SB 50 & SB 51 Provider Resource Document

Topic	**SB50 Provider Contracts**
Applicability	Applies to HMO and PPO provider contracts entered into or renewed on or after January 1, 2006.
Contract Provision	Upon request by a participating provider, a carrier shall include a provision in the provider contract that the carrier or its clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted in a batch submission with a claim that is deficient.
	28 TAC 11.901 Subchapter J (HMO)
	28 TAC 3.3703 Subchapter X (PPO)
Topic	**SB50 Clean Claims**
Applicability	The carrier or its clearinghouse that receives an electronic clean claim is subject to the rules regarding the Effect of Filing a Clean Claim regardless of whether the claim is submitted together with or in a batch submission with a claim that is deficient.
	28 TAC 21.2807
Underpayment Penalties	The Underpaid Amount is calculated on the ratio of the balance owed by the carrier to the total contracted rate, including any patient financial responsibility, as applied to the billed charges.
	Benefit Payment Remaining =
	Contracted Rate _____% x Billed Charges = Underpaid Amount
	The applicable percentage of the Underpaid Amount is then determined to calculate the Penalty Amount. Additional interest may also be due.
	28 TAC 21.2815
Late Payment Penalties	Patient Responsibility amount is not to be deducted from the contracted rate when calculating penalties.
Penalties for Secondary Carrier	When the carrier is the secondary payer (Carrier B), the contracted rate and billed charges must be reduced in accordance with the percentage of the entire claim that is owed by the secondary carrier.
	Contracted Rate Applicable for Carrier B = the Amount Owed by Carrier B under the COB Provision of Its Policy
	Amount Owed by Carrier B
	Billed Charge Applicable for Carrier B = Carrier A Contract Rate x Billed Amount
	28 TAC 21.2815(e)
Reporting Requirements	A carrier shall annually submit to the department on or before August 15th at a minimum, information related to the number of declinations or requests for verifications from July 1st of the prior year to June 30th of the current year.
	28 TAC 21.2821
Topic	**SB 51 Utilization Review Agents**
Applicability	An HMO providing routine vision services or dental health care services as a single health care service plan
Requirements for Responding to Preauthorization Requests for Dental and Vision Single Health Care Service Plans	1. Required to have appropriate personnel reasonably available at a toll-free telephone number to provide preauthorization determinations between 8:00 a.m. and 5:00 p.m. CST Monday through Friday on each day that is not a legal holiday.
	2. Required to have a telephone system capable of accepting or recording incoming inquiries after 5:00 p.m. CST Monday through Friday and all day on Saturday, Sunday and legal holidays.
	3. Must acknowledge each of those calls not later than the next business day after the call is received.
	4. Provide a written notification to the preferred provider within three (3) calendar days of receipt of the request.
	28 TAC § 19.1723(f)

Requirements for Responding to Verification Requests for Dental and Vision Health Care Service Plans	1. Required to have appropriate personnel reasonably available at a toll-free telephone number to accept telephone requests for verification and to provide determinations of previously requested verifications between 8:00 a.m. and 5:00 p.m. CST Monday through Friday on each day that is not a legal holiday.
	2. Required to have a telephone system capable of accepting or recording incoming inquiries after 5:00 p.m. CST Monday through Friday and all day on Saturday, Sunday and legal holidays.
	3. Must acknowledge each of those calls not later than the next business day after the call is received.
	28 TAC § 19.1724(d)
Topic	**SB 1149 Eligibility Statements**
Applicability	Applies to health benefit plan issuers that enter into or renew contracts with participating providers on or after January 31, 2006. Does not apply to Medicaid and CHIP Plans. Does not apply to coverage that provides limited-scope dental or vision benefits or single service HMO plans.
Method(s) of Requests	The health benefit plan issuer shall communicate in writing to participating providers the method(s) by which the providers may request an eligibility statement. Methods may include requests received by telephone, internet website portal or other electronic means.
	28 TAC 21.3803
Requests for Eligibility Statements	Participating provider requests for Eligibility Statements must include the enrollee's full name, the enrollee's relationship to the primary enrollee and the enrollee's birth date.
	28 TAC 21.3804
Requirement to Provide Eligibility Statements	A health benefit plan issuer shall maintain a system to enable it to provide eligibility statements to participating providers using the information provided under §21.3804. On receipt of a compliant request for an eligibility statement, a health benefit plan issuer must provide an eligibility statement to the participating provider allowing the provider access to the information at the time of the enrollee's visit.
	28 TAC 21.3805(a)
Inability to Provide Eligibility Statement Based on Information Provided	If the health benefit plan issuer is unable to provide an eligibility statement, the health benefit plan issuer shall notify the participating provider and may request additional information to assist the health benefit plan issuer in providing an eligibility statement. A health benefit plan issuer may not use a request for additional information to satisfy the requirement that the issuer maintain a system to provide eligibility statements using the required information.
	28 TAC 21.3805(b)
Eligibility Statements Content Requirements	Eligibility Statements shall include the following information:
	1. Enrollee's ID number
	2. Name of the enrollee and affected covered dependents
	3. Date of Birth of the enrollee and affected covered dependents, if necessary for the provider to obtain payment for services to be provided
	4. Gender of enrollee and each affected covered dependent
	5. Current enrollment and eligibility status of the enrollee
	6. Enrollee's benefits
	7. Excluded benefits or limitations
	8. Whether the specific type or category of service is a benefit under the policy (if the details were included in the request)
	9. Enrollee's co-payment requirements
	10. The unmet amount of the enrollee's deductible or financial responsibility
	28 TAC 21.3805(c)

Refusal to Issue Eligibility Statement Due to Privacy Laws	A health benefit plan issuer may refuse to provide all or part of an Eligibility Statement if applicable state or federal law prohibits the disclosure of an enrollee's personally identifiable information to the requesting provider. The health benefit plan issuer shall provide a written response within three (3) days of the refusal that describes the particular state or federal law provision(s) that prevent the disclosure.
	28 TAC 21.3806
Effect of Issuance	An Eligibility Statement is not a verification, as described in 28 TAC § 19.1724.
	28 TAC 21.3807