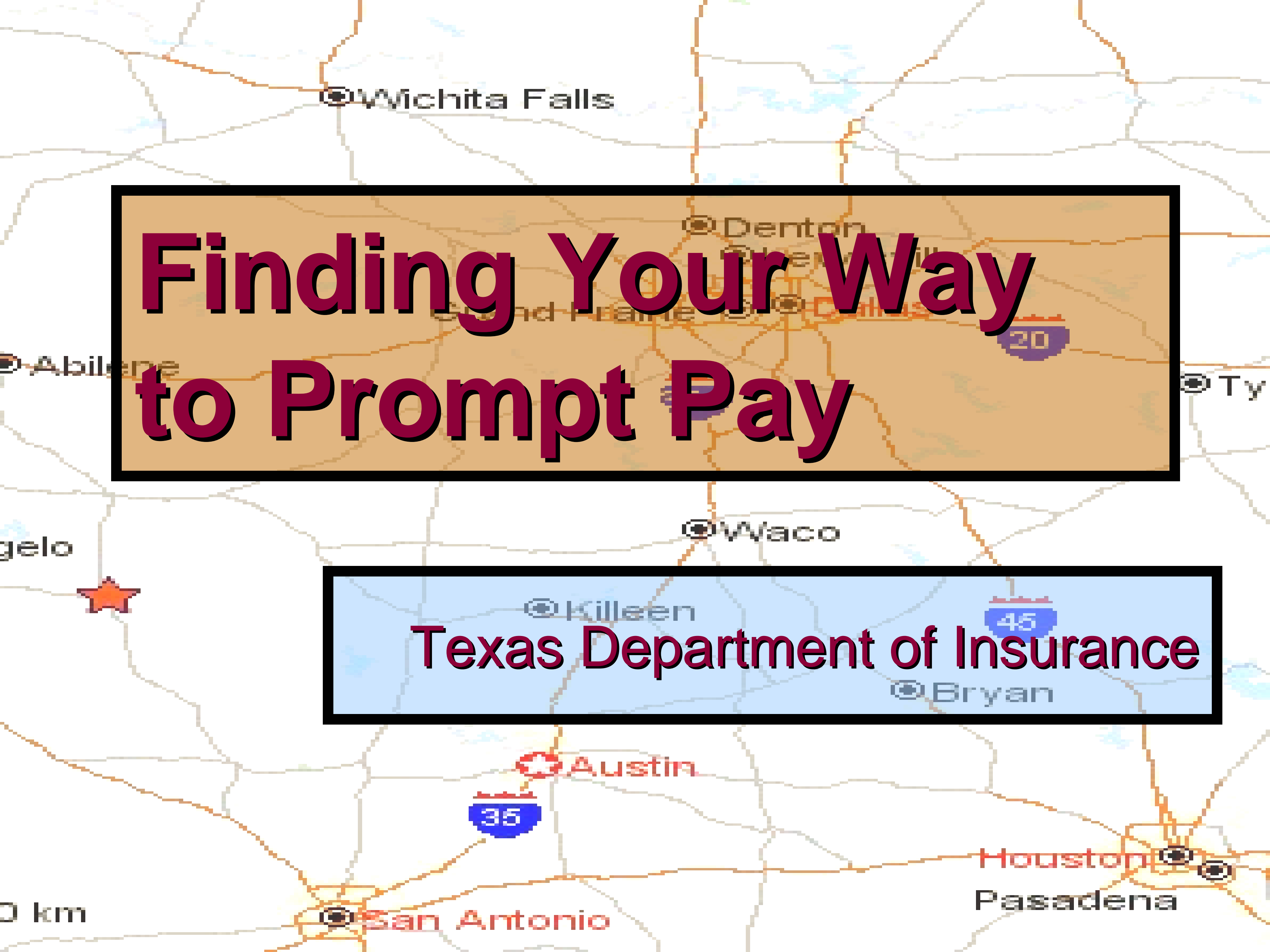

Finding Your Way
to Prompt Pay
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TDI's Strategy

- 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)

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/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?

