Report on the Activities of the Technical Advisory Committee on Claims Processing

September 2004

Texas Department of Insurance

Jose Montemayor
Commissioner of Insurance

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September 1, 2004

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
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The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

The Honorable Tom Craddick
Speaker, Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Governors and Speaker:

In accordance with Senate Bill 418, 78th Regular Legislature, I appointed a technical advisory committee on claims processing consisting of insurers, health maintenance organizations, physicians and other health care providers, trade associations, and other interested parties such as the Office of Public Insurance Counsel. Committee members, along with experts in topics discussed by the committee, worked diligently and cooperatively to document and coordinate issues associated with claims processing. As required by Senate Bill 418, the attached report to the Legislature reflects the activities of the committee.

Senate Bill 418 has had a significant positive effect since its inception. The improvements are evidenced by a 98 percent or greater compliance rate of timely payment to physicians and providers during the three periods for which data has been reported and a reduction in provider complaints filed with the department since fiscal 2003. Payors and providers affected by the bill continue to adapt to its requirements and other federal mandates associated with claims payment. Given this changing climate, additional time is needed to allow the provisions of the bill to take full effect and to track its impact. I will continue to monitor the timeliness of claims payment and take action as necessary and authorized by the bill.

My staff and I are available to discuss any of the issues contained in the report and to provide technical assistance. Please contact me or David Durden, Director of Government Relations, at 463-6410 with any questions or if you need additional information.

Thank you for your consideration.

Sincerely,

Jose Montemayor
Commissioner of Insurance

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OVERVIEW OF PROMPT PAY STATUTES AND RULES

HB 610, passed in 1999, was designed to expedite HMO and insurance company payment of "clean claims" submitted by physicians and providers. The Commissioner of Insurance adopted rules and, on April 9, 2001, appointed a provider ombudsman. As of August 2004, the Texas Department of Insurance had instituted enforcement actions against carriers that culminated in 47consent orders and one settlement agreement which resulted in more than $48.6 million in restitution to providers and $19 million in penalties.

Because providers continued to have concerns that claims were not being paid in a timely manner, SB 418, which the Legislature passed in 2003, made changes to the law to make claims filing and prompt payment processes streamlined, standardized, and more efficient. As authorized by the bill, TDI adopted emergency rules effective August 16, 2003, the effective date of most of SB 418's provisions. Final rules were adopted on September 15, 2003.

In developing the SB 418 rules, TDI had extensive discussions and consultations with the Clean Claims Working Group (CCWG), a group originally created by TDI in 2001 and composed of representatives of carriers, providers, trade associations and physicians, the Office of Public Insurance Counsel and open in attendance to all other interested persons. SB 418 required the Commissioner of Insurance to appoint a Technical Advisory Committee on Claims Processing (TACCP) to consult with the Commissioner before the adoption of any rules. The TACCP was also charged with advising the Commissioner on technical aspects of coding of health care services and claims development, submission, processing, adjudication, and payment. In 2003, the Commissioner appointed most of the CCWG members to the TACCP.

While both HB 610 and SB 418 are prompt pay regulations that apply to insurers that issue preferred provider benefit plans and HMOs (collectively "carriers"), SB 418 only applies to contracts between carriers and physicians and providers that are entered into or renewed on or after August 16, 2003. Certain provisions of SB 418 also apply to emergency services and specialty services provided on or after August 16th at the request of the carrier or preferred provider, by a non-network physician or provider because those services are not reasonably available from a network physician or provider. SB 418 does not apply to plans that TDI does not directly regulate, such as valid self-funded ERISA plans; workers' compensation coverage; government, school, and church health plans; federal employee plans; Medicaid; and various Medicare-related plans.

As discussed in further detail in the education and outreach section, TDI continues to accomplish outreach goals by advising carriers and providers regarding prompt pay requirements and how to determine which rules, those of HB 610 or SB 418, apply. SB 418 and related rules apply if the preferred provider's contract with the carrier in question has been entered into or renewed on or after August 16, 2003. Otherwise, HB 610 and related rules apply.

Some contracts have not yet been renewed for a variety of reasons, including the lack of a clear renewal date or a renewal date that is set at some point in the future. Consequently, such contracts remain subject to HB 610 and its related rules. To avoid having to maintain dual claims processing systems, some carriers elected to renew all of their existing contracts as of a certain date rather than transitioning them over a number of renewal dates. Some also renewed contracts for the benefit of providers.

As part of TACCP discussions, TACCP payor members were asked to report on the percentage of their business that is subject to SB 418. Because reporting was voluntary and the responses represent a non-random and very small percentage of the universe of carriers, the reported information cannot be considered representative of the status of SB 418 implementation. The carriers that reported indicated that a large percentage of their business subject to prompt pay regulation is now operating under SB 418 regulations.

HOUSE BILL 610 AND RELATED RULES

HB 610 required carriers to process claims (other than electronically submitted and affirmatively adjudicated pharmacy claims, for which the processing timeframe was 21 days) within 45 days of receipt of a claim. Once a clean claim was received, the carrier was required, within the statutory claim payment period, to: (1) pay the total amount of the claim in accordance with the contract, (2) deny the entire claim and notify the provider why the claim will not be paid, (3) audit the entire claim, pay 85 percent of the contracted rate and notify the provider that the claim is being audited, or (4) pay a portion of the claim and deny or audit the remainder, paying 85 percent of the audited portion.

A clean claim consisted of data elements required or conditionally required by TDI rules, along with properly noticed additional data elements and attachments required by the carrier. Data elements were required to be complete, legible and accurate, and additional data elements or information did not render the claim deficient.

If a claim determination was not able to be made within 45 days after receipt of a clean claim, the carrier was required to pay 85 percent of the claim at the contracted rate and notify the provider that the claim was being audited. If additional payment was due upon completion, the carrier was required to pay within 30 days after completing the audit. The carrier could continue the audit/investigation for 180 days after the claim was received. If the claim still was not able to be adjudicated, the carrier was required to pay the remaining 15 percent. However, the carrier could continue to investigate the claim and obtain a refund if it was determined that the claim was not payable.

A carrier who failed to correctly pay or audit a claim within the statutory claim payment period was liable for either 100 percent of “billed charges” which was described in the applicable HB 610 rule adoption order as “usual and customary” charges or the penalty rate contained in the contract between the carrier and the provider. The carrier could deduct from the penalty amounts that were already paid and amounts for non-covered

services. A carrier was also subject to administrative fines of up to $1,000 per day for each day a claim remained unpaid.

SENATE BILL 418 AND RELATED RULES

SB 418, unlike HB 610, addresses the following additional prompt pay issues: (1) refunds due to overpayments, (2) additional information requested from a treating provider, (3) additional information requested from sources other than a treating provider, (4) ID cards, (5) catastrophic events, (6) reporting requirements, (7) applicability to certain non-contracting physicians and providers, (8) a claim filing deadline, (9) duplicate claims, and (10) preauthorization and verification.

HB 610's description of a clean claim had given carriers a significant amount of control by allowing them to include clean claim elements and attachment requirements that varied from carrier to carrier. SB 418 required standardization by requiring TDI to specify by rule the information that must be entered on the appropriate claim forms. TDI developed these elements through a series of meetings with representatives from the CCWG and TACCP. The rules that stemmed from SB 418 identify a non-electronic clean claim as consisting of specified data elements on CMS 1500 and UB-92 claim forms. Electronic clean claims must comply with all federal laws applicable to electronic claims, and relevant implementation guides, companion guides, and trading partner agreements.

Claims must be filed within 95 days after services are provided. A physician or provider who fails to timely file forfeits the right to payment unless prevented from filing by a catastrophic event. A physician or provider may not submit a duplicate claim prior to the 46th day if filed non-electronically, the 31st day if filed electronically, or the 22nd day if for prescription drugs, after the date the original claim is presumed to be received.

While SB 418 no longer permits a carrier to include additional elements as clean claim requirements, a carrier is allowed one request to the treating provider for additional information within 30 days of its receipt of a clean claim. This request for additional information stops the claims payment clock until the carrier receives (1) the requested information or (2) the provider's response that the requested information is not in the provider's medical/billing record. Upon receiving the response, the carrier must act on the claim on or before the later of the 15th day after receiving the response or the expiration of the statutory claims payment period. The carrier may also request information from a source other than the treating provider, but that type of request does not stop the claims payment clock.

With regard to the statutory claim payment period, the carrier has 45 days for payment, denial or audit of non-electronic, non-pharmacy clean claims; 30 days for payment, denial or audit of electronic, non-pharmacy clean claims; and 21 days for payment, denial, or audit of electronically submitted, affirmatively adjudicated pharmacy claims.

Upon receipt of a clean claim, the carrier must within the statutory claim payment period: (1) pay the total amount of the claim in accordance with the contract, (2) deny the entire claim and notify the provider why the claim will not be paid, (3) audit the entire claim, pay 100 percent of the contracted rate and notify the provider that the claim is being audited, or (4) pay a portion of the claim and deny or audit the remainder, paying 100 percent of the audited portion.

If a claim determination cannot be made within the applicable statutory claim payment period, the carrier must pay 100 percent of the claim at the contracted rate before expiration of the applicable payment period and must notify the provider on the explanation of benefits that the claim is being audited. The carrier may request additional information and continue the investigation. The carrier must complete the audit in 180 days, give written notice of audit results, list specific claims paid and not paid, and list specific claims and amounts for which refund is due. The carrier must give the basis and specific reasons for a refund request. The carrier is entitled to a complete refund if the preferred provider fails to timely respond to a request for additional information.

Late payment and underpayment penalties vary according to when a claim is paid. A carrier is not liable for such penalty if the failure to timely pay was due to a catastrophic event. The carrier must notify TDI if it is affected by a catastrophic event in order to suspend deadlines for the period of the catastrophe. With regard to penalties for late payment of clean claims, a carrier that fails to correctly pay a clean claim within the statutory claim payment period is liable for the contracted rate owed on the claim plus a penalty amount that varies depending on the time frame and a billed charges calculation.

SB 418 rules changed the term “billed charges” to be “the charges for medical care or health care services included on a claim submitted by a physician or provider,” and the term “must comply with all other applicable requirements of law.” TDI received numerous comments concerning this change, which included concerns that the new definition would allow overcharging by physicians and providers. As a result, TDI has conducted an aggressive education campaign to inform all interested persons of the new provisions.

Because TDI collects data to monitor compliance and is required by SB 418 to compute a compliance percentage for clean claims payment, the rules require carriers to submit quarterly claims payment information to TDI. If a carrier violates the claims payment provisions for more than two percent of clean claims, such non-compliance may result in fines of $1,000 per claim per day.

To advance SB 418’s intent to make ID cards uniform and useful, the rules require that ID cards or other similar documents for plans subject to SB 418, if issued, display the date of initial enrollment or a toll-free number to obtain that information, and the letters “TDI” or “DOI”.

