

***Technical Advisory Committee on Claims Processing
Report on Activities***

September 2010



Texas Department of Insurance

**Mike Geeslin
Commissioner of Insurance**



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September 1, 2010

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
Austin, Texas 78711

The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

The Honorable Joe Straus
Speaker, Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Governors and Speaker:

This letter conveys the fourth report to the Legislature issued by the Technical Advisory Committee on Claims Processing (TACCP) in accordance with Senate Bill 418, 78th Regular Session. TACCP members are appointed by the Commissioner and include insurers, health maintenance organizations, physicians and other health care providers, trade associations and other interested parties, such as the Office of Public Insurance Counsel. The TACCP is charged with advising the Commissioner on the technical aspects of claims processing.

Since passage of SB 418 in 2003, the Department continues to see a downward trend in the number of complaints received, reflecting increased carrier compliance with requirements for timely payments to providers. Even though reported data shows improved progress around prompt payment of claims, the Department continues to watch the trends closely and will update the Legislature as needed. Because of the issues initially addressed by the TACCP have improved considerably, the Committee has shifted its focus from the basics of ensuring timely claim payments to broader policy issues affecting providers and carriers.

This report outlines the history of prompt pay and the Committee's progress, along with updates on the Committee's most recent activities. It also includes prompt pay data and progress on issues from prior reports. The TACCP made great strides to bridge the gap between carriers and providers and address issues that concern each group. The Department continues to work with the TACCP, monitors the timeliness of claims payments, and takes necessary actions as authorized by the bill.

Should you have any questions about this report or activities related to claims processing, please contact me; Carol Cates, Director of Government Relations, at 463-6123; or Katrina Daniel, Senior Associate Commissioner of Life, Health & Licensing, at 322-4315. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Mike Geeslin".

Mike Geeslin
Commissioner of Insurance

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Technical Advisory Committee on Claims Processing Overview

Texas law requires the Commissioner of Insurance to appoint a Technical Advisory Committee on Claims Processing (TACCP) to consult before the adoption of any rules related to claims processing. The TACCP is charged with advising the Commissioner on:

- the technical aspects of coding health care services and claims development, submission, processing, adjudication, and payment;
- the impact of those processes on contractual requirements and relationships, including relationships among employers, health benefit plans, insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), electronic clearinghouses, physicians and other health care providers, third-party administrators, independent physician associations, and medical groups; and
- the implementation of standardized coding and bundling edits and logic.¹

The current list of members and the organization or role they represent is included in the table, *TACCP Membership*.

| TACCP Membership | |
|-------------------------|--|
| Member | Representation |
| Gary Looney | Alamo Insurance Group |
| Robert Cook | Attorney |
| James Nelson | Attorney |
| Teresa Devine | Blue Cross and Blue Shield of Texas |
| Nathalie Woolfrey | CIGNA Healthcare of Texas Inc. |
| Mary McGuire | Covenant Management Systems, Mediview Division |
| Pat Harris | Harris County Medical Society |
| Denise Cotter | HealthMarkets |
| Holly Brooke | HealthSouth |
| Brittney Powlesson | Hospital Corporation of America |
| Jenny Aghamalian | Humana |
| Gwendolyn Dalcour | Kelsey-Seybold Clinic |
| Lyle Ross | New Era Life Insurance Company |
| Karen Van Wagner, Ph.D. | North Texas Specialty Physicians |
| Aelia Khan Akhtar | Office of Public Insurance Counsel |
| Krista Crews | ProPath Associates |
| Kandice Sanaie | Texas Association of Business |
| Jared Wolfe | Texas Association of Health Plans |
| Jennifer Cawley | Texas Association of Life and Health Insurers |
| Patrick Smith | Texas Children's Hospital |
| Richard Schirmer | Texas Hospital Association |
| Genevieve Davis | Texas Medical Association |
| Lynette Klingeman | Medco Health Solutions |
| Melissa Eason | UniCare/WellPoint |
| James McNaughton | United Healthcare of Texas, Inc. |
| John Tietjen | University of Texas, MD Anderson Cancer Center |

¹ Texas Insurance Code Ch. 1212

Prompt Pay Statutes and Rules Overview

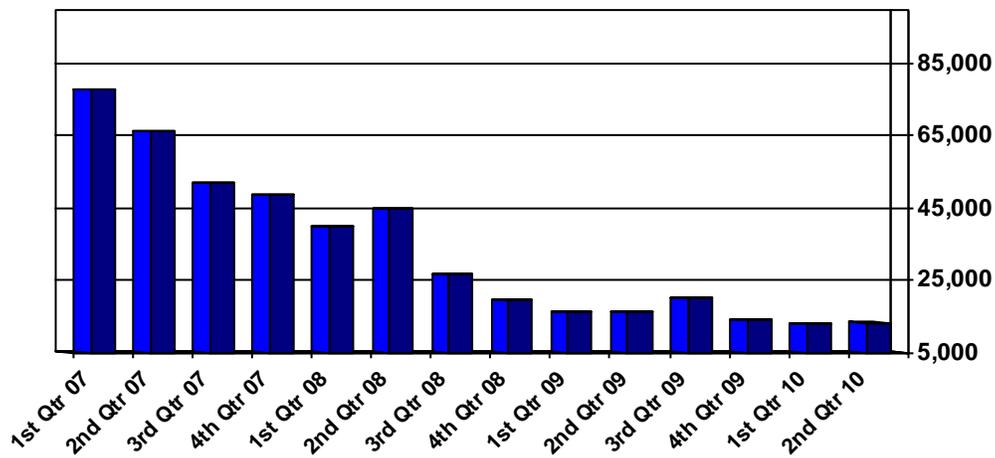
The primary body of law that relates to claims processing in Texas is the prompt payment statutes. Two pieces of legislation shape the prompt payment landscape in Texas today, House Bill (HB) 610, effective in 1999, and Senate Bill (SB) 418, effective in 2003. The table below, *Prompt Pay Statutes and Rules Overview*, describes the history of these two bills, the subsequent rules adopted by the Commissioner of Insurance, and significant features of each.

| Prompt Pay Statutes and Rules Overview | | |
|---|---|---|
| | Senate Bill 418 (2003) | House Bill 610 (1999) |
| Statutory Reference | <ul style="list-style-type: none"> Health Maintenance Organization (HMO) – Texas Insurance Code (TIC) §§ 843.336 – 843.353 Preferred Provider Benefit Plan (PPBP) – TIC §§ 1301.101 – 1301.138 | |
| Rules | 28 Texas Administrative Code (TAC) §§ 3.3703 – 3.3707, 11.901, 19.1703, 19.1723, 19.1724, 21.2801 – 21.2809, and 21.2811 – 21.2826 | 28 TAC §§ 21.2801 – 21.2820 |
| History and Purpose | <ul style="list-style-type: none"> Passed in 2003, affecting claims filing and prompt payment processes. Addresses certain prompt pay issues: <ol style="list-style-type: none"> deadlines for claims payments; clean claim requirements; graduated penalties for late and underpaid paid claims, overpayment refund limits; carrier compliance reporting requirements; applicability to contracted providers and certain non-contracting providers; and preauthorization and verification. | <ul style="list-style-type: none"> Passed in 1999 to expedite HMO and preferred provider benefit plans clean claim payment to contracted providers; and Required carriers to process clean claims within 45 days of receipt. Required carriers to: <ol style="list-style-type: none"> pay the total amount of the claim in accordance with the contract; or deny the entire claim and notify the provider of the reason; or audit the entire claim, paying 85 percent of the contracted rate, notifying the provider of the audit, or pay a portion of the claim and deny or audit the remainder, paying 85 percent of the contracted rate for the audited portion. Provided penalties to providers for non-compliance <p>Required that electronically submitted and affirmatively adjudicated pharmacy claims were required to be processed in 21 days.</p> |
| Applicability | <p>Applies to:</p> <ul style="list-style-type: none"> Insured preferred provider benefit plans and HMO plans issued in Texas; Contracts entered into or renewed on or after August 16, 2003; and Certain provisions apply to non-network services in certain circumstances. <p>Does not apply to certain plans, such as self-funded plans; workers' compensation coverage; and government plans.</p> | <p>Applies to:</p> <ul style="list-style-type: none"> Insured preferred provider plans and HMO plans issued in Texas; and Preferred provider contracts entered into or renewed prior to August 16, 2003. |

