Texas Department of Insurance
Commissioner of Insurance, Mail Code 113-1C
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104

October 18, 2007 **COMMISSIONER'S BULLETIN #B-0042-07**

TO: **ALL INSURERS WRITING PREFERRED PROVIDER HEALTH BENEFIT PLANS AND ALL HEALTH MAINTENANCE ORGANIZATIONS (HMOs)**

RE: **Call for Reports Regarding Provider Claims Processing and Related Functions**

DUE: **November 15, 2007 – Third Quarter 2007 (July - September) Provider Claims Data**

Pursuant to §38.001 of the Texas Insurance Code (TIC), the Texas Department of Insurance (TDI) issues the attached mandatory data call for insurers writing preferred provider health benefit plans in Texas, and for health maintenance organizations doing business in Texas (collectively, hereafter, "carriers"). This data call is necessary for TDI to determine carriers' compliance with various "prompt pay" requirements relating to claims submitted by providers, as addressed under TIC Ch. 1301 and Ch. 843, Subchapter J and rules adopted to implement those statutes. Carriers' complete responses to this data call are also necessary for compliance with 28 Texas Administrative Code §21.2821.

Third Quarter 2007 Provider Claims Data: The provider claims data for the reporting period July through September, 2007, is **due no later than November 15, 2007.** Please use the tips listed on page 3 to review the data before you submit it.

In certain circumstances, claims will be reported in more than one quarter. Specifically, if an initial underpayment is made (and reported) and a subsequent additional payment is made in a different quarter, then the subsequent payment must be reported as a late payment as appropriate. If the subsequent payment is made outside the applicable statutory claims payment period, the carrier must reflect this in the report.

The online data reporting forms may be accessed on the TDI website at: http://www.tdi.state.tx.us/webinfo/datacall.html. You can still access the data reporting forms from the TDI Web site: www.tdi.state.tx.us . From the TDI home page, click on surveys under Section Links on the right side of the page. Then scroll down to Life Health Data Calls and select Senate Bill 418. Your data collection contact will receive a reminder of this data call by email as well. If you have questions about the data call or how to access the data collection application, please contact Katrina Daniel via e-mail at katrina.daniel@tdi.state.tx.us or call her at 512-322-4315.

Sincerely,

Mike Geeslin
Commissioner of Insurance

Texas Department of Insurance
Provider Claims Data Call

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	Third 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

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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://apps.tdi.state.tx.us/pcci/pcci_search.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 were last issued or renewed before 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 Received	Verify that the figure reported equals the sum of the figures for Number of Verifications Issued and Number of Declinations issued. Please provide an explanation if the number of declinations plus the number of verifications issued does not equal the number of requests for verification.
	Reporting "underpaid" claims	If an initial underpayment is made (and reported) and a subsequent additional payment is made in a different quarter, then the subsequent payment must be reported as a late payment as appropriate. If the subsequent payment is made outside the applicable statutory claims payment period, the carrier must reflect this in the report.

Texas Department of Insurance
Provider Claims Data Call

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 where the date of service is on or after August 16, 2003. 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	Third 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:	

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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 where the date of service is on or after August 16, 2003.

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.

In certain circumstances, claims will be reported in more than one quarter. Specifically, if an initial underpayment is made (and reported) and a subsequent additional payment is made in a different quarter, the subsequent payment must be reported as a late payment as appropriate. If the

subsequent payment is made outside the applicable statutory claims payment period, the carrier must reflect this in the report.

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.

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SB 418 Quarterly Data Entry Screen

Reporting Year	2007
Reporting Period	Third 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:	

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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