Finding Your Way to Prompt Pay

Texas Department of Insurance
TDI’s Strategy

- Education
  - Helping you find the way

- Enforcement
Applicability

- Applicable to:
  - HMOs
  - Insured PPO Plans

- Not applicable to:
  - Self-funded ERISA plans
  - Indemnity plans
  - Medicaid, Medicare, Med Supp
  - Government and school plans – except HMO or fully insured PPO plans
  - Children’s Health Insurance Program (CHIP)
The Primary Laws

- HB 610
  - Rules

- SB 418
  - Emergency rules
  - Final rules

Texas Department of Insurance
HB 610 – Key Provisions

- Contracted providers only
- Carrier-required additional clean claim elements and attachments permitted with 60-day notice
- Clean claim paid in 45 days (electronically adjudicated pharmacy claims in 21 days)
- Pay 85% of contracted rate on audited claims
- Late payment penalty:
  - Contract penalty
  - Billed charges as defined by rule
SB 418 - Key Dates

- August 16, 2003
  - Emergency rules

- October 5, 2003
  - Final rules
SB 418 – Physicians and Providers

- Contracted providers under HMO plans, insured PPO plans
  - Contract issue/renewal dates
- Non-contracted providers who provided emergency and referral services
- Other non-contracted providers under certain circumstances

Texas Department of Insurance
SB 418 – Delegated Entities

- HMOs and insured PPOs are responsible for SB 418 compliance, even when delegated entities and PPO networks are used.
- Key contract date – carrier and delegated entity.
SB 418/HB 610 Prompt Payment
Deadlines and Penalties
Decision Tree

As a Texas licensed physician or provider, did I provide services to a person covered under an HMO or insured PPO plan?

Yes

No

Did I provide, on or after August 16, 2003, (a) services on referral from an HMO, PPO, or a preferred provider because the services were not reasonably available in-network or (b) emergency care services?

Yes

No

Your services are not subject to Texas’ prompt pay requirements.

Do you have a contract with an HMO or PPO?

Yes

No

Was my contract entered or last renewed on or after August 16, 2003?

Yes

No

Services provided on or after August 1, 2000, are subject to HB 610 and related rules.

Your services are subject to SB 418 and the Emergency rules until your contract renews on or after 10-5-03. Once the contract renews on or after 10-5-03, your services are subject to SB 418 and the Final rules.

Your services are subject to SB 418 and related rules.

Were services provided before or after 10-5-03?

Before

After

Your services are subject to SB 418 and the Emergency rules.

Your services are subject to SB 418 and the Final rules.
SB 418 – Key Provisions

- Final rules
  - 95-day filing deadline
  - Limit on clean claim elements
  - Payment deadlines
    - Non-electronic – 45 days
    - Electronic – 30 days
    - Affirmatively adjudicated pharmacy – 21 days
  - Requests for additional information deadlines
    - From treating provider
    - From third parties

Texas Department of Insurance
SB 418 – Key Provisions

Catastrophic Event:
- Business interruption of claims filing or processing activities
  - More than 2 consecutive business days
- Notice TDI within 5 days of the catastrophe
- Sworn affidavit due within 10 days of return to normal business operations
SB 418 – Key Provisions

- Final rules
  - Duplicate claims
  - Audits
  - Coordination of benefits
  - Overpayments
  - Underpayments

Texas Department of Insurance
Billed Charges

- HB 610
- SB 418 Emergency
- SB 418 Final
Billed Charges

- Definition: The charges for medical care or health care services included on a claim submitted by a physician or provider. Billed charges must comply with all other applicable requirements of law, including:
  - Texas Health and Safety Code §311.0025
  - Texas Occupations Code §105.002
  - Texas Insurance Code Art. 21.79F
Penalty Provisions

- Graduated penalty
  - Later claim paid, greater amount owed
  - 1 - 45 days late
    - (50% - $100,000 maximum)
  - 46 - 90 days late
    - (100% - $200,000 maximum)
  - 91 or more days late
    - (100% - $200,000 maximum + 18% interest)

- No contracted penalty rates
Penalty Provisions

- Always recover full contracted rate in addition to any applicable penalty
Late Payment Penalty Calculation

Formula:

- Billed charges
- Minus the contracted rate
- Multiplied by the percentage for the applicable statutory claim payment period
- Equals the amount of the penalty payment
Late Payment Penalty Calculation Example

