BILL ANALYSIS

Senate Research Center

H.B. 1862
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Business & Commerce
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Engrossed

DIGEST AND PURPOSE

Currently, when a physician sends a claim to a health maintenance organization or a preferred provider organization (health care plan provider) for payment the health care plan provider may assert that the claim was not received. The statutory limit of 45 days does not begin until the health care plan provider receives the claim; therefore, the health care plan provider may delay payment. H.B. 1862 establishes a standardized clean claim form for health care plan providers and sets forth provisions for the receipt of a claim by a health care plan provider.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 2 (Article 3.70-3C, Insurance Code), SECTION 5 (Section 18B, Texas Health Maintenance Organization Act), SECTION 6 Chapter 20A, V.T.I.C.) of this bill.

SECTION BY SECTION ANALYSIS

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

(14) Defines "preauthorization."

(15) Defines "verification."

SECTION 2. Amends Section 3A, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, as follows:

(a) Redefines "clean claim."

(b) Requires a physician or provider to 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. Requires an insurer to accept as proof of timely filing a claim filed in compliance with Subsection (c) of this section or information from another insurer showing that the physician or provider submitted the claim to the insurer in compliance with Subsection (c) of this section. Provides that if a physician or provider fails to submit a claim in compliance with this subsection, the physician or provider forfeits the right to payment. Authorizes the period for submitting a claim under this subsection to be extended by contract. Prohibits a physician or provider from submitting a duplicate claim for payment before the 46th day after the date the original claim was submitted. Requires the commissioner of insurance (commissioner) to adopt rules under which an insurer may determine whether a claim is a duplicate claim. Deletes language regarding acknowledgment of a receipt.

(c) Requires a physician or provider to, as appropriate, take certain actions.

(d) Provides that if a claim for medical care or health care services under a health care plan is

mailed, the claim is presumed to have been received by the insurer on the third 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. Provides that 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. Requires the physician's or provider's clearinghouse to provide the confirmation, if the insurer or the insurer's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or provider,. Requires the physician's or provider's clearinghouse to be able to verify that the filing contained the correct address of the entity to receive the filing. Provides that if the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. Provides that if the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed. Requires the commissioner to promulgate a form to be submitted by the physician or provider that easily identifies all claims included in each filing and that can be used by a physician or provider as the physician's or provider's log.

(e) Requires the insurer, not later than the 45th day after the date that the insurer receives a clean claim from a preferred provider, to make a determination of whether the claim is eligible for payment and:

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

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

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

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

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

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

(g) Provides that an insurer that determines under Subsection (e) of this section that a claim is eligible for payment and does not pay the claim on or before the 45th day after the date the insurer receives a clean claim commits an unfair claim settlement practice in violation of Article 21.21-2 of this code and is subject to an administrative penalty under Chapter 84 of this code. Requires the insurer to pay the physician or provider making the claim the lesser of the full amount of billed charges submitted on the claim and interest on the billed charges at a rate of 15 percent annually or two times the contracted rate and interest on that amount at a rate of 15 percent annually. Requires billed charges to be established under a fee schedule provided by the preferred provider to the insurer on or before the 30th day after the date the physician or provider enters into a preferred provider contract with the insurer. Prohibits the preferred provider from modifying the fee schedule if the provider notifies the insurer of the modification on or before the 90th day before the date the modification takes effect.

(h) Provides that the investigation and determination of eligibility for payment, including any coordination of other payments, does not extend the period for determining whether a claim is eligible for payment under Subsection (e) of this section. Deletes language regarding electronic adjudication.

(i) Requires the insurer, except as provided by Subsection (j) of this section, if the insurer acknowledges coverage of an insured under the health insurance policy but intends to audit the preferred provider claim, to pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the insurer receives the claim from the preferred provider. Requires the insurer to complete the audit, and any additional payment due a preferred provider or any refund due the insurer to be made not later than the 90th, rather than the 30th, day after the receipt of a claim or 45 days after receipt of a completed attachment from the physician or provider, whichever is later.

(j) Requires the insurer, if an insurer needs additional information from a treating preferred provider to determine eligibility for payment, the insurer, not later than the 30th calendar day after the date the insurer receives a clean claim, to request in writing that the preferred provider provide any attachment to the claim the insurer desires in good faith for clarification of the claim. Requires the request to 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. Requires an insurer that requests an attachment under this subsection to determine whether the claim is eligible for payment on or before the later of the 15th day after the date the insurer receives the completed attachment or the latest date for determining whether the claim is eligible for payment under Subsection (e) of this section. Prohibits an insurer from making more than one request under this subsection in connection with a claim. Provides that Subsections (c) and (d) of this section apply to a request for and submission of an attachment under this subsection.