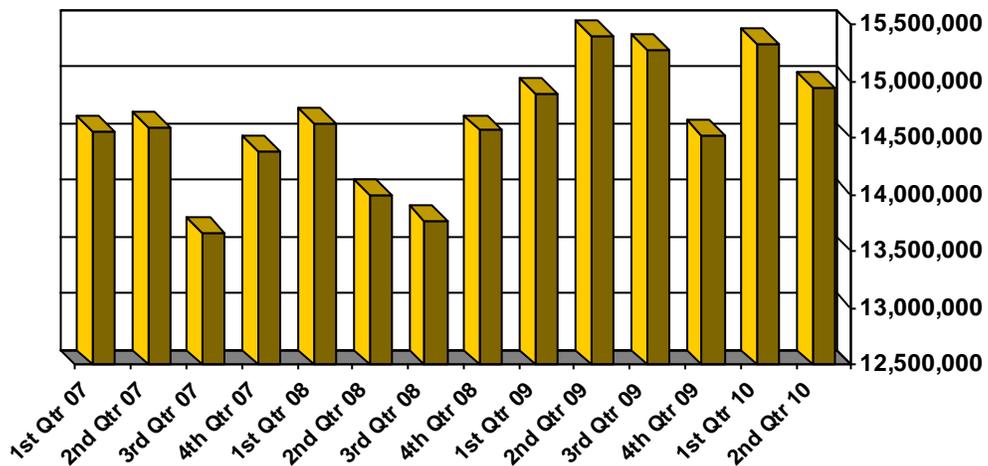
SB 418 and HB 610 Claim Data

Since the passage of SB 418 in 2003, the number of claims governed by HB 610 has decreased steadily and now represents a minute portion of the claims subject to prompt pay laws. At publication, the most recent two quarters of the 2010 reporting period reflect that carriers reported fewer than 14,000 claims during each quarter were subject to HB 610 as compared to more than 15 million claims that were subject to SB 418. The two charts below, *HB 610 Claims Filed* and *SB 418 Claims Filed*, reflects the number of claims in each quarter since the first quarter of 2007. Claims regulated by SB 418 reach into the tens of millions, while claims regulated by HB 610 have reached as low as the tens of thousands.

HB 610 Claims Filed



SB 418 Claims Filed



TACCP Activities



Since the 2008 TACCP report to the legislature the TACCP met four times on a quarterly schedule except during the legislative session. At the beginning of this series of meetings, several new members joined the group, which brought fresh perspectives to the committee. Also, group participation and attendance has increased as has the number of members and non-member stakeholders who have elected to attend the meetings via teleconferencing.

The TACCP's statutory function is to guide the Texas Department of Insurance (TDI) in the development of rules related to claims processing and payment. Initially, the committee worked diligently to assist the Department in writing rules to implement SB 418 and worked to achieve consensus on a number of important issues. Subsequently, the committee continued its assistance to the Department with rule amendments needed to address current practices and to implement subsequent legislation. However, in the current biennium only one bill will require an amendment to the prompt pay rules: HB 2064 (2009). This bill requires that a portion of prompt pay penalties that carriers previously paid to providers be paid instead to the Texas Health Insurance Pool to fund premium subsidies for qualifying pool applicants.

In the absence of the large number of rules that were considered by the committee in past years, the committee has turned its attention to other topics to include coding and bundling claim charges, silent preferred provider organizations (PPOs) and recovery of overpayments. Despite its statutory charge to make recommendations on issues such as implementation of standardized coding and bundling edits, the committee has not reached a consensus on several issues. Three of these issues are discussed further in the *Ongoing Issues* section of this report.

In addition, the committee has discussed the upcoming transition from the ICD-9 to the ICD-10, efforts by alternative non-licensed health care delivery models to become preferred providers under HMO and PPO plans, Rx copayment waiver cards and coupons, and coding for cardiovascular screenings.

In addition to the rule and broad issue consideration, the Department uses the committee forum to keep members informed on issues that may be of interest to them. The *Department Updates* section summarizes information Department staff provided to the TACCP.



Updating Claim Coding Systems: Implementation of ICD-10-CM

TACCP Discussion:

The effective use of health information in an increasingly complex and diverse health care system depends on well defined, commonly understood terminology and coding systems. The coding systems used to describe diagnoses and treatments are directly used by virtually every participant in the system, other than the patient, and are deeply embedded in the delivery, management and financing of care.

On October 1, 2013 medical coding in the U.S. health care settings will change from ICD-9 to ICD-10. The transition will require business and systems changes throughout the health care industry. To accommodate the ICD-10 code structure, the transaction standards used for electronic health care claims, Version 4010/4010A, must be upgraded to Version 5010 by January 1, 2012. Version 5010 includes updated standards for claims, remittance advices, eligibility inquiries, referral authorizations and other administrative transactions.

Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect the Current Procedural Terminology (CPT) used for all ambulatory and physician procedure reporting. Health care providers, payers, clearinghouse, and billing services must be prepared to comply with the Version 5010 and ICD-10 transitions which means:

- Health care providers, payers, billing services, clearinghouse, and other organizations that conduct electronic transactions should complete internal testing of Version 5010 systems in time to begin external testing with each other by January 1, 2011.
- All electronic claims submitted on or after January 1, 2012 must use Version 5010 transaction standards. Electronic claims that do not use Version 5010 standards cannot be paid.
- ICD-10 diagnosis codes must be used for all health care services provided in the U.S. on or after October 1, 2013. ICD-10 procedure codes must be used for all hospital inpatient procedures performed on or after October 1, 2013. Claims with ICD-9 codes for services provided on or after October 1, 2013 cannot be paid.

The ICD-10-CM/PCS (International Classification of Diseases, 10th edition, Clinical Modification/Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10-PCS for inpatient procedure coding.

ICD-10-CM is for use in all U.S. health care settings. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding. The transition to ICD-10 is occurring because ICD-9 produces limited data about patient' medical

conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, is not descriptive enough and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. The first version of ICD-10-PCS was released by CMS in 1998 with annual updates since that time.

The implementation of ICD-10 will provide for the following enhancements:

- Enhance accurate payment for services rendered
- Facilitate quality by evaluation of medical processes and outcomes
- Flexible enough to quickly incorporate emerging diagnoses and procedures
- Additional precision to identify diagnoses and procedures precisely.
- Improved ability to measure health care services
- Increased sensitivity when refining grouping and reimbursement methodologies
- Enhanced ability to conduct public health surveillance
- Decreased need to include supporting documentation with claims.

The assessment for ICD-10 implementation is an opportunity for providers and payers to review current work flow and medical documentation practices. It will also allow providers to make improvements that streamline future processes and strengthen the basis for code assignment.

With the recent passage of the American Recovery and Reinvestment Act (ARRA), financial incentives are provided for providers to modernize their health information technology. This funding is provided to hospitals that have adopted and are considered “meaningful users” of electronic health records (EHR) technology. Accurate clinical coding relies on having complete and readily available health record documentation. The development of electronic health records is an added benefit that not only supports ICD-10 assignment but also helps to improve the quality of the care by providing better and more readily available patient health information.

Despite the many advantages associated with the implementation of the ICD-10 system, there are numerous challenges facing providers and payers. These are not simple changes. The costs associated with training physicians, coders, and nurses as well as the acquisition and installation of new technology and software are considerable. CMS estimates additional costs to the medical industry of adopting the new coding system of \$1.64 billion over 15 years. Other sources have estimated the cost of implementation for a ten physician practice to be approximately \$285,000 and a three physician practice to be approximately \$83,000.² Many feel these costs are significantly understated. The failure to successfully implement ICD-10 could create coding and billing backlogs, cause cash flow delays, increase claims rejections/denials, lead to unintended shifts in payment and place payer contracts and/or market share arrangements at risk due to poor quality ratings or high costs. Inaccuracy in clinical coding creates distorted or misinterpreted information about patient care which also results in faulty investment decisions to improve health delivery

Because of the complexity of the changes CMS expects the initial implementation of the new system will boost by as much as 10 percent the number of claims returned because of coding errors. Others in the insurance industry predict billing errors are likely to rise between 10 percent and 25 percent in the first year.

