SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
28 TAC §§21.5001 - 21.5031

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC Chapter 21, Subchapter PP, §§21.5001 - 21.5031 (relating to Out-of-Network Claim Dispute Resolution). The amendments are adopted with changes to the proposed text published in the May 27, 2016, issue of the *Texas Register* (41 TexReg 3834).

REASONED JUSTIFICATION. The amendments are necessary because of changes made to Texas Insurance Code Chapter 1467. Senate Bill 481, 84th Legislature, Regular Session (2015), amended Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution). As a result, the department must make conforming changes to 28 TAC Chapter 21, Subchapter PP.

Both Chapter 1467 and Subchapter PP provide for mediation of certain claims by certain facility-based physicians for services provided to enrollees of preferred provider benefit plans issued under Insurance Code Chapter 1301 and to enrollees of health benefit plans, other than health maintenance organization plans, provided under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act).

Senate Bill 481 added assistant surgeons to the list of facility-based physicians subject to mediation. The department's rules at 28 TAC Chapter 21, Subchapter PP need to be updated to include this change. The rule amendments as proposed and adopted include "assistant surgeons" but do not include "surgical assistants" because surgical assistants who are not also assistant surgeons are not physicians whose claims are subject to mediation under the statute. Senate Bill 481 also lowered the threshold amount for mediation to amounts greater than $500 for services provided on or after September 1, 2015. The rules have been updated to include these changes and adopt a new mediation request form. The amendments also make it clear that the statute does not allow claims to be unilaterally reduced to an amount below the mediation threshold to avoid mediation of a qualified claim and allow balance billing. The amendments also make nonsubstantive changes to conform to agency style and usage guidelines.

The department has made the following changes to the proposed language in response to comments:

1. did not implement the department's proposed deletion of the qualifying statement, "provided the claim is filed on or after November 1, 2010," in §21.5002(a)(1) and (a)(2);
2. made changes to §§21.5002(b), 21.5003(3), 21.5003(3)(B), and 21.5003(10) to avoid the proposed deletion of the "and/or" construct while preserving clarity, generally by substituting "A or B or both" for "A and/or B," and made the same kind of nonsubstantive changes to §21.5020 and §21.5030(b)(3) for the same reason;
3. retained the "contracted with an" administrator language in §21.5003(10); and
4. added the hospital-based physician and the hospital-based physician's representative to the list in proposed §21.0511(a)(7) of persons to whom authorized disclosures may be made.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received timely written comments from two commenters. Commenters on the proposal were: one individual and the Texas Medical Association. The commenters were for the proposal, with changes.

General Comment.

One commenter stated that the proposed amendments do not address a situation where an individual is balance billed for special equipment used in a surgical operation. The commenter stated that many consumers of health care are familiar with the issue of inadvertently receiving care from an out-of-network doctor, even though the treatment was at an in-network hospital, but that most people probably are unaware that an in-network doctor's surgical equipment might be classified as out-of-network. The commenter suggested that a global solution to the issue of inadvertent out-of-network charges should be undertaken to obviate mediation services. The commenter noted that the solution must apply to any major medical health insurance plan and not be limited to hospital-based physicians.

Agency Response to General Comment.

The department appreciates the comment and acknowledges that balance billing can occur in contexts other than the physician services covered in Insurance Code Chapter 1467. However, the

Insurance Code does not currently provide for the global solution advocated by the commenter. The department therefore respectfully declines to make the changes suggested by the commenter.

Comment on §21.5002(a).

One commenter opposed the department's proposed deletion of the qualifying statement, "provided the claim is filed on or after November 1, 2010," from §21.5002(a)(1) and (a)(2). The commenter noted that it was possible that a plan could audit a claim dated before this date, and said that the language adds clarity to the rules, as it makes it clear that the mediation process applies only after the effective date specified in the original bill. Were it changed, according to the commenter, claims dated before the bill enacting Chapter 1467 (HB 2256, 81st Legislature, Regular Session, 2009) might be eligible for mediation.

Agency Response to Comment on §21.5002(a).