(k) Requires the insurer, if an insurer requests an attachment or other information from a person other than the physician or provider who submitted the claim, to provide a copy of the request to the physician or provider who submitted the claim. Prohibits the insurer from withholding payment pending receipt of an attachment or information requested under this subsection. Authorizes the insurer, if on receiving an attachment or information requested under this subsection the insurer determines an error in payment of the claim, to recover under Section 3C of this article.

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

(m) Requires the insurer's claims payment processes to:

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

(2) be consistent with nationally recognized, generally accepted, clinically appropriate bundling logic and edits.

(n) Authorizes a preferred provider to recover reasonable attorney's fees and court costs in an action to recover payment under this section.

(o) Provides that in addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Subsection (e), rather than (c), or (i), rather than (e), of this section is subject to an administrative penalty under Article 1.10E of this code. Prohibits the administrative penalty imposed under that article from exceeding $1,000 for each day the claim remains unpaid in violation of Subsection (e) or (i) of this section.

(p) Requires the insurer to provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures.

(q) Provides that 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.

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

Sec. 3B. ELEMENTS OF CLEAN CLAIM. (a) Provides that a claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using Health Care Financing Administration Form 1500 or a successor to that form developed by the National Uniform Billing Committee or its successor and adopted by the commissioner by rule for the purposes of this subsection that is submitted to an insurer for payment and that contains the information required by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form.

(b) Provides that a claim by an institutional provider is a "clean claim" if the claim is submitted using Health Care Financing Administration Form UB-92 or a successor to that form developed by the National Uniform Billing Committee or its successor and adopted by the commissioner by rule for the purposes of this subsection that is submitted to an insurer for payment and that contains the information required by the commissioner by rule for the purposes of this subsection entered into the appropriate fields on the form.

(c) Authorizes an insurer to require any data element that is required in an electronic transaction set needed to comply with federal law. Prohibits an insurer from requiring a physician or provider to provide information other than information for a data field included on the form used for a clean claim under Subsection (a) or (b) of this section, as applicable.

(d) Provides that 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.

Sec. 3C. OVERPAYMENT. Authorizes an insurer to 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.

Sec. 3D. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) Requires an insurer, on the request of a physician or provider for verification of the eligibility for payment of a particular medical care or health care service the physician or provider proposes to provide to a particular patient, to inform the physician or provider whether the service, if provided to that patient, is eligible for payment from the insurer to the physician or provider.

(b) Requires an insurer to provide verification under this section between 6 a.m. and 6 p.m. central standard time each day.

(c) Requires verification under this section to be made in good faith and without delay.

(d) Defines "verification."

(e) Authorizes an insurer to establish a time certain for the validity of verification.

(f) Prohibits an insurer, if an insurer has verified medical care or health care services, from denying or reducing payment to a physician or health care provider for those services unless certain requirements are met.

Sec. 3E. COORDINATION OF PAYMENT. (a) Authorizes an insurer to require a physician or provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the insurer on the applicable form described by Section 3B of this article. Prohibits an insurer, except as provided in this subsection, from requiring a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Provides that coordination of payment under this section does not extend the period for determining whether a service is eligible for payment under Section 3A(e) of this article.

(c) Requires a physician or provider who submits a claim for particular medical care or health care services to more than one health maintenance organization or insurer to provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) Requires an insurer, on receipt of notice under Subsection (c) of this section, to coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or provider.

(e) Authorizes an insurer, if the insurer is a secondary payor and pays more than the amount for which the insurer is legally obligated, to recover the amount of the overpayment from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) Provides that if the portion of the claim overpaid by the secondary insurer was also paid by the primary health maintenance organization or insurer, the secondary insurer may recover the amount of overpayment under Section 3C of this article from the physician or provider who received the payment.

(g) Authorizes an insurer to share information with another health maintenance organization or insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

(h) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 3F. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) Requires an insurer that uses a preauthorization process for medical care and health care services to provide to each participating physician or health care provider, not later than the 10th working day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process.

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

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

(d) Requires that if the proposed medical care or health care services involve inpatient care, the determination issued by the insurer be provided within one calendar day of the request by telephone or electronic transmission to the physician or health care provider of record and followed by written notice to the physician or provider on or before the third day after the date of the request and specify an approved length of stay for admission into a health care facility based on the recommendation of the patient's physician or health care provider and the insurer's written medically acceptable screening criteria and review procedures. Requires the criteria and procedures to be established, periodically evaluated, and updated.

(e) Prohibits an insurer, if an insurer has preauthorized medical care or health care services, from denying or reducing payment to the physician or health care provider for those services unless certain requirements are met.

(f) Provides that 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.

