Tips for Reporting Pharmacy Claims Data

Pursuant to the requirements of 28 Texas Administrative Code §21.2821(d)(19)-(23), carriers should report data for all electronically submitted, affirmatively adjudicated pharmacy claims subject to prompt pay requirements by Texas Insurance Code Sections 1301.104 and 843.339.

Carriers have previously reported that prescription drugs dispensed by an institutional provider are a component of the institutional claims and are not the electronically submitted and affirmatively adjudicated claims that are the subject of the 21-day statutory claims payment period. Section 21.2821 recognizes this and does not split the reporting requirements into institutional and non-institutional categories. Therefore, carriers should report all electronically submitted, affirmatively adjudicated pharmacy claims in the "Non-institutional" field.

EXAMPLE

NOTE: Enter pharmacy claims data in the Non-Institutional section of the data entry screen, as shown below.

SB 418 Quarterly Data Entry Screen

Reporting Year	2007
Reporting Period	Second Quarter

Non-Institutional Provider Data	
Number of Claims Received:	200,000
Number of Clean Claims Received:	200,000
Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	
Pharmacy:	50,000
Electronic:	150,000
Non-Electronic:	0

Texas Department of Insurance
Provider Claims Data Call

Tips to Assure Accurate Data Reporting

Company Contact Information

√	Field Name	Tip
	Company Legal Name	Please check the spelling of the company's legal name.
	TDI Company Number	TDI assigns each licensed company a unique number. This number is different from the company's NAIC number. To look up your company's TDI number, please visit TDI's company search page at https://wwwapps.tdi.state.tx.us/pcci/pcci_internal.jsp .
	E-mail Address	Please enter an e-mail address; do not enter a street address. Also, the e-mail address of the person who entered the data should be listed. If TDI staff have questions about the data, they will contact this person.

HB 610 Quarterly Data Collection Form

√	Field Name	Tip
	When to use this form	Use this form to report provider claims paid under contracts that have not been issued or renewed on or after August 16, 2003. TDI understands that many carriers may no longer have claims that fall into this category so those carriers will not use this form.
	Number of Clean Claims Paid	Verify that the figure reported for Number of Clean Claims Paid is the sum of the figures reported in these categories: • Number of Clean Claims Paid On or Before the 45th Day Following Receipt of Claim (the clean claims that were paid timely) • Number of Clean Claims Paid After the 45th Day Following Receipt of Claim
	Number of Clean Claims Paid After the 45th Day Following Receipt of Claim	Verify that the figure entered is the sum of the figures reported in these categories: • Number of Clean Claims Paid on Day 46-59 Following Receipt of Claim • Number of Clean Claims Paid on Day 60-89 Following Receipt of Claim • Number of Clean Claims Paid on Day 90 or Later Following Receipt of Claim

SB 418 Quarterly Data Collection Form

√	Field Name	Tip
	Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	Verify that the figure reported is the number of clean claims paid timely, that is, paid within 21 days for pharmacy claims, 30 days for electronic claims, and 45 days for non-electronic claims. Do not include the number of claims paid late.
	Number of Clean Claims Paid between 1 and 45 days after the end of the Applicable Statutory Claims Payment Period	This field is for clean claims that are paid **late**. Verify that the figure reported is the number of clean claims that were paid 1 to 45 days late, that is, 1 to 45 days after the end of the applicable statutory claims payment period.
	Number of Requests for Verification	Verify that the figure reported equals the sum of the figures for Number of Verifications Issued and Number of Declinations. Please provide an explanation if the number of declinations plus the number of verifications issued does not equal the number of requests for verification.

