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

September 2006

Texas Department of Insurance

Mike Geeslin

Commissioner of Insurance

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August 31, 2006

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
Austin, Texas 78711

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

Dear Governors and Speaker:

This letter conveys the second report to the Legislature issued by the Technical Advisory Committee on Claims Processing (TACCP) in accordance with Senate Bill 418, 78th Regular Session. As directed by the bill, I appoint TACCP members, comprising insurers, health maintenance organizations, physicians and other health care providers, trade associations and other interested parties, such as the Office of Public Insurance Counsel. Together, the TACCP members and Department staff work to find solutions to issues surrounding claims processing.

Since the TACCP issued the last report in 2004, the Department continues to see a downward trend in the number of complaints received, reflecting improved compliance with requirements for carriers' timely payments to providers. Many of the issues initially addressed by the TACCP in the first report, such as timeliness of claims payments, have improved considerably. Now, the committee has shifted its focus from the basics of ensuring timely payment of claims to challenges presented from technological advances and market evolution. Emerging industry issues that affect claims payment, such as silent preferred provider organization discounts and claims payment clearinghouses, have become major topics considered by the TACCP.

This report outlines some of those newer concerns along with progress on the ongoing issues from the first report, such as coding and bundling practices and verification procedures. The TACCP has made great strides to bridge the gap between carriers and providers and address issues that concern each group. Going forward, the TACCP continues to work on unresolved issues. As such, the Department will continue to work with the TACCP, monitor the timeliness of claims payments, and take necessary actions as authorized by the bill.

Should you have any questions about this report or activities related to claims processing, please contact me or Carol Cates, Director of Government Relations, at 463-6123. Thank you for your consideration.

Sincerely,

Mike Geeslin
Commissioner of Insurance

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OVERVIEW OF PROMPT PAY STATUTES AND RULES

House Bill (HB) 610, passed in 1999, was designed to expedite payment by HMOs and issuers of preferred provider benefit plans of "clean claims" submitted by contracted physicians and providers. The Commissioner of Insurance adopted rules and, on April 9, 2001, appointed a provider ombudsman. Because providers continued to have concerns that claims were not being paid in a timely manner, Senate Bill (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, the Texas Department of Insurance (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. As of June 2006, TDI has instituted enforcement actions against carriers that have culminated in 48 consent orders and one settlement agreement, resulting in more than $48.6 million in restitution to providers and $24.24 million in penalties. Further, TDI instituted an enforcement action against a carrier for failure to provide an adequate process for the verification of medical benefits, resulting in a consent order entered in November 2004 and a $15,000 administrative penalty. Carriers indicate via quarterly provider claims data reports that 98 to 99 percent of claims were paid timely for the period of July 2004 through June 2006.

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 related to claims processing, as further described in TIC § 1212.002(a). 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 some individual members of the committee have changed since that time, the diversity of interests represented has remained constant.

Both HB 610 and SB 418 are prompt pay laws 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. In addition, certain provisions of SB 418 also apply to non-network emergency services and also to non-network specialty services provided on or after August 16, 2003, by a non-network physician or provider at the request of the carrier or preferred provider because those services are not reasonably available within the network. SB 418 does not apply to plans that TDI does not regulate directly, such as valid self-funded ERISA plans; workers' compensation coverage; self-funded 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.

HOUSE BILL 610 AND RELATED RULES

HB 610 required carriers to process clean claims (other than electronically submitted and affirmatively adjudicated pharmacy claims, for which the processing timeframe was 21 days) within 45 days of receipt. 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 would not be paid; (3) audit the entire claim, pay 85 percent of the contracted rate, and notify the provider that the claim would be audited; or (4) pay a portion of the claim and deny or audit the remainder, paying 85 percent of the contracted rate for 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. The presence of additional data elements or information not required did not render the claim deficient.

If a carrier was unable to pay or deny a clean claim within 45 days of receipt of the clean claim and the unpaid portion of the claim was classified as an audit, then the carrier was required to pay 85 percent of the contracted rate on the unpaid portion of the clean claim and notify the provider that the claim was being audited. The carrier was required to complete the audit within 180 days from receipt of the clean claim. Upon completion of the audit, if the carrier determined that a refund was due from the provider, the refund was due within 30 days of the later of either written notification to the provider of the audit results or exhaustion of subscriber or patient appeal rights, as applicable. If, however, additional payment was due to the provider, such payment was due within 30 days of completion of the audit. If the carrier did not finalize its determination of liability during the 180 day audit period, the carrier was required to submit the remaining 15 percent of the contracted rate to the provider, but carriers retained the ability to continue investigation of audited claims beyond the 180 day audit period, and, if the carrier

subsequently determined that it had no liability on the clean claim, the carrier could seek a refund.

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 in violation of the requirements.

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) identification 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 clean claim provisions had given carriers a significant amount of control by allowing them to require additional clean claim elements and attachments that varied from carrier to carrier. SB 418 requires standardization by providing that TDI 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 claim forms for physicians and noninstitutional provider claims and UB-92 claim forms for institutional provider claims. 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 to carriers within 95 days after services are provided, unless a provider has notified TDI of a catastrophic event. A physician or provider who fails to timely file forfeits the right to payment. 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 contracted rate for 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 mean “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 conducted an aggressive education campaign to inform all interested persons of the new provisions. Concerns related to health care claim fraud are more specifically addressed elsewhere in this report.

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 identification cards uniform and useful, the rules require that identification 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." The effect of this provision is to allow for easier identification of plans subject to TDI enforcement, as opposed to plans not regulated by TDI.

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 level of routine or emergency care 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. Concerns related to requests for verification are more specifically addressed elsewhere in this report. 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.

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 January 29, 2004, the Commissioner adopted rules setting forth the elements of a clean claim which must be included on a claim form submitted by a dental provider to an HMO. On June 21, 2004, 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 Texas Insurance Code (TIC) Article 21.52Z, now recodified to Chapter 1213. Consistent with TIC Chapter 1213, 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.

Carriers note that electronic claims have lower transaction costs and result in more accurate and timely payment. According to survey results published by America's Health Insurance Plans (AHIP), national statistics indicate that electronic submission is

on the rise.[1] AHIP reports that in 2006, 75 percent of claims were submitted electronically, and 25 percent of claims were submitted on paper. In contrast, in 2002, 44 percent of claims were submitted electronically, and 56 percent of claims were submitted on paper. AHIP reports that its 2006 survey is based upon aggregate data from almost 25 million claims, processed by 26 large and small health plans throughout the United States.

By comparison, data reported to TDI in response to TDI's SB 418 Provider Claims Data Calls for September 2003 through December 2003 indicates that for that quarter, 74 percent of claims were submitted electronically, and 26 percent of claims were submitted on paper. More recently, data reported to TDI for April 2006 through June 2006 indicates 85 percent of claims were submitted electronically, and 15 percent were submitted on paper.

Members representing providers note that the actions of both providers and carriers affect the number of claims available for electronic submission. Providers note the need for reasonably priced claims submission software and either direct electronic access to the carrier or indirect access via an electronic clearinghouse. Providers also desire that carriers limit the situations in which providers and physicians must submit clinical documentation in support of a claim, noting that both lack of access and inclusion of additional clinical document requirements directly affect the ability of the provider to submit claims electronically, thus resulting in lower electronic submission rates.

SENATE BILL 50 AND RELATED RULES

SB 50, passed in 2005, requires carriers, upon request by a participating physician or provider, to include in the physician or provider's contract a provision that neither the carrier nor the carrier's clearinghouse may refuse to process or pay a clean electronic claim because the claim is submitted together with or in a batch submission with a claim that is not a clean claim. SB 50 further provides that the Commissioner may issue a cease and desist order against or impose sanctions on a carrier that violates SB 50 or a contract provision adopted under SB 50. SB 50 only applies to contracts that were entered into or renewed on or after January 1, 2006.

All rules implementing SB 50 were discussed with the TACCP. On December 29, 2005, the Commissioner adopted amendments to the rules which included the contracting requirement of SB 50 and also defined the term "batch submission." The definition makes clear that the language of the statute and the amendment applies not only to clean claims submitted in a batch that includes a deficient claim, but also to groups of claims that may not be classified as a batch submission for federal standardized transactions. A carrier or carrier's clearinghouse that receives an electronic clean claim is subject to the requirements of Subchapter T (regarding Submission of Clean Claims) regardless of

[1] Source for AHIP survey results: Center for Policy and Research, America's Health Insurance Plans, *An Updated Survey of Health Care Claims Receipt and Processing Times*, May 2006, www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf .

whether the claim is submitted together with or in a batch submission with a claim that is deficient.

