter, the organization shall issue its determination regarding the complaint to the parties to the dispute. The nonprevailing party shall satisfy any order in the determination not later than the 15th day after the date the determination is issued.

(b) In the determination, the organization shall choose only one of the following:

(1) the physician's initial charge;

(2) the initial amount the plan issuer paid; or

(3) the alternative proposed payment suggested in the relevant notice under Section 1275.005 or 1275.006.

(c) The alternative proposed payment must be selected if the plan issuer paid nothing initially or the plan issuer believes the payment at the interim payment rate constituted an overpayment.

(d) A determination under this section must be based on a preponderance of the evidence and select the amount that more closely reflects the reasonable and customary rate of the relevant service consistent with the reimbursement standard identified in Section 1275.008 and the coding and bundling standards identified in Section 1275.009.

(e) The nonprevailing party shall pay the fee set under Section 1275.003.

Sec. 1275.011. ADMINISTRATIVE PENALTY. (a) The department shall impose an administrative penalty under Chapter 84 if the department determines that the health benefit plan issuer:

(1) shows a pattern or practice of violating this chapter and Section 843.351(b) or 1301.069(b); or

(2) engages in a practice that abuses the dispute resolution process under this chapter.

(b) If the department determines that the physician has engaged in a practice described by Subsection (a)(1) or (2), the department shall refer the matter to the Texas Medical Board for appropriate disciplinary action, including imposition of an administrative penalty under Chapter 165, Occupations Code.

Sec. 1275.012. REPORTING. (a) The organization shall collect information regarding results obtained through the dispute resolution process under this chapter and file the information with the department monthly.

(b) The department shall report on the information submitted to the department under this section to the governor, the lieutenant governor, and the speaker of the house of representatives on or before January 1, 2013. The report must contain information regarding:

(1) the effectiveness of the dispute resolution process under this chapter;

(2) whether the operation of the dispute resolution process should be continued; and

(3) the impact of the dispute resolution process on emergency safety net providers, reimbursement rates, contracts, and enrollee access to care.

Sec. 1275.013. PUBLIC INFORMATION; CONFIDENTIALITY. Except as provided by this section, the records of and determinations made by the organization are public information. The department shall keep confidential:

(1) any information determined by the commissioner to be proprietary information of a health benefit plan issuer or physician; and

(2) in accordance with state and federal law, any individually identifiable patient information.

SECTION 6. Subtitle B, Title 3, Occupations Code, is amended by adding Chapter 161 to read as follows:

CHAPTER 161. PATIENT BILLING

Sec. 161.001. ENROLLEES COVERED BY CERTAIN MANAGED CARE PLANS. (a) In this section:

(1) "Issuer," with respect to a managed care health

benefit plan, includes a third-party administrator.

(2) "Managed care health benefit plan" means:

(A) a health maintenance organization contract or evidence of coverage issued under Chapter 843, Insurance Code; or

(B) a preferred provider organization policy issued under Chapter 1301, Insurance Code.

(b) Except as provided by this section, an emergency physician who provides services at a general acute care hospital may seek reimbursement for covered services provided to an enrollee in a managed care health benefit plan only from the issuer of that plan. The physician may seek payment from an enrollee for any copayments, deductibles, or coinsurance for which the enrollee is responsible under the plan for the services provided.

(c) An enrollee who is billed by a physician in violation of this section may report receipt of the bill to the managed care health benefit plan issuer, the Texas Department of Insurance, and the board. A managed care health benefit plan issuer that becomes aware that one of the plan's enrollees has been billed in violation of this section shall report the violation to the department and the board. The department and the board shall take appropriate action against a physician who is determined to have violated this section.

(d) An enrollee in a managed care health benefit plan is not liable for an amount billed in violation of this section.

SECTION 7. (a) On or before December 1, 2008, the commissioner of insurance and the Texas Medical Board shall adopt

rules as necessary to implement this Act.

(b) The change in law made by this Act applies to payment for services under a health maintenance organization contract or preferred provider organization policy delivered, issued for delivery, or renewed on or after January 1, 2010. A policy or contract delivered, issued for delivery, or renewed before that date is subject to the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 8. This Act takes effect September 1, 2009.