

THE NEW TEXAS CLEAN CLAIMS STATUTE

Thomas J. Bond, Esq.
Suzanne Spradley, Esq.
(512) 499-6217

During the 2003 legislative session, the Texas legislature passed Senate Bill 418,¹ which expands the current statutory requirements for prompt payment by health maintenance organizations and preferred provider organizations of medical and health care services. The legislation is the product of at least six years of effort by the lobbying arms of the medical and other provider communities to overcome the marketplace power of managed care in all its forms. The effort began with the “Patient Protection Act” and the “Managed Care Liability Act” of 1997; melded into the “Physician Joint Negotiation Act,” the “Delegated Network Act,” and the “Prompt Payment of Claims Act” of 1999; became a stronger “Prompt Payment of Claims Act” of 2001; and culminated with SB 418 in its current form. (*Note:* The Texas Legislature only meets in regular session in odd-numbered years.)

The 2001 Act was vetoed by the Texas governor primarily because it included a provision restricting the use of alternative dispute resolution in contractual matters between payors and providers. In the *Veto Message of Gov. Perry, Tex. H.B. 1862, 77th Leg., R.S. (2001)*, the Governor instructed the Commissioner of Insurance to adopt by rule many of the “prompt pay” provisions of the legislation. The Commissioner convened rulemaking proceedings that lasted for many months before adopting in 2001 stringent new requirements for prompt adjudication and payment of claims by doctors, hospitals and other providers.

But the doctors and hospitals were not happy with the veto nor placated by the rulemaking which had gone almost completely their way. In one of the most stunning political developments of an already unusual general election season, the Texas Medical Association threw its support – and money – behind the Democratic challenger to the Republican incumbent, Rick Perry. Governor Perry, of course, won. Were the doctors then finished as a political force in Texas? Absolutely not.

After the general election of 2002 Governor Perry announced that he intended to sign any bill similar to the one he had vetoed in 2001. All pending negotiations on the legislation came to an abrupt end because the doctors and hospital associations had been given the green light to pursue their legislative desires again. Early in the 2003 regular session it became clear that SB 418 was going to pass and that it would likely reflect the desires of the medical community.

Senate Bill 418 makes 4 important changes to the law:

1. Once a benefit is authorized or verified by the HMO or PPO (“Plan” or “Plans”) payor, coverage for that benefit may not be denied or reduced absent fraud or misrepresentation. This essentially guarantees payment for services.
2. Payment for benefits must be made within 45 days of the filing of a “clean claim” by the provider to avoid penalties and fines (30 days if the claim is properly filed electronically).
3. The payor may audit a claim but only after it has paid 100% of the claim. A recovery for overpayment may not be sought until the provider has exhausted all appeal rights.
4. Penalties are paid to the provider in the following ways and amounts:
 - a. A payment that is made after 45 days (nonelectronic claim) but before 90 days carries with it a penalty equal to 50% of the difference between the provider’s retail rate and the contracted rate or \$100,000, whichever is less.
 - b. Between 91 and 135 days, 100% of the difference or \$200,000, whichever is less.
 - c. Any claim after 90 days is also subject to an 18% interest penalty.

Any Plan is also liable for a \$1,000 state administrative penalty for each late claim if the total of late claims exceed 2% of the payors portfolio for a period. This will be enforced through market conduct audits.

All the above provisions – indeed all of the bill – apply as well to non-contracting providers who are providing services required by contracting providers.

All in all, the legislation appears to have finally given Texas health care providers the upper hand in the managed care war that has been raging for 20 years.

The following is a summary of the important aspects of the bill and their potential impact on the insurance industry:

Verification of Eligibility and Preauthorization of Services

The verification and preauthorization provisions are the most controversial provisions of the bill and will have the highest cost impact. When a provider requests verification of a health care service for a particular patient, the Plan is required to inform the provider, without delay, whether the provider will be paid for the service if rendered to that patient.²

Once a health care service is verified, a Plan may not deny or reduce payment to the provider for that service unless the provider materially misrepresented the service or substantially failed to perform the service.³ The Plan must specify any deductibles, copayments, or coinsurance for which the patient is responsible and verification may be limited to a specific time period of 30 days or more.⁴

The Plan may decline to determine eligibility for payment as long as it notifies the requesting provider of the specific reason why the determination was not made.⁵ Notably, the statute and the proposed rules are silent as to appropriate reasons for declining verification.