No

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

Yes

Do you have a contract with an HMO or PPO?

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

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

No

Your services are not subject to SB 418 and related rules.

Yes

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

No

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

Yes

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.

Before

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

After

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

Texas Department of Insurance

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
- All non-contracted providers regarding certain requirements (e.g., claim filing deadlines)

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 – 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

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

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

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 - continued

- **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 Chapter 552
- 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 minus the contracted rate
- Equals the "underpaid amount"
- Multiplied by the percentage for the applicable statutory claim payment period
- Equals the penalty payment

Underpayment Penalty Calculation Example

For a clean claim 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%) **X** $1,500-$1000 = $100
- Multiply by 50%
- $50 = 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

Preauthorization

- Definition: A determination by an HMO or preferred provider carrier that medical care or health care services proposed to be provided to an enrollee are medically necessary and appropriate
  28 TAC §19.1703
- 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

Preauthorization - continued

- Response deadlines
  - Life-threatening condition or post-stabilization - 1 hour
  - Concurrent hospitalization - 24 hours
  - All other requests - 3 calendar days
- Preauthorization/Verification combination

Verification Requests and Eligibility Inquiries

- Verification
  - Guarantee of payment: "cannot reduce or deny payment…."
  - Exceptions: misrepresentation and failure to perform
- Eligibility confirmation
  - Not a guarantee of payment

Verification

- **Definition**: 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 §19.1724(d) of this title (relating to Verification). 28 TAC § 19.1703(37)

Verification Bulletin

- 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.

Verification - continued

- Copay/deductible: HMO or preferred provider carrier shall specify any applicable deductibles, copayments, or coinsurance for which the enrollee/insured is responsible 28 TAC § 19.1724(j)(7)
- Duration: Effective for 30 days or longer if specified by the carrier
- Declination: A response to a request for verification in which an HMO or preferred provider carrier does not issue a verification for proposed medical care or health care services. A declination is not necessarily a determination that a claim resulting from the proposed services will not ultimately be paid.

  28 TAC § 19.1703(9)

Verification - continued

- 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

Preauthorization & Verification Requests

- Toll-free numbers
- Required availability of personnel
  - 6 a.m. - 6 p.m., Monday – Friday
  - 9 a.m. – noon, Saturday, Sunday, & legal holidays
  - Dental/vision HMOs: 8 a.m. – 5:00 p.m., Monday – Friday (except for legal holidays)

Preauthorization & Verification Requests - continued

- After hours and weekend calls
  - After the start of the next time period requiring telephone personnel, carrier must acknowledge the call within
    - Life-threatening condition or post-stabilization - 1 hour
    - Concurrent hospitalization - 24 hours
    - All other -
      - 3 calendar days (Preauthorization)
      - 2 calendar days (Verification)

Coordination of Benefits

- 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

Coordination of Benefits

- 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

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

Fraud - continued

- TIC §701.051

  Insurers must report suspected fraud to TDI

- 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

Fraud - continued

- Issues relating to billed charges:
  - Definition of billed charges
  - Concerns about overcharges
    - Texas Health and Safety Code §311.0025 Texas Department of Health
    - Texas Occupations Code §105.002 Texas State Board of Medical Examiners
  - Investigations of fraud
    - TAC §21.2804; TIC §541.060

ID Cards

- For coverages effective on or after January 1, 2004, ID cards issued after that date must include:
  - “TDI” or “DOI”
  - Name of insured/enrollee
  - Initial date of eligibility, or toll-free number to obtain that date

Required E-filing: Waiver

- Provider can request waiver of requirement to file claims electronically
- Provider can appeal denial of waiver or conditions
- TDI process permits telephone conferences to consider appeals

Recent Legislation & Rules

- SB 50 - Batch rejections
- SB 51 - Changes to preauthorization and verification availability for dental and vision HMOs
- SB 1149 - Eligibility information

Additional Recent Rule Activity

- Underpayment penalty calculation clarification
- Date clarification re: Annual verification reporting
- Proposed rule: SB 51 – Continuation of group coverage after losing group membership

Provider Claims Data Reports

- Carriers report provider claims data quarterly
  - January – March data due 5/15
  - April – May data due 8/15
  - July – September data due 11/15
  - October – December data due 2/15
- Reasons for declinations are reported once a year on 8/15
- Since 3rd quarter 2004: Includes pharmacy claims

Recent disciplinary action

United Healthcare Ins. Co. &

United Healthcare of Texas, Inc.