SB 418 allows physicians and providers to request, and requires carriers to respond to requests for, preauthorization and verification. Preauthorization is only applicable for

those services for which the carrier requires preauthorization as a condition of payment. Upon request, carriers must provide a list of services that require preauthorization. Verification is a process that can be used regardless of whether preauthorization is required. A carrier must respond to a verification request within certain specified time frames, which vary depending on the type of situation involved. Once a verification is provided, a carrier cannot reduce or deny payment for the verified services if performed within 30 days of the verification unless the provider materially misrepresented the services to be performed. Therefore, verification essentially is a guarantee of payment. Although preauthorization is not a guarantee of payment, a carrier may not deny or reduce payment based on medical necessity or appropriateness of care once a service is preauthorized. The topic of preauthorization and verification is discussed in more detail in Chapter 3 of this report.

All rules implementing SB 418 were discussed with the TACCP. On January 12, 2004, the Commissioner adopted rules relating to the use of identification cards as a method for distinguishing between plans that were or were not required to comply with Texas' prompt pay requirements. On June 21, the Commissioner adopted rules setting forth requirements for the reporting of pharmacy claims. On August 9, 2004, the Commissioner adopted electronic waiver rules, necessary to implement Insurance Code Article 21.52Z. Consistent with Article 21.52Z, the rules identify criteria that must be used by a carrier in considering a physician's or provider's request for a waiver of a carrier's electronic filing requirements, and provide physicians and providers with the ability to submit claims non-electronically upon submission of a request for a waiver until a final determination is made.

SUMMARY

TDI has engaged in continued efforts to ensure that the goals of prompt pay legislation are being implemented and enforced. The prompt pay rules that have been proposed and adopted exemplify these efforts.

CHAPTER 1: CLAIMS PROCESSING

On September 15, 2003, the Texas Department of Insurance adopted final rules implementing major portions of SB 418, concerning prompt payment to physicians and providers by insurers issuing preferred provider benefit plans and HMOs. The rules, as well as the statute, are designed to ensure that providers receive prompt payment for services they provide to insureds and enrollees. To assist in achieving this goal, the TACCP reviewed the entire claim processing procedure to identify those issues that may affect the timely payment of a claim. Specifically, the TACCP evaluated issues relating to: (1) claim submission; (2) claim processing; and (3) claim payment.

CLAIM SUBMISSION

The TACCP considered various aspects of claim submission, including issues relating to clean or deficient claims, duplicate claims, and methods for submitting a clean claim, including electronic claims. The committee also discussed the use of entities other than providers and carriers that may be involved in the claim submission process, including clearinghouses and billing services.

The Submission of a Clean Claim

The success of SB 418 and the satisfaction of all parties involved in the claim payment process require that both providers and carriers meet their responsibilities under the statute and related rules. While the primary responsibility for an expedited process rests with these two parties, the clearinghouses and/or billing services involved in the process can significantly impact its success.

For the prompt payment provisions of the statute and rules to apply, a provider must file a clean claim. A clean claim may be submitted electronically or non-electronically (by mail, hand-delivery, or fax). For non-electronic submissions, a claim is considered clean if it contains all the required data elements set forth in the rules and, if applicable, the amount paid by the primary plan or other valid coverages. Claims submitted electronically are considered clean if they are submitted using the ASC X12N 837 format and are in compliance with federal Health Insurance Portability and Accountability Act (HIPAA) requirements related to electronic health care claims, including applicable implementation guidelines, companion guides, and trading partner agreements. A deficient claim is one that does not comply with these requirements.

Because deficient claims are not clean claims, they are not eligible for a penalty payment if payment is not made within the specified statutory claim payment period. Some TACCP provider members indicate they do not always receive deficiency notices from carriers. Some payors, on the other hand, say they are not making distinctions between clean and deficient claims and instead are trying to pay all claims, including deficient claims, timely. However, if a deficient claim is paid late, the potential for confusion may arise because the provider may be expecting payment with a penalty, since the claim was

not paid within the statutory claim payment period. If a carrier does not send a deficiency notice, the provider may be unaware that the claim was deficient until payment is received and penalties are not included. While the failure to send a deficiency notice to the provider violates the prompt pay rules, no penalty is due the provider when a deficiency exists. Instead, such a violation may result in an administrative penalty against the carrier.

While a claim may be deficient, it may contain sufficient information to enable the carrier to process it. In such a case, because the statute and rules do not prohibit carriers from processing and paying deficient claims, many carriers have elected to pay the claim. The perspective of many carriers is that it is in the best interest of their providers to pay the deficient claim, instead of having the provider file a corrected claim before payment is issued.

The TACCP discussed the issue of electronic claims filing and the percentage of claims filed electronically or via other means. Some payor committee members reported in June 2004 on the percent of claims they received electronically. Although percentages varied depending on a variety of factors, including the size of the business, the type of business, and the type of provider submitting the claims, carriers generally reported receiving between 40 and 85 percent of their claims electronically. One small carrier reported receiving a much smaller percentage of electronic claims.

For those that distinguished between the two, carriers reported receiving a slightly larger percentage of electronic claims from non-institutional providers than from institutional providers. Often carriers require hospitals to submit additional information, such as medical records, invoices or operations reports to their UB92 or CMS 1500 for most of their inpatient and outpatient claims. The requirement for additional information currently prevents a hospital filing an inpatient or outpatient facility claim electronically. The Texas Hospital Association reported that hospitals prefer to file claims electronically and have done so historically for Medicare and Medicaid, which do not impose the same attachment requirements that can be experienced with commercial carriers.

Because the information received on how claims are submitted reflects a small, non-random number of payors and may also include information associated with Medicare and other non-SB 418 related claims, it cannot be considered to be representative of the experience of all payors subject to SB 418.

Duplicate Claims

SB 418 required the Commissioner of Insurance to adopt rules under which a carrier can determine whether a claim is a duplicate claim. SB 418 also prohibits a provider from submitting a duplicate claim within the statutory claims payment period. Duplicate claims are defined in 28 TAC §21.2802 (11) as any claim submitted by a physician or provider for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. The term

does not include corrected claims, or claims submitted by a physician or provider at the request of the HMO or preferred provider carrier.

Ten payor members reported receiving duplicate claims in percentages ranging from less than 1 percent to 26 percent of all claims received. Two carriers indicate that they received slightly more duplicate claims in 2004 compared to 2003. Two carriers reported a slight decrease; one of these indicated the decrease was due to increased provider education. Three carriers said they had not experienced an increase in duplicate claims. One carrier reported that providers appeared to send duplicate claims according to a submission schedule in which they resubmitted weekly or every other week. The carrier stated that it had received the same claim from the same provider within a two-day period. Some carriers decided to notify providers of the number of electronic duplicate claims they have submitted.

Current SB 418 rules require providers to place a "C" or "D" on a CMS 1500 paper claim and either a stamp or cover sheet on a UB 92 paper claim to indicate that the claim is a corrected claim or a duplicate**.** Some carriers reported, however, that relatively few providers used the corrected claim field on the paper claims form to indicate the submission of a corrected claim. Because of the requirement that providers must file their claims within 95 days or forfeit reimbursement of the entire claim for services provided, providers indicated they would likely continue to stamp "corrected claim" on the form or include an explanatory letter with the claim.

Providers indicated that duplicate claims are sometimes necessary to assure claims are received. Some providers contended that if the payors' claim systems could acknowledge receipt of a claim, and provide accurate claim status information upon provider inquiry, the filing of duplicate claims would become less of an issue. Providers asserted that because of the payors' inability to provide this information and because of the requirement that they must file their claims within 95 days or forfeit reimbursement for services provided, providers would continue to err on the side of caution and submit duplicate claims. In addition, providers occasionally send duplicate claims because carriers asked them to do so during a routine follow-up telephone call regarding the original claim. Providers and carriers agreed that duplicate claims are often the result of billing service practices. While carriers noted that duplicate claims come from all types of providers and their billing or collection vendors, some reported that collection vendors appeared to send them sooner and some in as few as 10 days from the date the original claim was filed.

Payors said they believed that SB 418 does not sufficiently discourage duplicate claims because there are no penalties for providers that routinely submit duplicate claims. Payors also indicated duplicate claims slow down the claim payment process due to the time spent researching to see if a claim is a duplicate of another claim. Providers opposed any penalty assessment for filing duplicate claims until the payors consistently acknowledge receipt of claims or provide reliable claim status information.

Clearinghouses

Because of the implementation of the HIPAA transaction standards and the requirements relating to the submission of electronic claims, clearinghouses have become an important component in the submission and payment of claims. Generally, clearinghouses are entities that translate or convert data submitted by a health care provider to a payor (HMO/PPO) and vice versa. Specifically, a health care clearinghouse may be a public or a private entity, including a billing service, re-pricing company, community health management information system or community health information system, or "value added" networks and switches, that does either of the following functions: (1) processes, or facilitates the processing of, health information received from another entity in a nonstandard (non-HIPAA compliant) format, or in a format that contains nonstandard data content, into standard data elements or a standard transaction (HIPAA compliant format); or (2) receives a standard transaction from another entity and processes or facilitates the processing of health information into non-standard format or nonstandard data content for the receiving entity.

Because clearinghouses translate or transform information going between providers and payors, they are "covered entities" under HIPAA. HIPAA requires that covered entities that conduct transactions for which an electronic standard has been adopted, conduct the transaction as a standard transaction. However, where no standard has been adopted, clearinghouses and other "covered entities" are free to use their own transaction methods.

On April 7, 2004, the TACCP invited several representatives from the clearinghouse industry to clarify their role in the processing and payment of electronic HMO and PPO claims. The panelists included Walt Culbertson (Webify Solutions), Lonnie Hardin (ProxyMed, Inc.), Tina Compton-Rozek (THIN, Inc.), Mary Rita Hyland (The SSI Group), Mark McLaughlin (McKesson), Don Bechtel (Siemens), and James Mechan (WebMD Envoy). These panelists represent organizations that conduct the vast majority of clearinghouse transactions.

The clearinghouses identified certain issues that they believe are hindering the electronic claim payment process including, among other things, lagging implementation, the lack of standards relating to certain transactions, and the need for education concerning HIPAA transaction standards. While information concerning the extent of HIPAA compliance varied depending on the particular entity and transaction involved, the clearinghouses indicate that overall only about 10 percent of all transactions received by clearinghouses are HIPAA compliant. However, clearinghouses reported that a much larger percentage of transactions communicated by clearinghouses to payors are HIPAA compliant. The clearinghouses also indicated that when HIPAA electronic claim implementation began, no standard response or acknowledgement format had been adopted. Consequently, payors and clearinghouses have been using different responses for all transactions, including accepted and rejected electronic claims.