Paid on or before the 45th day after the end of the applicable statutory claim payment period:

- Billed charges = $15,000
- Minus contracted rate of $10,000
- Equals $5,000
- Multiplied by 50%
- $2,500 = penalty payment
Underpayment Penalty Calculation

**Formula:**

- Amount underpaid on the contracted rate
- Divided by the amount of the contract rate
- Multiplied by the billed charges
- Equals the “underpaid amount”
- Multiplied by the percentage for the applicable statutory claim payment period
- Equals the penalty payment
Underpayment Penalty Calculation Example

Paid on or before the 45th day after the end of the applicable statutory claim period:

- Billed charges = $1,500
- Amount of contracted rate = $1,000
- Amount paid timely = $800
- Amount underpaid on contracted rate = $200
- $200 / $1,000 (= 20%) \times $1,500 = $300
- Multiply by 50%
- $150 = penalty payment
Administrative Penalty

- TDI collects data to monitor compliance
- 98% compliance
  - Institutional claims
  - Non-institutional
  - Quarterly computation
- Less than 98% compliance may result in fines of $1,000 per claim per day
- Individual violations – other remedies may apply
TDI will collect industry information via the Web
- Claims payment activities
- Verifications and declinations
- Catastrophic events
- Delegated entities information
- HB 610 information

First report due February 15, 2004 (September – December 2003 data)
If enrollee has other coverage, these fields are required:

- 11d (CMS 1500) – Disclosure of other coverage
- 9a - d (CMS 1500) – Name and address of other coverage
- 29 (CMS 1500) – Payments by other carrier
- 54 (UB-92) – Payments by other carrier
Physician or provider may submit a written statement that demonstrates a good-faith but unsuccessful effort to obtain information about other insurance.

Health plans may require by contract that physicians maintain information about other coverage in their office records.
Coordination of Benefits

- 95-day filing deadline for claim to secondary payer begins when the physician or provider receives payment from the primary carrier.
- If primary carrier’s payment date is not available, proof of timely filing with the primary payer is adequate.
Preauthorization

- May not be required by the carrier for certain procedures
- Once service is preauthorized, carrier may not deny nor reduce payment based on medical necessity or appropriateness of care
- Response deadlines
  - Life-threatening condition or post-stabilization - 1 hour
  - Concurrent hospitalization - 24 hours
  - All other requests - 3 calendar days
- Preauthorization/Verification combination
Eligibility Inquiries and Verification Requests

- Eligibility
  - Not a guarantee of payment

- Verification
  - Guarantee of payment: “cannot reduce or deny payment….”
  - Exceptions: misrepresentation and failure to perform
SB 418 – Key Provisions

- Final rules …
  - Verification response times, without delay, not to exceed:
    - Life-threatening condition or post-stabilization - 1 hour
    - Concurrent hospitalization - 24 hours
    - All other requests - 5 calendar days
  - Required information for verification requests and responses
  - Toll-free numbers
All carriers subject to SB 418 must make a good faith effort to entertain requests for verification rather than adopting a corporate policy of no verifications. If the carrier is unable to verify, it may decline so long as it states the specific reason for the declination. Such reason, according to the statute, must be specific to the request for the proposed service rather than a blanket refusal. Carriers should review their verification procedures to ensure that they are compliant with this requirement.
Fee Schedules

- Provide within 30 days of request
- Software identification
- 90 days notice for change
- No retroactive effect
Fraud

- Material misrepresentation
- Failure to perform services
- Unreasonable charges
- Report fraud
  - Call the TDI Fraud Hotline
    888-327-8818
  - Use the form on TDI’s Website
    www.tdi.state.tx.us/fraud/onlinereport.html
TACCP

- Technical Advisory Committee on Claims Processing
- Successor to Clean Claims Working Group (meeting since 2001)
- Information on TDI Web site
  - Agendas
  - Meeting minutes
- Report to Legislature

Texas Department of Insurance
Current Topics

- Additional rules
  - ID cards
  - Waiver
  - Dental clean claim elements
- 2004 TACCP meetings
  - Consideration of coding and bundling standards
  - Clearinghouses
- Electronic filing waiver procedures
Reference Materials