While the department believes that this scenario is unlikely, and believes that Chapter 1467 makes it clear that claims filed before November 1, 2010, are not eligible for mediation, it agrees to leave the date references intact to avoid any possible confusion.

Comments on §§21.5002(b), 21.5003(3), 21.5003(3)(B), 21.5003(10), 21.5020, and 21.5030(b)(3).

One commenter opposed the proposed alteration of the "and/or" language in §§21.5002(b), 21.5003(3), 21.5003(3)(B), and 21.5003(10). The commenter asserted that this construct adds clarity, as it encompasses "A" or "B" or some combination thereof. The commenter did not mention §21.5020 or §21.5030(b)(3), but the department assumes the same concern would apply there.

Agency Response to Comments on §§21.5002(b), 21.5003(3), 21.5003(3)(B), and 21.5003(10).

The department now generally discourages the use of the "and/or" construct, but has made changes to the proposed deletions to preserve clarity. The department has made the same kind of nonsubstantive change to §21.5020 and §21.5030(b)(3) for the same reason.

Comment on §21.5003(10).

One commenter recommended retaining the "contracted with an" language in the current rules. The commenter contended that deleting "contracted with an" preceding "administrator" potentially alters the meaning of §21.5003(10). Deleting "contracted with an" makes the rule read as if, for a claim

to be an "out-of-network claim," it must be a claim by a hospital-based physician who is not contracted as a preferred provider with a preferred provider benefit plan or with an administrator. The commenter noted that this language is imprecise because, although a physician may contract with the administrator of a state plan under Chapter 1551, he or she does not contract with the administrator "as a preferred provider" as defined in §21.5003(11)

Agency Response to Comment on §21.5003(10).

The department appreciates the commenter's concern, and agrees to retain the "contracted with an" language.

Comment on §21.5010(d).

One commenter opposed the language as currently drafted and contended that the language of Insurance Code Chapter 1467 does not contain an express exception that allows mediation requests for aggregate amounts falling below the statutory threshold due to unilateral reductions in enrollee responsibility. The commenter was concerned that the language in the rule proposal is broadly drafted and may have unintended consequences. The commenter urged the department to:

(1) Clarify that the unilateral reduction exception in proposed §21.5010(d) applies to a claim that meets the criteria for a qualified claim after claim adjudication. The commenter contended that it is important to add clarifying language, because: (a) physicians should have the flexibility to set or modify their charges prior to claim submission or adjudication, and (b) the department's concern about attempts to inappropriately circumvent mediation by reducing aggregate amounts due has no validity before claim adjudication, as the physician has no idea what an enrollee's ultimate payment responsibility will be until after the claim is adjudicated.

(2) Include exceptions for correction of errors and to allow use of established prompt pay discount policies to the proposed unilateral reduction exception. The commenter stated that the language of §21.5010(d) fails to acknowledge that there are many legitimate reasons for a unilateral reduction in the aggregate amount due, such as to correct a billing error, claim payment, or claim submission or adjudication. The commenter was concerned that § 21.5010(d), as currently proposed, would inhibit the use of legitimate, established written prompt pay discount policies, because there may be confusion as to what constitutes "consent" for purposes of §21.5010(d)'s qualified claim status continuation provision. The commenter's suggested language provided that an enrollee who either

agrees to pay or pays a prompt pay discounted amount under an established prompt pay billing policy is deemed to have consented to the reduction.

(3) The commenter commented that the department should include additional language in proposed §21.5010(d) to: (a) minimize the unintended consequences of the "consent" requirement language, and (b) ensure that the regulatory provision targets the specific behavior that it wants to address (such as inappropriate circumvention of mediations). The commenter's suggested language involved the aggregate amount for which the enrollee is responsible being reduced below the thresholds set out in the section if the reduction occurs: (a) without the consent of the enrollee, (b) after receipt of notice from the department that an enrollee has made a request for mediation, and (c) with the specific intent and for the sole purpose of avoiding mediation.

Agency Response to Comment on §21.5010(d).