Sec. 3G. AVAILABILITY OF CODING GUIDELINES. (a) Requires a preferred provider contract between an insurer and a physician or provider to contain certain provisions.

(b) Authorizes a physician or provider who receives information under Subsection (a) of this section to use or disclose the information only for the purpose of practice management, billing activities, or other business operations. Authorizes the attorney general to impose and collect a penalty of $1,000 for each use or disclosure of the information that violates this subsection.

(c) Requires that nothing in this section be interpreted to require an insurer to violate copyright or other law by disclosing proprietary software that the insurer has licensed. Requires the insurer, in addition to the above, to, on request of a physician or provider, provide the name, edition, and model version of the software that the insurer uses to determine bundling and unbundling of claims.

Sec. 3H. DISPUTE RESOLUTION. (a) Prohibits an insurer from requiring by contract or otherwise the use of a dispute resolution procedure or binding arbitration with a physician or health care provider. Provides that this subsection does not prohibit an insurer from offering a dispute resolution procedure or binding arbitration to resolve a dispute if the insurer and the physician or provider consent to the process after the dispute arises. Prohibits this subsection from being construed to conflict with any applicable appeal mechanisms required by law.

(b) Prohibits the provisions of this section from being waived or nullified by contract.

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

Sec. 10. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH CARE

PROVIDERS. Provides that the provisions of this article relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a physician or health care provider who meet certain requirements.

Sec. 11. CONFLICT WITH OTHER LAW. Provides that to the extent of any conflict between this article and Article 21.52C of this code, this article controls.

Sec. 12. APPLICATION OF CERTAIN PROVISIONS UNDER MEDICAID. Prohibits a provision of this article from being interpreted as requiring an insurer, physician, or health care provider, in providing benefits or services under the state Medicaid program, to take certain actions.

SECTION 4. Amends Section 2, Texas Health Maintenance Organization Act (Article 20A.02, V.T.I.C.), by adding Subdivisions (ff) and (gg), as follows:

(ff) Defines "preauthorization."

(gg) Defines "verification."

SECTION 5. Amends Section 18B, Texas Health Maintenance Organization Act (Section 20A.18B, Vernon's Texas Insurance Code), as follows:

Sec. 18B. PROMPT PAYMENT OF PHYSICIAN AND PROVIDERS. (a) Defines "clean claim."

(b) Requires a physician or provider to submit a claim under this section to a health maintenance organization not later than the 95th day after the date the physician or provider provides the medical care or health care services for which the claim is made. Requires a health maintenance organization (HMO) to accept as proof of timely filing a claim filed in compliance with Subsection (c) of this section or information from another health maintenance organization showing that the physician or provider submitted the claim to the health maintenance organization in compliance with Subsection (c) of this section. Provides that if a physician or provider fails to submit a claim in compliance with this subsection, the physician or provider forfeits the right to payment. Authorizes the period for submitting a claim under this subsection to be extended by contract. Prohibits a physician or provider from submitting a duplicate claim for payment before the 46th day after the date the original claim was submitted. Requires the commissioner to adopt rules under which a health maintenance organization may determine whether a claim is a duplicate claim. Deletes language regarding acknowledgment of a receipt.

(c) Requires a physician or provider to, as appropriate, take certain actions.

(d) Makes a conforming change.

(e) Requires that not later than the 45th day after the date that the health maintenance organization receives a clean claim from a physician or provider, the HMO make a determination of whether the claim is eligible for payment and:

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

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

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

(f) Requires the HMO, not later than the 21st day after the date a health maintenance organization or the health maintenance organization's designated agent affirmatively adjudicates a pharmacy benefit claim that is electronically submitted, to pay the total amount of the claim or notify the benefit provider of the reasons for denying payment of the claim.

(g) Provides that an HMO that determines under Subsection (e) of this section that a claim is eligible for payment and does not pay the claim on or before the 45th day after the date the health maintenance organization receives a clean claim commits an unfair claim settlement practice in violation of Article 21.21-2, Insurance Code, and is subject to an administrative penalty under Chapter 84, Insurance Code. Requires the HMO to pay the physician or provider making the claim the full amount of billed charges submitted on the claim and interest on the billed charges at a rate of 15 percent annually, except that the HMO is not required to pay a physician or provider with whom the HMO has a contract an amount of billed charges that exceeds the amount billable under a fee schedule provided by the physician or provider to the HMO on or before the 30th day after the date the physician or provider enters into the contract with the HMO. Authorizes the physician or provider to modify the fee schedule if the physician or provider notifies the HMO of the modification on or before the 90th day before the date the modification takes effect.

(h) Provides that the investigation and determination of eligibility for payment, including any coordination of other payments, does not extend the period for determining whether a claim is eligible for payment under Subsection (e) of this section.