² Richard Schirmer, Texas Hospital Association

Member Perspective:

As the health care industry moves toward adoption of updated transactions and code sets, TACCP will play an important role in advising TDI on how these changes will impact health care transactions for which TDI has oversight. Committee members decided to monitor the conversion process to determine whether issues arise in the future that require discussion or action by the TACCP.

Unlicensed health care delivery models**TACCP Discussion:**

The committee discussed the emergence of new, unlicensed health care delivery models that are providing facility services and filing claims for reimbursement with carriers. Often there is no licensing statute or requirement for the new type of model or facility, as was the case with freestanding emergency health care facilities prior to the 81st Legislature's enactment of HB 1357. The unlicensed facilities have contacted TDI in their efforts to be reimbursed directly by carriers as facilities in addition to payments received for physician services under a preferred provider agreement or as an out-of-network provider. Some have proposed that the Department define providers to include those that have certification by an outside organization in lieu of state licensure. The Department notes that Texas Insurance Code (TIC) provisions relating to health insurance and HMO coverage define eligible physicians and health care providers as licensed individuals and facilities.

Member Perspective:

Provider representatives support the TIC requirements for provider licensure noting that without a licensure requirement patient safety would be compromised regardless of the provider type. They also foresee that contracting issues could arise, especially if the agreement is between the unlicensed facility and a provider but not with the payor. Provider representatives also asserted that certification by a professional certification organization is not the same as state licensure, and that requirements for certification vary considerably among certifying organizations, with some requirements being quite minimal. Such variability would not yield the same consistency and thoroughness that a licensure requirement would give. Other provider representatives contend that this is actually a scope of practice issue that infringes upon the licensed entities that are required to meet state licensure and quality of care standards.

Carrier representatives believe that any discussions on the new delivery models should only address how the Department should handle these licensure and definitional issues. Other representatives stated that the Department has already established a precedent in handling unlicensed delivery models by upholding the TIC provider licensing requirement with regard to unlicensed freestanding emergency health care facilities.

The committee agreed that there was a need to invite other entities (professional associations licensing entities, etc.) to the TACCP meetings to discuss this topic in greater detail.

Ms. Rene Clack, Director of Health Care Quality, Texas Department of State Health Services (DSHS), Ms. Debbie Peterson, Unit Manager, DSHS Regulatory Licensing Unit, and Mr. Derek Jakovich, Unit Director, DSHS Patient Quality Care Unit, attended the next TACCP meeting. Ms. Clack provided information concerning trends in the different types of providers and facilities, including mobile facilities, that have approached DSHS concerning licensure. DSHS cannot issue licenses to facilities or providers for whom no licensing standards exist. Ms. Peterson provided information regarding the growth in the numbers of facilities and providers licensed by DSHS since 2001 and Mr. Jakovich provided a detailed report concerning the process and scope of DSHS quality of care surveys.

At the TACCP's last meeting, Mari Robinson, J.D., Executive Director, Texas Medical Board, (TMB) provided a detailed overview of the telemedicine rules that are scheduled for adoption. In addition, Ms. Robinson provided information to the committee concerning TMB's process for handling complaints filed against licensees including complaints about billing practices.

Rx Copayment Waiver Cards

TACCP Discussion

The committee discussed waivers of copayments for prescription drugs. TDI has become aware of the increasing prevalence of cards and coupons that waive all or part of an enrollee's prescription drug copayment for non-generic prescription drugs. An enrollee may receive the card or coupon from various sources which may include drug manufacturers, prescribing practitioners, magazines, internet sites and through the mail. The waiver cards or coupons reduce enrollee costs for brand drugs and eliminate incentives for enrollees to use low cost generic drugs. Costs to the health plans are increased by the use of brand drugs and these increased costs are eventually reflected in the premium charged for the coverage. TDI has been asked whether this practice constitutes an illegal rebate.

Member Perspective

TDI solicited input from the committee regarding the practice and the method of processing the waiver card. TDI was particularly interested in learning whether the issuer of the copayment waiver card was the pharmacy benefit manager or the drug manufacturer. Pharmacy representatives provided an overview of the claim processing procedures when a copayment waiver card is presented at the pharmacy. Another representative stated that while coupons for small discount amounts have been distributed by pharmacy benefit managers, they understand that the copayment waiver cards are distributed by the drug manufacturers. Ultimately, the committee members determined that the copayment waiver issue is an enforcement matter and not an issue for the TACCP to address.

Coding for Cardiovascular Screenings

TACCP Discussion

TDI has received an inquiry regarding billing and appropriate coding for cardiovascular disease screening. HB 1290, 81st Legislature, Regular Session, requires coverage for computerized tomography (CT) scanning measuring coronary artery calcification or ultrasonography measuring coronary artery intima-media thickness and plaque (CINT). The inquiring provider states that codes 93882 or 0126T are used to bill for these services; but carriers' payment practices are not consistent regarding the two codes. The provider asks which code is acceptable to carriers.

Member Perspective

Carrier representatives reported that they previously submitted this issue to their medical experts and were informed that code 0126T was the appropriate code. According to the medical advisors, this code is more specific to the mandate for a screening procedure while CPT 93882 would be the appropriate code when billing for a diagnostic procedure. The provider stated he was agreeable to using 0126T if carriers would consistently reimburse under that code. TDI agreed to monitor the situation and asked the provider to advise us if carriers are denying claims because code 0126T is used.

Ongoing Issues for the Committee

In the committee's 2008 report, three principal issues were discussed: coding and bundling, silent PPOs, and recovery of overpayments. The members report that these issues remain, and as a result, the committee has elected to include these topics in the current report.

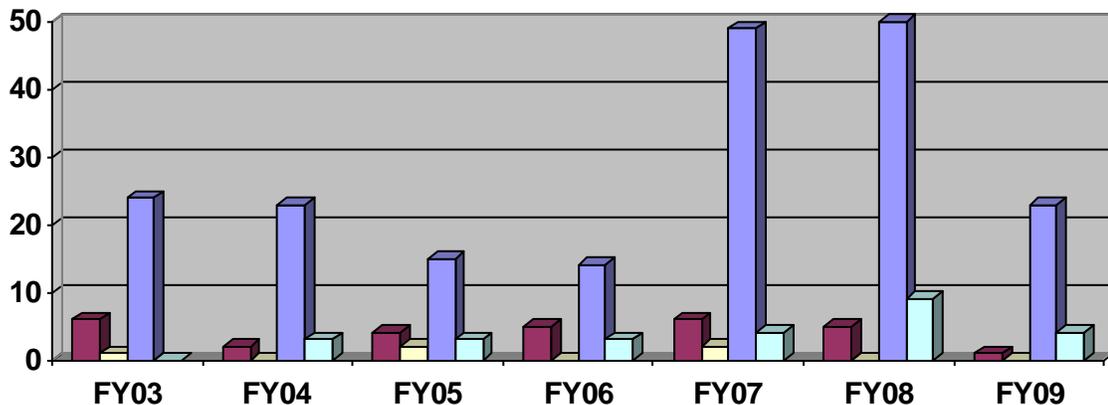
Coding and Bundling

Overview

Coding, the use of standard alphanumeric codes on an insurance claim, describes specific elements necessary for reimbursement for provider services. While codes are assigned to describe the service performed by the provider, billing activities also affect reimbursement. Payors -- generally insurance carriers, HMOs, or their designees -- use proprietary electronic adjudication systems based on complex computer programs to process and pay claims. If a physician or provider participates in a third-party payor network, pricing is established through a contractual fee agreement. For physicians or providers who participate in Medicare, reimbursement is determined by rates established by Medicare.

To estimate the magnitude of this issue in Texas, the Department examined the number of complaints related to bundling and coding. The graph below shows the number of complaints the Department has received since FY03 related to bundling and downcoding and how many of each were justified. In FY09, while 23 complaints were received regarding bundling, fewer than 5 were determined to be justified.