Because there is no standard for responding to claims receipt and because claims translators and systems are set up differently, some payors and/or clearinghouses have set

up processes that result in rejection of entire batches of claims instead of, or in addition to, the specific claims with the deficiency. The Center for Medicare and Medicaid Studies (CMS) is the federal agency responsible for establishing regulations on conditions under which a claim may be rejected. CMS has not specified definitively as to whether claims may be rejected at the "batch level" or the "individual claim level." Providers indicated that "batch rejection" requires significant review of individual claims in the rejected batch to determine which claim(s) caused the rejection. Providers indicated that the SB 418 rules requiring payors to notify providers when a claim is deficient provide adequate justification for requiring the payor to identify the specific claim that caused the rejection and prohibiting the rejection of an entire batch. The clearinghouses also noted that HIPAA's allowance of the use of Companion Guides and Implementation Guides has resulted in unique rather than standard transactions. Finally, the clearinghouses suggested a need for additional education for providers regarding HIPAA compliance and translation issues. The clearinghouses indicated that, to date, hospitals have demonstrated the most effective practices with HIPAA compliance.

Billing Services

A billing service is an entity that contracts with a provider to bill on the provider's behalf. Unless it acts as a clearinghouse by translating or transforming information between carriers and providers, it is not a "covered entity" under HIPAA, nor is it regulated by TDI. Both providers and carriers agreed that the TACCP should explore the need for statutory changes necessary for TDI to effectively regulate billing services.

CLAIM PROCESSING

Certain issues related to claim processing have been the subject of some discussion by the TACCP, including coordination of benefits, HIPAA electronic claims requirements, and audits.

Coordination of Benefits

SB 418 requires physicians or providers submitting a claim to more than one carrier to provide notice on the claim form of the identity of the other carriers with whom the same claim is being filed. It also requires the carriers receiving such notice to coordinate the appropriate payments. Some providers indicated that additional communication between carriers in these types of multiple payor situations would improve the claim payment process. Carriers agreed to establish a system for better communication between regulated carriers. However, carriers noted that a large portion of payors (such as Medicare, Medicaid and ERISA self-funded plans) were not involved in this coordination and communication effort because they are not regulated by the department, and do not traditionally communicate with the carriers for coordination of benefit purposes**.** Many carriers agreed that this is the major obstacle to effective coordination and communication efforts. Some carriers reported that they experience no problems with coordination of benefits.

Other problems identified by payors who submitted information include:

- Providers submit claims to primary and secondary carriers simultaneously.
- Providers and members do not always provide necessary information.
- Carriers who are asked for information from other carriers are reluctant to provide the information or ask for tax identification numbers before providing the information.
- Providers fail to attach the EOB from a primary carrier to a claim when submitting it to a secondary carrier. (One carrier deals with this problem by paying as a primary carrier and then attempting to recover an overpayment; another carrier requests the primary carrier's payment directly from the member instead of the provider.)

Some physicians and providers noted that some coordination of benefit problems occur because patients withhold secondary payor information. Some also indicated that they have experienced problems when the timing of a primary payor's recovery of an overpayment has prevented physicians and providers from being able to timely submit a claim to the secondary payor.

HIPAA

HIPAA, enacted on August 21, 1996, required, among other things, that providers who file Medicare claims and providers who file electronic claims use the HIPAA-prescribed standardized electronic format. HIPAA also required that carriers be able to receive any electronically filed claims in this standardized electronic format. The deadline for compliance was October 16, 2002. However, the federal government subsequently extended the deadline for compliance for one year to October 16, 2003.

The HIPAA requirement that electronic health care claims transactions be conducted using the standardized format has created the need for providers and carriers to develop standard electronic systems. Senate Bill 418 defines an electronic clean claim as a HIPAA compliant claim. 28 TAC §21.2803(d) defines an electronic clean claim as one that complies with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements. In addition, SB 418 allows carriers to require the electronic filing of claims, but also requires them to grant waiver of the filing requirement under certain circumstances. However, because SB 418 and the rules allow adherence to federal standards rather than prescribe adherence to particular provisions, they allow affected entities to have some flexibility in complying with the law. While the federal government did not extend the October 16, 2003, deadline for compliance, it has allowed for contingency plans, which allows for the continued use of legacy formats for the filing of electronic claims. Some providers indicate that CMS' allowance of "contingency plans" has led to some administrative difficulty because of the inconsistent application of CPT and HCPCS codes for inpatient claims. Some large payors, the providers report, still require the use of HCPCS codes on outpatient claims, which is inconsistent with the HIPAA electronic transaction requirement that HCPCS codes should only be used on inpatient claims. Institutional providers indicate that this practice causes costly

resubmission of claims and does not lend itself to standardization; claims for professional services are not impacted by the practice. With no official confirmed date for enforcement of compliance with the HIPAA standards, carriers and providers continue to use a myriad of legacy formats that result in a lack of standardization in the processing of electronic claims.

Both providers and carriers agree that the current complex process of dealing with multiple formats creates electronic claims processing problems. Despite the allowance of the use of contingency plans, HIPAA requires that payors have the ability to accept electronic claims. Consequently, payors indicate that a large number of payors are HIPAA compliant.

Many providers have concerns with the requirement to file claims electronically and SB 418 allows carriers to waive electronic claims filing requirements in certain circumstances. On August 9, 2004, in compliance with SB 418, the Department adopted rules that outline the circumstances and procedures for addressing requests for waiver.

Audits

An audit is defined in 28 TAC §21.2802 (1) as a procedure under which an HMO or preferred provider carrier may investigate a claim beyond the statutory claims payment period without incurring penalties. The audit procedure described in §21.2809 allows a carrier to audit a claim to determine whether the claim is payable. The carrier must notify the provider before the end of the required claim payment period that the claim is being audited and pay the provider 100 percent of the contracted rate for that claim while it is being audited. Carriers must complete the audit within 180 days and may recover the payment if they determine the claim is not payable.

Some TACCP payor members provided the committee with information regarding the extent of and reasons for auditing claims. One large carrier reported having audited 722 claims between September 1, 2001 and April 30, 2004. Another large carrier reported having conducted 637 audits under SB 418. Three carriers reported 301, 54 and 36 audits respectively. One carrier reported conducting only two audits for possible fraud, and five respondents indicated they had not conducted any audits under SB 418.

Some of the reasons for auditing claims, as reported by the payors, include:

- Claims were complex and therefore required extended review
- Information is needed from a provider other than the treating provider
- Individual and small group reasons—requiring records from referring physicians and utilization management/underwriting reviews
- Eligibility questions were identified
- Ambulance claims
- Services billed with certain modifiers (e.g., return to operating room for a related procedure during postoperative period or unusual procedure services)
- Other insurance coverage

- Charges inconsistent with diagnosis or levels of care billed differed from levels of care authorized
- Invoices for implants/prosthetics/orthotics
- Drug and supply charges

CLAIM PAYMENT

After an HMO or PPO provider renders a service and submits a claim to a payor, the payor issues a payment (check or authorized electronic funds transfer) accompanied by an explanation of benefits (EOB), or remittance advice. The TACCP discussed the payment process, including overpayments and underpayments, and the providers' inability to consistently reconcile or comprehend the payment amount received from the information provided on the EOB. Overpayments are payments to providers that are greater than the provider's contracted rate or payments made to a provider in error for a service that is not eligible for payment. Underpayments are payments to a provider that are less than the provider's contracted rate or the failure to pay the full range of services billed.

Providers have expressed concerns that the EOBs do not clearly indicate what portion of the claim payment is a claim payment or a penalty. The lack of specific explanatory information leads the providers to believe that they may have received an overpayment, instead of the appropriate penalty for a late claim.

In June 2004, some TACCP payor members submitted information regarding their current practices with regard to EOBs. The payor practices regarding EOBs that were reported are listed below, along with the number of responding payors who provided such comments. A number of the respondents perform more than one of the practices listed below; two respondents did not include a specific response relating to EOB practices. Responding carriers reported that they:

- specify on the EOB that a penalty is included in the claim payment or send a separate penalty payment with an explanatory letter or EOB. (10 respondents)
- indicate in writing that "the payment is being made in accordance with Texas prompt pay legislation." (One respondent)
- indicate that when a claim is found not to meet the requirements of a "clean claim", the deficiency is reported on an EOB. (Two respondents)
- explain the reason for the denial on the EOB or sends a separate deficiency notice. (Five carriers)
- do not include language on the EOB that a claim is not clean, but will provide this information in response to providers' inquiries. (One respondent)
- treat all claims as clean, but if a payment exceeds the payment time limitations, includes an EOB code explaining the delay. (One respondent)

Providers have suggested that standardized EOBs would reduce confusion regarding claims payments. Payors indicate that standardization of EOBs would be costly due to extensive programming and systems changes that would be required.

DATA REPORTED TO TDI

In 2001, TDI began a series of enforcement actions under the HB 610 prompt pay statutes and rules against carriers who had received the largest numbers of complaints from providers regarding prompt payment of claims. Forty-seven carriers reported provider claims data beginning with January 2001 through August 2003. Data requested include the number of claims paid timely (day 1-45), the number of claims paid late (day 46-59, day 60-89, day 90+), and the number of claims for which contracted penalties or billed charges were paid. The Appendix of this report provides additional HB 610-related data.

SB 418 requires HMOs and insurers that have preferred provider health benefit plans in force to report certain aggregate claims data to TDI at the end of each quarter. In addition, these carriers are required to report aggregate data about their reasons for declining to verify claims once a year, on July 31 (SB 418 Annual Reasons for Declination Report).

SB 418 also established a 21-day payment period for electronically submitted, affirmatively adjudicated pharmacy claims. In June 2004, TDI adopted rules clarifying the pharmacy claims data reporting requirements. Carriers will report pharmacy claims data beginning with the third calendar quarter, July – September 2004, due on November 15, 2004.

Because SB 418 took effect for provider contracts entered into or renewed on or after August 16, 2003, the provider contracts renewed, implementation of the SB 418 prompt pay provisions has been staggered. For example, some carriers decided to renew all their provider contracts on a specific date (example: January 1, 2004); others decided to renew based on the schedule they already had in place. Some carriers have not yet renewed their contracts. As a result, some carriers continue to pay claims based on the "old" prompt pay HB 610 statute and rules, while other carriers are paying claims under both HB 610 and SB 418, and still others are under SB 418. For this reason, TDI provided two models that carriers can use to report the data - the HB 610 model and the SB 418 model. Currently, 97 carriers are reporting quarterly provider claims data:

- 18 HMOs
- 8 dental HMOs
- 68 preferred provider benefit plan carriers
- 3 vision-only plans

When processing claims, many carriers treat all claims as though they were "clean," that is, they do not separate "clean" from "deficient" claims during claims processing. As a result, for some carriers "all" claims – both "clean" and "deficient" – are included in their data reports. Other carriers separate "clean" claims and report their data based on "clean" claims only.