Upon request, a Plan must provide a list of medical and health services that require preauthorization within ten days of the request.⁶ The insurer must issue a preauthorization determination within three days of a request or within 24 hours if the request pertains to a patient who is an inpatient in a health care facility at the time of the request.⁷ For inpatient stays, a Plan must issue a length of stay determination based on the patient's physician's recommendation and the Plan's medical criteria.⁸

Additionally, the Plan must staff a toll-free telephone number to provide verification between 6:00 a.m. and 6:00 p.m. central time Monday through Friday and between 9:00 a.m. and 1:00 p.m. on legal holidays and weekends.⁹ Plans must also have telephone capability to accept or record incoming calls at all other times and must respond to those calls within two days. Similar staffing requirements are required for preauthorization inquiries.

Prompt Payment of Clean Claims

The insurer must take action on a clean claim within 30 days of receipt of an electronically submitted clean claim or within 45 days of receipt of a nonelectronically submitted clean claim.¹⁰ Such action by the insurer must include either: (1) payment of the entire claim in accordance with the contracted rate; (2) payment of a portion of the claim for the portion that is not in dispute and written notification as to why the remaining portion will not be paid; or (3) denial of the claim and written notification as to why the claim will not be paid.¹¹

A physician or provider must submit a clean claim within 95 days of when the health care service is rendered, or later if extended by contract.¹² If a physician or provider fails to submit a timely claim, he or she risks forfeiture of the right to payment unless the failure is the result of a catastrophic event that substantially interferes with normal business operation.¹³ A physician or provider may not submit a duplicate claim for payment prior to the 46th day after the date the original claim was submitted.¹⁴

Physicians and providers, including hospitals, will be required to submit a clean claim using a standardized format.

The required format differs depending on whether the claim is submitted nonelectronically or electronically and on whether the person submitting the claim is a physician, a provider, or an institution.

A nonelectronic claim and an electronic claim are deemed a “clean claim” if the claim is submitted on the required form set forth by statute. The Commissioner, by rule, may establish how each field on the respective form is to be completed.

Auditing the Claim

A Plan may audit a claim; however, the audit does not relieve the Plan from their duty to make a timely payment. The Plan must pay the claim at 100% of the contracted rate within 30 days of an electronically submitted clean claim and within 45 days of a nonelectronically submitted clean claim.¹⁵ In addition, the insurer must indicate on the explanation of payment that the payment is subject to completion of the audit.¹⁶ If a Plan requests additional clinical information to complete an audit,¹⁷ the provider must provide the requested information within 45 days of the request or risk forfeiture of the payment.¹⁸

An audit of a claim must be completed within 180 days of when the clean claim is received.¹⁹ Upon completion of the audit, any additional payment due the provider or any refund due the insurer must be made within 30 days of such completion.²⁰ A provider may request an appeal if he or she disagrees with a refund request.²¹ The Plan may not attempt to recover the payment until all appeal rights have been exhausted.²²

The new legislation simplifies the claims payment process by limiting the procedure by which a Plan may request additional information in that the entity may make only one request for additional information from a treating provider to determine eligibility.²³ The request must be specific and it must be made within 30 days of receipt of a clean claim.²⁴ Notably, the statutory claim payment period is tolled when a request for information is made, unless the request for information is directed to persons other than the provider, in which case, the Plan may not withhold payment from the provider pending receipt of the information.²⁵ The Plan must pay or deny the claim on or before the later of (1) 15 days after the date the Plan receives the requested attachment, or (2) within the statutory claims payment period.²⁶

Plans may require a provider to retain in its records updated information concerning other health benefit plan coverage and to provide such information upon request.²⁷ However, the Plan may not require a provider to investigate coordination of other health benefit plan coverage.²⁸ A provider who submits a claim for a particular medical service to more than one Plan must provide written notice on the claim of the identity of each Plan with which the claim is being filed.²⁹ The carriers must then work together to determine appropriate coordination of benefits payments.