- Erroneous prompt pay data reports
- Complaint log/records incomplete
- $4 million fine
- Quarterly compliance checks, with additional fines possible
- Independent audit

TACCP

- Technical Advisory Committee on Claims Processing
- 2005 & 2006 meetings
  - Rules to implement new legislation
  - Prompt pay data summary
  - Coding and bundling standards
  - National provider identifiers
  - CMS claim form revisions
  - Silent/rental PPOs
  - Standard contract language
- http://www.tdi.state.tx.us/consumer/ccwg.html

Reference Materials

- TDI Web site
  - Physician/Provider Resource page
  - Rules page
  - FAQs page
  - Physician/Provider Complaint form

TDI Web Site

Agent, Consumer, Industry News, Workers Compensation and Assistance from the Texas Department o - Microsoft Internet Explorer

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Texas Department of Insurance
Home Page
Commissioner of Insurance Mike Geeslin

Division of Workers' Comp Home
Office of Injured Employee Counsel
TDI-TWCC Transition | Provider Networks

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About TDI ¤ Audiocasts ¤ Codes & Rules ¤ Compact ¤ Events ¤ Forms
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- HMOs
- Industry Data
- Insurer Search
- Jobs | Bids
- Keyword Search
- News
- SDR Contract Admin
- TDI Lists
- UR Agents
- Windstorm

TDI Online

Storm+LINK

NEW! Revised 2006 Texas Standardized Credentialing Application - Effective July 1, 2006. Use of the application form by hospitals, HMOs and PPOs is required for credentialing and recredentialing of physicians. Hospitals and health plans may use this application for the credentialing of other health care professionals, as well.

Health Website! - TexasHealthOptions.com
A service of the State of Texas - with links to government & other Web sites to help Texans shop for health insurance

New Publications for Injured Workers

New TDI RSS XML Feeds Now Available!

Protected in Event of Hurricane?