TABLE 1: **HB 610 Timeliness of Provider Claims Payments**

Reporting Period	Clean Claims Paid Timely	Percentage Paid Timely	Clean Claims Paid Late	Percentage Paid Late
September – December 2003	3,887,337	99.19	31,803	0.81
January – March 2004	1,196,996	99.52	5,732	0.48
April – June 2004	588,953	99.27	4,308	0.73

Source: TDI HB 610 Provider Claims Data Calls – September 2003 through June 2004

TABLE 2: **SB 418 Timeliness of Provider Claims Payments**

Reporting Period	# of Clean Claims Paid Timely		Percentage Paid Timely		# of Clean Claims Paid Late		Percentage Paid Late	
	Inst.	Non - Inst.	Inst.	Non - Inst.	Inst.	Non – Inst.	Inst.	Non-Inst.
September – December 2003	717,900	2,673,814	99.70	99.03	2,135	26,111	0.30	0.97
January – March 2004	544,744	3,123,085	98.61	98.52	7,688	46,917	1.39	1.48
April – June 2004	568,094	2,956,455	99.17	99.04	4,767	28,780	0.83	0.96

KEY: Inst. = Institutional claims (facilities); Non-Inst. = Non-institutional claims (physicians)
Source: TDI SB 418 Provider Claims Data Calls – September 2003 through June 2004

TABLE 3: **Electronic vs. Non-Electronic Claims – SB 418 Claims Data**

Submission Method	September through December 2003	January through March 2004	April through June 2004
Electronic Institutional Claims	584,479 (17%)	409,547 (11%)	431,141 (12%)
Electronic Non-Institutional Claims	1,954,502 (57%)	2,272,329 (61%)	2,134,573 (60%)
Non-Electronic Institutional Claims	135,556 (4%)	142,885 (4%)	141,450 (4%)
Non-Electronic Non-Institutional Claims	745,423 (22%)	897,673 (24%)	850,662 (24%)
Total Reported Claims	**3,419,960 (100%)**	**3,722,434 (100%)**	**3,558,096 (100%)**

Source: TDI SB 418 Provider Claims Data Calls – September 2003 through June 2004

TABLE 4: **Requests for Verification**

Reporting Period	Requests for Verification	Verifications Issued	Verifications Declined
September – December 2003	7,131	4,927	2,204
January – March 2004	10,708	6,924	3,791
April – June 2004	10,430	4,446	5,983

Source: TDI SB 418 Provider Claims Data Calls – September 2003 through June 2004 as of 8/19/2004

TABLE 5: **SB 418 Annual Reasons for Declination Report - Summary**

Reason for Declination	Totals
Declinations due to premium payment time frames that prevent verifying eligibility for a 30-Day Period	8,244
Declinations due to policy deductibles, specific benefit limitations or annual benefit maximums	17,942
Number of declinations due to benefit exclusions	6,450
Number of declinations due to no coverage or change in membership eligibility, including individuals not eligible, not yet effective, or membership cancelled	2,191
Declinations due to pre-existing condition limitations	2,921
Declinations due to other policy or contract limitations	6,045
Declinations due to lack of information from the requesting physician or provider	6,723
Declinations due to lack of information from other physician or provider	219
Declinations due to lack of information from any other person	827
Declinations due to other reasons	8,779

NOTE: Includes declinations issued from September 2003 through June 2004 as of 8/25/2004; carriers may have reported more than one reason for a declination.
Source: SB 418 Annual Reasons for Declination Report

Complaints

The table below reports the complaints from physicians and providers received by TDI from fiscal 2000 through August 10, 2004. In fiscal 2004, the number of complaints has dropped to about half of the number received in fiscal 2003. The number of justified complaints has decreased as well. A complaint is justified if there is an apparent violation of a policy provision, contract provision, rule or statute, or there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice.

TABLE 6: **Complaints Received From Physicians and Providers (Fiscal 2000 through August 10, 2004)**

FY	Total Provider Complaints Received	Justified Complaints	Percentage Justified
FY 2000	10,150	3,777	37.21%
FY 2001	14,865	5,767	38.80%
FY 2002	19,510	5,950	30.50%
FY 2003	19,651	4,130	21.02%
FY 2004	10,410	1,946	18.69%

Source: TDI Complaints Inquiry System (CIS) database

SUMMARY

TDI continues to collect and review claims, verifications, and complaints data, and use the data to drive education and enforcement efforts.

CHAPTER 2: EDUCATION AND OUTREACH

SB 418 and its associated rules require significant change on the part of providers and carriers. New federal requirements for electronic claims transactions also present significant challenges to providers and carriers. Given the magnitude of the changes, a concentrated effort was initiated, and continues, for sharing information with physicians, providers, and carriers about how to comply with prompt pay statutes and rules.

Since the adoption of SB 418 during the 78th Legislative Session, the agency's Provider Ombudsman and other TDI staff completed 39 educational presentations on the new prompt pay statutes and rules. TDI has partnered with the Texas Hospital Association, Texas Medical Association (TMA), the Texas Association of Health Plans, and other organizations and groups to educate physicians, providers, and insurance industry representatives throughout Texas in the following cities:

- Austin (10)
- Dallas-Fort Worth (5)
- Houston (4)
- Plano (3)
- Corpus Christi (2)
- Abilene, Amarillo, College Station, Denton, El Paso, Galveston, Irving, Longview, Lubbock, Lufkin, McAllen, Midland, Mission, Tyler, and San Antonio (1 each).

One additional, but significant, way in which providers gained education was through the eight presentations provided by TMA staff. Two of the presentations were offered in Austin while one each was offered in Bedford, Dallas, Galveston, San Antonio, Victoria and Waco.

TDI also established a provider resource page with educational materials that is accessible through TDI's home page at www.tdi.state.tx.us/consumer/ppresource.html. This site, which has had more than 31,000 hits since September 2003, includes:

- summaries of legislation and rules relating to prompt pay (SB 418 and HB 610)
- a decision tree to demonstrate which rules apply to particular claims
- education materials including audio files and slide presentations about prompt pay and the clean claims process
- a series of frequently asked questions and answers (FAQs)
- the elements required for a "clean claim"
- verification/preauthorization requirements
- a "virtual workshop" and information about other educational events
- minutes and agendas for meetings of the TACCP
- an online complaint form.

TDI's website also includes a managed care payor resource page (www.tdi.state.tx.us/consumer/payors.html) with links to the statutes, rules, educational materials, and other information for carriers.

In addition, TDI issued three Commissioners' Bulletins about SB 418 and new rules, two in October 2003 and one in January 2004. These bulletins can be accessed at www.tdi.state.tx.us/commish/bulletins.html. The bulletins include:

- B-0041-03 Regarding Carriers' Refusal to Verify
- B-0042-03 Regarding Verification Provisions of SB 418
- B-0017-04 Regarding Disclosure of Information Such as Fee Schedules

Three other bulletins (B-0004-04, B-0018-04, B-0029-04) were issued regarding claims processing reporting requirements for payors subject to SB 418.

TACCP payor members reported that they extended a wide variety of education and outreach efforts to physicians, physician office staff, hospital and ancillary providers, agents and other affected stakeholders about new SB 418 prompt pay requirements. The topics discussed with stakeholders included information such as filing deadlines for electronic and paper claims, eligibility/verification information, expanded hours of member services availability, and prompt pay requirements and penalties.

Examples of such outreach and education are presented below:

- One carrier includes a discussion of SB 418 in each provider training in-service conducted. Such in-services are given within 30 days of executing a contract, annually, and on an as needed basis during monthly, quarterly and annual provider education visits. Provider orientations were reported as a means of disseminating information regarding SB 418, including during individual visits to provider offices. One carrier, for example, met with 3,980 providers in one-on-one meetings in which SB 418 was discussed;
- A large carrier conducted workshops in October 2003 in Plano, Austin and Houston for physicians and physician office staff on "Managing Your Claims: Keys to Successful Claims Payment." Each workshop included three separate sessions focused solely on SB 418 and additional sessions on electronic claims filing. A total of 1,214 attendees representing about 15,000 providers participated in such sessions. In addition, 340 agents attended seminars in Dallas, San Antonio, Houston, Austin and Lubbock on how employer groups might be affected by SB 418 changes, especially verification. In 2004, an additional nine workshops were offered with over 1,100 other attendees; an additional 15 or more workshops are planned;
- A large carrier also presented its implementation strategy for SB 418 to its Texas Physician Advisory Council (TPAC) in September 2003. The TPAC is composed of 15 key physicians with statewide influence through the TMA and other specialty groups and societies.

Payor members also reported the distribution of a variety of educational materials associated with SB 418. For example, payors:

- distributed SB 418 materials in physician workshops;
- used provider newsletters to disseminate information;
- relied on individual e-mail and correspondence to specifically address unique questions submitted by providers;
- made written amendments to Network Participation Agreements in which providers were notified that they may request all information necessary to determine they are being compensated in accordance with their new contracts
- updated provider manuals; and
- posted critical information, including provider manuals, on their Web sites.

SUMMARY

Significant education and outreach has occurred on SB 418 matters with many materials readily accessible through TDI, association and payor websites. The process of educating stakeholders about SB 418 is ongoing, however, and will likely evolve as new issues or educational needs are identified.

CHAPTER 3: PREAUTHORIZATION AND VERIFICATION

Over time, health maintenance organizations and issuers of preferred provider benefit plans (payors) have developed systems to control costs and to ensure that proposed care is medically necessary. Physicians and providers have used other systems to determine, prior to treatment, whether payors will provide reimbursement for the services they furnish.

Prior to passage of SB 418, payors often required that proposed services be submitted for utilization review which was commonly referred to as preauthorization. Utilization review is described in Insurance Code Article 21.58A, and is a determination of whether proposed services are medically necessary. Providers expressed concern that even after services were determined to be medically necessary, payors sometimes subsequently reversed their initial medical necessity determination, in whole or in part, upon review of medical records for the treatment provided.

Also, prior to SB 418, providers routinely telephoned payors as part of an eligibility check before treatment to ask whether a patient's coverage was in force and to determine the scope of benefits provided. Providers expressed concern that the information received was unreliable and, because the payor's response was not binding on the payor, it did not guarantee payment would be made. Payors countered that they lacked reliable information from employers as to a patient's current employment status as well as the employer's premium payment status. Payors also contended that they cannot guarantee payment of most claims in advance because they have no opportunity to investigate claims to determine if the payor owes the claim.

To help remedy these concerns, SB 418 established preauthorization and verification processes that apply to provider contracts that are entered into or renewed on or after August 16, 2003**.** SB 418 requires that a payor that uses preauthorization must provide to each contracted provider, not later than the 10th business day after a request is made, a list of services that require preauthorization. The statute also sets forth preauthorization requirements in addition to the existing utilization review processes, and provides that payors may not deny or reduce payment for a service based on medical necessity unless the provider has materially misrepresented or substantially failed to perform the service. The statute also requires that the payor or its designee provide toll free telephone access during stipulated hours during the week, on weekends and on holidays, to receive and respond to requests for preauthorization. Because of the nature of these requests, qualified clinical staff is also required to be available during these time frames.