In the same orders, the Commissioner adopted amendments to the rules set forth in Subchapter T to ensure that penalties for failure to meet the statutory claims payment period are calculated consistently and in accordance with statutory requirements. These amendments were also discussed with the TACCP. The amendments include a definition of "patient financial responsibility," an example of a penalty calculation for a carrier's failure to meet the statutory claims payment period, clarification regarding the calculation of penalties for underpaid claims, and clarification that penalty calculation for claims that are subject to coordination of benefits for multiple carriers require that the contracted rate and billed charges must be reduced in accordance with the percentage of the entire claim that is owed by the secondary carrier. The topic of penalty calculation is discussed in more detail in Chapter 7 of this report. Finally, the adopted amendments changed the deadline for the annual reporting requirement for the number of declinations of requests for verification and clarified the reporting period for the required verification data report to provide for consistency with the date for quarterly reporting of claims data.

SENATE BILL 51 AND RELATED RULES

SB 51, enacted in 2005, in pertinent part revised preauthorization and verification response procedures for single service HMOs providing routine vision services and dental health care services. SB 51 requires that an HMO that provides either routine vision services or dental health care services as a single health care service plan should: (1) have appropriate personnel available at a toll-free number from 8 a.m. to 5 p.m. central time Monday through Friday, except for legal holidays, to receive and respond to requests for preauthorization and verification; (2) have a telephone system capable of accepting or recording incoming calls for verifications after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and legal holidays; and (3) respond to calls accepted or recorded on the HMO's telephone system not later than the next business day after the call is received. All rules implementing SB 51 were discussed with the TACCP. On December 29, 2005, the Commissioner adopted amendments to the rules to implement these changes, and to add definitions for the terms "routine vision services" and "single health care service plan" that are consistent with SB 51 and the definition of "single health care service plan" set forth in TIC § 843.002(26).

SB 51 further added §§ 843.210 and 1301.0061 to the TIC. Under these provisions, a contract between an HMO and a group contract holder and between an insurer and a group policyholder under a preferred provider benefit plan must provide that, in addition to any other premiums for which the contract holder or group policyholder is liable, the group contract holder or policyholder is liable for an enrollee's or individual insured's premiums from the time the enrollee or individual is no longer a part of the group eligible for coverage until the end of the month in which the contract holder or policyholder notifies the HMO or insurer that the enrollee or individual is no longer part of the group

eligible for coverage by the contract or under the policy; the enrollee or individual remains covered until the end of that period.

Subsequent to the enrollment of SB 51, the department received requests for formal guidance and procedures necessary to implement the legislation uniformly. In response, on January 30, 2006, the department filed a proposal to add new Subchapter FF, §§ 21.4001—21.4003. A public hearing was held to consider adoption of the proposed new sections on February 21, 2006. In drafting the rule, the department sought to address the competing needs of providers, carriers, employers, group policyholders, and group contract holders while implementing the legislative goals of encouraging prompt notification of coverage termination and limiting retroactive coverage denials. The proposed rule established a minimal additional notice period to allow for timely notice of late-month coverage terminations, which was a primary topic of discussion at the February 21, 2006 hearing. An informal group of stakeholders subsequently convened, including Texas Hospital Association, Texas Medical Association, Texas Association of Health Plans, Texas Association of Health Underwriters, Texas Association of Business, and various other business representatives. The workgroup recommended changes to the proposed rule, including one related to the operational implementation of a grace period. Staff incorporated the workgroup language into the final adoption order, and the Commissioner adopted the new sections on June 26, 2006.

Among other things, the new rules: (1) explain the purpose and scope of the subchapter; (2) define relevant terms; (3) address group policyholder and contract holder liability for the obligation to continue premium payment and coverage requirements after notice of an individual's lost group eligibility and outline the requisite contract language; (4) define a receipt date for notice tendered by mail; and (5) detail means of complying with the statute, including providing notice of late-month terminations and situations involving duplicative or unnecessary coverage.

Under the rules, if an individual or enrollee ceases to be a part of the group eligible for coverage within seven calendar days prior to the end of the month, the group policyholder or contract holder will be deemed to have notified the health carrier in that same month as long as the carrier receives notification within the first three days of the subsequent month, excluding Saturdays, Sundays, and legal holidays. The rules require agreement between the group policyholder or contract holder and the health carrier regarding the transmission method of such late-in-the month notifications, which must provide for immediate written notification.

Recognizing that group policyholders or contract holders will sometimes be able to notify health carriers of an individual's prospective loss of coverage eligibility before the individual leaves the group, the rules allow for termination of premium payment and coverage on the date the individual leaves the group if the employer provides at least 30 days prior notice. Further, because an individual no longer a part of the group eligible for coverage under a plan may elect to terminate coverage and obtain coverage under a successor health benefit plan that takes effect after termination of group eligibility and

before the end of the coverage and requisite premium payment periods, the rules clarify that a group policyholder or contract holder may eliminate its premium payment and coverage responsibilities if the group policyholder or contract holder verifies the successor coverage and agrees to be responsible for payment of premium if the individual's successor plan fails to provide coverage during the period for which the rule otherwise obligates them to continue premium payment and coverage.

Finally, the rules clarify that the obligations to pay premium and to provide coverage do not apply to certain continuation coverage; do not apply to health benefit plans under which the group policyholder or group contract holder does not contribute to the payment of premium for any individual covered under the plan; and terminate upon an individual's demise.

Some members of the TACCP feel that the adoption of the SB 51 provisions requiring payment for an enrollee's coverage until the carrier is notified that the enrollee is no longer eligible for coverage will reduce the number of situations in which verification under SB 418 will be necessary.

SENATE BILL 1149 AND RELATED RULES

SB 1149, enacted in 2005, added TIC Ch. 1274, Electronic Transmission of Eligibility and Payment Status. SB 1149 requires health benefit plan issuers to provide certain enrollee eligibility, benefit, and financial information to participating providers upon a participating provider's submission of the patient's name, the patient's relationship to primary enrollee, and the patient's birth date. All rules implementing SB 1149 were discussed with the TACCP. On December 29, 2005, the Commissioner adopted rules which: (1) define the scope of the subchapter and clarify that the provisions of the subchapter do not apply to Medicaid and Children's Health Insurance Program (CHIP) plans; (2) define terms used within the subchapter; (3) require that, beginning January 31, 2006, a health benefit plan issuer communicate, in writing, to each participating provider that enters into or renews a contract with the health benefit plan issuer, the method(s) by which the provider may request an eligibility statement; (4) identify the information a provider must include in a request for an eligibility statement; (5) require health benefit plan issuers to maintain a system to enable it to provide eligibility statements upon receipt of compliant requests to allow the provider access to the information at the time of the enrollee's visit or, if the health benefit plan issuer is unable to provide an eligibility statement, require the health benefit plan issuer to notify the provider such that the provider receives the response at the time of the patient's visit and may contemporaneously request additional information to assist the health benefit plan issuer to issue the eligibility statement; (6) specify the required content of an eligibility statement; (7) provide that a health benefit plan issuer may refuse to provide all or a portion of an eligibility statement if applicable privacy laws prevent disclosure, but require the health benefit plan issuer to describe the reason(s) for refusal and, within three days of such refusal, to provide a written explanation of the reason(s) for refusal

identifying the applicable law(s) that prevent disclosure; and (8) clarify that an eligibility statement is not a verification.

Summary

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

EDUCATION AND OUTREACH

From April 2001 through August 2006, the agency's Provider Ombudsman and other TDI staff completed 93 educational presentations on prompt pay statutes and rules (HB 610 and SB 418). Following passage of SB 418 in 2003, TDI partnered with the Texas Hospital Association (THA), Texas Medical Association (TMA), the Texas Association of Health Plans (TAHP), and other organizations and groups to educate physicians, providers, and insurance industry representatives throughout Texas. The summary of presentations by city is:

- Austin (26)
- Dallas-Fort Worth (16)
- San Antonio (11)
- Houston (8)
- Plano (4)
- Round Rock (3)
- Corpus Christi (2)
- Irving (2)
- Lubbock (2)
- McAllen (2)
- San Diego (2)
- Birmingham, AL (2 - Healthsouth)
- Abilene, Amarillo, College Station, Denton, El Paso, Galveston, Kaufman, Longview, Lufkin, Midland, Mission, Tyler, and The Woodlands (1 each).

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 includes:

- summaries of legislation and rules relating to prompt pay (SB 418 and HB 610)
- links to bulletins and rules
- 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, provider groups report they conducted training and outreach activities regarding prompt pay. The Anesthesia Administrators of Texas included a clean claims/prompt pay presentation at its annual educational conferences. Some providers also conducted regular staff meetings regarding prompt pay issues and shared materials distributed via the TACCP and TDI. Also provider groups posted prompt pay updates on their websites.