Office of Injured Employee Counsel

Select Topic & Link

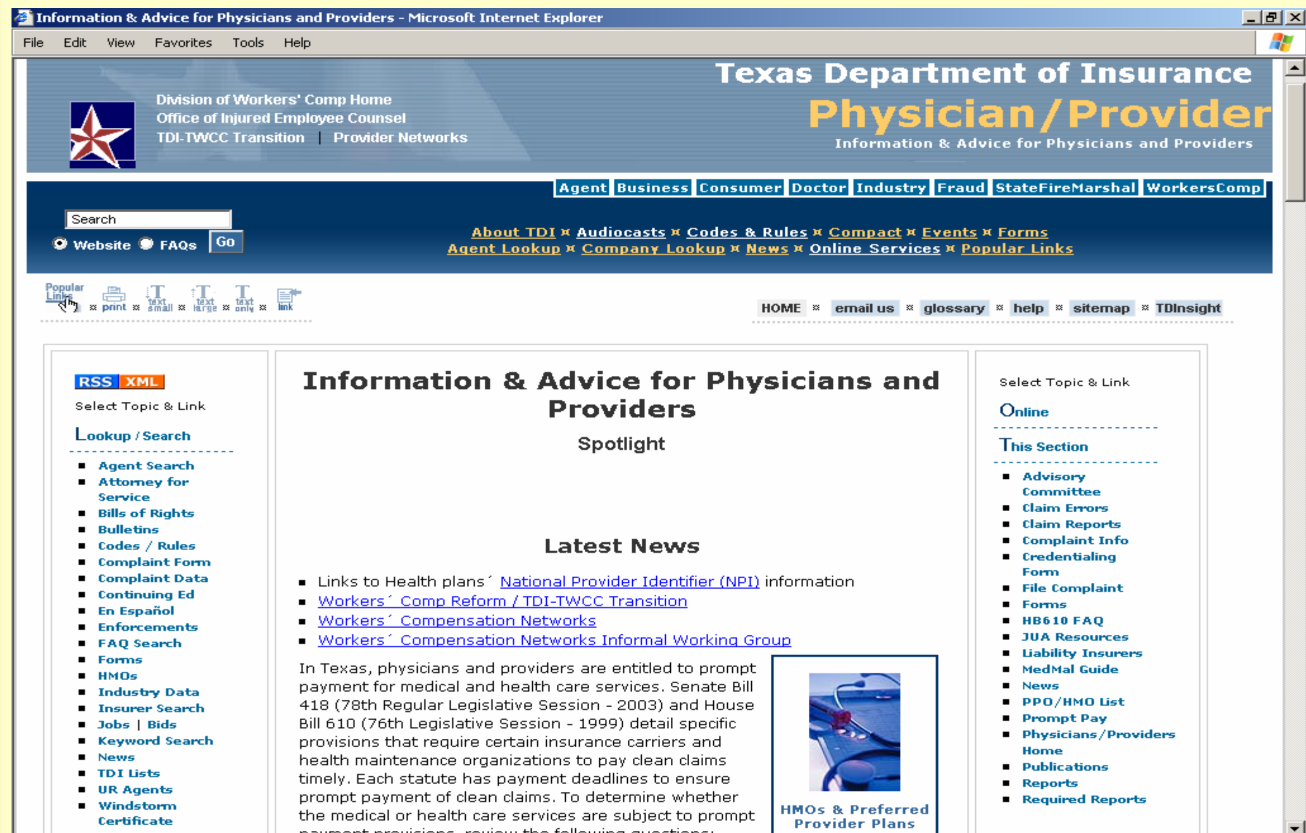
Online

Section Links

- About TDI
- Agent/Adjuster
- Auto
- Bond Resource
- Bulletins/Rules
- Business
- Business Development
- Company Licensing
- Commercial
- Consumer
- Data Calls
- Dates & Deadlines
- Doctor/Provider
- Fire Marshal
- Forms
- Fraud Unit
- Health
- Homeowner
- Industry