■ Downcoding Complaints □ Justified Downcoding Complaints ■ Bundling Complaints □ Justified Bundling Complaints



Coding Standards

Accurate coding is essential to ensure proper billing and payment. The Health Insurance Portability and Accountability Act (HIPAA) provisions set out standards for the electronic exchange of health care data: the Common Procedure Terminology (CPT), developed and maintained by the American Medical Association (AMA), and the Healthcare Common Procedure Coding System (HCPCS), developed and maintained by the Centers for Medicare and Medicaid Services (CMS). In addition to the primary codes, modifier codes communicate variable situations that affect reimbursement.

While payors are required to use the standard code sets, they process claims using proprietary software. CPT and HCPCS manuals contain guidelines for correct coding methods; however, the nature of these policies is highly technical.

Bundling and Other Practices

Bundling occurs when the payor combines two or more procedure codes reported separately by the provider and pays only one of the combined procedure codes. Payment policies like this vary considerably among health plans, and the American Medical Association believes that many bundling policies are inconsistent with standard CPT guidelines. Providers are adamant that bundling policies withhold payment for services provided to enrollees in good faith, and carriers report that some providers bill for procedures separately to maximize reimbursement in defense of bundling policies. While unbundling services can occur because of the complexity of coding, it is sometimes an indicator of fraud. In recent years, reports from the Office of the Inspector General (OIG) have found substantial numbers of claims – 5.1 percent – to be inappropriately coded in the Medicare fee-for-service (FFS) program, though it does not estimate whether any portion of the error rate is attributable to fraud. The two most prevalent types of unbundling found were fragmenting one service into separate component parts and reporting separate codes for related services in one comprehensive code.

A provider that bills for a service not supported by proper documentation engages in the practice of upcoding. Conversely, downcoding occurs when a payor denies or changes codes submitted on a medical claim. All parties agree that coding errors resulting in either practice are inevitable because of the complexity of coding. However, intentional upcoding by a physician or provider to generate higher reimbursement is viewed as unethical and as an indicator of potential fraud. Intentional downcoding by a payor that results in a payment less than the contracted rate may be a deceptive trade practice and may constitute a violation of the payor's contract with the provider.

TACCP DISCUSSION

Federal Guidance

In the previous biennium, TDI staff contacted CMS and found that no federal provision would prohibit the Department from adopting rules on standards related to bundling and coding procedures for commercial insurance claims in Texas. CMS authority over Medicare and Medicaid claims does not extend to the private insurance market. As long as a state entity does not change the meaning of a standardized code and does not edit or revise the code numbers, there is no prohibition against adopting usage directions that describe circumstances when certain codes may or may not be bundled, or that restrict the practice of downcoding by payors or upcoding by providers.

TACCP Member Perspectives

Carrier representatives urge the Department not to consider adopting standardized edits since research conducted on behalf of provider groups determined that such a system is not feasible. Additional studies commissioned as part of HIPAA implementation have reached similar conclusions. However, the Texas Medical Association counters that the coding issues addressed in the multistate litigation settlement agreements with the largest health plans in the United States can be a foundation to use in creating a standard. Health plans that agreed to the settlement's coding provisions included: Aetna, Blue Cross and Blue Shield of Texas, CIGNA, Humana, and WellPoint. These agreements are time limited and include an expiration date.

The carriers noted the findings of multiple studies that indicate that implementation of standardized edits, modifiers, and utilization of codes is not feasible; the fact that the federal government has opted not pursue such a system, and the lack of consensus among TACCP members. As a result, the carriers believe it would be reasonable for TACCP to report that this issue is too complex and contentious to be resolved by the state at this time.

PPO Regulation

Overview

Although the Texas Insurance Code does not define a preferred provider organization (PPO), several commonly accepted definitions exist. One such definition is "a group of health care providers each of whom agrees to offer services to a given employer or insurer at a lower cost in return for a stable volume of patients or other incentives."³

The term PPO is often used interchangeably with preferred provider benefit plan (PPBP). The Texas Insurance Code describes a PPBP as a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.⁴ The PPBPs' provision of incentives steers patients to utilize preferred providers, thus assuring the provider of a stable volume of patients. This practice is referred to as "steerage."

Silent PPOs buy, sell, lease or otherwise transfer provider discounts without regard for steerage of patients toward contracted providers. The provider has no knowledge that the discount information contained in a contract the provider signed with one PPO has been sold or leased to another vendor. The term "Silent PPO" can be used to describe the business practice in which a carrier may take a discount from a provider's charge based on the purchase or lease of the purported right to the discount under a contract between the physician and some other party that is either invalid or may not exist. Silent PPO transactions are not legitimate business arrangements. Legitimate PPO discounts are based on a contractual agreement and are not referred to as Silent PPOs.

Rental PPOs differ from silent PPOs in that the PPO will contract with providers to create a "panel" that is "sold" to a payor that does not have an in-house provider network. The provider sends the claim to the PPO; the PPO's logo and information is on the patient's

³ Robert W. Strain, *Insurance Words and Their Meanings* 99, 1987.

⁴ TIC § 1301.001(9)

ID card. The PPO reprints the claim and sends it to the payor, which adjudicates and pays the claim. In this model, the provider should be aware of the discount.

Patients and providers are hurt the most by the silent PPO practice. Patients may not get the benefit of the silent PPO unauthorized discount and may be held responsible for higher costs than anticipated. Physicians and providers are harmed because an unauthorized discount is taken when the physician does not have a direct contractual relationship, or because a provider is paid less than the amount for which the provider contracted or, if not contracted, is paid at a rate the provider had no part in negotiating. Additionally, a patient may get caught in a payment dispute between the provider and payor.

TDI Regulation of PPOs

TDI does not regulate PPOs, rather, it regulates certain insurance carriers and third-party administrators (TPAs) that contract with PPOs.⁵ The Insurance Code addresses silent PPOs through its regulation of preferred provider benefit plans (PPBPs).⁶

The Texas Legislature addressed the issue of silent PPOs in SB 130 (1999) with provisions that require agreement from a provider before he or she is reimbursed on a discounted basis. The statute prohibits an insurer or TPA from reimbursing a physician or provider on a discounted fee basis unless:

- The insurer or TPA has a contract with the physician or provider or a PPO that has a contract with the physician or provider;
- The physician or provider agreed to the contract terms; or
- The insurer or TPA agreed to provide coverage for health care services under the insurance policy.⁷

Based on this authority in 2008 and 2009, the Department has taken enforcement actions against two entities for Silent PPO practices.⁸

Because the Department does not regulate PPOs and no umbrella organization related to PPOs exists in Texas, little is known about the number operating in the state. However, some reports indicate that approximately 1,000 PPOs operate in the United States. The Department received 59 complaints in 2008 regarding silent PPOs; and only 6 complaints regarding silent PPOs in 2009.

In its 2008 self-evaluation report to the Texas Sunset Commission, TDI recommended that it be given additional authority to regulate PPOs, including authorizing TDI to require the registration of PPOs. In response, the Sunset Advisory Commission Staff Report concluded that the prevalence of this type of healthcare delivery system, combined with the potential consumer harm that can result, argued for regulation of PPOs by the State. As a result, Sunset staff recommended requiring PPOs to obtain a certificate of authority to operate in Texas to ensure that TDI has information about these entities and could take enforcement action against them if necessary. This minimal regulatory process would also allow the state to look more closely at the problems that can occur among

⁵ TIC §§ 1301.001(5) and 4151.001(1)

⁶ TIC § 1301.061(c)

⁷ TIC § 1301.056(a)

⁸ Great-West Life & Annuity Insurance Company and United Healthcare Insurance Company

PPOs, providers, insurers, and consumers. TDI also encouraged the Sunset Advisory Commission to consider principles that must be adhered to as a condition of maintaining a PPO certificate of authority.