In addition to the programs previously mentioned, over the past two years, TMA has conducted several education outreach programs regarding the benefits and obligations of Texas' prompt pay laws. In 2004, seminars were held in 10 Texas cities including Abilene, Austin, Corpus Christi, Dallas, Fort Worth, Houston, Lubbock, McAllen, San Antonio, and Tyler. In 2006, seminars were held in 12 cities including Abilene, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston, Lubbock, McAllen, Midland, San Antonio, and Tyler. The education efforts were designed to meet the needs of physicians, physician office managers and administrators, and coding staff.

CLEARINGHOUSES AND BILLING SERVICES

CLEARINGHOUSES

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" network and switch, 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 nonstandard 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.

As a result, 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 Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for establishing regulations on conditions under which a claim may be rejected. CMS has not specified definitively 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.

In response, the Legislature enacted SB 50 during the 79th Regular Session - 2005.

- SB 50 requires that carriers include, upon request, a provision in the provider's contract indicating that the carrier will not deny or refuse to process an otherwise clean claim submitted in a batch of claims that may contain deficient claims.
- The department has adopted amendments to rules in Texas Administrative Code (TAC) Chs. 3 and 11 to implement SB 50. TAC § 21.2807 is amended to provide that a carrier may not deny or refuse to process a clean electronic claim because the claim is submitted together with, or in a batch submission with, deficient

claims. This amendment is consistent with statutory and regulatory requirements that, upon receipt of an electronic clean claim at the designated address for claims receipt, a carrier must pay, deny, or audit the claim within 30 days.
- While SB 50 enables providers to be better informed of their rights under their contracts with health benefit plans, adopted § 21.2807 clarifies that the requirement to process an electronic claim exists independently of the existence of a provision in the contract addressing batch claim submissions.

In 2005, TDI received some complaints from TACCP members and providers regarding payor-contracted clearinghouses that were dropping electronic claims to paper then mailing the claims to payors. If an electronic claim is submitted by a provider and received at the payor's designated claim address in electronic format, then the claim is subject to the 30-day prompt pay timeframe for electronic claims. The payor and the two clearinghouses involved reached an agreement and the two clearinghouses have stopped this practice. TDI added an FAQ on this topic to the provider web page clarifying that if a provider submits an electronic claim to the designated claims payment address and the format is changed by a clearinghouse ("dropped to paper") then the payor is still subject to the prompt pay timeframes for an electronic claim. TDI has received no additional complaints about this practice. This success story is an example of how TACCP and TDI worked together to identify a claims payment issue and take positive action to address it.

BILLING SERVICES

A billing service generally acts as a provider's third-party billing company. Billing services can also provide a wide range of services in addition to preparation of health insurance claims. For example, some services review contracts for their physician customers, handle patient appointments and registration as well as charge entry, billing, payment posting, statements, and other "back office" functions. A billing service differs from a clearinghouse in that a billing service submits electronic claims, while a clearinghouse accepts electronic transmissions, re-formats them, and sends them on to the carrier.

Issues discussed by the TACCP with billing service representatives include:

- Minimizing the gap in time between the date of service and the electronic claim transaction date.
- Transferring information from the physician to the billing company timely.
- Minimizing carriers' requests for additional information by making sure procedure and diagnosis codes are properly linked, all charges are captured, assignment of benefit forms are signed, and other billing functions completed, before claims are submitted.
- If payment is received via lock box with documentation sent to the billing company, then the posted payment date may differ from the actual payment date.
- SB 418 created a new process, verification, which permits physicians and providers to rely upon the representations of a carrier that he or she will be paid

for a particular service provided to a particular patient. There is some confusion that may still exist regarding how to clearly communicate a request for a verification (a term of art under Texas prompt pay laws) versus a confirmation of eligibility for benefits, a distinction not contemplated by the TIC. Also verifications or guarantees of payment have been given for one procedure then later changed to another.

- Carriers' Explanation of Benefits (EOB) forms vary widely. As a result, it is often difficult to determine what a payment is for. Texas should consider adopting a standard EOB form.

In addition, billing services are not licensed by the state. Two organizations, the Healthcare Billing & Management Association (HBMA) and the Health Care Financial Management Association, offer credentials for billing service professionals. Billing services are often small businesses that have a high rate of business failure; for example, 89 percent of the HBMA members who did not renew their memberships are no longer in business. The federal Health and Human Services Office of the Inspector General is also looking at licensing of billing services. Both providers and carriers agreed that the TACCP should explore the need for statutory changes necessary to effectively regulate entities that provide billing services.

CODING AND BUNDLING

OVERVIEW

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…and with respect to the implementation of the standardized coding and bundling edits and logic." (TIC § 1212.002(a)).

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.
- 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.

Codes play an essential role in the reimbursement for physician services, which 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.
- The claims processing rules used by the health plan that is adjudicating (i.e., processing) the claim.

While codes are assigned to describe the service or procedure performed by the physician or provider on a claim form, billing and pricing activities also 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 contractual fee agreement. 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, global periods for surgical procedures, multiple surgery reduction policies, maximum frequency per day policies and other limitations relating to coding for diagnoses and procedures.

To estimate the magnitude of this issue in Texas, TDI examined the number of complaints related to bundling and coding. Since September 1, 2004, the department received 22 complaints related to bundling and eight complaints related to downcoding. Of those complaints, the department determined that only five of the bundling complaints and two of the downcoding complaints were justified.

TACCP PANEL

On March 8, 2006, TDI conducted a panel discussion including representatives of proprietary claims processing firms. Panelists made the following points:

- Coding affects the bottom line; for example, a 1 percent error in coding can result in a 15-20 percent change in the cost, according to one estimate.
- The U.S. Department of Health and Human Services Office of the Inspector General (OIG) estimates the misuse of modifier overrides costs millions of health care dollars. The OIG audits providers, issues findings, and assesses fines.
- Edits can be applied to a single medical procedure. A multi-code edit can be applied when certain procedures are done in combination. An edit to bundle has the effect of paying one part of a multi-code procedure, while other parts are not paid. Modifiers can be applied that may override multi-code edits.
- The key developers are:
    - The American Medical Association (AMA) – originates Current Procedural Terminology (CPT) codes, and vast amounts of resource materials, manuals, and publications about CPT coding
    - CMS – originates Healthcare Common Procedure Coding System (HCPCS) codes and directives, the National Correct Coding Initiative, the National Medicare Physician Fee Schedule, clinical laboratory fee schedules, and Relative Value Units (RVUs) used in Medicare
    - Fiscal intermediaries (carriers) – may suggest new codes
    - Medical specialty societies – may suggest new codes for their specialties as procedures change or new ones develop.
- It takes an estimated five to seven years to develop and adopt a new code for procedures or services. The coding system is not keeping pace with advances in medical treatment and procedures.
- Assignment of codes is extremely complex and requires interpretation, and this can lead to conflict among the stakeholders.
- To develop a standard for coding and bundling, some of the elements of such a process might include representatives from all stakeholders – AMA, CMS, carriers, medical societies, etc. – who would review an analysis of Texas claims data and then select certain codes or code combinations to focus on.
- Analysis of assigned codes occurs within the context of payors' health care reimbursement policy, contract management, benefits management, and efforts to identify fraud and abuse. These factors should also be considered.
- Electronic medical records will be implemented in the future, and this will have an impact on such a project.

- The consumer's point of view should also be considered.

TACCP members explained that codes are bundled differently by different payors, or the same payor could bundle and pay the same procedure(s) differently on different occasions. Physicians and providers are often caught in the middle between two conflicting systems – CMS and the Medicare program, and commercial HMOs and insurers. Providers say there needs to be a way to resolve such conflicts.

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 to be used when submitting standard transactions. Although payors are required to use the national standard code sets, payors are also allowed to continue their current adjudication processes. As a result, payors 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 CPT developed and maintained by the AMA and HCPCS developed and maintained by CMS. 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 "mid-level" Evaluation and Management, often referred to as an office visit, code 99213, and a "higher level" Evaluation and Management code 99214). However, 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 and payment 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 indicate an unusual circumstance that will affect reimbursement for the service or procedure.

BUNDLING AND OTHER PRACTICES

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 many bundling policies are inconsistent with its standardized CPT guidelines. Bundling of services has an enormous impact on physician reimbursement and is reportedly the basis of many disputes between physicians and health plans. Bundling policies were developed in response to concern among carriers that some providers unbundle procedures to maximize reimbursement. Physicians and other providers are equally adamant that bundling policies are used by carriers to withhold payment for services provided to enrollees in good faith.

Unbundling services can occur due to the complexity of coding, but is sometimes a fraudulent attempt to manipulate payments systems. In recent years, reports from the OIG have found substantial numbers of claims to be inappropriately coded. The OIG reports that the national paid claims error rate in the Medicare fee-for-service (FFS) program was 5.1 percent.[2] The report allocates improper payments among the following types:

- No documentation errors - 0.6 percent
- Insufficient documentation errors - 1.0 percent
- Medically unnecessary errors - 1.4 percent
- Incorrect coding errors - 1.8 percent
- Other errors - 0.3 percent

The OIG does not estimate whether any portion of the 5.1 percent error rate is attributable to fraud.