First, the department notes that the statutes allow very little discretion on this matter. A claim qualifies for mandatory mediation under Insurance Code §1467.051(a) if: (1) the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $500; and (2) the health benefit claim is for a medical service or supply provided by an out-of-network, facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator. Once that qualification occurs, as §1467.051(b) provides, barring the exception for disclosures under §1467.051(c) and (d), "if an enrollee requests mediation under this subchapter, the facility-based physician or the physician's representative and the insurer or the administrator, as appropriate, shall participate in the mediation." The statute provides no way for a claim to become "unqualified" or to be unilaterally removed from mediation under §§1467.054 - 1467.060, which contemplate the mediation process continuing until a resolution is reached. As §1467.056(d) puts it, "[t]he goal of the mediation is to reach an agreement among the enrollee, the facility-based physician, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based physician, the amount charged by the facility-based physician, and the amount paid to the facility-based physician by the enrollee." Indeed, §1467.055(h) provides that "[o]n receipt of notice from the department that an enrollee has made a request for mediation that meets the requirements of this chapter, the facility-based physician may not pursue any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and coinsurance before the earlier of: (1) the date the

mediation is completed, or (2) the date the request to mediate is withdrawn." This presents a significant barrier to any negotiations about amounts to be paid once the mediation process has begun. The department believes that the proposed rule accurately reflects the law.

Second, the small number of "unilateral claim reductions" with which the department is concerned in this subsection do not involve billing errors or prompt pay discounts, but appear to simply be unilateral reductions (sometimes referred to as the *Texas discount*). Their purpose appears to be solely to get the claim below the mediation threshold. While the department anticipates that this will become less of a problem with the new, lower, $500 threshold, it is not a practice permitted by the statute.

With regard to the first change suggested in the comment above (clarifying that a claim qualifies or not after claim adjudication), the department's concern is that a small number of facility-based physicians attempt to inappropriately circumvent mediation by reducing aggregate amounts due after, and not before, claim adjudication by the insurer or administrator. Until a claim is adjudicated, it is impossible to determine "the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer" under §1467.051(1). Similarly, until the claim is adjudicated, it is difficult to tell whether the "claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator" under §1467.051(2). Thus, a claim qualifies (or does not qualify) for mandatory mediation under Insurance Code §1467.051 after, not before, claim adjudication. The department agrees to change the language in §21.5010(d) to make it clear that the amount involved is that remaining after claim adjudication.

With regard to the second change suggested in the comment above (regarding prompt payment discounts), the department notes that the amount of the claim would be the amount before the discount, since that is the amount claimed. The discount is an inducement to pay earlier rather than later, and would not be deducted from the amount of the claim for the purpose of determining whether the claim is under or over the threshold for mediation. The department declines to make the requested change.

With regard to the possibility of any party unilaterally reducing the aggregate amount due in order to correct a billing error, claim payment, or claim submission or adjudication, §§1467.051 and 1467.054 - 1467.060 limit the actions of parties, as described above. The department cannot simply

create an exemption from the requirements of those sections, and declines to make the requested change.

With regard to the third change suggested in the comment above (regarding adding additional language), the department does not believe the suggested changes or the intent language are useful or advisable in light of the statutory constraints set out above, and declines to make the suggested change.

Comment on §21.0511(a)(7).

One commenter did not object to the department's obtaining an authorization form if the department determines that the form is necessary, but questioned why the department did not include the hospital-based physician and the hospital-based physician's representative in the list of persons to whom authorized disclosures may be made under the authorization form. The commenter recommended that the department add the hospital-based physician and the hospital-based physician's representative to the list in proposed §21.0511(a)(7).

Agency Response to Comment on §21.0511(a)(7).

The department assumed that the hospital-based physician and the hospital-based physician's representative already had consent from the patient for the disclosures in question, and thus did not include them in the form. The department agrees to alter the form to make it clear that the hospital-based physician and the hospital-based physician's representative are included in the list of persons to whom authorized disclosures may be made.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 1. GENERAL PROVISIONS

§§21.5001 – 21.5003

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.001, 1467.003, and 36.001.

Section 1467.001 contains definitions, including a definition for the facility-based physicians to whose billings Chapter 1467 applies.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§21.5001. Purpose.

