BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1284
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Business & Commerce
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Committee Report (Substituted)

DIGEST AND PURPOSE

Currently, a health plan is allowed to "add" or "change" the data elements that constitute a "clean claim." The addition or change is accomplished when the plan notifies the physician 60 days before the new elements go into effect. C.S.S.B. 1284 establishes standards for "receipt" of claims that begin the clean claim time limit.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1, Article 3.70-3C, Insurance Code, by adding Subdivision (14), defining "preauthorization."

SECTION 2. Amends Section 3A, Article 3.70-3C, Insurance Code, as follows:

Sec. 3A. PROMPT PAYMENT OF PREFERRED PROVIDERS. (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 to adopt rules under which an insurer may determine whether a claim is a duplicate claim. Deletes language regarding a preferred provider.

(c) Requires a physician or provider to, as appropriate, submit the claim by following certain procedures.

(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. Provides that if the insurer or the insurer's clearinghouse fails to provide a confirmation within 24 hours of submission by the physician or provider, the physician's or provider's clearinghouse is required to provide the confirmation. 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.

(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 follow certain procedures.

(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 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 insurer that makes a determination that a claim is eligible for payment under Subsection (e) of this section and does not pay the claim on or before the 45th day after the date the insurer receives a clean claim: is required to pay the physician or provider making the claim the full amount of billed charges submitted on the claim, based on the physician's or provider's charges for medical or health care services at the time the services are provided and interest on the billed charges at a rate of 15 percent annually; commits an unfair claim settlement practice in violation or Article 21.21-2 of this code; and is subject to an administrative penalty under Chapter 84 of this code.

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

(i) Makes a conforming change regarding an exception to the Subsection provided by Subsections (j), (k), and (l) of this article. Requires the insurer to complete the audit and make any additional payment due a preferred provider or any refund due the insurer not later than the 90th day after the date the claim is received by the insurer.

(j) Requires an insurer, if the insurer needs additional information from a treating preferred provider to determine benefits payable under the policy, not later than the 30th 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, provide a detailed description of the reasons for the request, and relate only to information the insurer can demonstrate is within the scope of the claim and specific to the claim. Prohibits an insurer from making more than one request under this subsection in connection with a claim.

(k) Requires that on or before the 20th day after the date a treating preferred provider receives a request that complies with Subsection (j) of this section, the preferred provider provide the requested attachment. Provides that the period for determining whether a claim is eligible for payment under Subsection (e) of this section is tolled until the attachment is provided. Provides that Subsections (c) and (d) of this section apply to an attachment provided by a preferred provider under this subsection.

(l) Requires an insurer, if the insurer needs additional information from the insured or a

physician or provider other than the physician or provider who submitted the claim to determine benefits payable under the policy, to notify the treating preferred provider and the person from whom the information is needed not later than the 30th calendar day after the date the insurer receives the claim. Requires the notice to describe with specificity the information requested and, if applicable, provide the name of the physician or provider from whom the information is needed, if the name is available to the insurer.

(m) Requires a person from whom the information is requested under Subsection (l) of this section to furnish the requested information on or before the 15th day after the date the person receives the request. Provides that the period for determining whether a claim is eligible for payment under Subsection (e) of this section is tolled by the number of days, not to exceed 30 days, by which the requested information is delinquent. Requires an insurer that does not receive information requested under this subsection to send a reminder notice to the treating preferred provider and to the person from whom the information is needed every 10th day after the date the information becomes delinquent. Authorizes a treating preferred provider to send a reminder notice to an insured or other person from whom information is requested under this subsection as the preferred provider considers necessary to ensure a prompt response.

(n) Requires the commissioner to adopt rules under which an insurer can easily identify attachments submitted by a physician or health care provider under Subsection (k) or (m) of this section. Deletes language regarding an insurer.

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

(p) Deletes language regarding other penalties.

(q) Deletes language regarding data elements and members of the legislature.

SECTION 3. Amends Article 3.70-3C, Insurance Code, by adding Sections 3B-3J, 10, 11, and 12, as follows:

Sec. 3B. ELEMENTS OF CLEAN CLAIM. (a) Defines when a claim, other than by an institutional provider, is a "clean claim."

(b) Defines when a claim by an institutional provider, is a "clean claim."

(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 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 clean 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 certain conditions are met.

Sec. 3D. VERIFICATION OF COVERAGE. (a) Requires the 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 that verification under this section be made in good faith and without delay.