If a secondary insurer pays a portion of the claim that the primary insurer is responsible for, the secondary insurer may try to recover the overpayment only from the primary insurer.³⁰ However, if the portion of the claim overpaid by the secondary insurer was also paid by the primary insurer, then the secondary insurer may try to recover the overpayment directly from the provider or physician.³¹ Importantly, coordination of benefits does not extend the time period for determining whether a service is eligible for payment or for auditing a claim.³²

Penalties

The new legislation establishes a new system of graduated penalties for late claims payments, based upon how late the payment is made.

Late Payment of a Clean Claim. If a Plan fails to make a timely payment of a clean claim, yet pays the claim within 45 days of the statutory deadline (i.e., electronic claims paid within 31-75 days or nonelectronic claims paid within 45-90 days), the provider must be paid the contracted rate plus a penalty equal to the lesser of (1) 50% of the difference between the billed charges and the contracted rate, or (2) \$100,000.³³

If the Plan pays the claim on or after the 46th day, but before the 91st day after the statutory deadline (i.e., electronic claims paid within 76-120 days and nonelectronic claims paid within 91-135 days), the Plan must pay a penalty equal to the lesser of (1) 100% of the difference between the billed charges and the contracted rate, or (2) \$200,000.³⁴

If the claim is paid on or after the 91st day after the statutory deadline (i.e., electronic claims paid after the 120th day or nonelectronic claims paid after the 135th day), the Plan must pay the same penalty as mentioned in the preceding paragraph, plus 18 percent annual interest on the penalty amount. Interest accrues beginning with the date the Plan was required to pay the claim and ends with when the claim is paid in full.³⁵

Partial Payment of a Clean Claim. Penalties for claims that were timely paid, but paid incorrectly, are based on the amount underpaid divided by the amount owed multiplied by the billed charges. The resulting base penalty is then discounted 50% for correcting the underpayment between days 31 to 75 for an electronic claim, and so forth in accordance with the previously outlined penalties.³⁶

The law requires a 98% compliance rate in meeting the statutory claims payment period. Therefore, Plans are subject to administrative penalties of up to \$1,000 for each unpaid claim if such violations equal more than 2% of clean claims submitted to the Plan.³⁷

The penalties do not apply if the Plan fails to pay the claim as a result of a catastrophic event that substantially interferes with normal business operations or if the claim was paid timely, but for less than the contracted rate. If the claim was paid timely but for less than the contracted rate, the provider must notify the Plan of the underpayment after 180 days of when the payment was received and the Plan must pay the balance of the claim within 45 days of when it receives notice.³⁸

Another change under the new legislation is the requirement for Plans to use nationally recognized and generally accepted CPT codes, modifiers, guidelines, edits, and logic.³⁹ Additionally, Plans must now disclose coding guidelines, including any underlying bundling, recoding or other payment process and fee schedules applicable to that provider if the provider requests such information. A provider who receives such information may only use or disclose the information for the purpose of practice management, billing activities and other business operations.⁴⁰ The Plans must provide coding information within 30 days of when the request is received and must notify the providers of any changes to the coding guidelines or fee schedules 90 days prior to when the changes will take effect.⁴¹ A PPO provider may now terminate the contract with the PPO within 30 days of when the provider receives the requested coding guidelines and fee schedules.⁴²

If the Commissioner, in consultation with the Commissioner of the Health & Human Services Commission, determines that compliance with the new law will cause a negative fiscal impact to the state, the Commissioner may waive certain portions of the prompt pay requirements for the state's Medicaid and CHIP programs.⁴³

The legislation expands the application of the prompt payment provisions to non-preferred providers who provide emergency services or specialty services provided at the request of a preferred provider if the services are not available within the network.⁴⁴ The law also applies to persons contracting with the Plan to (1) process or pay claims, (2) obtain the services of physicians and providers, or (3) issue verifications or preauthorizations.⁴⁵

Finally, there is another rulemaking proceeding underway pursuant to SB 418. The outcome of that process will likely raise new issues in this debate.