For Medicare, unbundling is defined by CMS within the National Correct Coding Policy 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

[2] Centers for Medicare and Medicaid Services, *Improper Medicare FFS Payments Long Report*, 2006.

identify procedures and services that are not normally reported together, but are appropriate under the circumstances. Examples include 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 so that medically necessary unrelated services may be paid for appropriately.

Upcoding occurs when a provider bills for a service which is not supported by proper documentation. Downcoding occurs when a payor denies or changes codes submitted on a medical claim. Upcoding and downcoding may be done for legitimate reasons, may be done in error, may be inappropriate, or may be fraudulent.

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/HCPCS and ICD-9CM as well as other standard code sets. However, the software is highly sophisticated and may be customized by the payor to suit their particular adjudication criteria.

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 is 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.

TACCP DISCUSSION

Overview of American Medical Association/Texas Medical Association Position

In 2004, the Board of Trustees of the American Medical Association was directed by its membership to study the feasibility of developing a national standard for the utilization of CPT codes by providers and payors. Providers feel that such a standard could help address the controversy over bundling and downcoding. While no entity may modify the meaning or definition of CPT codes or revise the actual code numbers themselves, there is no prohibition against "bundling edits" commonly used by insurers and other payors. AMA physicians argue that such edits are intended solely to reduce claims payments to physicians, are inconsistently applied by payors, and are not necessarily based on sound medical reasoning.

To address this issue, the AMA contracted with Health Policy Alternatives (HPA) to conduct a study of the problem and provide recommendations to the AMA. After a

lengthy study that included more than two dozen interviews and meetings with key stakeholders, HPA concluded that:

> "…developing a national standard for the utilization of codes, code combinations, and modifiers that is consistent with all CPT codes, guidelines and conventions, and that would be used by all commercial and government payors, is not feasible. Without exception, all interview subjects from public and private payors stated that they would oppose the mandatory use of CPT rules and guidelines in the form of code edits. Such a mandate was viewed as interference with the establishment of payment policies and would be strongly resisted."[3]

After reviewing the HPA report, the AMA Board of Trustees determined "that any AMA efforts to develop code combination edits would almost certainly be limited to voluntary use and existing problems with private code editing packages would continue. In addition, legislative or regulatory initiatives could have unintended consequences if they led to policy changes unacceptable to physicians, such as weakening the standing of CPT or formally recognizing insurers' ability to use a range of claim editing systems."[4] The AMA Board instead recommends that the AMA take several steps to continue working on the issue, such as opening CPT editorial panel meetings to all CPT stakeholders; creating a committee and process for reviewing private code editing packages, assuming they obtain the cooperation of code edit vendors; and developing an editorial process for publication of CPT Assistants that would include input from payors, physician organization, non-physician health care professionals, and other CPT stakeholders.

Following the conclusion of this study, in January 2006, the AMA wrote TDI and explained that, while the AMA continues to actively explore the feasibility of developing a standardized code editing system, they are not "opposed to TDI, working with TMA and other appropriately licensed interested parties, to develop its own code editing platform that adheres to all CPT codes, guidelines and conventions." TMA representatives on the TACCP reiterated this position and continue to encourage the TACCP to consider adoption of standardized edits for use in Texas. TAHP representatives urge the TACCP to not consider adopting standardized edits as even research conducted on behalf of provider groups determined that such a system is not feasible. Additional studies commissioned as part of HIPAA implementation have reached similar conclusions.

Federal Guidance

To determine whether federal law or regulations pre-empt the state from adopting standards for bundling and coding procedures, TDI staff contacted the CMS. CMS oversees implementation of the national electronic health claim transaction standards,

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[3] American Medical Association, *Report 7 of the Board of Trustees, Feasibility Study on Developing a National Standard for the Utilization of CPT Codes, Code Combination, and Modifiers*, 2005, 4.
[4] Ibid., 8.

which require payors and providers to use standard formats and codes for electronic health care transactions.

CMS staff explained that no federal provision would prohibit TDI from implementing guidelines or standards related to the usage of bundling and/or coding procedures for commercial insurance claims in Texas. While CMS does issue guidance related to bundling and coding for certain Medicare and Medicaid claims, that authority does not extend to the private insurance market. As long as a state entity does not change the meaning of a standardized code and does not edit or revise the code numbers themselves, there is no prohibition against adopting usage directions that describe circumstances when certain codes may or may not be bundled, or restrict the practice of downcoding by payors or upcoding by providers.

Multi-State Litigation and Settlement Agreements

At the May 2006 TACCP meeting, TMA presented a possible approach to developing coding and editing standards based on the settlement agreements reached in the multi-state litigation *In Re Managed Care Litigation* (00-MD-1334-MORENO). TMA is a party to the lawsuit along with the state medical associations of California, Florida, Georgia, Louisiana, and other states. The companies named in the suit included Aetna Inc., Anthem, Inc., CIGNA Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., PacifiCare, Prudential Insurance Company of America, UnitedHealth, and WellPoint Health Networks Inc. Of these companies, Aetna, CIGNA, Health Net, Prudential, WellPoint, and Humana have reached settlement agreements with the physicians. A side-by-side comparison of the coding-related provisions of the individual health plan's settlements reveals a similarity in language.[5] TMA proposes that the coding issues addressed in the settlement agreements could be a resource for discussing coding and editing standards. Some TACCP members suggest that further discussion is warranted before the committee makes a recommendation to the Commissioner.

NEXT STEPS/RECOMMENDATION

Coding and reimbursement methodologies are dynamic and based on ever-changing payment policies and market pressures. Attempting to implement a standardized coding and bundling system beyond what is already in place through CPT codes and other coding systems would be a complex, difficult, and controversial task. In directing the TACCP to advise the Commissioner on implementation of the standardized coding and bundling edits and logic, the bill language provides an opportunity for the recommendations to range from recognizing the complexity and intricacy and deferring to existing standards to the other extreme of imposing strict and specific requirements on coding and bundling edits by carriers.

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[5] Source: www.hmosettlements.com, "Settlements At-A-Glance Fairer Payment Rules, Coding Edits More Consistent with CPT Codes, Guidelines and Conventions."

The carriers emphasize that, given the incredible complexity of the coding issue in general, the fact that multiple studies have indicated that implementing a system of standardized edits, modifiers, and utilization of codes is not feasible, the federal government has opted not to pursue such a system, and there is no consensus among TACCP members, it would be reasonable for the TACCP to report that this issue is simply too complex and contentious to be resolved by the state at this time. TMA counters that the coding issues addressed in the multi-state litigation settlement agreements can be a resource to use in creating a standard.

DISCLOSURE OF FEE SCHEDULES

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. In addition, statute and rules require that payors give 90 days written notice prior to instituting any changes to the claims processing information.

Health plans report a wide range in the number of requests from providers for fee schedules. Some health plans reported they have received more than 100,000 requests while others indicated they had received no requests.

Since September 1, 2003, TDI has received 10 complaints regarding disclosure of fee schedules, five of which were "justified." Additionally, TDI, in discussions with individual payors and providers, has reminded those parties of the prior-notice requirements regarding changes to claims payment information.

TDI will continue to foster compliance with requirements related to fee schedules by informing affected parties of the provisions in the statute and rules and addressing any complaints as they arise. If significant complaint trends appear, TDI will present its findings to the TACCP for consideration.

IMPLEMENTATION OF THE NATIONAL PROVIDER IDENTIFIER NUMBER AND USE OF DEA NUMBERS

NATIONAL PROVIDER IDENTIFICATION

TIC §§ 843.336 and 1301.131 require that a clean nonelectronic claim by a physician or a provider other than an institutional provider must be submitted using the CMS Form 1500 or, if adopted by the Commissioner by rule, a successor to that form developed by the National Uniform Claim Committee (NUCC) or its successor. These sections also require that a clean nonelectronic claim by an institutional provider must be submitted using the CMS Form UB-92 or, if adopted by the Commissioner by rule, a successor to that form developed by the NUCC or its successor. Through the U.S. Department of Health and Human Services (DHHS) Office of the Secretary, CMS has proposed successor forms as part of its implementation of the Administrative Simplification subtitle F of the Health Insurance Portability and Accountability Act of 1996. On June 29, 2006, the Office of Management and Budget (OMB) approved the CMS 1500 for use by the Medicare program. The OMB has not approved the successor form for institutional claims as of the date of this report.