Sec. 3E. COORDINATION OF BENEFITS. (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. Prohibits this provision from being waived, voided, or nullified by contract.

(b) Provides that coordination of other health benefit plan coverage does not extend the period for determining whether a claim is eligible for payment under Section 3A(e) of this article.

(c) Requires a physician or provider who submits a claim for particular medical 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 of insurer with which the same claim is being filed.

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

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

(f) Authorizes the secondary insurer, if the portion of the claim overpaid by the secondary insurer was also paid by the primary HMO or insurer, to recover the amount of overpayment under Section 3C of this article from the physician or provider who received payment.

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

Sec. 3F. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) Requires an insurer that uses a preauthorization process for medical and health care services to provide 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 and health care services that require preauthorization and information concerning the preauthorization process.

(b) Requires the insurer, if proposed medical 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 or a physician or health care provider requests preauthorization of proposed medical or health care services, to determine whether the medical or health care services proposed to be provided to the insured are medically necessary and appropriate in a manner consistent with Article 21.58A of this code.

(c) Requires the insurer, on receipt of a request from a physician or health care provider for preauthorization of proposed medical or health care services, to review and issue a determination indicating whether the proposed services are preauthorized. Provides that if the determination requires a determination of medical necessity and appropriateness of the proposed medical or health care services, the determination, must be made within the time frame for a utilization review required by Section 5, Article 21.58A of this code.

(d) Provides that if the proposed medical or health care services involve inpatient care, the determination issued by the insurer must 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 as required by Section 4(i), Article 21.58A of this code.

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

Sec. 3G. RETROSPECTIVE REVIEW. (a) Requires an insurer that makes an adverse determination to deny or reduce payment to a physician or health care provider who provided medical or health care services with a retrospective review of the medical necessity and appropriateness of those services to conduct the retrospective review in compliance with the standards for a utilization review required by Sections 4 (b), (c), (d), (f), (h), (i), and (m), Article 21.58A of this code.

(b) Requires an insurer that makes an adverse determination to deny or reduce payment to a physician or health care provider based on a retrospective review of the medical necessity and appropriateness of the medical or health care services to notify the physician or provider of the determination not later than the 45th day after the date the insurer receives a clean claim, as defined by Section 3A of this article, from the physician or health care provider.

(c) Requires a notice of adverse determination required by Subsection (b) to include certain requirements.

(d) Requires the procedure for appeal to be reasonable and comply with Sections 6(b)(1), (2), (3), (5), and (6), Article 21.58A of this code.

(e) Provides that an adverse determination described by this section is eligible for review under Section 6A, Article 21.58A of this code, if the determination relates to certain items.

(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, a retrospective review of medical or health care services.

Sec. 3H. AVAILABILITY OF CODING GUIDELINES. (a) Requires a preferred provider

contract between an insurer and a physician or provider to provide certain requirements.

(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 commissioner to impose and collect a penalty of $1,000 for each use of the information that violates this subsection.

Sec. 3I. DISPUTE RESOLUTION. (a) Provides that an agreement or contract provision that requires the use of binding arbitration to resolve future disputes in a preferred provider contract is not enforceable if the agreement or provision is unconscionable at the time the agreement is made. 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 this contract.

Sec. 3J. 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 preauthorization and retrospective review of medical or health care services apply to a physician or health care provider who meets 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 meet certain requirements.

SECTION 4. Amends Section 2, Texas Health Maintenance Organization Act (Chapter 20.A2, V.T.I.C.), by adding Subdivision (ff), to define "preauthorization."

SECTION 5. Amends Section 18B, Texas Health Maintenance Organization Act (Section 20A18B, V.T.I.C.), as follows:

(a) Redefines "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 to accept as proof of timely filing a claim filed in compliance with Subsection (c) of this section or information from another maintenance organization showing that the physician or provider submitted the claim to the HMO 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 original claim was submitted. Requires the commissioner to adopt rules under which an HMO may determine whether a claim is a duplicate claim. Deletes language regarding acknowledgment of a receipt and electronic receipt.

(c) Requires a physician or provider, in filing a claim, to take certain appropriate actions.

(d) Makes a conforming change regarding the date a claim is received.

(e) Requires an HMO, not later than the 45th day after the date the HMO receives a clean claim from a physician or provider, to make a determination or whether the claim is eligible for payment and make certain other determinations.