SB 418 also provided for a verification process by which a provider may receive a guarantee of payment. If verification is issued by the payor, a claim for services rendered within 30 days of the verification may not be reduced or denied for any reason unless the provider materially misrepresented or substantially failed to perform the service. Payors may decline to issue the verification but, under applicable TDI regulations, must give a reason for denial that is specific to the proposed service. Payors

are also required to provide toll free telephone access during stipulated hours during the week, on weekends, and holidays, in order to receive and respond to requests for verification.

Final rules to implement the verification and preauthorization sections of SB 418, which were developed following extensive discussions with the CCWG and subsequent consultation with the TACCP, became effective October 5, 2003, and may be found at 28 TAC §§19.1703, 19.1723 and 19.1724. Since adoption of these rules, payors have established new units to receive, respond to, and track verifications and preauthorizations. Payors have also developed special materials for training staff in the new processes and have enhanced their computer systems and developed Web-based systems to implement the statute and rules. Commissioner's Bulletin # B-0017-04, was issued on March 30, 2004 to provide direction and clarification on issues relating to preauthorization and verification. Many payors have created user-friendly websites that provide clear instructions, but providers indicate that not all payor sites disclose clear and specific payor procedures, nor is it always clear how to find the information.

DATA REQUIREMENTS FOR VERIFICATION

The TACCP discussed the extent of information that the proposed rule required providers to submit in order to request a verification. Payors supported the proposed rule's verification data requirements and the requirement that the payor confirm the verification in writing. Although the original list contained many more requirements, ultimately, the adopted rule included the 13 listed below:

- Patient name
- ID number (if included on the ID card)
- Date of birth
- Enrollee or subscriber name, if shown on ID card
- Patient relationship to enrollee or subscriber
- Presumptive diagnosis, if known, otherwise presenting symptoms
- Description of proposed procedure(s) or procedure code(s)
- Place of service code where services will be provided and if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided
- Proposed date of service
- Group number if included on ID card
- Name and contact information (including name, address, telephone number, name of enrollee, ID number, group number and group name) of any other carrier, if known to provider
- Name of provider who will provide proposed services
- Federal tax ID number of provider

The adopted rule allows a payor to give a telephonic verification response which must be followed by the written decision within three days.

RESPONSE TIMES FOR VERIFICATION

The TACCP also explored the issue of response times allowed for a payor to respond to a provider's verification request. The time frames in the proposed rule were patterned after the time frames set forth in Insurance Code Article 21.58A for utilization review determinations. Providers contended that the process be instantaneous and handled over the telephone. Providers also expressed concern that a delay in receiving a verification or guarantee of payment could delay elective, non-emergency patient care. Some providers indicated that services would be provided without verification. Payors countered that, since verification is a guarantee that the insurer or HMO will pay the claim, they cannot issue a verification without sufficient time to conduct a basic investigation of the facts. The rules, as adopted, shortened the initially proposed 15-day review period to "without delay, but not later than 5 days, with 24 hours for concurrent hospitalization and 1 hour for post stabilization of emergency care."

WEEKEND AND HOLIDAY TELEPHONE COVERAGE

Payors commented during TACCP meetings that the required weekend and holiday hours for the preauthorization and verification toll-free telephone lines were onerous. Payors indicated that staffing the telephone lines with appropriate personnel for these types of determinations was unnecessarily burdensome when compared to the infrequency of calls for preauthorization and verification during the weekend and on holidays.

As part of the TACCP discussions, payor members of TACCP were invited to report on the volume of after-hour, weekend, and holiday calls they have received since implementing the requirements. Of the 11 payors who provided information on after-hour, weekend, and holiday calls, 5 indicated they had received no such calls since implementing SB 418. The remaining responses are as follow:

- One payor with about 250,000 members covered under business subject to SB 418 reported very few after-hour, weekend, and holiday calls relative to weekday volume; an average of 13 calls per weekend or holiday were received.
- One payor indicated that after-hours call volume is not available, but 126 weekend calls were received between February and April 2004.
- One payor reported receiving nine calls during weekends or after-hours.
- An unidentified payor reported three benefit-related calls between June 2003 and March 2004.
- An unidentified payor indicated that 1,824 calls were received from November 2003 through April 2004 and that some of these were requests for preauthorization.
- A large carrier reported 8 calls requesting verification on holidays/weekends between September 2003 and April 2004; 25 calls requesting verification were received after-hours on business days from April 1-30 in 2004.

Providers indicated that the weekend and holiday hours were necessary and that the frequency of such calls would increase as providers become more informed and experienced with the opportunity and procedures for preauthorization and verification.

DENTAL AND VISION PLANS

The TACCP heard comments related to preauthorization and verification from carriers that provide dental or vision benefits exclusively to their members. Commenters indicated that because dental and vision benefits are not typically delivered by providers outside of regular business hours, it would not be necessary or practical to impose verification and preauthorization processes on such carriers. Commenters indicated the requirement for the non-business and weekend hours availability of staff via a toll-free telephone line would result in an unnecessary expense and that the department's rules should therefore provide for an exception for these benefits. The department rules, however, may not exempt these carriers from the preauthorization and verification procedures because current state law does not exempt them. A change to the statute is the best route to establish such an exemption.

SUMMARY

Payors have established new units to receive, respond to, and track verifications and preauthorizations in compliance with SB 418. They have also developed special materials for training staff in the new processes and have enhanced their computer systems and developed web-based systems to implement the statute. Data received at TDI indicates that from the period September 2003 through June 2004, 28,269 verification requests were received and 16,297 verifications were issued. The most common reasons for declining verification were due to premium payment cycles that prevented verifying eligibility for a 30 day period; policy deductibles, specific benefit limitations or annual benefit maximums; and benefit exclusions. Utilization data received at TDI indicates low usage of the after-hours and weekend telephone coverage to date. Dental and vision plans have expressed concern that the preauthorization and verification requirements are not necessary for their pattern of delivering services; however, a statutory change would be necessary to exempt them from the requirement.

CHAPTER 4: CODING AND BUNDLING

The TACCP is charged with advising the Commissioner "…on technical aspects of coding of health care services and claims development, submission, processing, adjudication, and payment…." In addition, the TACCP is to "…advise the commissioner with respect to the implementation of the standardized coding and bundling edits and logic." To better understand coding and bundling, TDI invited a panel including representatives from the major coding software vendors, a coding manager from a physicians' billing service, and an expert on the Health Insurance Portability and Accountability Act (HIPAA) and the electronic submission of claims, to give presentations and participate in a panel discussion at the November 12, 2003, TACCP meeting. In addition, the Texas Medical Association (TMA) representative on the TACCP distributed copies of the American Medical Association's (AMA) informational packet about coding. The panelists included:

- Walt Culbertson, Chair, Southern HIPAA Administrative Regional Process
- Kevin Hickey, Chairman and CEO, IntelliClaim, Inc.
- Dr. Pierre Malek, Chief Medical Officer, and Carolyn Staudenmeier, Senior Vice President and General Manager, McKesson
- Karen Petroff, Senior Vice President-Transaction Management Solutions
  Kimberly Chapman, Vice President-Product Management and Marketing
  Karen Cunningham, Product Specialist, Ingenix
- Shawnna Tucker, Coding Manager, Physicians Administrative Services

OVERVIEW

Coding, or the use of standard alphanumeric and numeric codes on an insurance claim, serves several purposes:

- Codes describe the patient's illness and the level of care and quality of care given in response to the severity of the patient's illness.
- Codes describe the procedures or services rendered by the physician or provider so a payor can reimburse the physician or provider.
- Codes allow health care claims data to be compiled and analyzed by payors, providers, government agencies, and health care organizations for the purpose of identifying trends in medical procedures and practices, comparing care among providers, and planning for future health care needs.

Reimbursement for physician services is a function of three interrelated factors:

- The fee associated with the individual service,
- The manner in which the service is coded on the claim form, and
- The claims processing rules used by the health plan that is adjudicating the claim.

While coding is used to describe the service or procedure performed by the physician or provider on a claim form, two other activities affect reimbursement. Billing is the submission of claims from physicians and providers to payors for payment of services

rendered. Pricing is the fee a physician or provider sets for a particular service. If a physician or provider participates in a third party payor's network, then pricing is pre-established through a contract. If a physician or provider participates in Medicare, then reimbursement is determined by rates established by Medicare.

Payors use electronic adjudication systems to process and pay claims. These systems are proprietary and have been developed over time to reflect the payor's adjudication criteria. They are based on complex computer programs that may include the use of audit checks, recognition/non-recognition of modifiers, and policies for bundling, unbundling, downcoding, and upcoding.

CODING STANDARDS

The HIPAA Administrative Simplification Act provisions set out standards for certain electronic transactions. HIPAA has designated a standard format for exchanging data among physicians, providers, clearinghouses, and payors. HIPAA also adopted certain code sets as standards. Although payors are required to use the national standard code sets, payors are also allowed to continue their current adjudication processes; that is, they can continue to process claims using their proprietary software including the use of audit checks, code editing, bundling, and other tools.

The most common and universally accepted codes used to document services provided by physicians and providers are contained in the Current Procedural Terminology (CPT) developed and maintained by the AMA and Healthcare Common Procedure Coding System (HCPCS) developed and maintained by the Center for Medicare and Medicaid Services. CPT and HCPCS codes were selected as a HIPAA standard code set for procedures and services. CPT and HCPCS manuals contain guidelines for correct coding including methods for assigning the appropriate level or intensity of a service (for example, the difference between "Level III" Office Visit Code 99213 and a "Level IV" Office Visit Code 99214). CPT and HCPCS coding and coding policies are so technical that an industry has arisen to assist providers in the technical aspects of coding. Accurate coding is essential to assure accurate billing for services rendered.

CPT and HCPCS provide a method of communicating variable situations encountered in the diagnosis and treatment of patients. CPT and HCPCS also provide for a series of modifier codes to be used in addition to the primary codes. CPT and HCPCS modifiers are used when a physician or provider needs to communicate that the listed service has been altered by some specific circumstance but has not changed in its definition. For example, a physician may need to indicate that a service has been increased or decreased, performed bilaterally, performed more than once, or performed by more than one physician. Modifiers are two-digit alphanumerics appended to five-digit CPT or HCPCS codes to indicate an unusual circumstance that will affect reimbursement for the service or procedure. The service or procedure remains the same, but the circumstances of its delivery were altered.