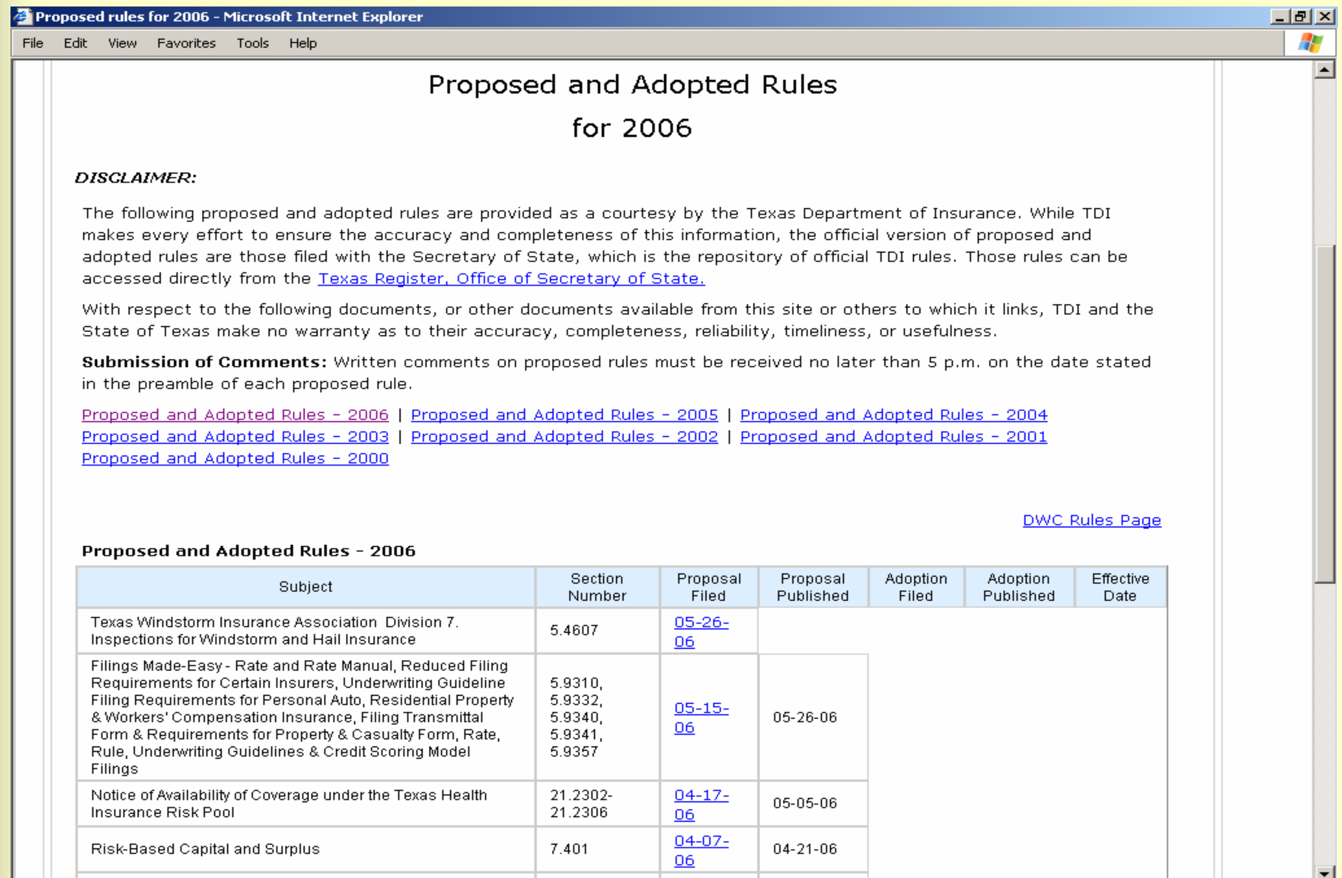
Reference Materials

- Physician/Provider Resource page



Reference Materials

- Rules page



Proposed rules for 2006 - Microsoft Internet Explorer

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Proposed and Adopted Rules for 2006

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. Those 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 others 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.

Proposed and Adopted Rules - 2006 | Proposed and Adopted Rules - 2005 | Proposed and Adopted Rules - 2004
Proposed and Adopted Rules - 2003 | Proposed and Adopted Rules - 2002 | Proposed and Adopted Rules - 2001
Proposed and Adopted Rules - 2000

