BILL ANALYSIS

Senate Research Center
77R7656 AJA-F

S.B. 1284
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Business & Commerce
3/26/2001
As Filed

DIGEST AND PURPOSE

Currently, a health plan is allowed to "add" or "change" the data elements that constitute a "clean claim." The addition or change is accomplished when the plan notifies the physician 60 days before the new elements go into effect. As proposed, S.B. 1284 establishes standards for "receipt" of claims that begin the clean claim time limit.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Commissioner of Insurance in SECTIONS 5 and 7 (Chapter 21E, Article 21.60, and Article 21.21 Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 3A(a), Article 3.70-3C, Insurance Code, to redefine "clean claim."

SECTION 2. Amends Article 3.70-3C, Insurance Code, by adding Sections 3C and 3D, as follows:

> Sec. 3C. DISPUTE RESOLUTION. (a) Prohibits an insurer from requiring the use of a dispute resolution procedure with a preferred provider if the use of the procedure results in a violation of Section 3A(c) or (e) of this article.
>
> (b) Prohibits the provisions of this section from being waived or nullified by contract.
>
> Sec. 3D. AVAILABILITY OF CODING GUIDELINES. Requires a preferred provider contract between an insurer and a physician to provide certain requirements.

SECTION 3. Amends Section 18B(a), Texas Health Maintenance Organization Act (Article 20A.18B, V.T.I.C.), to define, in this section, "clean claim."

SECTION 4. Amends The Texas Health Maintenance Organization Act (Chapter 20A, V.T.I.C.) by adding Sections 18D and 18E, as follows:

> Sec. 18D. DISPUTE RESOLUTION. (a) Prohibits a health maintenance organization from requiring the use of a dispute resolution procedure with a physician or provider if the use of the procedure results in a violation of Section 18B(c) or (e) of this Act.
>
> (b) Prohibits the provisions of this section from being waived or nullified by contract.
>
> Sec. 18E. AVAILABILITY OF CODING GUIDELINES. Requires a contract between a health maintenance organization and a physician to provide certain requirements.

SECTION 5. Amends Chapter 21E, Insurance Code, by adding Article 21.60, as follows:

Art. 21.60. PAYMENT OF CLAIMS AND VERIFICATION OF COVERAGE UNDER CERTAIN HEALTH BENEFIT PLANS

Sec. 1. DEFINITIONS. Defines “institutional provider” “plan issuer,” and “provider.”

Sec. 2. DEFINITION OF CLEAN CLAIM. (a) Provides that except as provided by Subsection (b), (c), or (e) of this section, a claim by a provider, other than an institutional provider, is a "clean claim" if the claim is submitted using Health Care Financing Administration Form 1500 or another Health Care Financing Administration form adopted by the commissioner for the purposes of this subsection that is submitted to a plan issuer for payment and contains certain data elements entered into the appropriate fields on the form.

(b) Requires that physician, if the provider indicates under Subsection (a)(12) of this section that there is another health benefit plan applicable to the claim, to, in addition to providing the data elements required under Subsection (a) of this section, enter certain data elements into the appropriate fields on the form if the provider knows the information required for those fields or if the physician is submitting a claim to a secondary payor plan issuer.

(c) Authorizes a plan issuer to, by contract with a provider, define "clean claim" to include certain elements.

(d) Provides that except as provided by Subsection (e) of this section, a claim by an institutional provider is a "clean claim" if the claim is submitted using Health Care Financing Administration Form UB-92 or another Health Care Financing Administration form adopted by the commissioner for the purposes of this subsection that is submitted for payment with certain data elements entered into the appropriate fields on the form.

(e) Authorizes a health maintenance organization to require a claim to contain any data element that is required in an electronic transaction set needed to comply with federal law.

Sec. 3. REQUEST FOR CLARIFICATION OF CLAIM. (a) Authorizes a plan issuer to, in good faith, request in writing that a provider provide in writing any information required to clarify information provided as part of a clean claim. Provides that the request is not valid unless certain conditions are met.