- TDI Web site
  - Physician/Provider Resource page
  - Rule comparison charts
  - Rules page
  - FAQs page
  - Physician/Provider Complaint form
Texas Department of Insurance

TDI Web Site

TDI Online

TDI Consumer Protection

recovered $48 million for Texans

AUSTIN - More than $48 million was returned to Texas consumers during the past year as a result of actions by the Consumer Protection Division of the Texas Department of Insurance (TDI), the agency announced today. The money came from premium refunds and additional claim payments to consumers that were recovered through TDI investigations of claims disputes. (September 18, 2003)

Texas Department of Insurance
Reference Materials

- Physician/Provider Resource page

In Texas, physicians and providers are entitled to prompt payment for medical and health care services. Senate Bill 410 (79th Regular Legislative Session - 2005) and House Bill 310 (79th Legislative Session - 1999) detail specific provisions that require certain insurance carriers and health maintenance organizations to pay claims timely. Each statute has payment deadlines to ensure prompt payment of claim. To determine whether the medical or health care services are subject to prompt payment provisions, review the following questions:

1. Are the services I provided covered under an HMO or insured PPO plan?
   - Yes: Go to 2.
   - No: Your services are not subject to Texas’ prompt pay requirements.

2. Do I have a contract with an HMO or a PPO?
   - Yes: Your services may be subject to the prompt pay requirements. Go to 3 to determine which requirements may apply.
   - No: Go to 4.

3. Was my contract entered or last renewed on or after August 16, 2003?
   - Yes: Your services would come under the provisions of SB410 and related rules.
   - No: Your services would come under the provisions of HB310 and related rules for claims with a date of service on or after August 1, 2003.

4. Did I provide, on or after August 16, 2003, (a) services on referral from an HMO, PPO, or a preferred provider because the services were not reasonably available in-network or (b) emergency care services?
   - Yes: Your services would come under the provisions of SB410 and related rules.
   - No: Your services are not subject to Texas’ prompt pay requirements.
Reference Materials

- Rule Comparison Charts

Verfication and Preauthorization Procedures

For contracted providers SB 418 is effective for new contracts issued or contracts renewed on or after 8/16/2003.

Emergency Room Physicians and Non-contracted providers that have received a referral may begin utilizing the verification procedures under SB 418 as of 8/16/2003.

For any conflicts between the following reference materials and the rules, the rules prevail.

<table>
<thead>
<tr>
<th>Topic</th>
<th>URA prior to SB 418</th>
<th>SB 418 and Emergency Rules</th>
<th>SB 418 and Final Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification, defined</td>
<td>NA</td>
<td>A guarantee by an HMO or preferred provider carrier that the HMO or preferred provider carrier will pay for proposed medical care or health care services if the services are rendered within the required timeframe to the patient for whom the services are proposed. The term includes pre-certification, certification, re-certification, and any other term that would be a reliable representation by an HMO or preferred provider carrier to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §18.1724(d) of this title (relating to Verification). Article 3.70-3C Sec. 1 (15) and §843.347, TIC contain statutory definitions.</td>
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Reference Materials

- Rules page

Texas Department of Insurance Proposed and Adopted Rules - Microsoft Internet Explorer provided by TDI

DISCLAIMER:
The following proposed and adopted rules are provided as a courtesy by the Texas Department of Insurance. While TDI makes every effort to ensure the accuracy and completeness of this information, the official version of proposed and adopted rules are those filed with the Secretary of State, which is the repository of official TDI rules. These rules can be accessed directly from the Texas Register, Office of Secretary of State.

With respect to the following documents, or other documents available from this site or elsewhere to which it links, TDI and the State of Texas make no warranty as to their accuracy, completeness, reliability, timeliness, or usefulness.

Submission of Comments: Written comments on proposed rules must be received no later than 5 p.m. on the date stated in the preamble of each proposed rule.

<table>
<thead>
<tr>
<th>Proposed and Adopted Rules - 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Credit Information or Credit Scores</td>
</tr>
<tr>
<td>Territory Rating Requirements</td>
</tr>
<tr>
<td>EMERGENCY ADOPTION - Preferred Provider Plans</td>
</tr>
<tr>
<td>EMERGENCY ADOPTION - Physician &amp; Provider Contracts &amp; Arrangements</td>
</tr>
<tr>
<td>Repeal - Variable Contract Agents</td>
</tr>
</tbody>
</table>

Texas Department of Insurance
FAQs

SB 418 FAQs

Effective Date and “Evergreen” Contracts

Q: Both SB 418 and the rules say they apply to contracts amended on or renewed on or after the effective date. However, many contracts have “evergreen” clauses that allow the contract to remain in force unless a party elects to terminate. Do the new law and rules apply to those contracts?

