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

INTRODUCTION. The Texas Department of Insurance proposes amendments to 28 TAC Chapter 21, Subchapter PP, §§21.5001 - 21.5003, 21.5010 - 21.5013, 21.5020, 21.5030, and 21.5031, relating to Out-of-Network Claim Dispute Resolution. The amendments are necessary because of amendments made to Texas Insurance Code Chapter 1467.

EXPLANATION. SB 481, 84th Legislature, Regular Session (2015) amended Insurance Code Chapter 1467 (Out-of-Network Claim Dispute Resolution). As a result, TDI 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 (the Texas Employees Group Benefits Act).

SB 481 added assistant surgeons to the list of covered physicians and lowered the threshold amount for mediation to amounts greater than $500 for services provided on or after September 1, 2015. The rules at 28 TAC Chapter 21, Subchapter PP, need to be updated to include these changes and adopt a new mediation request form. The proposal also makes 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, and makes nonsubstantive changes to conform to agency style and usage guidelines.

A description of changes to specific sections follows.

Section 21.5001. The proposal makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5002. The proposal removes the phrase "provided the claim is filed on or after November 1, 2010," because the time limitation is no longer required, since there should be no claims still pending that were filed before that date. The proposal also makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5003. The proposal adds assistant surgeons to the list of covered hospital-based physicians effective September 1, 2015, to conform to SB 481. The proposal also makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5010. The proposal changes the threshold amount for mediation to an amount greater than $500, effective September 1, 2015, to conform to SB 481. The proposal recognizes that a claim qualified for mandatory mediation under Insurance Code §1467.051 does not lose that status by being reduced without the consent of the enrollee so that the provider can balance bill without mediation, and there is no procedure to remove the claim from mediation under §1467.054. The proposal also makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5011. The proposal changes a reference to the Health Insurance Mediation Request Form to correct nomenclature and the form's location. The proposal adds an authorization to allow disclosure of protected health or other confidential information to simplify the mediation process by ensuring that the authorization is obtained at the start of the process. The proposal also corrects addresses and telephone numbers, and makes nonsubstantive changes to conform to agency style and usage guidelines.

Sections 21.5012 - 21.5013. The proposal makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5020. The proposal removes the phrase "on or after November 1, 2010," because the time limitation is no longer required, since there should be no claims still pending that were filed before that date. The proposal also makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5030. The proposal corrects addresses and telephone numbers, and makes nonsubstantive changes to conform to agency style and usage guidelines.

Section 21.5031. The proposal makes nonsubstantive changes to conform to agency style and usage guidelines.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Patricia Brewer, team lead for the Life and Health Regulatory Initiatives Team, has determined that during each year of the first five years that the proposed amendments are in effect, there will be no fiscal impact on state or local governments as a

result of enforcing or administering the sections, other than that imposed by the statute. There will not be any measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. Ms. Brewer has also determined that for each year of the first five years the amendments are in effect, the public benefit anticipated as a result of administration and enforcement of the amended sections will be: (i) adoption of a revised mediation request form that incorporates an authorization to disclose protected health information; (ii) clarification that once a claim is qualified for mediation, it does not lose that status by virtue of billing being reduced without the enrollee's consent; (iii) assurance that TDI's rules comply with Insurance Code Chapter 1467 as amended by SB 481; and (iv) a possible reduction in balance billing of patients for some out-of-network services. There is no anticipated economic cost to persons who are required to comply with the proposed amendments beyond that imposed by the statute.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. As required by Government Code §2006.002(c), TDI has determined that these proposed amendments will not have an adverse economic effect on small or micro businesses because, to the extent they contain requirements, they simply implement statutory requirements or contain minor revisions to existing forms. Therefore, in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI invites the public and affected persons to comment on this proposal. Submit your written comments on the proposal no later than 5 p.m., Central time, on June 27, 2016. Send written comments by mail to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov. You must simultaneously submit an additional copy of the comments by mail

to Patricia Brewer, Team Lead, Life and Health Regulatory Initiatives Team, Regulatory Policy Division, MC 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to LHLComments@tdi.texas.gov. You must submit any request for a public hearing separately to the Office of the Chief Clerk, MC 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov before the close of the public comment period. If a hearing is held, written comments and public testimony presented at the hearing will be considered.

STATUTORY AUTHORITY. These amendments are proposed under Insurance Code §§1467.001, 1467.003, 1467.051, 1467.054, and 36.001, and amendments made by Sections 4 - 6 of SB 481, 84th Legislature, Regular Session (2015) to Insurance Code §1467.001(4) and §1467.051(a)(1).

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.

CROSS REFERENCE TO STATUTE. The proposed amendments implement Insurance Code Chapter 1467 and Sections 4 - 6 of SB 481, 84th Legislature, Regular Session (2015), which amend Insurance Code §1467.001(4) and §1467.051(a)(1). Specifically, the amendment to 28 TAC §21.5003(6) implements §1467.001(4), the amendment to 28 TAC §21.5010(a)(3) implements §1467.051(a)(1), the amendment to 28 TAC §21.5010(d) implements §1467.051(a) and §1467.054, and the amendment to 28 TAC §21.5011(a)(7) implements §1467.054.

TEXT.

SUBCHAPTER PP. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

DIVISION 1. GENERAL PROVISIONS

§21.5001. Purpose.

As authorized by [~~under the~~] 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 [~~the~~]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 [~~the~~]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 [~~the~~]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 [~~the~~]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 [~~and/~~]or supplies, that is not a covered claim under the terms of the health benefit plan coverage.