On January 24, 2004, DHHS published its final rule regarding the Standard Unique Health Identifier for Health Providers. The rule establishes the standard for a unique health identifier for use in the health care system, adopts the National Provider Identifier (NPI) as that standard, and sets forth implementation specifications for use of the identifier. Under the rule, health care providers who transmit any health information in electronic form must obtain and use an assigned NPI on all standard transactions that require a health care provider identifier. Health plans and health care clearinghouses who transmit any health information in electronic form must also use the NPI of any health care provider that has been assigned an NPI on all standard transactions that require a health care provider's identifier. Except for small health plans, compliance with the rule is required by May 23, 2007. Small health plans must use the NPI by May 23, 2008.

As part of the CMS implementation of the NPI, CMS proposed to temporarily extend use of the CMS-1500 (12/90) form, used for professional nonelectronic claims, and concurrently proposed approval of the CMS-1500 (08/05) as the successor to the CMS-1500 (12/90). As indicated above, the OMB approved the CMS-1500 (08-05) for use by CMS on June 29, 2006. CMS has recently indicated that it will begin accepting the CMS-1500 (08/05) on January 2, 2007, and will require use of the new form effective April 2, 2007. CMS has indicated that it will discontinue use of the CMS-1500 (12/90) in 2007. While earlier implementation by CMS had been anticipated, CMS announced at the May meeting of the NUCC that the necessary systems changes required for acceptance of the revised form by CMS were not in place and would not occur with the October 1, 2006, release of the new form. CMS indicated that this delay was a result of a cutback in contractor work hours by the agency. A new request is being submitted for the systems changes to occur with the January 1, 2007, release, and further information from CMS will be forthcoming. The NUCC recommends that health plans,

clearinghouses, and other information support vendors be prepared to accept the new CMS-1500 by October 1, 2006, and to discontinue use of the CMS-1500 (12/90) on April 1, 2007. With regard to nonelectronic institutional provider claims, CMS has proposed approval of the CMS-1450 (UB-04) as the successor to the CMS-1450 (UB-92). CMS indicates that the UB-04 will be available for use beginning March 1, 2007 and will be required for use effective May 23, 2007, at which time the CMS-1450 (UB-92) form will be discontinued. The comment period for the CMS-1450 (UB-04) closed on April 25, 2006.

In anticipation that CMS will discontinue the currently adopted CMS 1500 and 1450 claim forms in 2007, the TACCP has determined that adoption of the successor forms by the Commissioner and a revision to the rules regarding elements of a clean claim is necessary. The federal timelines for transition to the new forms has been dynamic. TDI and the TACCP continue to monitor the federal transition process in an effort to maximize the department's responsiveness to these changes. The most recent changes to the federal timelines occurred in July 2006, and TDI plans to share a proposal to address those changes regarding submission of nonelectronic claims by a professional provider with the TACCP in August 2006. Based upon the timelines currently proposed by CMS for implementation of the new CMS-1500 (08/05), TDI anticipates that the resulting rule amendments will be proposed and adopted by late fall of 2006. Because current CMS estimates indicate that the new CMS-1450 (UB-04) will not be in use prior to March 2007, TDI anticipates that the resulting rule proposal regarding submission of nonelectronic claims by an institutional provider will be proposed and adopted in early winter of 2006/2007.

Finally, the TACCP has determined that because the rule regarding clean electronic claims set forth in 28 TAC § 21.2803 states that a physician or provider submits an electronic clean claim by submitting a claim using the applicable format that complies with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements, and because no successor form has been established for the Professional 837 (ASC X12N 837) or the Institutional 837 (ASC X12N 837) required by TIC §§ 843.336 and 1301.131 for use by professional and institutional providers respectively, no change to the current rule regarding clean electronic claims is necessary at this time.

USE OF DEA NUMBERS

TDI has received complaints that carriers are requiring health care professionals to furnish a Drug Enforcement Administration (DEA) registration number for non-controlled substances because it is required in order to pay the claim. Members representing physicians are very concerned about this practice. The issue was discussed during TACCP meetings, and on March 17, 2006, the Commissioner issued Commissioner's Bulletin No. B-0011-06 regarding such use of DEA registration numbers. A DEA registration number evidences an individual's authority through the DEA to buy, own, distribute, or prescribe controlled substances. The DEA's Office of

Diversion Control has indicated that a carrier's use of the DEA registration for identification purposes unrelated to such authorization is contrary to the intent of the national drug control policies and could weaken the registration system. The DEA neither requires nor approves the use of DEA registration numbers by health carriers for noncontrolled substance claims. A consensus statement[6] published by the DEA notes the following:

> The intent of the DEA registration number is to identify and validate those individuals who have been authorized by the federal DEA to prescribe controlled substances in the course of their professional practice. The disclosure of a practitioner's DEA registration number to entities other than those involved in the legal distribution of controlled substances or the enforcement of the laws governing their legal distribution may facilitate the diversion of controlled substances from the legal channels of distribution. The improper use of the DEA registration number by insurance companies and/or other health care providers for identification purposes is contrary to the spirit of the [Controlled Substances Act of 1970] and national drug control policies. The improper use of the DEA registration number for identification purposes results in an unnecessary proliferation in the issuance of DEA registrations to many health care professionals who have neither a need nor desire to use or handle controlled substances in their chosen professions. This increases the probability of prescription fraud and diversion.

A TACCP member representing providers has also expressed a concern that consumers will be affected by the practice of requiring DEA registration numbers for identification purposes where noncontrolled substances are being dispensed. The member notes that consumers purchase health insurance to assist in payment of health care when needed, and pharmacy benefits are often included in the insurance plan. Consumers are caught in the middle and having to pay full price for noncontrolled medications if the physician will not provide the DEA number to the pharmacy. Physicians, in turn, are refusing to provide the DEA number for noncontrolled substances because the DEA has indicated that the number is intended for controlled substances only.

TDI has determined that a health carrier's requirement of a provider's DEA registration number for identification of claims is inappropriate. TDI recommends that carriers therefore implement the new NPI system or an alternative method of identification of providers as soon as possible and discontinue inappropriate use of DEA registration numbers. The NPI creates a unique identifier for health care providers and further, according to 45 C.F.R. § 162.404, the NPI must be used by a covered health care provider, health care clearinghouse, or large healthcare plan for HIPAA transactions on and after May 23, 2007, and must be used by any HIPAA-covered small health plan on and after May 23, 2008. For identification purposes, health carriers should use the NPI

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[6] Source: *Consensus Statement to Eliminate the Improper Use of Drug Enforcement Administration Registration Numbers*, http://www.deadiversion.usdoj.gov/pubs/pressrel/consensus.pdf.

number or a suitable alternative and should discontinue any inappropriate use of the DEA number.

Some TACCP members representing carriers have pointed out that, while inappropriate, use of the DEA number for identification purposes is not illegal. Texas Health and Safety Code § 481.003(b) requires the director of the Department of Public Safety of the State of Texas to adopt a rule "prohibit[ing] a person in this state, including a person regulated by the Texas Department of Insurance under the Texas Insurance Code or the other insurance laws of this state, from using a practitioner's Federal Drug Enforcement Administration number for a purpose other than a purpose described by federal law or by this chapter. A person who violates a rule adopted under this subsection commits a Class C misdemeanor." However, pursuant to SB 1356, enacted in 2003, "the director of the Department of Public Safety of the State of Texas shall adopt the rules required by Section 481.003(b), Health and Safety Code, not earlier than the 180th day after, and not later than the first anniversary of, the date on which compliance with a rule adopted by the United States Department of Health and Human Services creating a universal provider numbering system is required…" As indicated earlier in this chapter, compliance with the NPI rule is required by May 23, 2007, or by May 23, 2008, for small health plans.

PROMPT PAYMENT PENALTIES

SB 418 changed the prompt payment penalty calculations for clean claims that were paid late or underpaid. These changes included a graduated penalty structure and a cap. During 2004 through mid-year 2006, three things occurred regarding prompt pay penalties: a bulletin concerning the timeliness of penalty payments was issued, a rule was revised to clarify appropriate calculation of the penalties, and a proposal was made to alter the penalty amount owed for underpaid clean claims.

In February 2005, TDI issued Commissioner's Bulletin No. B-0008-05, concerning the timely payment of prompt payment penalties. Physicians and providers reported that certain insurance carriers failed to pay penalty amounts at the time the late claims or balances of underpaid claims were paid. The bulletin cited TIC §§ 1301.137 and 843.342 and the requirement to "pay claim plus penalty." It also cited TAC § 21.2815 regarding the requirement for health care plans to "...pay to the preferred provider, in addition to the contracted amount owed, a penalty." The bulletin states payments should occur simultaneously and that TDI would consider enforcement action against carriers if penalty payments not timely paid. TDI has received 30 complaints about penalty payment since September 2004.