HIPAA designated another standard coding system for use in addition to CPT, the International Classification of Diseases, Ninth Revision, Clinical Modification or ICD-9CM. ICD-9CM is used to record diagnoses, signs and symptoms, and complaints. ICD-9CM also indicates the medical necessity of an encounter or procedure.

BUNDLING AND OTHER PRACTICES

Vendors including Ingenix, IntelliClaim, and McKesson sell software used by payors in conjunction with a payor's processing system to process and pay healthcare claims. The software products themselves use the standard code sets – CPT and ICD-9CM – as well as other standard code sets. However, the software is highly sophisticated so that it can be customized by the payor to suit their particular adjudication criteria.

Bundling occurs when the payor pays two or more procedure codes reported by the physician or provider under only one procedure code. While the physician or provider has indicated that several separate services have been performed, the payor may reimburse only a single service on the basis that the other billed services are included in payment for the single service. Payment policies like this vary considerably among health plans. For this reason, the AMA believes that bundling is inconsistent with its standardized CPT guidelines. Bundling of services has an enormous impact on physician reimbursement and is the basis of many disputes between physicians and health plans.

Unbundling is defined in the National Correct Coding Policy Manual (an initiative by the federal Center for Medicare and Medicaid Services (CMS)), to promote national correct coding methodologies and to eliminate improper coding. For Medicare, unbundling is defined within the manual as "the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code." Two types of unbundling are most prevalent:

- Fragmenting one service into component parts and coding each component part as if it were a separate service.
- Reporting separate codes for related services when one comprehensive code includes all related services.

For example, when multiple patient services are reported by the same physician on the same date of service, there may be a perception of unbundling when, in fact, the services were performed under separate and distinct circumstances. Modifier -59 is used to identify procedures and services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, or a different procedure not ordinarily encountered or performed on the same day by the same physician. Because insurance payors, including Medicare carriers, cannot identify these situations based solely on CPT code assignment, the -59 modifier was established to permit unrelated services to bypass correct coding edits.

Upcoding occurs when a provider wishes to communicate a more intense level of service and to support other codes on the claim. Another type of upcoding occurs when a provider lists multiple CPT codes on a medical claim in an effort to describe each service

component rendered to an insured, when the provider could have used more all-inclusive or "global" codes to describe the services.

Downcoding occurs when a payor denies or changes certain codes submitted on a medical claim. This reduces costs to the carrier, but may result in a dispute between the provider and the carrier as to whether the changes accurately reflect the services rendered to an insured.

All parties agree that coding errors resulting in either upcoding or downcoding are inevitable because of the complexity of the CPT coding system. However, if upcoding is done intentionally by a physician or provider to generate higher reimbursement, then it could be viewed as unethical and as an indicator of potential fraud. If downcoding is done intentionally by a payor, it may result in a payment to the provider that is less than the rate stipulated in the contract, which may be a deceptive trade practice. Furthermore, intentional unsupported downcoding by a payor may constitute a violation of the contract between the physician or provider and the payor.

The AMA recently decided to study the feasibility of developing a national standard for using codes, code combinations, modifiers and bundling. The study, ordered by the AMA in June 2004, would examine a national standard that is consistent with CPT guidelines and could be used by all commercial and government payors. Providers feel that such a standard could help address the controversy over bundling and downcoding.

SUMMARY

Physicians and providers wish to be paid correctly and timely for their services. Payors wish to pay claims correctly and timely. All parties agree that correct coding is essential to assure correct reimbursement.

The controversy seems to arise from the fact that while coding standards in the health care industry exist in the sense that there is agreement as to what specific CPT or ICD-9CM codes mean and how they should be used to describe services on a claim, there is no national standard as to how payors process and pay claims based on the standard codes. Although the contracts between providers and payors establish parameters for payment, disagreement may still occur between the parties over whether coding and bundling are clinically justifiable and whether the adjudication criteria used by payors are appropriate and fair.

Physicians and providers have indicated their reimbursements are controlled by "black box" technology about which they have no information. Given this situation, physicians and providers say they do not know what they will be paid. As a result, their income streams can be unpredictable.

Payors say they have a responsibility to pay all clean claims efficiently and correctly. In order to do this, they must rely on the coding presented on the claim form and use audit checks and system edits to review the coding.

In Texas, physicians and providers who contract with HMOs and insurers offering preferred provider health benefit plans have the right, under SB 418 and 28 TAC §3.3703 and 11.901 to request from payors certain claims payment information including fee schedules, payment methodologies, and coding and bundling rules or processes. The payors must include information such that a person with sufficient training could determine what the physician's or provider's rate of reimbursement for services would be. Disclosure of claims payment information is one tool Texas physicians and providers can use to determine if they are being paid according to the contract they signed with a given payor. Further details about this requirement and its impact are included in the Chapter 5 entitled Disclosure of Claims Payment Information.

CHAPTER 5: DISCLOSURE OF CLAIMS PAYMENT INFORMATION

DISCLOSURE RULES

On September 18, 2002, the department adopted rules that require health maintenance organizations (HMOs) and insurers that issue preferred provider plans (collectively "carriers") to disclose “all information necessary to determine that the provider is being compensated in accordance with the contract,” including fee schedules, coding methodologies and bundling processes, within 30 days from receipt of a request. (See 28 TAC §§3.3703 and 11.901.) The rules also required carriers to provide 60 days notice of any changes to the information.

Consistent with SB 418 and after TACCP input, the disclosure rules were amended to require that the carrier give 90, rather than 60, days written notice prior to instituting any changes to the claims processing information. In addition, the rules required that the carrier not make retroactive changes to any of the information provided; and, if software is used, the carrier must identify the publisher, product name and version of such product. The rule revisions also added "other business operations" and "communications with a governmental agency involved in the regulation of health care or insurance" to the list of acceptable uses of disclosed information. Further, the rules allow a provider that receives information under the disclosure requirements to terminate its contract with a carrier on or before the 30th day after the date the provider receives the information.

Pursuant to SB 418, the amended rules also require that disclosed rules and processes relating to coding and bundling be consistent with nationally recognized and generally accepted bundling edits and logic and clarify that the disclosure requirements may not be waived, voided, or nullified by contract. Finally, the amended rules allow a carrier to require a provider to retain in its records updated information concerning a patient’s other health benefit plan coverage.

CONTINUING ISSUES RELATED TO FEE SCHEDULE DISCLOSURE

Since the amended rules were adopted in September 2003, carriers have informed TDI that they have not received many requests for disclosure from providers. However, carriers indicated that, upon receipt of requests, they provide the information timely to requesting providers using various methods, including regular mail, e-mail, and by referring the requestor to information on web pages. One entity that provides claims payment information for some payors reported that approximately every 30 seconds someone uses a tool on its web page to look up sources for edits. A large carrier advised the department that it has implemented a reimbursement information site on its provider page, which provides a tool for providers to request specific contracted fee and coding and bundling information and which also provides information regarding the carrier’s general claims processing policies. The carrier included instructions on how to access the site in its first quarter 2003 provider newsletter. For those providers that do not have

access to the Internet, the carrier has a local contact to assist providers in obtaining copies of this information. (Edits, bundling and downcoding are discussed in Chapter 4.)

Some providers indicated that when they do request the information, it is not provided timely or at all. Providers also reported that some of the notices of changes to claims payment information they received were incomplete or "sample" notices that direct the provider to request information specific to the provider's practice. In addition, at least one provider indicated a preference to receive the information required by the statute and rule prior to contracting rather than afterwards.

TDI has requested information from carriers concerning the number of requests for information they have received. Since 2002, one large carrier reports that it has received only 33 requests for fee schedules (22 in 2002, 11 in 2003 and none through March 2004) and 790 requests for bundling information (25 in 2002, 590 in 2003, and 175 through March 2004). The same carrier received 327 requests for related medical policies (18 in 2002, 236 in 2003 and 73 through March 2004.)

TDI also requested that providers who do not receive information in accordance with the requirements of the rule file complaints with TDI. Since December 2003, TDI has received three complaints from providers on this issue.

Because of complaints concerning some carriers' change of information notices, on March 30, 2004, TDI issued Commissioner's Bulletin number B-0017-04. This bulletin reminds carriers that the rules require them to send to the provider the specific changes to the claims payment policies, procedures and information that will affect the payment to be made under the contract. The bulletin states that while a carrier may meet its obligation under the rules by giving notice and providing a source, such as a link to a Web page, where the provider can obtain information concerning the applicable change(s), the provider must be able to access the information without any additional request to the payor.

SUMMARY

TDI and the TACCP have worked together to implement the provisions of SB 418 to continue to ensure that providers have all the information necessary to enable them to determine the payment to be made under the contract. By providers making use of the rules' provisions and requesting all necessary information from carriers, and by carriers providing this information to providers timely, providers are better able to confirm that their payments are consistent with the terms of their contracts. TDI will continue to foster these necessary practices by informing all parties of the provisions in the rules and addressing any complaints as they arise.

CHAPTER 6: IDENTIFICATION CARDS

SB 418 includes a provision that requires HMOs and insurers offering preferred provider benefit plans to include on any identification card issued to enrollees or insureds a designation that will allow physicians and providers to determine whether such health benefit plan is regulated by the TDI. Carriers are not required to issue identification cards to enrollees or insureds, except that identification cards are required for health plans that include a pharmacy benefit. The language in SB 418 does not require that carriers issue identification cards. Instead, SB 418 details certain requirements for identification cards that carriers choose to issue.

The CCWG discussed the idea of a symbol on identification cards that would allow physicians and providers to determine which patients were covered by a health benefit plan regulated by TDI. The designation would give important information to physicians and providers concerning to whom complaints should be directed and whether prompt pay requirements apply. SB 418 subsequently required the inclusion of such a designation on any identification cards that are issued by a managed care plan that is regulated by TDI. Pursuant to the department's rules, identification cards issued after January 1, 2004, must include a designation that the plan is regulated by the department and the first date that coverage became effective under the health plan, or a toll-free telephone number that will allow physicians and providers to obtain that information.

RULE REQUIREMENTS

TACCP discussions on implementation of the SB 418 identification card requirements were focused primarily on the type of symbol to be used in order to identify a TDI-regulated health benefit plan. Providers emphasized the need for something simple and easily recognizable. Carriers commented on the costs of changing identification cards and the need for a delayed implementation date.

The department first implemented the identification card requirements of SB 418 through the adoption of emergency rules on August 16, 2003. The rules required a symbol to be included on the front of the identification card. The symbol was a star with the letters "TDI" in the middle of the star. The emergency rules required compliance for health plans issued or renewed on or after January 1, 2004. The department heard numerous comments from carriers during the subsequent TACCP meetings concerning the cost and difficulty in implementing the requirements for a symbol on identification cards. Carriers also requested that a non-Texas specific symbol be allowed so that a carrier that used a national vendor for printing cards could include a symbol that would serve a similar purpose in other states. Physicians and providers continued to stress that the symbol needed to be simple and recognizable. The department consulted with the TACCP prior to the proposal and adoption of the letters "TDI" or "DOI" being included on the front of the identification card. The various members of the TACCP agreed that the choice in letters served the needs of physicians and providers as well as carriers.