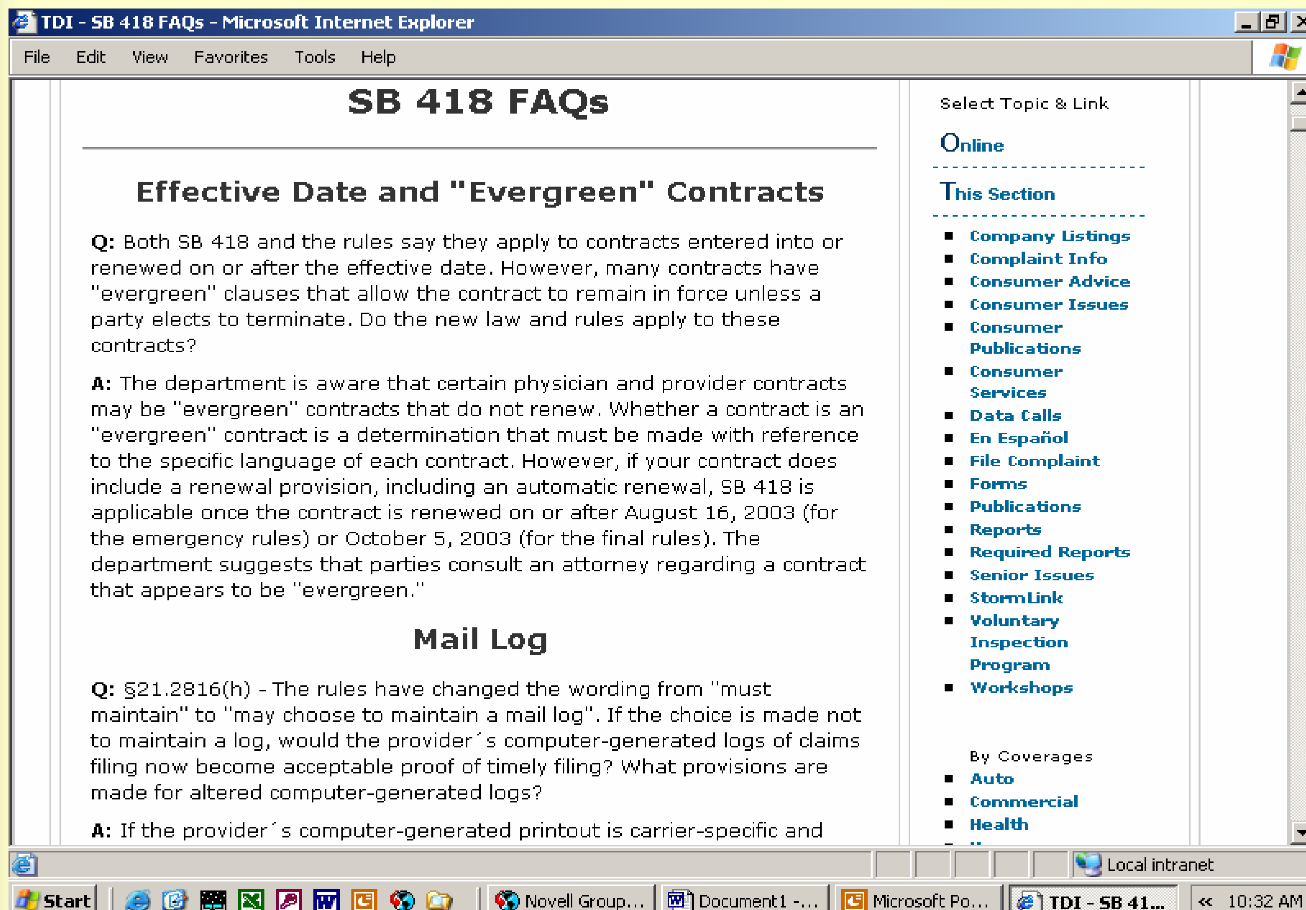
DWC Rules Page

Proposed and Adopted Rules - 2006

Subject	Section Number	Proposal Filed	Proposal Published	Adoption Filed	Adoption Published	Effective Date
Texas Windstorm Insurance Association Division 7. Inspections for Windstorm and Hail Insurance	5.4607	05-26-06				
Filings Made-Easy - Rate and Rate Manual, Reduced Filing Requirements for Certain Insurers, Underwriting Guideline Filing Requirements for Personal Auto, Residential Property & Workers' Compensation Insurance, Filing Transmittal Form & Requirements for Property & Casualty Form, Rate, Rule, Underwriting Guidelines & Credit Scoring Model Filings	5.9310, 5.9332, 5.9340, 5.9341, 5.9357	05-15-06	05-26-06			
Notice of Availability of Coverage under the Texas Health Insurance Risk Pool	21.2302-21.2306	04-17-06	05-05-06			
Risk-Based Capital and Surplus	7.401	04-07-06	04-21-06			