(f) Makes a conforming change.

(g) Makes a conforming change.

(h) Makes a conforming change.

(i) Makes a conforming change.

(j) Authorizes an HMO to make one request for attachments necessary for clarification of a clean claim. Requires the request to be in writing and sent to the physician or provider that submitted the claim on or before the 30th calendar day after the date the HMO receives the claim. Requires the request to describe with specificity the clinical information the HMO can demonstrate is directly related to the claim in question or the claim's related episode of care. Requires the HMO, on receipt of all required attachments, to determine whether the claim is eligible for payment. 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 from a person other than the physician or provider that submits the clean 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 information requested from a person other than the physician or provider who submitted the claim. Provides that if on receiving information requested from that person the HMO determines an error in payment of the claim, the HMO may recover under Section 18E of this Act.

(l) Requires the commissioner to adopt rules under which an HMO can easily identify attachments submitted by a physician or health care provider. Prohibits rules adopted under this subsection from requiring the use of additional forms or attachments.

(m) Makes a conforming change.

(n) Deletes language regarding other penalties and charges.

(o) Makes a conforming change.

SECTION 6. Amends the Texas Health Maintenance Organization Act (Chapter 20A V.T.I.C.), by adding Sections 18D-18M, 40, and 41, to apply to health maintenance organizations the same standards for payment of certain claims as are required of insurers under Sections 3B-3J, 10, 11, and 12, Article 3.70-3C, Insurance Code (SECTION 3 of this bill).

SECTION 7. Amends Section 5(d), Article 21.58A, Insurance Code, to require the notification of

adverse determination required by this section to be provided by the utilization review agent within one calendar, rather than working, day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the adverse determination, to be followed within three working days by written notification to the enrollee or a person acting on behalf of the enrollee and, if the original notification to the provider was not in writing, to the provider of record of an adverse determination, within three working days by written notification to the provider of record and the patient if the patient is not hospitalized at the time of the adverse determination. Requires that in such circumstances, notification of an adverse determination, is to be provided to the treating physician or health care provider to be followed within three working days by written notification to the enrollee or a person acting on behalf of the enrollee and, if the original notification to the provider was not in writing, the provider of record.

SECTION 8. Amends Sections 7(a) and (b), Article 21.58A, Insurance Code, as follows:

(a) Requires a utilization review agent to have appropriate licensed clinical review personnel, including physician reviewers, reasonably available each day by toll free telephone from 6 a.m. to 6 p.m. central standard time to discuss patients' care, allow response to telephone review requests, and provide the notification required by Section 5 of this Article.

(b) Requires a utilization agent to have a telephone system capable of accepting or recording or providing instructions to incoming phone calls, supported by on-call licensed personnel, between 6 a.m. and 6 p.m. central standard time each day and to respond to such calls not later than one day after the date on which the call was received or within one hour of the time a request for poststabilization care is received.

SECTION 9. (a) Makes application of this Act prospective.

(b) Makes application of this Act prospective.

SECTION 10. Effective date: September 1, 2001.

SUMMARY OF COMMITTEE CHANGES

SECTION 1. Amends As Filed S.B. 1284, by defining "preauthorization."

SECTION 2. Amends As Filed S.B. 1284, by amending Section 3A, Article 3.70-3C, Insurance Code.

SECTION 3. Amends As Filed S.B. 1284, by adding Sections 3B-3J, 10, 11, and 12, Insurance Code.

SECTION 4. Amends As Filed S.B. 1284, by amending the Texas Health Maintenance Organization Act (Chapter 20A V.T.I.C.), by adding Sections 18D-18M, 40, and 41.

SECTION 5. Amends As Filed S.B. 1284, by amending Section 18B, Texas Health Maintenance Organization Act (Section 20A18B, V.T.I.C.).

SECTION 6. Amends As Filed S.B. 1284, by amending the Texas Health Maintenance Organization Act (Chapter 20A V.T.I.C.), by adding Sections 18D-18M, 40, and 41.

SECTION 7. Amends As Filed S.B. 1284, by amending Section 5(d), Article 21.58A, Insurance Code.

SECTION 8. Amends As Filed S.B. 1284, by amending Sections 7(a) and (b), Article 21.58A, Insurance Code.

SECTION 9. Makes application of this Act prospective.

SECTION 10. Effective date: September 1, 2001.