A: The department is aware that certain physician and provider contracts may be “evergreen” contracts that do not renew. Whether a contract is an “evergreen” contract is a determination that must be made with reference to the specific language of each contract. However, if your contract does include a renewal provision, including an automatic renewal, SB 418 is applicable once the contract is renewed on or after August 16, 2003 (for the emergency rules) or October 5, 2003 (for the final rules). The department suggests that parties consult an attorney regarding a contract that appears to be “evergreen.”

Mail Log

Q: §21.3815(h) - The rules have changed the wording from “must maintain” to “may choose to maintain a mail log.” If the choice is made not to maintain a log, would the provider’s computer-generated logs of claims filing now become acceptable proof of timely filing? What provisions are made for altered computer-generated logs?

A: If the provider’s computer-generated printout is carrier-specific and contains all of the information required by 21.2816(h), the department believed that the printout could suffice as a mail log and could establish a presumption of claims receipt if the log is submitted with the claim and faxed or electronically submitted to the carrier on the date of claim submission. The department believes that an altered computer-generated log does not qualify as evidence of claim submission.

Proof of Receipt

Q: The rule says that claims sent by first class mail are presumed received on the fifth day after submission. Does this mean that the 45 -day clock starts after the fifth day? What happens if the provider does not use a mail log and the HMO says it never received the claim?

A: SB 418 states that “If a claim...is mailed, the claim is presumed to have been received by the carrier on the fifth day after the claim is mailed.” While the department is not requiring use of a mail log, in order to avoid disputes and to allow TDI to take action under these rules, there must be some documentation that the claim was actually mailed. If a provider has not used a mail log or other similar method, and has no other way to prove whether or when the claim was mailed, the received date...
Reference Materials

- Physician/Provider Complaint form

Texas Department of Insurance

Physician / Provider Complaint Form
Texas Department of Insurance
PO Box 14893
Austin, Texas 78711-9091

Email: ConsumerProtection@tdi.state.tx.us
Main Number: (512) 463-0500  (800) 252-0439
Fax Number: (512) 475-1771

English: Online Form | Easy Print Form (PDF)

Notice

TDI uses information disclosed in this form to help resolve your complaint. Resolution may require TDI to share this information with the person or company named in your complaint. Although by law much of the information you submit may be considered public record, portions may be confidential, for example, you may include private information protected by the doctrine of common law privacy, medical records protected by the Medical Practice Act, or an e-mail address provided for the purpose of communicating electronically with TDI which is protected by the Texas Public Information Act. Sharing this information for purposes of processing your complaint does not waive these confidentiality protections. However, you may affirmatively consent to release of your e-mail address in response to a public information request or inquiry.

In addition, the Health Insurance Portability and Accountability Act (HIPAA) allows doctors and health care providers to provide information about a person's health care to health oversight agencies such as TDI. The law permits doctors and providers to disclose this information without authorization if the disclosure is for any purpose for which the agency is legally authorized to collect information.

If you would like more information about the public or confidential nature of information maintained by TDI, please consult our Open Records Policy and our Website Privacy Policy. This form is exempt to meet privacy requirements.

Before Filing a Complaint

1. Mail, Fax or Online? - Print this on-line form (or the PDF version), fill in the information, and mail to the address or fax to the telephone number above or complete and submit this on-line form.

2. Supporting Documents? - Complaints requiring supporting documents should be mailed or faxed. If you file on-line, print a copy of your completed complaint form before clicking the “Submit” button at the bottom of the form. Then attach that copy to any supporting documents you mail or fax. Or, when you mail or fax supporting documentation, make a note on the top sheet that you have previously submitted an on-line form. This note will help us to identify your existing complaint file, reduce duplication, and assist you more quickly. You can expect an acknowledgement letter once your complaint form has been received.
Do You Know the Way to Prompt Pay?

- www.tdi.state.tx.us
- 800-252-3439