Legislation containing the Sunset recommendations and continuing the agency was introduced during the 81st Legislative Session but failed to pass. Instead, legislation passed in the 1st Called Session of the 81st Legislature continued the agency until 2011 and limited the Sunset Commission's review of TDI to the appropriateness of the recommendations made on the agency by the Sunset Commission to the 81st Legislature. Sunset staff have determined that the PPO licensing recommendation to the 81st Legislature remains appropriate. In a Sunset Advisory Commission hearing on July 6, 2010, the Commission did not adopt the recommendation to require PPOs to register with the Department and the provision will not be included in the Sunset bill. Members of the Commission discussed various pieces of legislation that had been introduced in the 81st Legislature to address PPO regulation and deferred to the legislative process for future decisions regarding the issue.

TACCP Member Perspectives

Carrier representatives maintain that more evidence of the silent PPO practice should be presented to TDI before any rule is proposed or considered. To date, little exists and the low number of complaints does not suggest a significant problem in Texas.

Additionally, health plans believe that TIC § 1301.056(b) sufficiently addresses the silent PPO issue and vests TDI with enforcement authority. The bill analysis of SB 130 states that the law "will hold insurers in violation of an unfair act or deceptive practice under the Insurance Code, if the insurers knowingly mislead a provider into giving them discounts to which the insurers are not entitled." TDI has taken enforcement actions against health plans for the application of a discount without a contract, which suggests that TDI already has sufficient authority to regulate this practice.

Likewise, physician representatives point out that TDI has agreed to consent orders with health plans for silent PPO activity. These consent orders addressed violations of TIC §1301.056 in which health insurers applied discounts to out-of-network claims when the insurer was not contractually entitled to do so, was not given express authority to access discount information, or did not give prior notification to such providers before taking discounts. Additionally, insurers were fined for taking advantage of contractual discounts with PPOs in which providers were to receive patient steerage in exchange for the discount and no steerage was provided.

Finally, the Texas Legislature attempted to address this issue through legislation (HB 223 – Eiland and SB 714 – Van de Putte) during the 81st Legislature, but the bills did not pass.

Recovery of Overpayment

Overview

Subsection (f) of TAC § 21.2818 of the TDI prompt payment regulations provides that an insurer may recover a refund due to an overpayment or completion of an audit if it

notifies the physician or provider of completion of the audit or provides notification of the overpayment within 180 days of receipt. The carrier must provide an opportunity for appeal before recovering a refund. The rule does "not affect a carrier's ability to recover an overpayment in the case of fraud or a material misrepresentation by a physician or provider."

Absent fraud or a material misrepresentation by the provider, carriers may not recover overpayments if notice has not been given within the timeframes established by the rule. However, the rule does not limit the time in which a carrier may investigate a claim in order to determine whether fraud or a material misrepresentation may have occurred.

As with all prompt pay laws, including recovery of overpayments, state regulation is limited to those plans that fall within TDI's jurisdiction. As a result, providers who experience notice of payment recovery outside of the 180 days may be dealing with a plan that is not subject to Texas prompt pay laws.

TACCP Member Perspectives

Hospital providers say that it is not uncommon for health plans or, more often, third-party auditing firms retained by health plans, to request bill audits on multiple accounts. Often, the requests by third-party auditing firms are for 50 to 100 (or more) accounts from multiple health plans. The requests are often for any accounts over a certain billed charge threshold or for any account that hits a stop-loss provision. Unless there is proof of fraud or material misrepresentation, or the health plan can establish and provide evidence of a pattern of fraud or material misrepresentation by a particular provider, a blanket request to audit multiple accounts outside the established time frame is not permitted by the regulation. Further, the submission of an incorrect bill does not constitute fraud or a material misrepresentation, nor should it form the basis for an audit or recovery of overpayments beyond the 180-day time frame.

Physicians state that a material misrepresentation can, and usually does, have an element of intention. A material misrepresentation is made when the person making the representation knows it is likely to induce another to assent.⁹ However, another meaning is that the false representation is likely to induce a reasonable person to assent. A mere error anywhere on the claim form is insufficient to fall under the definition of a material misrepresentation. The misrepresentation must address an item of import upon the claim form such that a reasonable person (which may differ from the perspective of an insurer) would find the distinction meaningful to the decision. Physicians report that TDI has emphasized the former approach (that the maker of the statement knows the misrepresentation will induce assent) rather than the latter approach. This interpretation, physicians say, carries out the intent of the legislation and ensures that the 180-day audit time frame is given meaningful effect.

Carriers indicate that providers complain about attempts to audit or investigate claims more than 180 days after the receipt of the claim payment. However, carriers go on to say the rule does not apply and does not "affect a carrier's ability to recover an overpayment in the case of fraud or a material misrepresentation by a physician or provider." This issue often arises in the context of a requested hospital bill audit to determine the validity of one or more submitted claims, which may take place at the facility location and require scheduling with hospital personnel. If the results of such a hospital bill audit indicate that the facility incorrectly billed for services or supplies that

⁹ Black's Law Dictionary 1022 (8th Ed.)

were not provided to the insurer's member, the claim for those services or supplies would fall within the exception for "a material misrepresentation" by the provider (regardless of intent), and the restrictions of TAC § 21.2818 would not apply. Because recovery of the overpayment would not be prohibited in this situation, the regulation must reasonably be read to permit insurers to perform necessary audits to discover such overpayments.

Fraud requires a showing of intent; a material misrepresentation does not. A material misrepresentation included on a claim submitted by a provider would fall within this exception, regardless of intent. A misrepresentation that results in a carrier overpaying a claim or paying for a service or supply that was not actually provided may be considered material.

Pharmacies have a different experience with recovery of overpayments. They report that they receive requests from pharmacy benefit managers (PBMs) for claims information in excess of the 180-day look-back limit provided by law, often justified by an allegation of "material misrepresentation" or "fraud." Additionally, some PBMs have told pharmacies that they do not have to comply with the audit provisions ascribed in law. Pharmacists report that PBMs recoup payments that were based on audit findings of clerical or administrative errors or practices unrelated to plan benefits or coverage.

Chapter 4151 requires persons holding themselves out or acting as a TPA to hold a certificate of authority under that chapter. An administrator is defined as a person who, in connection with annuities or life benefits, health benefits, accident benefits, *pharmacy benefits*, or workers' compensation benefits, collects premiums or contributions from or *adjusts or settles* claims for residents of this state.

What is not clear is:

- whether all PBMs that adjudicate and audit pharmacy claims are licensed as TPAs under Chapter 4151 or are regulated by other parts of the TIC;
- whether the term "adjusts or settles claims" includes claim adjudication, which to pharmacists mean that the claim was clean and the patient and prescribed drugs were eligible for coverage;
- whether the state holds sufficient enforcement authority and staff to take action against PBMs who violate state law and regulations, especially regarding claim payments and audits.

Department Updates to the Committee

In addition to discussing ongoing issues, the Department keeps TACCP informed on bills and other issues that affect or might be of interest to committee members. Below is a list of updates on bill implementation efforts and other issues for which the Department provided information to the committee.

Bills

- HB1342 requires that a health benefit plan issuer use information technology that provides a participating provider and enrollee with real-time information at the point of care concerning the enrollee's copayment and coinsurance, applicable deductibles, covered benefits and services, and the enrollee's estimated total financial responsibility. The Department continues to gather information and a stakeholder meeting is being rescheduled.
- HB1888 provides that health benefit plan issuers may not rate or compare physician performance unless the standards conform to nationally recognized standards adopted by the commissioner. Adopted rules were filed with the Secretary of State on April 27 2010, for publication in the *Texas Register*.
- HB2064 provides for sliding scale premium discounts for participants in the Texas Health Insurance Risk Pool -- now known as the Texas Health Insurance Pool (THIP) -- and for funding of those discounts by redirecting certain prompt pay penalties to THIP. Steve Browning, Executive Director, THIP, provided a draft of the HMO/Insurer Prompt Pay Penalty Reporting Form. The group discussed ways to educate providers about this change and the extent of information needed on explanations of benefits.
- HB2256 provides for mediation of out-of-network, facility-based provider billing disputes that exceed \$1,000. Additionally, TDI is to adopt preferred provider benefit plan network adequacy rules that are adapted to local markets. TDI posted informal rules on TDI's website; and proposed rules were published in the *Texas Register* on May 14, 2010.
- HB4290 provides that retrospective reviews of medical necessity and reviews to determine the experimental or investigational nature of health services are included within the definition of "utilization review." Rules re-establishing the Utilization Review Advisory Committee were effective November 8, 2009. The committee meets as scheduled regarding the draft rules.
- HB4341 provides for the regulation of discount health care program operators by TDI. The department posted a formal proposal and anticipates adoption in mid 2010.
- SB 78 created Healthy Texas, a statewide health insurance program designed to expand insurance coverage to Texas small business owners and their employees. TDI held stakeholder meetings and posted informal rules on our website in October, 2009. Rules became effective March 16, 2010. Enrollment in Healthy Texas is anticipated to begin in late 2010.