As authorized by Insurance Code §1467.003 (concerning Rules), the purpose of this subchapter is to:

(1) prescribe the process for requesting and initiating mandatory mediation of claims as authorized in Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution); and

(2) facilitate the process for the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network claim under Insurance Code Chapter 1467.

§21.5002. Scope.

(a) This subchapter applies to a qualified claim filed under health benefit plan coverage:

(1) issued by an insurer as a preferred provider benefit plan under Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans), provided the claim is filed on or after November 1, 2010; or

(2) administered by an administrator of a health benefit plan, other than a health maintenance organization (HMO) plan, under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act), provided the claim is filed on or after November 1, 2010.

(b) This subchapter does not apply to a claim for health benefits, including medical and health care services or supplies or both, that is not a covered claim under the terms of the health benefit plan coverage.

§21.5003. Definitions.

The following words and terms have the following meanings when used in this subchapter unless the context clearly indicates otherwise.

(1) Administrator--An administering firm or a claims administrator for a health benefit plan, other than a health maintenance organization (HMO) plan, providing coverage under Insurance Code Chapter 1551, (concerning Texas Employees Group Benefits Act).

(2) Chief administrative law judge--The chief administrative law judge of the State Office of Administrative Hearings.

(3) Claim--A request to a health benefit plan for payment for health benefits under the terms of the health benefit plan's coverage, including medical and health care services or supplies or both, provided that the services or supplies or both:

(A) are furnished for a single date of service; or

(B) if furnished for more than one date of service, are provided as a continuing or related course of treatment, or a continuing and related course of treatment, over a period of time for a specific medical problem or condition, or in response to the same initial patient complaint.

(4) Enrollee--An individual who is eligible to receive benefits through a health benefit plan.

(5) Health benefit plan--A plan that provides coverage under:

(A) a preferred provider benefit plan offered by an insurer under Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans); or

(B) a plan, other than an HMO plan, under Insurance Code Chapter 1551.

(6) Hospital-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon if the assistant surgeon's services are provided on or after September 1, 2015:

(A) to whom the hospital has granted clinical privileges; and

(B) who provides services to patients of the hospital under those clinical privileges.

(7) Insurer--A life, health, and accident insurance company; health insurance company; or other company operating under: Insurance Code Chapters 841 (concerning Life, Health, or Accident Insurance Companies); 842 (concerning Group Hospital Service Corporations); 884 (concerning Stipulated Premium Insurance Companies); 885 (concerning Fraternal Benefit Societies); 982 (concerning Foreign and Alien Insurance Companies); or 1501 (concerning Health Insurance Portability

and Availability Act), that is authorized to issue, deliver, or issue for delivery in this state a preferred provider benefit plan under Insurance Code Chapter 1301.

(8) Mediation--A process in which an impartial mediator facilitates and promotes agreement between the insurer offering a preferred provider benefit plan, or the administrator, and a hospital-based physician or the physician's representative to settle a qualified claim of an enrollee.

(9) Mediator--An impartial person who is appointed to conduct mediation under Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution).

(10) Out-of-network claim--A claim for payment for medical or health care services or supplies or both furnished by a hospital-based physician that is not contracted as a preferred provider with a preferred provider benefit plan or contracted with an administrator.

(11) Preferred provider--A hospital or hospital-based physician that contracts on a preferred-benefit basis with an insurer issuing a preferred provider benefit plan under Insurance Code Chapter 1301 to provide medical care or health care to enrollees covered by a health insurance policy.

DIVISION 2. MEDIATION PROCESS

§§21.5010 – 21.5013

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.001, 1467.003, 1467.051, 1467.054, and 36.001.

Section 1467.001 contains definitions, including a definition for the facility-based physicians to whose billings Chapter 1467 applies.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Section 1467.054 sets out the procedure for requesting mediation and preliminary procedures for that mediation, and provides that a request for mandatory mediation must be provided to the department on a form prescribed by the commissioner.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§21.5010. Qualified Claim Criteria.

(a) Required criteria. An enrollee may request mandatory mediation of an out-of-network claim under §21.5011 of this title (relating to Mediation Request Form and Procedure) if the claim complies with the criteria specified in this subsection. An out-of-network claim that complies with those criteria is referred to as a "qualified claim" in this subchapter.