The Department adopted the final rules relating to identification cards on January 12, 2004. The rules require compliance for health plans issued or renewed on or after February 1, 2004. The emergency rules were withdrawn effective February 1, 2004, so that there was no gap in time during which identification card requirements were not in place. Although the effective date for the final rules references health plans issued or renewed on or after February 1, 2004, the emergency rule provisions relating to identification cards applied to health plans issued or renewed on or after January 1, 2004. This results in identification card requirements beginning in January 2004 and a transition to the final rules on February 1, 2004. Any cards properly issued with the star symbol during or before January are deemed to be compliant with the final rules.

A small number of carriers that have voluntarily reported regarding implementation of the identification card rule requirements indicate that members covered under new or renewed plans are receiving compliant identification cards. Those carriers reporting indicate that compliant identification cards are being issued only upon plan issuance or renewal instead of issuing new identification cards to all existing members.

SUMMARY

The CCWG began discussing the idea of using identification cards as a method for distinguishing between plans that were or were not required to comply with Texas' prompt pay requirements. SB 418 required identification cards to include information relating to the first date of coverage under the plan and indicating that the plan is regulated by the Department. The Department consulted extensively with the TACCP to successfully implement these requirements in a manner that was simple and recognizable for physicians and providers and as efficient as possible for carriers. Carriers issuing identification cards for health plans issued or renewed on or after January 1, 2004, must include the information required by the Department's rules.

CHAPTER 7: DENTAL CLAIMS

While SB 418 applies to all insurers offering preferred provider benefit plans and HMOs, Texas law prevents insurers from offering preferred provider benefit plans with dental benefits. As a result, SB 418 applies to dental coverage only when offered through an HMO, including single-service HMOs offering only dental benefits. However, the SB 418 requirements relating to specific claims forms, both electronic and non-electronic claims, do not appear to allow specifically for claims for dental care services. Therefore, dentists that contract with HMOs offering dental benefits did not have a method for submitting a clean claim and availing themselves of the benefits of prompt pay. Payors brought this issue to the TACCP in order to properly address the manner in which dental claims should be handled under SB 418.

DENTAL CLAIMS STANDARD

Following the initial TACCP discussions related to the department's implementation of SB 418, the TACCP heard comments from HMOs concerning the applicability of SB 418 to dental claims. Members generally agreed that SB 418 applied to HMOs offering dental care services, and that dentists needed a method for submitting a clean claim. The specific claim forms referenced in SB 418 and the department's rules containing clean claim elements were inconsistent with dental care services and would not allow for submission of clean dental claims.

After discussions among members, the department proposed that amendments to the prompt pay regulations could provide for a new set of clean claim elements specifically for dental claims. In these discussions, the TACCP heard from representatives of the National Association of Dental Plans (NADP) and the Texas Dental Association (TDA). The Department worked closely with the NADP and TDA and consulted with the TACCP in adopting amendments to the prompt pay regulations. The amendments, adopted on January 12, 2004, added a new section to the elements of a clean claim that specifically addressed dental claims. The amendments also addressed internal references within the regulations to clarify that the regulations apply to dental claims.

SUMMARY

Dentists providing dental care services to patients covered by an HMO did not have a method to submit a clean claim and take advantage of SB 418. The issue was brought to the attention of the TACCP, who heard from the NADP and TDA. As a result of the TACCP discussions, the Department adopted amendments to the prompt pay regulations that established clean claim elements for dental claims.

CHAPTER 8: ERISA AND PROMPT PAY

The Employee Retirement Income Security Act (ERISA) is a federal statute that, among other things, details the responsibilities of employers that provide employee welfare benefit plans ("ERISA plans") that may include a health benefit plan to employees. ERISA generally preempts state laws that relate to these plans. However, state laws that regulate insurance are saved from preemption so long as they do not deem an ERISA plan to be an insurer. Therefore, states may regulate an insurer from whom the plan purchases coverage (known as fully-insured plans), thus indirectly impacting such plans. If an ERISA plan does not purchase coverage from an insurer, but instead takes on the risk of paying employees' claims for health benefits, such plans are referred to as self-funded ERISA plans. Self-funded ERISA plans often contract with a third party administrator (TPA) to oversee the administration of the plan. TPAs are often licensed insurers or HMOs that either offer coverage or administer services to an employer. Under self-funded ERISA plans' setup, the employer acts as a funding mechanism for the benefits, while a TPA may take on the responsibility for plan design, establishing provider networks, and/or claims adjudication. Although the result is a plan that may appear to insureds and providers like an insurance arrangement, the state may not regulate a self-funded ERISA plan, even if administered by a licensed insurer or HMO.

Self-funded ERISA plans make up an estimated 60-70 percent of the health plan market. The state's efforts at resolving physician and provider payment issues through prompt pay legislation have not reached the self-funded plans. The TACCP's discussions relating to ERISA have focused on how physicians and providers can better identify ERISA plans (see Chapter 6 of this report entitled Identification Cards) and whether state prompt pay statutes and regulations should be extended to better regulate this large segment of the market.

EXTENDING PROMPT PAY TO ALL EMPLOYER PLANS

The TACCP discussions relating to ERISA focused on ERISA's preemption of state laws affecting self-funded employer-sponsored health plans. Physician and provider members of the TACCP suggested that TDI extend the prompt pay provisions of SB 418 to licensed carriers acting as TPAs to self-funded ERISA plans. The department's long-standing interpretation of the issue, based upon consultation with the Office of the Attorney General, is that TDI may not regulate self-funded ERISA plans and instead may only regulate the carriers from whom a fully-insured ERISA plan purchases coverage. Inclusion of a TPA that is also a licensed carrier does not change this interpretation.

The TACCP discussed two recent court cases related to ERISA preemption: *Kentucky Association of Health Plans v. Miller* and *Baylor v. Arkansas Blue Cross Blue Shield*. While neither case appears to immediately affect Texas' prompt pay laws, some members of the TACCP view the cases as providing potential for increased state authority in regulating self-funded plans.

In *KAHP v. Miller*, the United States Supreme Court changed the test for application of the ERISA preemption savings clause and therefore changed the scope of state laws that may be saved from preemption under ERISA. After the decision in *KAHP v. Miller*, in order for a state law to be saved from preemption by the savings clause, the statute must be "specifically directed toward entities engaged in insurance" and must "substantially affect the risk pooling arrangement between the insurer and the insured."

Language in a footnote to the Court's opinion has raised questions regarding whether state laws that regulate insurers engaged in purely administrative functions (as opposed to risk-bearing) for self-funded ERISA health plans may also escape preemption under the new savings clause test. If so, a state could arguably extend the requirements of prompt pay to self-funded plans that use TPAs that are also insurers. However, this theory, derived from only the footnote, would represent a major shift in the interpretation of ERISA preemption law.

Another method that physicians and providers, as private litigants, have recently used in attempting to extend prompt pay to ERISA plans is to argue that the state's prompt pay laws do not relate to the ERISA plan because the laws affect only the relationship between the carrier and the physician or provider. Because the plan sponsor and plan participant relationship remains unaffected, ERISA should not preempt the state law.

In *Baylor v. Arkansas Blue Cross Blue Shield*, Baylor University Medical Center (Baylor) filed suit against Arkansas Blue Cross Blue Shield (ABCBS) for breach of contract and late claims payment under the Texas Insurance Code. ABCBS sought to remove the case to federal court, asserting that the claims were preempted by ERISA. The federal district court analyzed the prompt pay claim in relation to ERISA's civil enforcement provision and concluded that the enforcement provision does not preempt Baylor's prompt pay claims because the health plan is only peripheral to the obligations to the providers under the prompt pay statutes. The case was not removed to federal court and is still being litigated in a Dallas County court. The case does not involve a self-funded plan and the issue of ERISA's conflict preemption provisions remains undecided. Only the question of removal to federal court under the civil enforcement provisions of ERISA has been decided.

Some of the physician and provider members commenting on this case during a TACCP meeting concluded that the case should provide adequate support for the Department to move forward in enforcement of Texas' prompt pay statutes against self-funded ERISA plans. The department's response during the meeting included the department's acknowledgement of the potential import of the case. The TACCP was informed that the department consulted the Office of the Attorney General regarding the case and concluded that the case had no effect on the current interpretation of Texas' prompt pay statutes. The specific references to insurers and HMOs limits the applicability of the prompt pay statutes to licensed insurers and HMOs that are operating pursuant to their authority to offer preferred provider benefit plans and HMO evidences of coverage and not to a self-funded plan's third party administrator operating pursuant to Chapter 21 of the Insurance Code. While the case is a signal that there may be an avenue for extending

the requirements of prompt pay, the case has not at this time decided all matters related to this issue.

SUMMARY

TDI has historically regulated employer plans only indirectly through the plans' purchase of health benefits from a licensed insurer or HMO. This practice is consistent with the preemption provisions of ERISA, which preempts state laws that relate to an ERISA plan, but saves from preemption state laws regulating insurance so long as the state law does not deem the ERISA plan to be an insurer. Self-funded ERISA plans comprise a large portion of the health benefit plan market and are not required to comply with Texas' prompt pay laws. Possible changes include requiring licensed carriers acting as third party administrators for self-funded ERISA plans to comply with prompt pay requirements. Although recent cases suggest a possibility for expansion of prompt pay requirements to self-funded ERISA plans, Texas' current prompt pay statutes do not apply to such plans.

CHAPTER 9: HEALTH CARE CLAIMS FRAUD

As part of its discussions, the TACCP held a meeting on May 26, 2004, to consider health care fraud-related issues in the context of SB 418 requirements. The session included presentations by a panel comprised of representatives of the Texas Hospital Association (THA), Texas Medical Association (TMA), Texas State Board of Medical Examiners (TSBME), National Health Care Anti-fraud Association (NHCAA), and the Texas Department of Insurance's (TDI) Associate Commissioner for Insurance Fraud. The full committee participated in discussions following the presentations. The issues discussed follow.

MAGNITUDE AND TYPES OF HEALTH CARE FRAUD

There are no state-specific estimates of the costs associated with health care fraud in Texas, and carriers are not required to report such data to TDI. National health care fraud estimates vary; a panelist in the session mentioned above, representing the NHCAA, indicated that his organization estimates fraud at $54 billion, or 3 percent, of all health care expenditures. The panelist further indicated that the U.S. Government Accounting Office suggests that health care fraud could reach 10 percent of expenditures, or about $180 billion nationally in 2004.

The type of health care fraud primarily discussed in the TACCP session involved actions associated with billing including billing for services not rendered, upcoding, and fee splitting among providers (e.g., for unnecessary referrals).

