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

January 15, 2004 **COMMISSIONER'S BULLETIN #B-0004-04**

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

RE: Call for Report Regarding Provider Claims Processing and Related Functions for Period of September – December 2003

DUE: February 15, 2004

Pursuant to §38.001 of the Texas Insurance Code (TIC), the Texas Department of Insurance (TDI) issues the attached mandatory data call from insurers writing preferred provider health benefit plans in Texas, and from 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 Art. 3.70-3C and Ch. 843, Subchapter J (TIC), and rules adopted to implement those statutes. Carriers' complete responses to this data call are also necessary for compliance with §21.2821, 28 Texas Administrative Code, Part I.

TDI will collect the data via a Web application using an on-line data collection form. Please see the attached sample screens and instructions. The final Web-based forms may have a different appearance and will include boxes for carrier contact information. However, the data requested will not change. Also note that TDI is requesting summary data only and carriers are not requested to send claims data files. Carriers should retain data files and appropriate documentation in the event of an audit. **The data for the first reporting period, September through December 2003, is due no later than February 15, 2004.**

Please note that although the data collection format for this reporting period will not include data concerning pharmacy claims, subsequent calls will contain a request for this data. The attached instructions include information concerning the reporting of pharmacy claims that will be required for second quarter (April, May, and June) 2004 data. In the interim, TDI will propose a rule amendment clarifying that pharmacy claims data must be reported.

No later than January 23, 2004, please send an e-mail to Melissa Hield with the name, e-mail address, and telephone number of the contact who will be responsible for reporting your company's data. Because this data request is new, TDI staff will contact your representative to provide further details about the Web application and data reporting requirements.

If you have questions, please contact Melissa Hield via e-mail at melissa.hield@tdi.state.tx.us or call her at 512-322-4349.

Sincerely,

Jose Montemayor
Commissioner of Insurance

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. 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. The Department expects this dual reporting scheme to be short-term.

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

HB 610 Quarterly Data Entry Screen

Reporting Year

Reporting Period

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:	

Texas Department of Insurance
Provider Claims Data Call
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 are for the reporting year and quarter reporting period. 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 the Department 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 the Department, please send an e-mail to melissa.hield@tdi.state.tx.us.

Texas Department of Insurance
Provider Claims Data Call
SB 418 Quarterly Data Entry Screen

Reporting Year

Reporting Period

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:	

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:	

Texas Department of Insurance
Provider Claims Data Call

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

Texas Department of Insurance
Provider Claims Data Call
SB 418 Annual Data Instructions

Carriers are required to report annual information pertaining to the reasons for the declinations made by carriers. 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 the Department for a minimum of three years and must be available for review by the Department.

The first box of the SB 418 annual data form is for the reporting year. Carriers must complete this field on all data reported, including delegated entity data. After the first box, there are five boxes for categories of declinations for policy or contract limitations. The sixth box is an "other" category. If there are policy or contract limitations reasons other than the four specified on the form, please go to the comment fields and 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

Declinations For 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 waiting periods	
Number of declinations due to pre-existing condition limitations	
Number of declinations due to other policy or contract limitations	
Comments	
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	