Sunset: Legislation containing the Sunset recommendations and continuing the agency was introduced during the 81st Legislative Session but failed to pass. Instead, legislation passed in the 1st Called Session of the 81st Legislature continued the agency until 2011 and limited the Sunset Commission's review of TDI to the appropriateness of the recommendations made by the Commission to the 81st Legislature.

Appendices



Appendix A - Resolved Issues

The table below lists examples of issues that were covered in previous reports and were addressed by TACCP before this reporting period. The table serves to show the effectiveness and accomplishments of the committee to date.

| Issue | Background | Resolution Summary |
|---|---|---|
| Clearinghouses | | |
| <p>Clearinghouses convert data submitted by a health care provider to a payor and can be public or private entities, including billing services or re-pricing companies.</p> | <p>Federal HIPAA provisions require clearinghouses to conduct standard transactions where enacted. However, clearinghouses are free to use their own transaction methods. As a result, some processes reject entire batches of claims in addition to the deficient claims. CMS has not specified whether claims may be rejected at the "batch level" or must be the individual claim level". Providers indicated that "batch rejection" requires significant review of individual claims to determine which claim(s) caused the rejection. Providers believe SB 418 rules requiring payors to notify providers when a claim is deficient provide adequate justification for requiring the payor to identify the specific claim that caused the rejection and prohibiting batch rejection.</p> | <p>In response, the Legislature enacted SB 50 (2005), which requires carriers to include, if requested, a provision in the provider's contract indicating that the carrier will not deny or refuse to process a clean claim submitted in a batch that may contain deficient claims. The Department has adopted amendments to rules in TAC Chapters. 3 and 11 to implement SB 50 (TAC § 21.2807). These amendments are consistent with statutory and regulatory requirements that, upon receipt of an electronic clean claim at the designated address for claims receipt, a carrier must pay, deny, or audit the claim within 30 days. Additionally, TDI clarified that if a provider submits an electronic claim to the designated claims payment address and the format is changed by a clearinghouse ("dropped to paper"), the payor remains subject to electronic claim timeframes.</p> |
| Disclosure of Fee Schedules | | |
| <p>SB 418 allows contracted providers the right to request certain claims payment information, including fee schedules, payment methodologies, and coding and bundling rules or processes. In addition, payors must give 90 days written notice prior to instituting any changes to the</p> | <p>Since September 1, 2003, TDI has received 10 complaints regarding disclosure of fee schedules, five of which were "justified." Additionally, TDI, in discussions with individual payors and providers, has reminded those parties of the prior-notice requirements regarding changes to claims payment information.</p> | <p>TDI will continue to ensure compliance with requirements related to fee schedules by informing affected parties of the provisions in the statute and rules and addressing any complaints as they arise. If significant complaint trends appear, TDI will present its findings to the TACCP for consideration.</p> |

| Issue | Background | Resolution Summary |
|---|--|--|
| <p>claims processing information. Some health plans reported they have received more than 100,000 provider requests while others indicated they received no requests.</p> | | |
| National Provider Identifier (NPI) | | |
| <p>On May 28, 2008, CMS implemented new claim forms and required providers to use a new National Provider Identifier number on claim forms. As a result, providers needed to obtain NPI numbers from CMS and carriers needed to prepare to accept claims using the NPI as the provider identifier.</p> | <p>The NPI is a HIPAA standard and is a unique identification number for health care providers. Beginning May 23, 2007 (May 23, 2008, for small health plans), CMS required Medicare health care providers, health plans, and clearinghouses to use the NPIs in administrative and financial transactions in lieu of legacy provider identifiers in the HIPAA standards transactions.</p> <p>To implement these standards, CMS implemented new claim forms, which are used in commercial transactions as well. CMS delays in implementing the forms created challenges for providers and carriers to transition to the new forms and NPI requirements.</p> | <p>Throughout implementation, TDI worked with carrier and provider representatives to encourage preparedness by May 2008. In addition, the Department modified clean claim rules to implement the new claim forms and included flexibility in the rule to accommodate the shifting implementation dates. In addition, the Department worked closely with carriers to ensure that contingency plans were in place to ease the transition during the initial phases.</p> |
| Prompt Payment Penalties | | |
| <p>SB 418 changed the prompt payment penalty calculations for clean claims that were paid late or underpaid. These changes included a graduated penalty structure and a cap. Under SB 418, health carriers must pay penalties for claims paid timely but incorrectly. In certain situations, the formula contained in the TDI rule results in a total payment to the provider, including the penalty, which exceeds billed charges. Under the late payment penalty structure, the maximum penalty is billed charges. The underpayment penalty formula under TAC § 21.2815(d) is: Underpaid Amount/Contracted Rate X Billed Charges = Penalty Payment.</p> | <p>During the 81st Legislative Session, a carrier proposed the following formula as an alternative: $\text{Underpaid Amount/Contracted Rate} \times \text{Discount (Billed Charges less Contracted Rate)} = \text{Penalty Payment}$</p> <p>Under this alternative formula, the penalty increases as the underpayment amount increases and the total payment eventually reaches billed charges. TACCP provider representatives asserted that the method for calculating a penalty is a statutory construction which may not be altered by regulation. Additionally, the legislative language for the method for calculating underpayment penalties is in proportion to the serious nature of the violation of the Insurance Code.</p> | <p>The Legislature passed Senate Bill 1884 (2007) which adjusts the calculation for underpayment penalties under the prompt pay statutes. Accordingly, the Department conformed prompt pay rules to the new legislative language. The adoption order for the rule was signed on January 18, 2008.</p> |

| Requests for Verification | | |
|--|---|---|
| <p>Verification is a statutorily established process that allows providers to verify a patient's coverage for specific services. It can be used regardless of whether preauthorization is required. A carrier must respond to a verification request within certain specified time frames. If approved, a carrier cannot reduce or deny payment for the verified services if performed within 30 days of the verification unless the provider materially misrepresented the services to be performed. Therefore, verification is a guarantee of payment.</p> <p>Although not a guarantee of payment, once a service is preauthorized a carrier may not deny or reduce payment based on medical necessity or appropriateness of care.</p> | <p>Some carrier representatives indicate that the personnel costs associated with weekend and holiday staffing are significant and excessive considering the number of requests for verification submitted. They recommend that the statute governing verification be amended to remove the requirement that carriers have staff available during these times. In contrast, provider members have indicated the frequency of declinations and the strict requirements necessary for a verification request have discouraged providers from using the process.</p> | <p>TDI collects data quarterly on carrier declinations of provider verification requests. This report contains some of that information in Appendix C. In addition, as the Department notices unexpectedly high rates of declinations or low rates of verification requests, the Department contacts the carrier to ensure compliance with the statute. If necessary, the Department has authority to take enforcement actions for a carrier's failure to comply this prompt pay statute.</p> |

Appendix B – Department Provider Ombudsman Activities

Department’s Role in Assisting Providers

| | |
|---------------------------|--|
| Provider Ombudsman | <p>The role of the Provider Ombudsman is to assist health care providers in dealing with insurance carriers. The Provider Ombudsman expedites resolution of provider complaints and analyzes complaint data for patterns or particularly serious violations that require corrective action. In some cases the Provider Ombudsman suggests changes in TDI rules if necessary to improve compliance with insurance laws.</p> <p>The program was developed in 2001 following prompt payment for medical insurance claims legislation. In the fall of 2006, the Commissioner transferred the function from the Consumer Protection Program to the Life, Health and Licensing Program. The change was driven by a shift from the previously high number of complaints to monitoring prompt pay trends and issues that arise from evolution of the health care industry.</p> <p>Mission: To assist providers on matters involving prompt payment of claims.</p> <p>Duties include:</p> <ul style="list-style-type: none">• Monitor complaints in aggregate to determine trends that identify new issues or carrier-specific issues;• Collect and analyze quarterly prompt pay data for compliance with prompt pay laws;• Plan and conduct quarterly and ad hoc meetings of the Technical Advisory Committee on Claims;• Develop rules necessary to enforce prompt payment;• Partner with the Consumer Protection Program as needed on specific complaints; and• Partner with the Enforcement Program to ensure compliance with prompt pay laws. |
|---------------------------|--|

Outreach and Education

Department staff respond to requests and invitations to speak on issues important to various groups and travels throughout Texas. Staff respond to interview requests from different types of media sources. The table on the next several pages includes speaking engagements and interviews for fiscal years 2009 and 2010. From September 2008 through August 2010, TDI, including DWC staff, has presented, or interviewed on numerous occasions at organizations or media outlets on health or workers’ compensation-related issues.