(1) The out-of-network claim must be for medical services or supplies, or both, provided by a hospital-based physician in a hospital that is a preferred provider with the insurer or that has a contract with the administrator.

(2) For services provided before September 1, 2015, the aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than $1,000.

(3) For services provided on or after September 1, 2015, the aggregate amount for which the enrollee is responsible to the hospital-based physician for the out-of-network claim, not including copayments, deductibles, coinsurance, or amounts paid by an insurer or administrator directly to the enrollee, must be greater than $500.

(b) Submission of multiple claim forms. The use of more than one form in the submission of a claim, as defined in §21.5003(3) of this title (relating to Definitions), does not prevent eligibility of a claim for mandatory mediation under this subchapter if the claim otherwise meets the requirements of this section.

(c) Ineligible claims.

(1) An out-of-network claim is not eligible for mandatory mediation under this subchapter if:

(A) the hospital-based physician has provided a complete disclosure to an enrollee under Insurance Code §1467.051 (concerning Availability of Mandatory Mediation; Exception), and this subsection before providing the medical service or supply or both and has obtained the enrollee's written acknowledgment of that disclosure; and

(B) the amount billed by the hospital-based physician is less than or equal to the maximum amount specified in the disclosure.

(2) A complete disclosure under paragraph (1) of this subsection must:

(A) explain that the hospital-based physician does not have, as applicable, either a contract with the enrollee's health benefit plan as a preferred provider or a contract with the administrator of the plan, other than an HMO plan, provided under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act);

(B) disclose projected amounts for which the enrollee may be responsible; and

(C) disclose the circumstances under which the enrollee would be responsible for those amounts.

(d) Qualification continues. A claim that meets the criteria for a qualified claim after claim adjudication by the insurer or administrator does not lose that status by virtue of the aggregate amount for which the enrollee is responsible being reduced below the thresholds set out in this section without the consent of the enrollee.

§21.5011. Mediation Request Form and Procedure.

(a) Mediation request form. The commissioner adopts by reference Form No. CP029 (Health Insurance Mediation Request Form), which is available at www.tdi.texas.gov/consumer/cpmmediation.html. Form No. CP029 (Health Insurance Mediation Request Form) requires information necessary for the department to properly identify the qualified claim, including:

(1) the name and contact information, including a telephone number, of the enrollee requesting mediation;

(2) a brief description of the qualified claim to be mediated;

(3) the name and contact information, including a telephone number, of the requesting enrollee's counsel, if the enrollee retains counsel;

(4) the name of the hospital-based physician;

(5) the name of the insurer or administrator;

(6) the name and address of the hospital where services were rendered; and

(7) an authorization allowing the department to disclose the enrollee's protected health information or other confidential information to the hospital-based physician and the hospital-based physician's representative, the enrollee's health benefit plan's insurer or administrator, the appointed mediator, and the State Office of Administrative Hearings.

(b) Submission of request. An enrollee may submit a request for mediation by completing and submitting Form No. CP029 (Health Insurance Mediation Request Form) as provided in paragraphs (1) - (4) of this subsection. The request may be submitted:

(1) by mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;

(2) by fax to 512-490-1007;

(3) by email to ConsumerProtection@tdi.texas.gov; or

(4) online, when the department makes Form No. CP029 (Health Insurance Mediation Request Form) available to be completed and submitted online.

(c) Assistance. Assistance with submitting a request for mediation is available at the department's toll-free telephone number, 1-800-252-3439.

§21.5012. Informal Settlement Teleconference.

An insurer or administrator subject to mandatory mediation requested by an enrollee under §21.5011 of this title (relating to Mediation Request Form and Procedure) must use best efforts to coordinate the informal settlement teleconference required by Insurance Code §1467.054 (concerning Request and Preliminary Procedures for Mandatory Mediation) by:

(1) arranging a date and time when the insurer or administrator; the enrollee or the enrollee's representative, if the enrollee or the enrollee's representative, chooses to participate; and the hospital-based physician or the hospital-based physician's representative can participate in the informal settlement teleconference, which must occur not later than the 30th day after the date on which the enrollee submitted a request for mediation; and

(2) providing a toll-free telephone number for participation in the informal settlement teleconference.

