BILL ANALYSIS

Senate Research Center
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S.B. 1590
By: Zaffirini
Human Services
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As Filed

DIGEST

Currently, a person or a health care provider may fraudulently obtain or deny a workers' compensation medical benefit or payment for a medical service, such as Medicaid. The comptroller states in a report, the Health Care Claims Study, that the State Office of Risk Management (office) has no authority to sanction providers who do not comply with the requirements of the state's workers' compensation system. Subsequently, the comptroller recommended providing the office with sanctioning authority. S.B. 1590 would establish the investigation and prosecution of fraud in the workers' compensation program for state employees, and would provide administrative penalties.

PURPOSE

As proposed, S.B. 1590 establishes the investigation and prosecution of fraud in the workers' compensation program for state employees, and provides administrative penalties.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the risk management board of the State Office of Risk Management in SECTION 1 (Section 412.064, Chapter 412, Labor Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 412, Labor Code, by adding Subchapter G, as follows:

SUBCHAPTER G. FRAUD INVESTIGATION AND PREVENTION REGARDING MEDICAL BENEFITS

Sec. 412.061. DEFINITIONS. Defines "fraudulent act" and "program."

Sec. 412.062. CLAIM REVIEW BY OFFICE. Requires the State Office Risk Management (office) to conduct periodic reviews of claims for medical benefits as necessary to determine the medical necessity and appropriateness of the provided services. Requires the office to conduct certain claim reviews, in additional to periodic reviews. Authorizes the office to withhold payments to a health care provider who does not provide certain documentation to verify a medical service related to a claim.

Sec. 412.063. CLAIMS AUDIT. Requires the director of the office (director) to conduct an annual audit of claims for medical benefits as provided by this section. Requires the director to select certain random claims and to audit the claims to ensure that the health care services were received. Requires the audit to include a review of the claimant's medical history and medical records. Authorizes the director to contract with a private entity for performance of the audit.

Sec. 412.064. PREPAYMENT AUDIT. Requires the risk management board of the office to require, by rule, each person who processes claims for the office to implement certain prepayment audit procedures.

Sec. 412.065. TOLL-FREE TELEPHONE NUMBER. Requires the office to maintain a toll-free number for the receipt of complaints regarding fraudulent acts by claimants of health care providers. Requires the director to provide claimants with information regarding the telephone number when a workers' compensation claim is submitted and periodically to notify state employees of the telephone number in a manner determined to be appropriate by the office.

Sec. 412.066. TRAINING CLASSES IN FRAUD PREVENTION. Requires the director to implement annual training classes for staff of state agencies, contractors, or administering firms who process workers' compensation claims submitted under the program to assist the attendees to identify potential misrepresentation or fraud in the operation of the program. Authorizes the director to contract with the Health and Human Services Commission (commission) or with a private entity for the operation of the training classes.

Sec. 412.067. ACTION BY OFFICE; COOPERATION REQUIRED. Requires the office to take action against a provider who has obtained payment through a fraudulent act. Requires the office to report any action in writing to the commission. Requires each participating state agency and health care provider to participate and cooperate, including providing access to patient medical records, in any investigation conducted by the director, as a condition of participation. Entitles the director to access to patient medical records and is a "governmental agency" for purposes of this subchapter, notwithstanding any other provision of law. Provides that any medical record submitted to the director is confidential and not subject to disclosure.

Sec. 412.068. FRAUDULENT ACTS BY PROVIDERS. Requires the director to investigate each complaint alleging a fraud by a claimant, a health care provider, or a state agency regarding a participating provider. Requires the director to terminate the investigation if, after an initial investigation, the complaint is unfounded. Requires the director to refer the complaint to the risk management board, if further action is warranted, and to provide the relevant information. Sets forth sanction against the provider.

Sec. 412.069. ADMINISTRATIVE PENALTY. Authorizes the risk management board of the board to impose an administrative penalty on a person or provider committing fraud. Prohibits the amount of the penalty from exceeding $10,000 and each day a violation continues or occurs is a separate violation for the purpose of the penalty. Sets forth conditions on which the amount must be based. Authorizes the enforcement of the penalty to be stayed during the time the order is under judicial review, if the penalty is paid to the clerk or a supersedeas bond is filed in the court. Authorizes a person to file an affidavit, if the person cannot afford to pay the penalty or file the bond. Authorizes the attorney general to sue to collect the penalty. Requires the penalty to be transmitted to the comptroller. Requires the comptroller to deposit the penalty into the state workers' compensation account to be used for the detection and prosecution of fraud, but prohibits a deposit from exceeding $200,000 per state fiscal biennium. Considers a proceeding to impose the penalty as a contested case under Chapter 2001, Government Code.

SECTION 2. Requires the office to implement the toll-free number under Section 412.065, Labor Code, by January 1, 2000.

SECTION 3. Requires the office to implement the training classes under Section 412.066, Labor Code, by January 1, 2000.

SECTION 4. Requires the board to conduct a study regarding the use of fraud detection software. Authorizes the study to include an analysis of the fraud detection program used by the Health and Human Services Commission under Chapter 22, Human Resources Code, for the detection of fraud in the Medicaid program. Requires the board to report the results of its study by February 1, 2001.

SECTION 5. Makes application of this Act prospective.

SECTION 6. Effective date: September 1, 1999.

SECTION 7. Emergency clause.