HB 610 Quarterly Report Instructions

In 2001, TDI began collecting provider claims data from certain carriers in order to monitor compliance with HB 610 prompt pay requirements. SB 418 requires all licensed HMOs and insurers that write PPO plans to report data to TDI so TDI can determine compliance with SB 418 prompt pay requirements. However, SB 418 takes effect when carriers issue or renew their contracts with providers on or after August 16, 2003. Also SB 418 applies to claims for emergency care services, as well as services that were performed on referral from an HMO, PPO, or a preferred provider because the services were not reasonably available in-network. For this reason, carriers will report contracts that were last issued or renewed prior to August 16, 2003, using the HB 610 format; for certain referral and emergency care claims, and claims for those contracts that have been issued or renewed after August 16, 2003, they will use the SB 418 format.

In addition, each carrier that uses delegated entities to pay claims must report claims payment data from each of the carrier's delegated entities. Therefore, each carrier that uses delegated entities will complete and submit a quarterly on-line data form for each delegated entity that processes a carrier's provider claims. Additionally, the data used to calculate the totals reported to TDI must be maintained for a minimum of three years and must be available for review by TDI. The retention of the data applies to a carrier's delegated entities as well.

HB 610 Quarterly Data Entry Screen

Reporting Year	2007
Reporting Period	Second Quarter

Number of Claims Received:	
Number of Claims Paid:	
Number of Clean Claims Received:	
Number of Clean Claims Paid:	
Number of Clean Claims Paid on or before the 45th day following receipt of claim:	
Number of Clean Claims Paid after the 45th day following receipt of claim:	
Number of Clean Claims Paid on day 46-59 following receipt of claim:	
Number of Clean Claims Paid on day 60-89 following receipt of claim:	
Number of Clean Claims Paid on day 90 or later following receipt of claim:	
Number of Clean Claims Subject to Audit Paid at 85 percent following receipt of claim:	
Number of Claims Paid at Billed/Contracted Penalty Rate:	

SB 418 Quarterly Report Instructions

SB 418 applies to provider claims under an HMO or insured PPO plan for which the provider's contract was issued or renewed on or after August 16, 2003. SB 418 also applies to claims for emergency care services, as well as services that were performed on referral from an HMO, PPO, or a preferred provider because the services were not reasonably available in-network.

The first boxes of the SB 418 quarterly data form indicate the reporting year and quarterly reporting periods. Carriers must complete these fields on all data reported, including delegated entity data. The rest of the first page of the SB 418 quarterly data form includes boxes for data pertaining to **non-institutional providers**. The second page includes boxes for data pertaining to **institutional providers**. Carriers must separate claim payment information for institutional and non-institutional providers.

In addition, carriers must report the total number of claims received (this number includes deficient claims) and the total number of **clean claims** received (this number excludes deficient claims) during the reporting period. The deficient and clean claim data must also be separated by non-institutional and institutional providers, so carriers will complete these boxes on pages one and two accordingly. Once the totals have been entered, the rest of the boxes on page one and page two are for data on **clean claims only**. Again, page one is for non-institutional provider data and page two is for institutional provider data.

Carriers must report the number of clean claims paid **within** the applicable statutory claims payment period for electronically-adjudicated pharmacy, other electronic, and non-electronic claims. The applicable statutory claims payment period is:

- **21 days** for electronically-adjudicated pharmacy claims
- **30 days** for other electronic claims and
- **45 days** for non-electronic claims.

Carriers must also report the number of clean claims paid **after** the applicable statutory claims payment period for electronically-adjudicated pharmacy, other electronic, and non-electronic claims. For clean claims that were not paid within the applicable statutory claims payment period, carriers must report the number of clean claims that were paid:

- between 1 and 45 days after the end of the applicable statutory claims payment period (Pharmacy = days 22-66; Electronic = days 31-75; Non-electronic = days 46-90 following date of receipt)
- between 46 and 90 days after the end of the applicable statutory claims payment period (Pharmacy = days 67-111; Electronic = days 76-120; Non-electronic = days 91-135 following date of receipt) and
- after the 91st day after the end of the applicable statutory claims payment period (Pharmacy = days 112+; Electronic = days 121+; Non-electronic = days 136+ following date of receipt).