§21.5013. Mediation Participation.

(a) An insurer or administrator subject to mediation under this subchapter must participate in mediation in good faith and is subject to any rules adopted by the chief administrative law judge in accordance with Insurance Code §1467.003 (concerning Rules).

(b) Under Insurance Code §1467.101 (concerning Bad Faith), conduct that constitutes bad faith mediation includes failing to:

(1) participate in the mediation;

(2) provide information that the mediator believes is necessary to facilitate an agreement; or

(3) designate a representative participating in the mediation with full authority to enter into any mediated agreement.

DIVISION 3. PLAN ADMINISTRATOR'S REQUIRED NOTICE OF CLAIMS DISPUTE RESOLUTION

§21.5020

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.003, 1467.151, and 36.001.

Section 1467.001 contains definitions, including a definition for the facility-based physicians to whose billings Chapter 1467 applies.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Section 1467.151 provides, in pertinent part, that the commissioner adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467, and requires that the rules require plan administrators to include a notice of the claims dispute resolution process available under Chapter 1467 with the explanation of benefits sent to an enrollee.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§21.5020. Required Notice of Claims Dispute Resolution. An administrator of a plan under Insurance Code Chapter 1551 (concerning Texas Employees Group Benefits Act), must include a notice of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim for services, supplies, or both, furnished in a hospital that has a contract with the administrator.

DIVISION 4. COMPLAINT RESOLUTION AND OUTREACH

§21.5030 and §21.5031

STATUTORY AUTHORITY. The amendments are adopted pursuant to Insurance Code §§1467.003, 1467.151, and 36.001.

Section 1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467.

Section 1467.151 provides, in pertinent part, that the commissioner adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement TDI's powers and duties under the Insurance Code and other laws of this state.

TEXT.

§21.5030. Complaint Resolution.

(a) Written complaint.

(1) An individual may submit a written complaint to the department regarding a qualified claim or a mediation that has been requested under §21.5010 of this title (relating to Qualified Claim Criteria). A recommended form for filing a complaint under this subsection is available online at www.tdi.texas.gov/consumer/cpmmediation.html. The complaint may be submitted by:

(A) mail to the Texas Department of Insurance, Consumer Protection Section, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091;

(B) fax to 512-490-1007;

(C) email to ConsumerProtection@tdi.texas.gov; or

(D) online submission.

(2) Assistance with filing a complaint is available at the department's toll-free telephone number, 1-800-252-3439.

(b) Complaint form. The recommended form for filing a complaint under subsection (a) of this section requests information concerning the complaint, including:

(1) whether the complaint is within the scope of Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution);

(2) whether medical care has been delayed or has not been given;

(3) whether the medical service, supply, or combination thereof that is the subject of the complaint was for emergency care; and

(4) specific information about the qualified claim, including:

(A) the type and specialty of the hospital-based physician;

(B) the type of service performed or supplies provided;

(C) the city and county where service was performed; and

(D) the dollar amount of the disputed claim.

(c) Department Processing. The department will maintain procedures to ensure that a written complaint made under this section is not dismissed without appropriate consideration, including:

(1) review of all of the information submitted in the written complaint;

(2) contact with the parties that are the subject of the complaint;

(3) review of the responses received from the subjects of the complaint to determine if and what further action is required, as appropriate; and

(4) notification to the enrollee of the mediation process, as described in Insurance Code Chapter 1467, Subchapter B (concerning Mandatory Mediation).

§21.5031. Department Outreach.

In addition to the notice provided to consumers regarding the availability of mandatory mediation described in §21.5030(c) of this title (relating to Complaint Resolution), the department will provide outreach as required by Insurance Code §1467.151(a)(2) (concerning Consumer Protection; Rules), by making information concerning the availability of this mandatory mediation process available:

(1) on the department's website; and

(2) in consumer publications.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on October 12, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to 28 TAC §§21.5001 - 21.5031.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2016-4725**