Also, TDI amended the prompt pay rules to assure that penalties for failure to meet the statutory claims payment periods are calculated consistently and in accordance with statutory requirements. The rules clarified patient responsibility – any portion of the contracted rate for which the patient is responsible pursuant to the terms of the patient's health benefit plan. Also, the rules included examples to illustrate payments that involved a patient responsibility component or a secondary carrier. Finally, TDI updated provider educational materials to reflect additional penalty payment calculations.

In addition to the timely payment of penalties, TACCP members also discussed a second issue regarding penalty payments. Under SB 418, health carriers must pay penalties for claims paid timely but incorrectly. The formula for determining the penalty for an underpaid claim is contained in 28 TAC § 21.2815(d). At the TACCP January 11, 2006, meeting, a carrier member, UniCare, presented a request for a rule change related to the underpayment penalty. In certain situations, the formula contained in the TDI rule results in a total payment to the provider, including the penalty, that exceeds billed charges. Under the late payment penalty structure, the maximum penalty is billed charges. (The penalty amount for both late and underpaid claims may also be subject to additional interest of 18 percent.)

The underpayment penalty formula under § 21.2815(d) is:

Underpaid Amount/Contracted Rate X Billed Charges = Penalty Payment

The TAHP and the health carrier members of the TACCP, including UniCare, propose the following formula as an alternative:

> Underpaid Amount/Contracted Rate X Discount (Billed Charges less Contracted Rate) = Penalty Payment

Under this alternative formula, the penalty increases as the underpayment amount increases and the total payment eventually reaches billed charges**.** Using the alternative formula, the maximum penalty for underpayments would be the same as for late payments.

The carriers also pointed out that the statutory language related to underpaid claims, contained in TIC §§ 843.342 (g) and 1301.137 (g), states "the underpaid amount is calculated on the ratio of the amount underpaid to the contracted rate as applied to the billed charges." They believe the legislative intent behind the underpayment penalties in SB 418 was to provide for a penalty structure that was proportionate to the amount of the underpayment. Health plans argue that the legislative intent did not support a penalty structure where underpayment penalties could exceed the penalties from untimely paid claims.

TACCP provider representatives asserted that the method for calculating a penalty is a statutory construction which may not be altered by regulation. Additionally, the legislative language for the method for calculating underpayment penalties is in proportion to the serious nature of the violation of the Insurance Code and was agreed to, in writing, by representatives of both physicians and health plans at the time the bill adopting the underpayment penalty provision was passed.

TDI determined that the proposed formula is not consistent with the statute and would require a legislative change.

SILENT AND RENTAL PPOS

BACKGROUND

PPO is an acronym commonly used to refer to a "preferred provider organization." The Texas Insurance Code does not define a PPO, but instead defines a preferred provider as a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy (TIC § 1301.001(8)).

Although Texas law does not define PPOs, several commonly accepted definitions exist. Black's Law Dictionary defines PPO as "a group of health-care providers (such as doctors, hospitals, and pharmacies) that agree to provide medical services at a discounted cost to covered persons in a given geographic area.".[7] Similarly, Strain defines a PPO as "a group of health care providers each of whom agrees to offer services to a given employer or insurer at a lower cost in return for a stable volume of patients or other incentives."[8] This stable volume of patients is often referred to as steerage. The American Association of Preferred Provider Organizations defines a PPO as a healthcare delivery system through which providers contract to offer medical services to enrollees at various reimbursement levels in return for more patients and/or timely payment.

A "silent PPO" buys, sells, leases or otherwise transfers provider discounts without regard for steerage of patients to preferred providers. The provider has no knowledge that the discount information contained in a contract the provider signed with one PPO has been "sold" or "leased" to another vendor. These PPOs are also referred to as "ghost," "non-directed," or "blind" PPOs. "Silent PPO" can be used to describe the business practice where a carrier may take a discount from a physician's or provider's charge for services based upon the "purchase" or "lease" of the purported right to said discount under a contract made between the physician and some other party.

Rental PPOs differ from silent PPOs in that the PPO contracts with providers to create a "panel," then the PPO "sells" the panel to a payor (insurer, self-insured business, etc.) who does not have an in-house provider network. The provider sends the claim to the PPO; the PPO's logo and information is on the patient's ID card. Then the PPO re-prices the claim and sends it on to the payor. The payor adjudicates the claim and sends the payment to the provider. In this model, the provider is aware of the discount.

In addition to contracting with providers, selling access to provider panels, and re-pricing claims, PPOs may also credential providers and handle provider relations. However, PPOs do not assume risk. Typically they do not adjudicate and pay claims nor are they typically involved in utilization management, or determination of benefits and coverage; these functions are performed by the payor.

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[7] Black's Law Dictionary 1217, 8th ed., 2004.
[8] Robert W. Strain, Insurance Words and Their Meanings 99, 1987.

TDI REGULATION OF PPOS

TDI does not regulate PPOs, rather, it regulates certain insurance carriers and third-party administrators (TPAs) that contract with PPOs (TIC §§ 1301.001(5) and 4151.001(1)). The Texas Insurance Code addresses silent PPOs through its regulation of preferred provider benefit plans (PPBPs) (TIC §1301.004). A PPBP is a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider (TIC § 1301.001(9)).

The Texas Legislature addressed this issue in Senate Bill 130, enacted in 1999, which restricts the ability of insurers or third-party administrators to reimburse health care providers on a discounted basis and establishes safeguards against the improper transfer of contractual payment and reimbursement terms. Senate Bill 130 was passed to ensure that providers are reimbursed on a discounted basis only if they agree to the discount. Specifically, the statute prohibits an insurer or TPA from reimbursing a physician or provider on a discounted fee basis unless:

- The insurer or TPA has a contract with the physician or provider or a PPO that has a contract with the physician or provider.
- The physician or provider agreed to the contract terms.
- The insurer or TPA agreed to provide coverage for health care services under the insurance policy (TIC § 1301.056(a)).

Because the department does not regulate PPOs and no umbrella organization in Texas related to PPOs exists, little is known about the number operating in Texas. However, some reports indicate that approximately 1,000 PPOs operate in the United States. As for silent PPOs, the Department relies on complaint statistics to gain some sense of the magnitude of the concern. In 2006, the Department has received 16 complaints regarding silent PPOs.

Recent legislation gives TDI authority to promulgate rules regarding a carrier's or TPA's ability to reimburse providers who participate in a workers' compensation (WC) health care network similar to that set forth in TIC §1301.056. TDI certifies WC health care networks and reviews contracts as a part of the certification process. As a result, these networks are subject to a greater degree of scrutiny.

Based on the statute cited above and the recent WC network legislation, some parties argue that, in Texas, there is clear legislative intent to regulate the discount of provider services.

SILENT PPO PANEL

To address increasing concern about the role "silent PPOs" are playing in reimbursement for health care services, on May 1, 2006, the department convened a panel of experts to discuss their perspectives in a joint meeting of the TACCP and Workers' Compensation Working Group. The purpose of the panel was to provide basic information about PPOs and their role in managed healthcare and to discuss silent PPOs and other issues of concern.

The panelists described the market around silent PPOs. Buying and selling discounts often occurs with out-of-network claims. For example, if about 90 percent of claims are in-network, then 10 percent are out-of-network and not covered by a contractual discount. So the payor searches the silent PPO marketplace for discounts to cover as much of the 10 percent as possible. Because payors are willing to "buy" or "lease" discounts, through a commission based upon the savings to the carrier to reduce the impact of out-of-network claims, a market for buying/selling/leasing discounts developed.

Databases exist that contain providers' tax ID numbers linked to their PPO contracts and discounts. The discount information is sometimes noncurrent, having been culled from a long-since-terminated agreement. Repricers, third party administrators, some rental PPOs and other entities access these databases and market their ability to find the "best," i.e. deepest discount to payors. When the silent entity receives the claim, it finds the deepest discount in the database, re-prices the claim, and forwards the claim to the payor to be paid according to the new price.

Patients and providers are hurt the most by the silent PPO practice. Patients/consumers may not get the benefit of the silent PPO unauthorized discount and may pay deductibles with the higher out-of-network level of financial responsibility at the higher out-of-network price. Physicians and providers are harmed because an unauthorized discount is taken where the physician does not have a direct contractual relationship (i.e., the physician is out-of-network) or the provider is paid less than the amount for which the provider contracted if the "incorrect" discount is applied. In either case, money is coming "out of" providers' pockets. Also, consumers can get caught in a payment dispute between the provider and payor.

Providers have developed strategies for dealing with silent PPOs. For example, some providers will honor only the contract rate that matches the logo on the patient's identification card, if one is issued (Texas carriers are not required to issue cards). If another organization pays the claim at a different rate, then the provider will not honor the discount.