The last page of the SB 418 quarterly data form applies to both clean and deficient claims. Carriers must report the total number of audited claims paid at 100 percent, the total number of requests for verifications the carrier received, the total number of verifications issued, the total number of declinations, the total number of certifications of catastrophic events sent to TDI and the total number of business days that were interrupted due to catastrophic events.

Please read these instructions carefully before entering the SB 418 quarterly data. If you have questions regarding the information that must be reported to TDI, please send an e-mail to katrina.daniel@tdi.state.tx.us.

Texas Department of Insurance
Provider Claims Data Call

SB 418 Quarterly Data Entry Screen

Reporting Year	2007
Reporting Period	Second Quarter

Non-Institutional Provider Data	
Number of Claims Received:	
Number of Clean Claims Received:	
Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid between 1 and 45 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid between 46 and 90 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid on or after the 91st day after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	

Texas Department of Insurance
Provider Claims Data Call

Institutional Provider Data	
Number of Claims Received:	
Number of Clean Claims Received:	
Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid between 1 and 45 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid between 46 and 90 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid on or after the 91st day after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Audited Claims Paid Pursuant to §21.2809:	
Number of Requests for Verification Received Pursuant to §19.1724:	
Number of Verifications Issued Pursuant to §19.1724:	
Number of Declinations Pursuant to §19.1724:	
Number of Certifications of Catastrophic Events Sent to TDI:	
Total Number of Days Business was Interrupted for Catastrophic Events:	

You are responsible for the accuracy of the data submitted. Please print this page now and immediately check for accuracy before clicking the submit button. If you are delayed in checking for accuracy, this page may "expire" and you will have to fill out the form again.

Clear/Start Over Submit SB 418 Quarterly Data

Instructions for SB 418 Annual Reasons for Declination Report

Carriers are required to report annually the reasons for declining to verify a claim, referred to as declinations. Carriers must also report declination data from all of the carrier's delegated entities. Each carrier will complete and submit a SB 418 annual on-line data form for each delegated entity that processes that carrier's insured and/or enrollees claims. Additionally, carriers and their delegated entities, if applicable, must retain the data used to calculate the totals reported to TDI for a minimum of three years and must be available for review by TDI. The reporting period is July 1, 2006, through June 30, 2007. The report is due on **August 15, 2007**.

The first box of the SB 418 annual data form is for the reporting year; please enter 2006. Carriers must complete this field on all data reported, including delegated entity data. The next five boxes are for categories of declinations due to insurance policy or contract limitations. If there are policy or contract limitation reasons for declinations other than the four specified on the form, use the Comments field to explain the other policy or contract limitations.

The last set of boxes pertains to declinations due to the carrier's inability to obtain necessary information in order to verify requested services. There are four boxes. The first box pertains to the inability to obtain information from the requesting physician or provider. The second box pertains to the inability to obtain information from another physician or provider and the third box pertains to the inability to obtain information from any other person (not a physician or provider.) The fourth box is an "other" category. If carriers have declinations for any reason other than a policy/contract limitation or an inability to obtain information, please explain these reasons in the "other" box.

SB 418 Annual Data Entry Screen

Reporting Year 2006

Declinations for insurance policy or contract limitations:	
Number of declinations due to premium payment time frames that prevent verifying eligibility for a 30-day period	
Number of declinations due to policy deductibles, specific benefit limitations or annual benefit maximums	
Number of declinations due to benefit exclusions	
Number of declinations due to no coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership canceled	
Number of declinations due to pre-existing condition limitations	
Number of declinations due to other policy or contract limitations	
If other policy or contract limitations, please explain	
Declinations due to inability to obtain necessary information in order to verify requested services from the following persons:	
Number of declinations due to lack of information from the requesting physician or provider	
Number of declinations due to lack of information from other physician or provider	
Number of declinations due to lack of information from any other person	
Number of declinations due to other reasons	
If other reasons, please explain	