(i) Provides that, except as provided by Subsection (j) of this section, if the health maintenance organization acknowledges coverage of an enrollee under the health care plan but intends to audit the physician or provider claim, the health maintenance organization shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the health maintenance organization receives the claim from the physician or provider. Requires the HMO to complete the audit, and any additional payment due a physician or provider or any refund due the HMO to be made not later than the 90th, rather than the 30th, day after the receipt of a claim or 45 days after receipt of a completed attachment from the physician or provider, whichever is later.

(j) Requires an HMO, if an HMO needs additional information from a treating physician or provider to determine eligibility for payment, not later than the 30th calendar day after the date the health maintenance organization receives a clean claim, to request in writing that the physician or provider provide any attachment to the claim the health maintenance organization desires in good faith for clarification of the claim. Requires the request to 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. Requires an HMO that requests an attachment under this subsection to determine whether the claim is eligible for payment on or before the later of the 15th day after the date the HMO receives the completed attachment or the latest date for determining whether the claim is eligible for payment under Subsection (e) of this section. Prohibits an HMO from making more than one request under this subsection in connection with a claim. Provides that Subsections (c) and (d) of this section apply to a request for and submission of an attachment under this subsection.

(k) Requires an HMO, if the HMO requests an attachment or other information from a person other than the physician or provider who submitted the claim, to provide a copy of the request to the physician or provider who submitted the claim. Prohibits the HMO from withholding payment pending receipt of an attachment or information requested under this subsection. Authorizes the HMO, if on receiving an attachment or information requested under this subsection the HMO determines an error in payment of the claim, to recover under Section 18E of this Act.

(l) Requires the commissioner to adopt rules under which an HMO can easily identify attachments or information submitted by a physician or provider.

(m) Requires an HMO's claims payment processes to meet certain requirements.

(n) Authorizes a physician or provider to recover reasonable attorney's fees and court costs in an action to recover payment under this section.

SECTION 6. Amends The Texas Health Maintenance Organization Act (Chapter 20A, V.T.I.C.) by adding Sections 18D-18L, 40, and 41 to read as follows:

Sec. 18D. ELEMENTS OF CLEAN CLAIM. (a) Makes a conforming change.

(b) Makes a conforming change.

(c) Makes a conforming change.

(d) Makes a conforming change.

Sec. 18E. OVERPAYMENT. Makes a conforming change.

Sec. 18F. VERIFICATION OF ELIGIBILITY FOR PAYMENT. (a) Makes a conforming change.

(b) Makes a conforming change.

(c) Makes a conforming change.

(d) Makes a conforming change.

(e) Makes a conforming change.

(f) Makes a conforming change.

Sec. 18G. COORDINATION OF PAYMENT BENEFITS. (a) Makes a conforming change.

(b) Makes a conforming change.

(c) Makes a conforming change.

(d) Makes a conforming change.

(e) Makes a conforming change.

(f) Makes a conforming change.

(g) Makes a conforming change.

(h) Makes a conforming change.

Sec. 18H. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) Makes a conforming change.

(b) Makes a conforming change.

(c) Makes a conforming change.

(d) Makes a conforming change.

(e) Makes a conforming change.

(f) Provides that 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 medical care or health care services.

Sec. 18I. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. Provides that the provisions of this Act relating to prompt payment by an HMO of a physician or provider and to preauthorization of medical care or health care services apply to a physician or provider who meets certain requirements.

Sec. 18J. AVAILABILITY OF CODING GUIDELINES. (a) Requires a contract between an HMO and a physician or provider contain that certain provisions.

(b) Authorizes a physician or provider who receives information under Subsection (a) of this section to use or disclose the information only for the purpose of practice management, billing activities, or other business operations. Authorizes the attorney general to impose and collect a penalty of $1,000 for each use or disclosure of the information that violates this subsection.

(c) Requires that nothing in this section be interpreted to require a health maintenance organization to violate copyright or other law by disclosing proprietary software that the HMO has licensed. Requires that in addition to the above, the HMO, on request of the physician or provider, provide the name, edition, and model version of the software that the HMO uses to determine bundling and unbundling of claims.

Sec. 18K. DISPUTE RESOLUTION. (a) Makes a conforming change.

(b) Makes a conforming change.

Sec. 18L. AUTHORITY OF ATTORNEY GENERAL. Makes a conforming change.

Sec. 40. CONFLICT WITH OTHER LAW. Makes a conforming change.

Sec. 41. APPLICATION OF CERTAIN PROVISIONS UNDER MEDICAID. Makes a conforming change.

SECTION 7. (a) Makes application of this Act prospective.

(b) Makes application of this Act prospective.

SECTION 8. Effective date: September 1, 2001.