Providers pay significant fees to reimbursement and contract management experts and services to match payments to claims to identify the "blind" discount. These services may then aid in the appeal or resubmission of claims to seek correct payment. If the problem persists, the provider may not renew their contract with the payor. However,

when the physician is out-of-network and has no contractual relationship with the payor, often patients/consumers and physicians are left with little recourse. Large providers, such as hospitals, have some leverage, while physicians in solo practices or small group practices generally have none.
One panelist urged TDI to adopt the approach outlined by the TMA. TMA says TDI should adopt regulations to define “express authority” as that term is used in TIC § 1301.056 (b), to require separate, signed contract amendments to authorize the sale, rental, or lease of the provider's discount each time the discount is brokered. TDI should also request the Legislature to authorize TDI to regulate the activities of repricers or entities that act as repricers so that a claim could only be re-priced by the PPO network with which the provider has a direct contract (i.e., a prohibition on assignment or lease of physician contractual fees). Another panelist noted that 14 states have laws that address the “silent PPO” problem in some manner. In his opinion, however, no state has eliminated blind discounts.

Carriers disagreed with the TMA recommendations, noting that before TDI promulgates rules, TDI should document the specific problems regarding silent PPOs and also seek clarification regarding the “express authority” provision of the current statute. TAHP contends that TIC § 1301.056(b) governs only the sale, lease, or transfer of information regarding the payment or reimbursement terms of the contract and not the sale or lease of the discount itself. As such, any effort to define "express authority" through rule would only impact the terms by which a party could sell the information regarding payment or reimbursement terms of a contract. TIC § 1301.056(a) already provides for regulation of the sale or leasing of provider discounts. TAHP argues that in order to require a separate, signed contract amendment for each instance in which a provider discount is brokered, a change in statute would be required. Given the current statute prohibiting unauthorized use of provider discounts and the exceptionally low volume of complaints regarding silent PPO activity, TAHP believes that such a change to the law is unnecessary.

PROVIDER CONTRACTS

Title 28 TAC § 11.901(a)(8) requires that physician and provider contracts and arrangements include provisions regarding prompt payment of claims as described in TIC § 1271.005(c) and all applicable statutes and rules pertaining to payment of clean claims, with respect to the payment of the physician or provider for covered services that are rendered to enrollees. Title 28 TAC § 3.3703(a)(11) sets forth a similar requirement for preferred provider benefit plans. The TACCP discussed whether action is necessary to ensure that provider contracts are actually drafted in accordance with Texas prompt pay statutes and rules.

One commenter introduced this discussion by proposing model language for use in contracts with carriers for consideration by the TACCP. The proposed model language, when included in provider contracts, would incorporate by reference into such contracts the protections, rights, and obligations of carriers and providers set forth in:

- TIC Chapter 843, Subchapter J, and 28 TAC Chapter 21, Subchapter T, regarding clean claims and prompt payment of physician and provider claims;
- TIC Chapter 1213 and 28 TAC § 21.3701, regarding electronic claims filing requirements; and
- 28 TAC §§ 19.1703, 19.1723 – 19.1724, regarding authorization and verification.

The TACCP further discussed legislation in Colorado concerning contractual agreements with health care providers to provide health care services. As introduced, the effect of the Colorado SB 06-198 would have been:

- to require any person or entity contracting with a health care provider on or after January 1, 2008 to use a standard form contract as directed by the commissioner of insurance;
- to create an advisory panel to advise the commissioner of insurance regarding adoption of a contract;
- to require the commissioner of insurance to adopt the standard contract by July 1, 2007, specifying certain terms to be included in the contract;
- to allow a health care provider to choose an alternative to the standard contract; and
- to prohibit retaliation or discrimination against a health care provider who chose not to use the standard contract, making such retaliation or discrimination a violation of the *Unfair Practices Act.*

Subsequent to introduction, SB 06-198 was amended substantially, passed by both houses of the Colorado legislature, and then vetoed by Governor Bill Owens on May 26, 2006.

The TACCP discussed three possible options regarding provider contract language in Texas:

- Take no action because TDI may already take disciplinary action against carriers regarding contractual provisions that fail to comply with prompt pay requirements.
- Adopt by rule specific (standard) required language reflecting applicable prompt pay requirements.
- Adopt by rule model language incorporating general prompt pay requirements by reference.

Some committee members favored the option of taking no action because contract revision is a costly and time-consuming undertaking for all parties involved, and the lack of complaints filed with the department indicates that there is not a great problem with current provider contracts in this regard. Thus, some members felt that any violations should be addressed through enforcement actions with individual carriers. Alternatively, some members favored adoption of a rule standardizing language for inclusion in provider contracts in order to reduce the potential for mischaracterization or omission of rights and obligations under the prompt pay requirements, while recognizing that not all providers or provider organizations felt such required language to be necessary. Finally, some members supported adoption by rule of model language for use in provider contracts, pointing out that similar model language regarding hold-harmless provisions has been very successful, becoming the *de facto* standard for many contracts (28 TAC § 11.901(a)(1)(C)). Some committee members noted that model language incorporating prompt pay requirements by reference would reduce the need to amend contracts with each change in the law. Other members opposed inclusion of either standard or model language regarding prompt pay requirements in contracts, pointing out that such language might mislead a provider to believe the protections therein had broader application than is actually the case, and requesting that, if the department does undertake to adopt such a rule, the rule should both be sensitive to the possibility of future changes in the law and regulations and disclose to the provider that the application of prompt pay protections in these laws and regulations is limited.

The department has considered the advice of the members and taken the matter under advisement. TDI has the authority to identify or describe the subject matter which must be addressed in provider contracts with HMOs or preferred provider benefit plans, as required or authorized by law. This authority includes the power to adopt, by rule, model language which exemplifies an approvable provision. TDI has adopted model language for "hold harmless" provisions that health plans may choose to utilize to meet the Texas Insurance Code mandate that all contracts between physicians and health plans include provisions regarding the obligation of the physicians and providers to hold enrollees harmless. Although TDI's authority to require inclusion of standardized language regarding those provisions may be debatable, the department's model "hold harmless" language has become the *de facto* standard even in the absence of a requirement for its inclusion in a contract.

REQUESTS FOR VERIFICATION

Some members representing carriers have expressed concern that the use of verification procedures is not consistent with the cost of maintaining the personnel necessary to respond to requests for verification as required by SB 418. Carriers must have appropriate personnel reasonably available at a toll-free number to provide a verification under SB 418 between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. Carriers must have a telephone system capable of accepting or recording incoming phone calls for verifications after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls on or before the second calendar day after the call is received.

Single health care service plans, such as vision plans and dental health care plans, are required to have a toll-free telephone number from 8 a.m. to 5 p.m. central time Monday through Friday on each day that is not a legal holiday. In addition, these single health care service plans are required to have a telephone system capable of accepting and recording incoming requests during other times and to respond to those off-hour requests no later than the next business day after the call is received.

Some members representing carriers recommend that the statute governing verification be amended to remove the requirement that carriers have staff available on weekends and holidays to receive verification requests. TAHP recently conducted a survey regarding verification requests, and the health plans responding to this survey reported that only 54 requests for verification on weekends and holidays have been received since these verification requirements have been in place. The health plans further indicate that 33 of the 54 requests for verification were received by a single health plan on a single holiday. These members urge that the personnel costs associated with weekend and holiday staffing are significant and excessive considering the number of requests for verification submitted during those hours. It should be noted that this reporting was voluntary and that the responses represent a non-random response pool. Furthermore, the survey did not include all carriers subject to verification requirements.

TDI data regarding verification requests indicates that carriers received more than 94,850 requests for verification between July 2004 and June 2006. Of these requests, more than 70,470 verifications were issued and 24,360 verifications were declined (see chart on page 47 of this report). However, TDI does not collect data regarding the number of requests submitted after hours, on weekends, or on legal holidays. Additionally, TDI has received no documentation evidencing the costs of after-hours, weekend and holiday staffing.

In contrast, TACCP members representing providers have indicated that carrier practices have made it impractical to request verification in many situations. These representatives indicate that the frequency of declinations and the stringency of requirements and

information necessary for forwarding and evaluating a request for verification have discouraged providers from using the verification process. One member asserts that several of the larger carriers refuse to give verifications at all, failing to provide the reason for declination and contending that only physicians, and not hospitals, may request verifications. Another member has stated that it is too easy for a carrier to issue a declination under the current statute and rules and argues that verification provisions should be amended accordingly. The member further suggests that in instances where a patient is being transferred from one hospital to another, carriers should be required to respond to requests for verification within three hours.

Between the dates of September 1, 2003 and August 23, 2006, TDI has received 78 complaints related to declinations in response to requests for verification. Of the 78 complaints, TDI has determined that 15 complaints were justified. TDI has undertaken one enforcement action for a carrier's failure to provide an adequate process for verification, which resulted in a $15,000 administrative penalty. The order for this action was entered in November 2004.