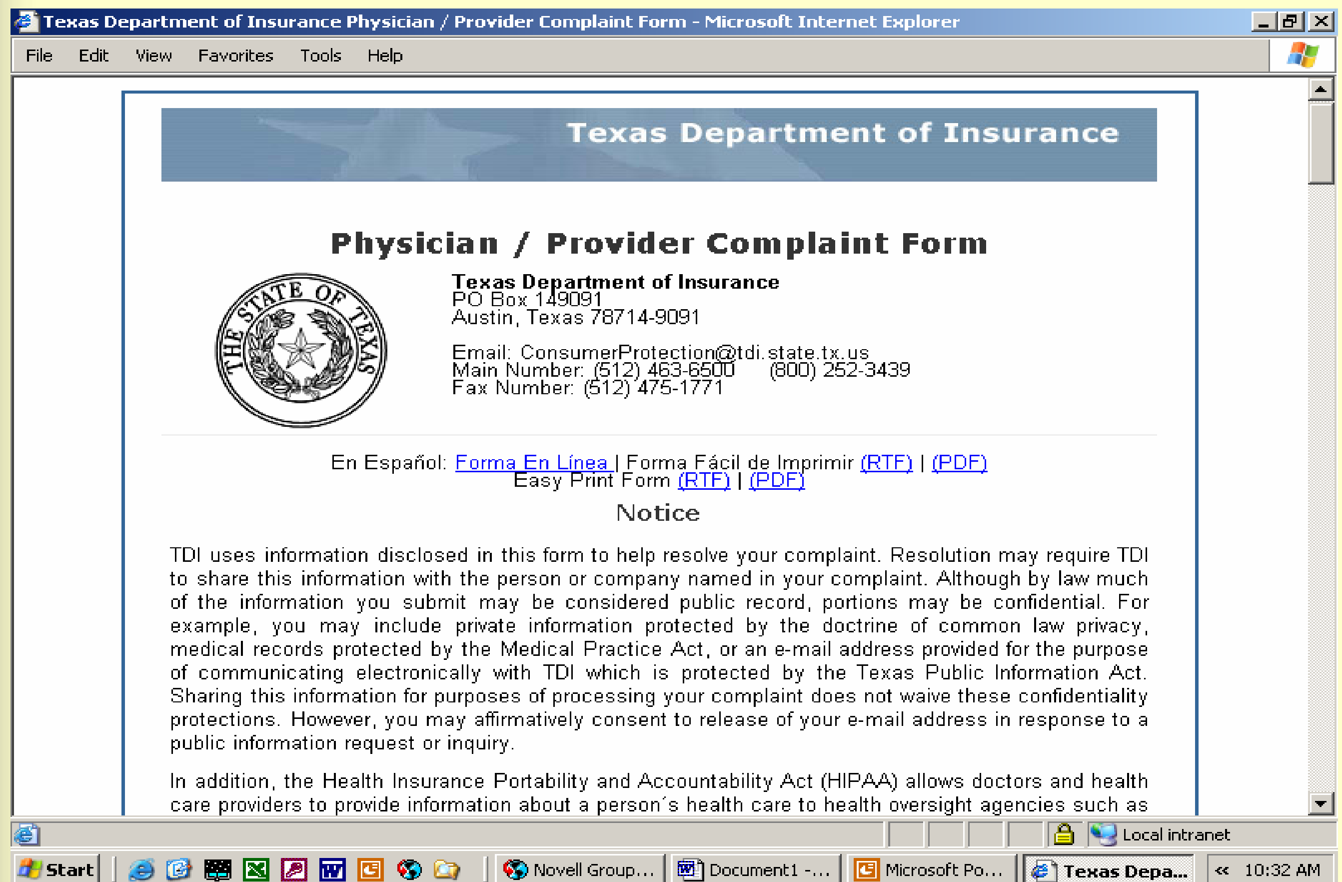
FAQs

- SB 418 FAQs



Reference Materials

- Physician/Provider Complaint form



Texas Department of Insurance Physician / Provider Complaint Form - Microsoft Internet Explorer

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Texas Department of Insurance

Physician / Provider Complaint Form

Texas Department of Insurance
PO Box 149091
Austin, Texas 78714-9091

Email: ConsumerProtection@tdi.state.tx.us
Main Number: (512) 463-6500 (800) 252-3439
Fax Number: (512) 475-1771

En Español: Forma En Línea | Forma Fácil de Imprimir (RTF) | (PDF)
Easy Print Form (RTF) | (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

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