FRAUD PREVENTION AND INVESTIGATION

Fraud prevention and investigation activities are conducted by a variety of public and private organizations. Several public entities play a role. TDI's Fraud Unit, for example, is a law enforcement entity that receives referrals and conducts investigations about a wide variety of insurance fraud. If appropriate, the Fraud Unit refers cases to District and U.S. Attorneys for criminal prosecution or to regulatory agencies such as TSBME, the Board of Nurse Examiners, the Texas State Board of Pharmacy or the Board of Chiropractic Examiners. The Fraud Unit received 89 reports involving health care providers in fiscal 2002 and 71 such reports in fiscal 2003. In this two-year period, 10 cases were referred to regulatory agencies. To date, none of the cases involved criminal actions and there have been no indictments. Most reports were determined to involve disputed coding.

The Department issued a Commissioner's Bulletin (B-0057-04) in July 2004 that addresses requirements in the Insurance Code for reporting suspected insurance fraud and the governmental and non-governmental agencies to which fraud may be reported. The Insurance Code, Article 1.10D Sec.4 (2) directs each person, including insurers, to report suspected fraud that has been or is about to be committed to a local, state, or federal law

enforcement authority. Fraud may be reported to TDI via the Internet at www.tdi.state.tx.us/fraud/ or toll free at 1-888-327-8818.

The TSBME uses a complaint-driven process for investigating persons licensed by that agency. Anyone may file a complaint and, if TSBME opens an investigation, most are completed within 180 days.

The Texas Committee on Insurance Fraud, a cooperative association of insurers, law enforcement agencies, consumer members, TDI's Fraud Unit and national anti-fraud organizations meet voluntarily to communicate and coordinate their anti-fraud efforts. The goal of the Committee is to reduce insurance fraud, encourage effective prosecution of those who commit fraud, and provide education to the public about the impact of insurance fraud. This Committee is also working to develop legislation to fight fraud.

The TACCP also discussed the Health Facilities and Licensure Division of the Texas Department of Health and whether certain suspected fraud cases may fall within that entity's purview. At the time of this writing, Committee members are gathering additional information regarding the existing and possible roles of this entity.

TMA and THA also conduct programs that help providers comply with regulatory requirements. Both TMA and THA make referrals to the TSBME when an issue is identified that requires regulatory review.

Finally, the insurance industry invests significant resources in identifying and investigating fraud. By state law, insurance carriers must develop an anti-fraud plan, but are not required to submit them to a regulatory agency. One payor indicated that the cost to investigate a potentially fraudulent claim averages $5,000 and that it typically takes 18 months to resolve the case.

HEALTH CARE FRAUD ISSUES

The TACCP discussed a number of issues and concerns associated with fraud. In general, providers expressed concerns about the possible interpretation of unintentional errors as fraud. Providers are concerned that the complexity of coding and the varying provisions in contracts create differences in billing that might be seen as upcoding or overbilling, when they may actually reflect a coding error or a billing variance related to contract provisions. Payors, on the other hand, are concerned that a reduction in payment from the amount billed due to reasons such as inaccurate coding may be viewed as downcoding or inappropriate underpayment.

Carriers expressed concerns that SB 418 requires them to authorize payments in certain cases where fraud is suspected when the payment should actually be at least temporarily withheld until an investigation is completed. The process of documenting an intent to defraud often requires the confirmation of a pattern of fraudulent activity. Carriers indicate that they should not be subject to prompt pay penalties for delaying payments on cases where fraud is being investigated. Some affected parties believe that claims

involving suspected fraud were never intended to fall under the requirements of SB 418, while others indicate that the lack of a clear exception for such claims leaves the issue open to question. Specific issues regarding payments when fraud is suspected are discussed below.

Time Lines for Claims Payment

Payors suggested that SB 418's 180-day time period to audit a claim, even if combined with possible additional days allowed for carriers to make one information request of providers, does not give adequate time to process a fraud investigation to completion before they become obligated to make payment. One payor indicated that claims may meet the criteria for a clean claim set out in law and rule, thereby requiring payment of the claim within SB 418 time frames. One member expressed concern that paying a claim under such a circumstance could create a conflict with a carrier's fiduciary responsibility.

Providers indicated that payors should not be subject to SB 418 time lines unless the claim meets all criteria for a clean claim, including accuracy. A fraudulent claim would not be accurate. Providers indicated that SB 418 was aimed at payment of legitimate claims and not intended to inhibit valid anti-fraud activities.

Payment of Claims Where Verification Has Been Granted

Payors expressed concern that the verification process created by SB 418 requires carriers to pay a claim for which they have issued a verification, even if they suspect the claim is fraudulent. Providers suggest, however, that a verification is granted under a presumption that nothing about the associated claim will be fraudulent. If the claim is fraudulent, carriers should be able to use remedies currently available to them. If the provider misrepresented or failed to perform the proposed services, no payment is due.

Tools and Remedies for Addressing Health Care Fraud

The TACCP heard a variety of opinions on possible remedies for addressing fraud. At the Committee's request, TDI prepared and distributed to the TACCP a list of available tools and remedies for members' review.

Providers generally indicated that the industry should rely on existing legal and regulatory remedies along with creative industry solutions to deal with any issues of fraud. Providers indicated the intent of SB 418 was to address claims payment issues, not fraud. Providers suggest that under certain circumstances, for example, carriers may terminate a contract or recover claims paid if the claim involved material misrepresentation.

Payors, however, indicated that they experience considerable difficulty in retroactively recovering inappropriately paid claims, and that SB 418 does not include penalties for

providers who file fraudulent claims, whereas it does require penalties for carriers when claims are not paid timely.

One TACCP member representing a carrier suggested that TDI could adopt a rule change whereby a payor could suspend payment for fraud investigation given that a time limitation would be established by which the payor would be required to refer the case to an appropriate criminal or regulatory agency. In circumstances where fraud could not be substantiated by the allowed time frame, a payor would be required to pay the claim and applicable penalties to the provider. Payors expressed concerns about the need, at times, to keep an investigation confidential until adequate information is available to confirm suspected fraud.

SUMMARY

Parties affected by SB 418 differ on whether the legislation impedes a carrier's ability to deal with suspected fraudulent claims and whether any action is needed to clarify conditions as to when payment may be delayed or withheld during a fraud investigation.

APPENDIX A: PROVIDER CLAIMS DATA COLLECTION

JANUARY 2001 THROUGH AUGUST 2003

The TDI Provider Ombudsman Team initially identified 23 insurers and HMOs with the highest number of provider complaints. In May 2001, TDI requested data about claims payments to physicians and providers for the first quarter of calendar year 2001. The Provider Ombudsman and top TDI executives met with representatives from these carriers to reiterate TDI's expectations regarding prompt payment and put the carriers on notice regarding possible regulatory actions.

In August 2001, TDI requested second quarter data from the first group of 23 carriers. In addition, TDI identified a second group of 17 carriers for review and included them in the second quarter data call. Then TDI identified a third group of 12 carriers and included them in the third quarter data call in November 2001.

Fourth quarter 2001 data was requested from the 52 carriers in January 2002. These companies continued to report data each calendar year quarter through August 2003. As companies merged or left the market, the number of reporting companies dropped to 47. A table summarizing the data is included at the end of this section.

Reporting Companies

First Group

- Aetna Life Insurance Company
- The Prudential Insurance Co. of America
- Aetna U.S. Healthcare Inc.
- Aetna U.S. Healthcare of North Texas Inc.
- Prudential Health Care Plan, Inc.
  - Aetna Delegated Entities
- Blue Cross and Blue Shield of Texas (BCBS)
- Rio Grande HMO, Inc.
- Southwest Texas HMO, Inc.
- Texas Gulf Coast HMO, Inc.
  - BCBS Delegated Entities
- Cigna Healthcare of Texas, Inc.
- Connecticut General Life Insurance Co.
  - Cigna Delegated Entities
- Great-West Life & Annuity Insurance Co.
- Alta Health & Life Insurance Company
- One Health Plan of Texas, Inc.
- Humana Health Plan of Texas, Inc.
- Humana Insurance Company
- Employers Health Insurance Company
- PacifiCare of Texas, Inc.
  - PacifiCare Delegated Entities

- Sierra Health and Life Insurance Co. Inc.
- Texas Health Choice, L.C.
- UNICARE Life & Health Insurance Co.
  - UNICARE Health Plans of Texas
- United Healthcare Insurance Company
- United Healthcare of Texas, Inc.

Second Group

- Amcare Healthplan (HMO)
  - Amcare Delegated Entities
- Amerihealth Insurance Co.
- Avemco Insurance Company
- Central Reserve Life Insurance Co.
- Combined Insurance Co. of America (reinsured by Methodist Care)
- Conseco Medical Insurance Company
- Continental Assurance Company
- Dallas General Life Insurance Co.
- Fortis Benefits Insurance Company
  - Fortis Insurance Company
- Freedom Life Insurance Co. of America
- Gerber Life Insurance Company
- Guardian Life Insurance Company
- New England Life Insurance Company
  - Metropolitan Life Insurance Company
- Oxford Life Insurance Company
- Principal Life Insurance Company
- Trustmark Insurance Company
- World Insurance Company

Third Group

- American Heritage Life Insurance Company
- Amil International Insurance Company, Inc.
- Continental General Insurance Company
- Coventry Health and Life Insurance Company
- Golden Rule Insurance Company
- John Alden Life Insurance Company
- Methodist Care, Inc.
- Methodist Health Insurance Company
- Pacific Life and Annuity Company
- Protective Life Insurance Company
- Provident American Life & Health Insurance Company
- Provident Indemnity Life Insurance Company

TABLE 7: HB 610 Data Summary – January 2001 through August 2003

Note: Some carriers reported data that includes all claims, while others reported only clean claims.

Quarter/Year	Number of Clean Claims Paid Timely	Percentage Paid Timely	Number of Clean Claims Paid Late	Percentage Paid Late
January - March 2001 (23 companies)	6,401,404	96.06%	262,299	3.94%
April - June 2001 (39 companies)	6,752,838	99.29%	47,937	0.71%
July - September 2001 (49 companies)	6,661,544	98.16%	125,278	1.84%
October - December 2001	6,622,645	97.88%	143,217	2.12%
January - March 2002	5,915,499	99.53%	28,168	0.47%
April - June 2002	6,327,463	99.31%	44,211	0.69%
July - September 2002	5,064,238	99.23%	39,072	0.77%
October - December 2002	5,548,528	99.31%	38,423	0.69%
January - March 2003	5,214,433	99.23%	40,479	0.77%
April - June 2003	5,312,408	98.66%	71,923	1.34%
July - August 2003	3,392,778	97.50%	86,900	2.50%

Source: TDI HB 610 Provider Claims Data Quarterly Reports – January 2001 though August 2003