HOUSE RESEARCH ORGANIZATION bill analysis — 5/5/1999 — HB 2883 Bailey (CSHB 2883 by Wise)

SUBJECT: Payment information requests by podiatrists to insurers and HMOs.

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Smithee, Eiland, Burnam, J. Moreno, Olivo, Thompson, Wise

1 nay — Seaman

1 absent — G. Lewis

WITNESSES: (*On original bill:*)
For —Timothy Abigail, MD, American College of Foot and Ankle Surgeons and First National Guild of Medical Providers; Mark Hanna, Texas Podiatry Association; Walter Hinojosa, Texas AFL-CIO; Kirk Koepsel, Texas Podiatric Medical Association

Against — Jerry Patterson, Texas Association of Health Plans; Jay Thompson, Texas Association of Life and Health Insurers

BACKGROUND: Podiatrists sometimes contract with insurers using preferred provider contracts and health maintenance organizations (HMOs). Podiatrists in Texas are licensed by the Texas State Board of Podiatric Medical Examiners.

Preferred provider benefit plans are authorized by the Insurance Code, Art. 3.70-3C. These plans involve contracts between health care providers and insurers where the providers agree to charge discounted fees in exchange for preferred status in the insurers' health plans. These discounted fees are set by coding guidelines and payment schedules. Insurers encourage plan members to see preferred providers by covering more of the costs than when a plan member sees any other provider. Some of the insurers who use these plans exclusively are known as preferred provider benefit organizations (PPOs).

DIGEST: CSHB 2883 would require contracts between a licensed podiatrist and an insurer using a preferred provider benefit plan or an HMO to provide that:

- the podiatrist could request a copy of the coding guidelines and payment schedules that applied to the podiatrist according to the contract;

- the insurer or HMO would have to provide those copies within 30 days of the request;
- the insurer or HMO could not make material retroactive revisions to the coding guidelines and payments schedules without notifying the podiatrist; and
- the podiatrist could furnish x-rays and non-prefabricated orthotics (medical devices customized for the patient) covered by the health insurance policy.

CSHB 2883 would take effect September 1, 1999, and apply to contracts entered into on or after that date.

SUPPORTERS SAY:

CSHB 2883 would require insurers and HMOs to reveal their coding guidelines and payment schedules to podiatrists to prevent confusion and mistakes in billing.

Some insurers and HMOs use coding schedules that are different from the coding schedules routinely used by podiatrists, called physician's current procedural terminology (CPT) codes. There is a code for every treatment and diagnosis. Podiatrists can be confused and underpaid because they do not understand the different coding schedules that are unique to individual insurers and HMOs. A podiatrist may bill an expensive procedure under one code and be reimbursed for a less expensive procedure if the codes used by the insurer or HMO are not standard.

CSHB 2883 would also prohibit insurers and HMOs from changing their codes and payment schedules after the podiatrist has agreed to the contract and its terms. Reimbursement terms should not be changed without the podiatrist's approval once the contract has been signed.

Podiatrists already can furnish x-rays and medical devices customized to the patient according to the terms of the health insurance policy, yet some insurers and HMOs have refused to reimburse podiatrists for these costs even if the x-rays and devices are covered by the policy. CSHB 2883 would give statutory support for podiatrists to hold insurers and HMOs to the terms of their own policies.

The committee substitute was written to address the concerns of insurers and HMOs. CSHB 2883 is an agreed bill that now is supported by podiatrists, insurers, and HMOs.

OPPONENTS SAY: No apparent opposition.

NOTES: The original version would have applied to all health care providers, not just podiatrists. The original version would have applied the following requirements to all contracts between health care providers and insurers using preferred provider benefit plans or HMOs:

- The inclusion of a complete fee schedule, coding guidelines, and a complete explanation of the method for determining payment in the contract;
- A prohibition against unilateral changes to the fee schedule or amendments to the contract without giving the provider 90 days' prior written notice and allowing the provider to terminate the contract before the implementation of the revised fee schedule without penalty;
- A prohibition against the insurer or HMO assigning the contract to another entity and binding the provider to another health care plan without the provider's consent;
- Allowing the provider 90 days after the date of service to submit a claim for payment;
- A requirement that the insurer or HMO would have to pay a properly submitted and complete claim no later than the 45th day after a claim was submitted or forfeit any applicable fee discount and pay the provider's standard fee;
- Clearly describe all information that must be included on a claim form submitted by a provider to render the claim full and complete for payment purposes;
- Provide that once eligibility and benefits had been properly verified by the provider, the insurer or HMO could not deny a claim because the enrollee no longer was eligible for coverage or that the benefits had changed;
- Define "medical necessity" as "the standard for health care services as determined by physicians and providers in accordance with the prevailing practices and standards of the medical profession and the community"

and allow a provider to appeal an adverse decision regarding medical necessity to a panel of providers of the same specialty;

- Clearly explain the insurer's or HMO's policy regarding payment terms for multiple surgical procedures performed during the same operation;
- Prohibit the HMO or insurer from denying or interfering with the provider's right to render medical services and furnish durable medical equipment as was customary for providers of the same medical specialty;
- Provide for the automatic annual renewal of the contract, unless a party to the contract gave 90 days' prior written notice of termination to the other party stating the reason for the termination; and
- Provide for all unresolved disputes between the insurer or HMO and a provider to be resolved through binding arbitration on the request of either party.

The companion bill, SB 781 by Madla, passed the Senate by voice vote on April 20 and has been referred to the House Insurance Committee.