§21.5003. Definitions.

The following words and terms [~~when used in this subchapter shall~~] 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 [~~an~~] (HMO) plan, providing coverage under [~~the~~]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 and[~~/or~~] supplies, provided that the [~~such~~] services and [~~or~~] supplies:

(A) are furnished for [~~pursuant to~~] a single date of service; or

(B) if furnished for [~~pursuant to~~] more than one date of service, are provided as a continuing [~~and/~~]or 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 [~~the~~]Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; or

(B) a plan, other than an HMO [~~a health maintenance organization~~] plan, under[~~the~~] Insurance Code Chapter 1551.

(6) Hospital-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, [~~or~~]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 [~~the~~] 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 [~~the~~] 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 [~~the~~]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 [~~and/~~]or supplies [~~that are~~] 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 [~~the~~] 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. Qualified Claim Criteria.

(a) Required criteria [~~Criteria~~]. An enrollee may request mandatory mediation of an out-of-network claim under §21.5011 of this title [~~division~~] (relating to Mediation Request Form and Procedure) if the claim complies with the criteria specified in [~~paragraphs (1) and (2) of~~] this subsection. An out-of-network claim that complies with those [~~such~~] criteria is referred to as a "qualified claim" in this subchapter.

(1) The out-of-network claim must be for medical services [~~and/~~]or supplies 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 [~~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 [~~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 [~~subchapter~~] (relating to Definitions), does not prevent [~~preclude~~] eligibility of a claim for mandatory mediation under this subchapter if the claim otherwise meets the requirements of this section.

(c) Ineligible claims [~~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 [~~the~~]Insurance Code §1467.051, concerning Availability of Mandatory Mediation; Exception, and this subsection before providing the medical service [~~and/~~]or supply 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 [~~the~~] 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 qualified claim 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 [~~Request Form~~]. The commissioner adopts by reference Form No. CP029 [~~LHL619~~] (Health Insurance Mediation Request Form), which is available at www.tdi.texas.gov/consumer/cpmmediation.html [~~http://www.tdi.state.tx.us/consumer/cpmmediation.html~~]. Form No. CP029 [~~LHL619~~] (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; [~~and~~]

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

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

(b) Submission of request [~~Request~~]. An enrollee may submit a request for mediation by completing and submitting Form No. CP029 [~~LHL619~~] (Health Insurance Mediation Request Form) as provided in paragraphs (1) - (4) of this subsection.

[~~(1)~~] The request may be submitted:

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

(2) by [~~The request may be submitted via~~] fax[~~,~~] to (512)-490-1007; [~~(512) 475-1771.~~]

(3) by [~~The request may be submitted via~~] email [~~e-mail,~~] to ConsumerProtection@tdi.texas.gov; or [~~ConsumerProtection@tdi.state.tx.us.~~]

(4) online, when the department makes [~~Upon the department's making~~] Form No. CP029 [~~LHL619~~] (Health Insurance Mediation Request Form) available to be completed and submitted online[~~, an enrollee may submit the request in this manner~~].

(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 [~~that is~~] subject to mandatory mediation requested by an enrollee under §21.5011 of this title [~~division~~] (relating to Mediation Request Form and Procedure) must [~~shall~~] use best efforts to coordinate the informal settlement teleconference required by [~~the~~] Insurance Code §1467.054, concerning Request and Preliminary Procedures for Mandatory Mediation, [~~§1467.054(d)~~] 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 [~~shall~~] 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 [~~shall~~] participate in mediation in good faith and is subject to any rules adopted by the chief administrative law judge in accordance with [~~pursuant to the~~] Insurance Code §1467.003, concerning Rules.

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

(1) [~~failing to~~] participate in the mediation;

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

(3) [~~failing to~~] 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. Required Notice of Claims Dispute Resolution. An administrator of a plan under [~~the~~] Insurance Code Chapter 1551, concerning Texas Employees Group Benefits Act, must [~~shall~~] include a notice [~~notification~~] of the availability of mandatory mediation under this subchapter with each explanation of benefits sent to an enrollee for an out-of-network claim [~~filed on or after November 1, 2010,~~] for services [~~and/~~]or supplies furnished in a hospital that has a contract with the administrator.

DIVISION 4. COMPLAINT RESOLUTION AND OUTREACH

§21.5030. Complaint Resolution.

(a) Written complaint [~~Complaint~~].

(1) An individual may submit [~~to the department~~] a written complaint to the department regarding a qualified claim or a mediation that has been requested under §21.5010 of this title [~~subchapter~~] (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 [~~http://www.tdi.state.tx.us/consumer/cpportal.html~~]. The complaint may be submitted by:

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

(B) fax [~~to the department~~] to (512)-490-1007 [~~(512) 475-1771~~];

(C) email [~~e-mail,~~] to ConsumerProtection@tdi.texas.gov [~~ConsumerProtection@tdi.state.tx.us~~]; 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 [~~Form~~]. The recommended form for filing a complaint under subsection (a) of this section requests [~~that certain~~] information concerning the complaint [~~be provided~~], including:

(1) whether the complaint is within the scope of [~~the~~] 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 [~~and/~~]or supply 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 [~~shall~~] 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 [~~the~~] 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 [~~as~~] described in §21.5030(c) of this title [~~division~~] (relating to Complaint Resolution), the department will provide outreach as required by [~~the~~] 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 [~~via~~] consumer publications.

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposed repeal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on May 9, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance