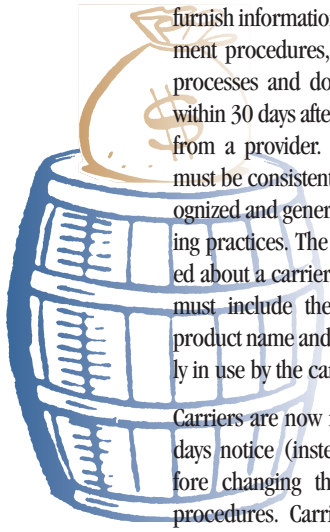
# TDI Adopts Prompt Pay Rules

## Senate Bill 418

THE TEXAS DEPARTMENT OF INSURANCE has adopted final rules to implement Senate Bill 418, the prompt pay legislation passed by the 78th Legislature. These rules will apply to all health care provider contracts that are entered into or renewed on or after October 5, 2003 and to certain non-contracted providers for services provided on or after that date.

Senate Bill 418 made significant changes in the laws requiring HMOs and preferred provider insurance carriers to promptly pay clean claims submitted by contracted physicians and providers. Some of the rules also apply to non-contracted physicians and providers who offer emergency care or other services.



**Claim Payment Processing Information**

As under previous rules, carriers must furnish information on their claim payment procedures, including bundling processes and down-coding policies, within 30 days after receiving a request from a provider. Bundling processes must be consistent with nationally recognized and generally accepted bundling practices. The information provided about a carrier's bundling software must include the publisher's name, product name and the version currently in use by the carrier.

Carriers are now required to give 90-days notice (instead of 60-days) before changing their claim payment procedures. Carriers may not make retroactive changes to these procedures.

A provider's permissible uses of claim payment information received from a carrier was expanded to include "other business operations" and communications with government agencies that regulate health care and insurance.

Providers that receive claim payment procedure information from a carrier may terminate their contracts, without penalty, within 30 days after receiving the information. Those enrolled in the plan must be given advance notice as required by existing law before such a termination may occur. Carriers may require providers to keep updated information about a patient's other health benefit plan coverage in their records.

Effective January 1, 2004, coverage identification cards issued by insurers and HMOs must bear a symbol to show that the coverage is subject to state regulation. A card must either show the first date that coverage is in force or include a toll-free number that providers may call to obtain that date.

**Preauthorization**

Within 10 business days after receiving a request from a provider, a carrier must provide information about the carrier's preauthorization process along with a list of services so that the provider may determine which services require preauthorization.

After receiving a request for preauthorization, a carrier must meet response deadlines as outlined below:

- Within a time appropriate to the circumstances and to the condition of the patient but not to exceed one hour, for post-stabilization treatment and life-threatening conditions
- Within 24 hours for concurrent hospitalization care
- And no later than three days for all other services

After preauthorizing treatment, a carrier may not deny or reduce payment for reasons of medical necessity or appropriateness of care unless the provider misrepresented the proposed services or substantially failed to perform the preauthorized services.

A carrier approving a preauthorization also must issue a "length of stay" for admitting the patient into a health care facility based on the provider's recommendation and the carrier's written screening criteria and review procedures.

When issuing an adverse determination in response to a request for preauthorization, a carrier must provide notice to the plan member, a person acting on the member's behalf or the member's provider of record. The plan member has the right to appeal an adverse determination.

**Verification**

The new rules specify 13 items of information that a request for verification must contain. These include:

- the patient's relationship to the enrollee or subscriber
- presumptive diagnosis, or the presenting symptoms
- description of proposed procedures or procedure codes
- place where services will be provided
- proposed date of service
- group number, if included on a health care coverage ID card
- name and contact information of any other carriers

A provider may request verification by telephone, in writing or by any other means agreed to by the provider and carrier, including the internet.

If a provider requests verification, a carrier may make one request for additional information. Such a request would have to be made within one day after the carrier receives the request for verification.

A carrier is required to issue either a verification or a declination without delay, but not later than one hour for

*See* **Senate Bill 418** *on Page 10*