In response to a request by chiropractors for more involvement, the Department began holding quarterly meetings to provide a platform for their concerns and questions. In addition, TDI staff created a Chiropractors Resource Page on the Department website that includes quarterly meeting summaries, a mini conference video, and frequently asked questions and answers.

The Department also increased its outreach to pharmacists, including a representative on the TACCP. In addition, based on concerns raised by pharmacy representatives, the Department conducted special efforts to educate pharmacists on filing complaints, created a Pharmacists Resource Page on the Department’s website and in July, 2009,

began holding monthly meetings with pharmacists and representatives from their professional associations. Meeting summaries are posted on the Pharmacists Resource Page.

The table on the next page shows a sample of the speaking and informational requests to which the Department responds to educate consumers, providers, and carriers.

Speeches, Presentations and Interviews 2009 to 2010

| CATEGORY | ORGANIZATION | CITY |
|-----------------------------|--|-------------|
| Children's Health Insurance | Dell Children's Medical Center of Central Texas | Austin |
| | Seton Health Express | Austin |
| Health insurance | Chronic Disease Coalition | Austin |
| | Texas Chiropractic Association Mid-Winter Conference | Irving |
| | Texas Chiropractic Association Annual Convention | Austin |
| | UT Health Fair | Austin |
| | Asian Health Fair | Austin |
| | National Juvenile Arthritis Conference | Houston |
| | National Council of Jewish Women | Austin |
| | McLennan Community College: 5th Annual Tax and Financial Planning Institute | Waco |
| | Texas Assn. of Life & Health Insurers | Austin |
| | Austin Association of Health Underwriters | Austin |
| | LOMA Health Underwriting Study Group | San Antonio |
| | Texas Health & Human Services, DADS & TDI | Austin |
| | Texas Ambulatory Surgery Center Society | Austin |
| Minority Health Insurance | Texas Health Resources | Austin |
| | South Rural Community Ctr. Cinco de May Celebration | Del Valle |
| | Austin/Travis County Health and Human Services Department | Austin |
| | American Heart Association African American Outreach Task Force | Austin |
| | American Heart Association Festival Hispano de la Salud | Austin |
| | Austin/Travis County Health and Human Services Department: Greater Mount Zion Baptist Church | Austin |
| | 9th Annual Central Texas African American Family Support Conference | Austin |
| | 10th Annual Central Texas African American Family Support Conference | Austin |
| | Dove Springs Community Health Fair | Austin |
| | The Austin Health Connection: H.E.B. Riverside | Austin |
| | Neighborhood Fest 2010 | Austin |
| | The Smile Center Health Fair and Fun Day | Austin |
| | Healthcare Landscape 2009 Conference | San Antonio |

| | | |
|-----------------------|---|---------------|
| | Texas Medicine Magazine | Austin |
| | Victoria Medical Foundation | Victoria |
| Regulatory Update | AMBA Regional Conference | Round Rock |
| | SBDC Small Business Development Center | Houston |
| | TMA Select Committee on Medicaid, CHIP and the Uninsured | Austin |
| | Texas Ambulatory Surgery Center Society Conference | Austin |
| | Houston Association of Health Underwriters | Houston |
| | TSHA Convention | Fort Worth |
| | Austin Bar Association Breast Cancer Legal Advocacy Workshop | Austin |
| | TDI Life, Health & Licensing 2010 Compliance Conference | Austin |
| | TAHP 2009 Texas Managed Care Conference | Bastrop |
| | Texas Pharmacy Association 2009 Rxperts SW Conference & Expo | San Antonio |
| Prompt pay | Texas Association of Health Plans | The Woodlands |
| | Denton Medical Office Manager's Association | Denton |
| | Association of Voluntary Hospitals | Austin |
| Federal Health Reform | Office of Dispute Resolution of Lubbock County | Lubbock |
| | Dell Jewish Community Center Health Care Panel | Austin |
| | Alamo Insurance Group | San Antonio |
| Workers' Compensation | SBDC Small Business Development Center | Dallas |
| | Texas Ambulatory Surgery Center Society (TASCS) | Austin |
| | Deer Park Education Association | Deer Park |
| | Anesthesia Administrators of Texas | Grapevine |
| | San Antonio Small Business Development Center | San Antonio |
| | Texas Association of Occupational Health Nurses | Houston |
| | TDI/DWC 2009 Safety Summit | Austin |
| | TWC Texas Business Conference | South Padre |
| | TARPPS - Texas Association of Rehabilitation Professional and Providers of Services | Frisco |
| | TDI/DWC Texas Safety Summit | Austin |
| | International Workers' Compensation Foundation | Austin |
| | Ind. Insurance Agents of El Paso | El Paso |

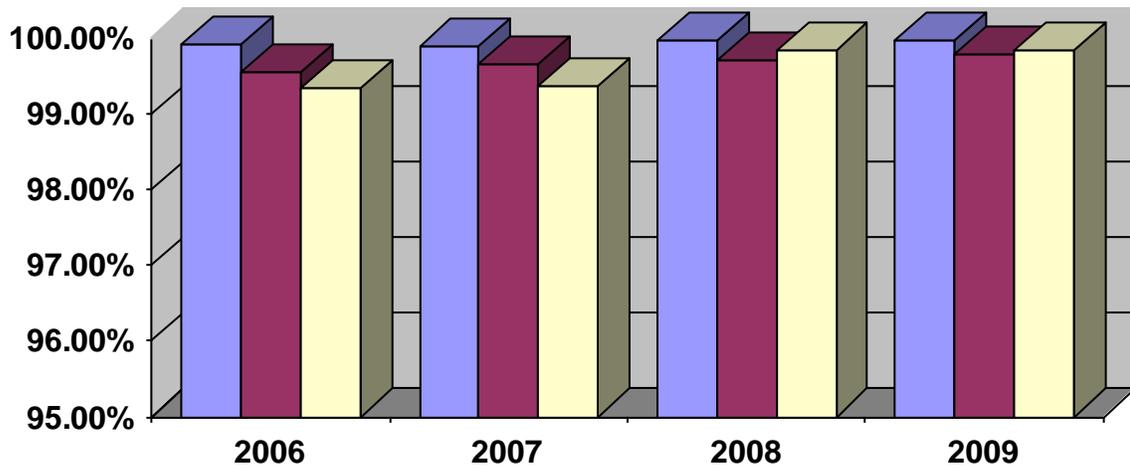
| | | |
|--|--|------------------|
| | American Academy of Disability Evaluating | San Antonio |
| | American Academy of Disability Evaluating Physicians | Dallas |
| | American Academy of Disability Evaluating Physicians | Houston |
| | American Academy of Disability Evaluating Physicians | Fort Worth |
| | American Academy of Disability Evaluating Physicians | San Antonio |
| | American Academy of Disability Evaluating Physicians | Austin |
| | International Workers' Compensation Foundation | Dallas |
| | Austin Radiology Association | Austin |
| | Sterling Education Services Inc | Houston |
| | World Research Group | Chicago |
| | Houston Interpreters & Translators Assn. | Houston |
| | Coventry Workers' Compensation Services | Houston |
| | South San Antonio Chamber of Commerce | San Antonio |
| | Texas Bar CLE | Austin |
| | Insurance Council of Texas: Workers Compensation Conference | Austin |
| | Intracorp | Richardson |
| | Intracorp | Houston |
| | Intracorp | Houston |
| | Texas Self Insurance Association (TSIA) | Austin |
| | American Academy of Disability Evaluating Physicians | Indian Wells, CA |
| | National Association of Church Business Administrators Caprock Chapter | Lubbock |
| | Lamar University | Beaumont |
| | Kilgore College SBDC | Longview |
| | Paris Small Business Development Center | Paris |
| | Del Mar College Small Business Development Center | Corpus Christi |
| | Workers' Compensation Claims Professionals | Marco Island, FL |
| | Southwestern Insurance Information Service (SIIS) Annual Conference | Dallas |
| | Texas Tech Physicians of Lubbock | Lubbock |
| | Office of David K. Hagstrom, MD | Lubbock |
| | University of North Texas Workplace & Sustainable Employment Program | Mesquite |