(b) Provides that if a provider who receives a valid request under Subsection (a) of this section does not provide the requested information on or before the 20th calendar day after the date the request is received, the 45-day payment period under Section 3A, Article 3.70-3C, of this code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, or Section 18B, Texas Health Maintenance Organization Act (Article 20A.18B, Vernon's Texas Insurance Code), as applicable, will be extended by a day for each day after the 20th day that the requested information is not received by the plan issuer.

Sec. 4. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES AND PROCEDURES. (a) Requires a plan issuer that preauthorizes medical or health care services or procedures to provide to each provider who provides services or procedures to the plan's enrollees under a contract between the provider and the plan issuer and to each enrollee a complete list of the services and procedures requiring preauthorization and the procedures required to obtain preauthorization of a service or procedure.

(b) Requires a plan issuer that receives a request for preauthorization of a service or

procedure for which preauthorization is required to review the request and issue a determination of coverage within the time frames for utilization review required by Section 5, Article 21.58A, of this code, or by Section 3A, Article 3.70-3C, of this code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, as appropriate.

(c) Authorizes a plan issuer to deny preauthorization of the service or procedure if the plan issuer certifies in writing within the time frames described by Subsection (b) of this section that the person to whom the service or procedure is to be provided is not entitled to coverage under the plan and the plan issuer was notified not later than the 30th day after the date the person's coverage under the plan was terminated.

Sec. 5. DENIAL OF PREAUTHORIZATION OR CLAIM BASED ON MEDICAL NECESSITY OR APPROPRIATENESS OF CARE. (a) Prohibits a plan issuer from denying a claim for payment for a medical or health care service or procedure because the service or procedure is not medically necessary or appropriate care unless the procedure or service is required to be preauthorized.

(b) Authorizes a plan issuer to deny a request for preauthorization of a medical or health care service or procedure or a claim for payment for a service or procedure if certain requirements are met.

Sec. 6. VERIFICATION OF COVERAGE. Requires a plan issuer to provide access to verification of coverage and benefits 24 hours a day, seven days a week, and to verify coverage and benefits for an enrollee to a provider who requests the information before rendering a covered service or procedure. Prohibits a plan provider from requiring a provider to request verification of coverage and benefits as a condition of providing coverage. Prohibits a plan issuer, after coverage and benefits have been verified, from denying payment for services rendered unless certain conditions are met.

SECTION 6. Amends Section 4, Article 21.21, Insurance Code, to provide that the following is hereby defined as an unfair method of competition and unfair and deceptive act or practice in the business of insurance: engaging in certain unfair settlement practices with respect to a claim by an insured, beneficiary, or health care provider.

SECTION 7. Amends Article 21.21, Insurance Code, by adding Section 4A, as follows:

Sec. 4A. CLAIMS BY HEALTH CARE PROVIDERS. (a) Defines, in this section, “claim,” “health care provider,” and “person.”

(b) Provides that a person engages in an unfair method of competition or unfair or deceptive act or practice in the business of insurance if the person makes certain misrepresentations of fails to take certain actions.

(c) Provides that for purposes of enforcement, a person who engages in an unfair method of competition or an unfair or deceptive act or practice under Subsection (b) of this section is considered to be engaging in an unfair method of competition or an unfair or deceptive act or practice defined in Section 4 of this article.

(d) Prohibits the provisions of this section from being waived or nullified by contract.

(e) Authorizes the commissioner to adopt rules as necessary to implement this section.

SECTION 8. (a) Makes application of this Act prospective.

(b) Provides that Sections 3C and 3D, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, as those sections are added by this Act, apply only to a preferred provider contract entered into on or after the effective date of this Act. Makes application of this Act prospective.

(c) and (d) make application of this Act prospective.

SECTION 9. Effective date: September 1, 2001.