Finding Your Way to Prompt Pay

Texas Department of Insurance
TDI’s Strategy

- Education
  - Helping you find the way

- Enforcement
Applicability

- Applicable to:
  - HMOs
  - Insured PPO Plans

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

Yes

Do you have a contract with an HMO or PPO?

No

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

No

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

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

Services provided on or after August 1, 2000, are subject to SB 418 and related rules.

Yes

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

Before

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

After

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

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

Texas Department of Insurance
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, the carrier may not deny nor reduce payment based on medical necessity or appropriateness of care.

Texas Department of Insurance
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, recertification, or representation by an HMO or preferred provider carrier to a physician or provider if the request for the pre-certification, certification, recertification, 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.

Texas Department of Insurance
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)
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)
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

Texas Department of Insurance
TACCPC

- 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

Texas Department of Insurance
Reference Materials

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

Rules page

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 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 - 2000

Proposed and Adopted Rules - 2006

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<td>05-26-06</td>
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<td>Filing's Made Easy - Rate and Rate Manual, Reduced Filing Requirements for Certain Insurers, Underwriting Guidelines for Insurers, Coverage for Personal Auto, Residential Property &amp; Motorists Compensation Insurers, Filing Transmittal Form &amp; Requirements for Property &amp; Casualty Insurers, Rate, Rule, Underwriting Guidelines &amp; Credit Scoring Model Filing</td>
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Texas Department of Insurance
Effective Date and "Evergreen" Contracts

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

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

Mail Log

Q: §21.2816(h) - The rules have changed the wording from "must maintain" to "may choose to maintain a mail log". If the choice is made not to maintain a log, would the provider’s computer-generated logs of claims filing now become acceptable proof of timely filing? What provisions are made for altered computer-generated logs?

A: If the provider’s computer-generated printout is carrier-specific and
Reference Materials

- Physician/Provider Complaint form
Do You Know the Way to Prompt Pay?

- [link] www.tdi.state.tx.us
- [phone] 800-252-3439

Texas Department of Insurance