| | | |
|--|-------------------------------|----------|
| | Lamar Institute of Technology | Beaumont |
| | MedConfirm | Dallas |

Appendix C – Compliance Oversight

Timeliness of Provider Claims Payments

This graph represents the percentage of clean claims paid timely.



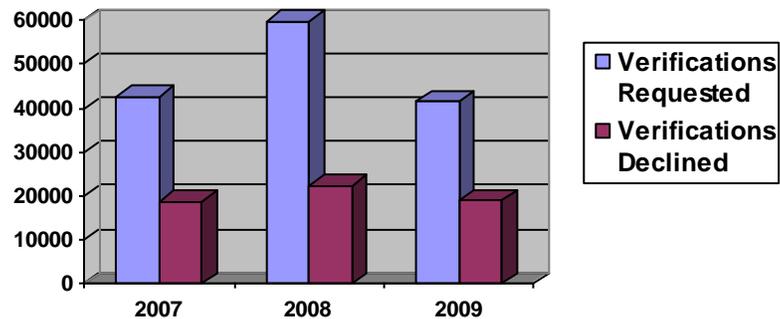
■ Pharmacy claims ■ Institutional/hospital claims □ Non-institutional/physician or professional claims

Source: TDI SB 418 Provider Claims Data Calls - July 2006- June 2009

Note: Each year illustrated in the graph begins in July of that year and runs through June of the following year. (2009 = July 2009 to June 2010)

Verification Requests

This graph compares the number of verification of benefit requests by providers to the number of declines for verification by carriers.



Note: Each year illustrated in the graph begins in July of that year and runs through June of the following year. (2009 = July 2009 to June 2010)

Source: TDI SB 418 Provider Claims Data Calls - July 2007 - June 2010

Reasons for Verification Declinations

Carriers also report to the Department reasons for declining to verify benefits and the chart below shows the reasons and number of times those reasons were given in the previous three years.

| Reason for Declination | 2007 | 2008 | 2009 |
|---|--------|--------|--------|
| Declinations due to premium payment time frames that prevent verifying eligibility for a 30-Day Period | 2,717 | 1,500 | 743 |
| Declinations due to policy deductibles, specific benefit limitations or annual benefit maximums | 26,564 | 10,566 | 12,408 |
| Number of declinations due to benefit exclusions | 24,515 | 12,913 | 9,458 |
| Number of declinations due to no coverage or change in membership eligibility, including individuals not eligible, not yet effective, or membership cancelled | 6,693 | 13,843 | 14,920 |
| Declinations due to pre-existing condition limitations | 2,102 | 3,037 | 4,524 |
| Declinations due to other policy or contract limitations | 3,079 | 12,344 | 14,393 |
| Declinations due to lack of information from the requesting physician or provider | 2,971 | 25,113 | 2,750 |
| Declinations due to lack of information from other physician or provider | 166 | 1,276 | 214 |
| Declinations due to lack of information from any other person | 5,769 | 1,538 | 818 |
| Declinations due to other reasons | 16,238 | 18,352 | 19,023 |

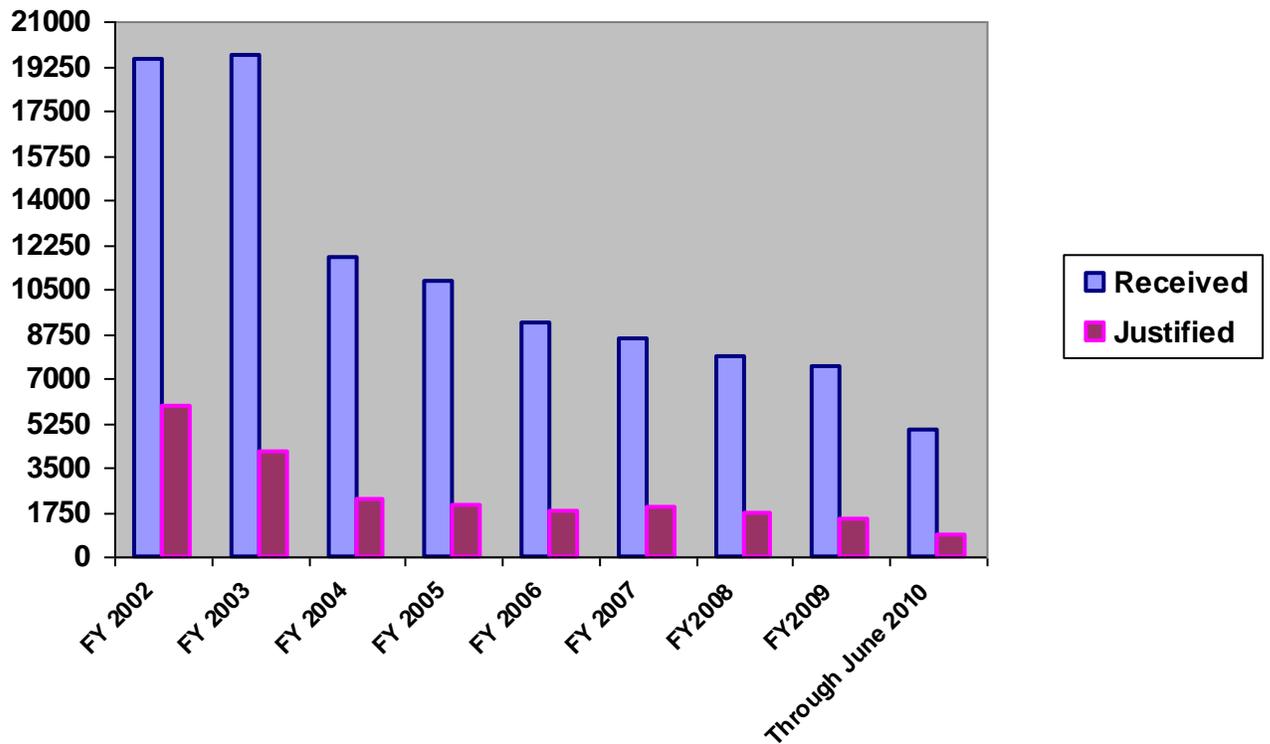
Source: SB 418 Annual Reasons for Declination Report - July 2007 - June 2010

Notes: 1. Carriers may have reported more than one reason for a declination. Each year illustrated in the chart begins in July of that year and runs through June of the following year. (2009 = July 2009 to June 2010)

2. This data is preliminary. TDI is in the process of verifying the data of multiple carriers.

Complaints Received from Physicians and Providers: FY 2002 through June, 2010

The graph below illustrates that since SB 418 was passed by Legislature in 2003, the number of complaints dropped dramatically in 2004 and has steadily declined since. The number of justified complaints has also declined after the passage of SB 418 and has been about the same during the last several years. Received complaints include all complaints received by TDI from a physician or a provider. A justified complaint involves an apparent violation of a policy provision, contract provision, rule or statute, or there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice.



Source: TDI Complaints Inquiry System (CIS) database

The electronic version of this report is available on the TDI website at:
<http://www.tdi.state.tx.us/reports/report5.html>