Endnotes

1. S.B. 418, 78th Leg., Reg. Sess. (TX. 2003).
2. *Id.* art. 3.70-3C, §3E(b); *Id.* §843.347(b).
3. *Id.* art. 3.70-3C, §3E(g); *Id.* §843.347(g).

4. *Id.* art. 3.70-3C, §3E(g); *Id.* §843.347(g).
5. *Id.* art. 3.70-3C, §3E(d); *Id.* §843.347(d).
6. *Id.* art. 3.70-3C, §3G(a); *Id.* §843.348(b).
7. *Id.* art. 3.70-3C, §3G(c)(d); *Id.* §843.348(d)(e).
8. *Id.* art. 3.70-3C, §3G(d); *Id.* §843.348(e).
9. *Id.* art. 3.70-3C, §3E(c); *Id.* §843.347(c).
10. *Id.* art. 3.70-3C, §3A(e); *Id.* §843.338.
11. *Id.*; *Id.*
12. *Id.* art. 3.70-3C, §3A(b); *Id.* §843.337(a).
13. *Id.* art. 3.70-3C, §3A(b); *Id.* §843.337(b).
14. *Id.* art. 3.70-3C, §3A(b); *Id.* §843.337(d).
15. *Id.* art. 3.70-3C, §3A(g); *Id.* §843.340(a).
16. *Id.*; *Id.*
17. *Id.* art. 3.70-3C, §3A(g); *Id.* §843.340(b).
18. *Id.* art. 3.70-3C, §3A(g); *Id.* §843.340(c).
19. *Id.* art. 3.70-3C, §3A(h); *Id.* §843.340(d).
20. *Id.*; *Id.*
21. *Id.* art. 3.70-3C, §3A(h); *Id.* §843.340(e).
22. *Id.*; *Id.*
23. *Id.* art. 3.70-3C, §3A(j); *Id.* §843.3385(d).
24. *Id.* art. 3.70-3C, §3A(j); *Id.* §843.3385(b).
25. *Id.* art. 3.70-3C, §3A(k); *Id.* §843.3385(e).
26. *Id.* art. 3.70-3C, §3A(j); *Id.* §843.3385(c).
27. *Id.* art. 3.70-3C, §3F(a); *Id.* §843.349(a).
28. *Id.*; *Id.*
29. *Id.* art. 3.70-3C, §3F(c); *Id.* §843.349(c).
30. *Id.* art. 3.70-3C, §3F(e); *Id.* §843.349(e).
31. *Id.* art. 3.70-3C, §3F(f); *Id.* §843.349(f).

32. *Id.* art. 3.70-3C, §3F(b); *Id.* §843.349(b).
 33. *Id.* art. 3.70-3C, §3I(a); *Id.* §843.342(a).
 34. *Id.* art. 3.70-3C, §3I(b); *Id.* §843.342(b).
 35. *Id.* art. 3.70-3C, §3I(c); *Id.* §843.342(c).
 36. *Id.* art. 3.70-3C, §3I(d)-(g); *Id.* §843.342(d)-(g).
 37. *Id.* art. 3.70-3C, §3I(k); *Id.* §843.342(k).
 38. *Id.* art. 3.70-3C, §3I(h); *Id.* §843.342(h).
 39. *Id.* art. 3.70-3C, §3A(m); *Id.* §843.341(b).
 40. *Id.* art. 3.70-3C, §3H(b); *Id.* §843.319(b).
 41. *Id.* art. 3.70-3C, §3H(a); *Id.* §843.319(a).
 42. *Id.*; *Id.*
 43. *Id.* §843.353.
 44. *Id.* art. 3.70-3C, §10; *Id.* §843.351.
 45. *Id.* art. 3.70-3C, §3J; *Id.* §843.344.■
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