TMA believes that the payment environment may have changed since the SB 418 verification provisions were enacted in 2003. SB 1149 and SB 51, two bills enacted during the 2005 legislative session, have the potential to render the verification procedures unnecessary. Upon a participating provider's submission of a patient's name, relationship to the primary enrollee, and birthdate, SB 1149 requires carriers to make enrollee eligibility and payment information available to physicians and other providers telephonically, electronically, or by an Internet website portal. SB 51 addresses the obligation of certain group health coverage policyholders and contract holders to continue premium payment, and a carrier's corresponding obligation to continue coverage, after notice of an individual's lost group eligibility. Both bills are described in more detail in the overview section of this report. SB 51 thus addresses the same underlying problem which prompted providers to seek enactment of the SB 418 verification requirements – retroactive denials of services provided to enrollees who are later determined to be ineligible for coverage.

The TACCP member believes that if the statutes enacted through SB 51 remain unchanged, the TACCP should take up the issue of verifications during the interim upon the adjournment of the 2007 legislative session. At that time, the member believes the TACCP should examine data on the number and timing of verifications, as well as instances of retroactive terminations of coverage, with the purpose of determining whether the verification requirements as currently written continue to be relevant.

USAGE OF SITUATIONAL ELEMENTS IN ELECTRONIC CLAIMS SUBMITTED BY PHYSICIANS AND NON-INSTITUTIONAL PROVIDERS

TDI has received complaints that some carriers are requiring physicians and non-institutional providers who submit electronic claims to indicate, where applicable, the lack of a referring provider in the Professional 837 (ASC X12N 837). These carriers have been requiring the physicians and non-institutional providers to enter terms such as "self-referral," "none," or "n/a" on the claim in the field designated for the referring provider's name and treating electronic claims submitted with no data in this segment as deficient claims. Because federal law holds that entry of a referring provider's name in this segment is a situational element required only where services are tendered pursuant to a referral, this practice violates Texas clean claim requirements.

TIC §§ 843.336(b) and 1301.131(a) state that an electronic claim by a physician or non-institutional provider is a clean claim if the claim is submitted using the Professional 837 format and certain successor formats. The prompt pay rules also confirm that submission using the ASC X12N 837 format and compliance with all appropriate federal standards, including applicable implementation guides, companion guides, and trading partner agreements, define electronic clean claims.

The ASC X12N 837 format, adopted by the Secretary of the U.S. Health and Human Services Commission (the Secretary) in accordance with HIPAA Administrative Simplification requirements, is the standard for professional electronic claims or equivalent encounter information. More specifically, the Secretary has established the ASC X12N 837 - Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, 004010X098A1 ("the Implementation Guide") as the implementation standard for these claims. In the Implementation Guide, the specifications for the segment regarding the "referring provider name" clearly indicate that this data element's usage is situational and required only if the claim involved a referral.

The law forbids the required addition of any data elements or segments to the maximum defined data set even if physicians and non-institutional providers agree to the requirement. In Section D of the preamble to the Final Rules on Health Insurance Reform: Standards for Electronic Transactions, the Secretary noted that to allow trading partners to negotiate which conditional data elements will be used in a standard transaction would defeat the purpose of standardization. Thus, a covered entity may not enter into a trading partner agreement that would change the definition, data condition, or use of a data element or segment in a standard or that would add any data elements or segments to the maximum defined data set.

The Secretary has further appointed the Accredited Standards Committee X12N (ASC X12N) as the organization charged with maintaining the Professional 837 format, and this organization has upheld this regulatory standard, stating: "Referring Provider Name

(Loop ID-2310A) is only required if the claim involved a referral. This usage rule is specified in Note 4 on the Loop ID-2310A NM1 segment. A requirement to use the referring provider name segment when a referral is not involved would be a modification of the data condition and use of the segment. Such a modification is not permitted by the Implementation Guide…"

Accordingly, under the Implementation Guide, entry of the referring provider's name is a situational element required only where a referral exists. Where there is no referral, requiring physicians and non-institutional providers submitting electronic claims to indicate the lack of a referring provider by entering terms such as "self-referral," "none," or "n/a" on the claim in the referring provider's name segment is an impermissible modification of the Implementation Guide. Thus, an insurer offering a preferred provider benefit plan or an HMO may neither impose such a requirement through companion guides or trading partner agreements nor make a determination that a claim is deficient based upon the lack of such a notation. TDI notified carriers of this clarification in Commissioner's Bulletin B-0023-06 on June 28, 2006. TDI will scrutinize any allegation that an insurer or HMO has imposed inappropriate use requirements for a data condition, data element, or segment in an electronic claim and initiate enforcement action as appropriate.

HEALTH CARE CLAIM FRAUD

The rules regarding recovery of refunds due to overpayment do not affect a carrier's ability to recover an overpayment in the case of fraud or a material misrepresentation by a physician or provider. However, carriers have expressed concern that under the current prompt pay laws carriers must pay claims that are flagged as fraudulent within the applicable claims payment period and, if the claim is finally determined to be fraudulent, attempt to recover funds from providers after completing an investigation. Health plans support allowing claims deemed potentially fraudulent to be pended while an investigation is conducted.

Carriers have additionally expressed concern regarding the current definition of "billed charges." Under the SB 418 rules, billed charges are defined as "…the charges for medical care or health care services included on a claim submitted by a physician or provider…[B]illed charges must comply with all other applicable requirements of law, including Texas Health and Safety Code § 311.0025, Texas Occupation Code § 105.002, and Texas Insurance Code [§ 552]." Carriers express concern that this definition of billed charges may offer an incentive to providers to increase their billed charges.

TACCP provider representatives do not support such a change, believing that carriers could misuse an exception for claims deemed potentially fraudulent by employing an overly broad definition of "potentially fraudulent." Such a definition could allow carriers to inappropriately delay or deny payment for services properly rendered.

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 activities. If appropriate, the Fraud Unit refers cases to District and U.S. Attorneys for criminal prosecution or to regulatory agencies such as Texas Medical Board; the Board of Nurse Examiners; the Texas State Board of Pharmacy; the Board of Chiropractic Examiners; the State Board of Podiatric Medical Examiners; the Executive Council of Physical Therapy & Occupational Therapy; the State Board of Dental Examiners; the Board of Examiners of Psychologists; or the Health Facility Program of the Texas Department of State Health Services.

The Fraud Unit received 304 reports involving providers between July 1, 2004 and May 31, 2006. Of these reports, 35 cases were referred to regulatory agencies/licensing boards. To date, one case has involved criminal action resulting in a referral for prosecution. TDI's Consumer Protection division has received only four complaints regarding provider fraud in the period between September 1, 2003 and August 23, 2006, of which two were determined by TDI to be justified. TDI's Fraud Unit notes that reports of provider fraud increased in fiscal year 2006 (September 2005 through August 2006).

TMA and THA also conduct programs that help providers comply with regulatory requirements. Both TMA and THA make referrals to the Texas Medical Board when an issue is identified that requires regulatory review. Additionally, 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 the plans to a regulatory agency.

SUMMARY

While there is not a consensus among members of the TACCP regarding whether changes to SB 418 provisions and rules are necessary in order to prevent fraud, carriers, providers, and regulators recognize the need to remain vigilant with regard to health care claim fraud. Each of these parties is active in fraud prevention and/or investigation, and TDI remains committed to the investigation and appropriate disposition of any allegation of fraud.

DATA REPORTED TO TDI

SB 418 requires HMOs and insurers that have preferred provider health benefit plans in force to report certain aggregate claims data to TDI each quarter. In addition, these carriers are required to report aggregate data once a year about their reasons for declining to verify claims.

SB 418 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 began reporting pharmacy claims data beginning with the third calendar quarter, July - September 2004.

Because SB 418 took effect for provider contracts entered into or renewed on or after August 15, 2003, implementation of the SB 418 prompt pay provisions was staggered. Some carriers decided to renew all their provider contracts on a specific date (for example, January 1, 2004) while others decided to renew based on the schedule they already had in place. As a result, some carriers continued to pay claims based on the "old" prompt pay HB 610 statute and rules, while other carriers paid claims under both HB 610 and SB 418, and still others are under SB 418. For this reason, TDI provided two models that carriers use to report data – the HB 610 model and the SB 418 model. Currently, 98 carriers are reporting quarterly provider claims data:

- 14 HMOs
- 9 dental HMOs
- 70 preferred provider benefit plan carriers
- 5 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 processing. Consequently some carriers include "all" claims – both clean and deficient – in their data reports. Other carriers separate clean claims and report their data based on clean claims only.

Table 1: Timeliness of Provider Claims Payments

Source: TDI SB 418 Provider Claims Data Calls – July 2004 – June 2006

Reporting Period	Clean Claims Paid Timely			Percentage Paid Timely			Clean Claims Paid Late			Percentage Paid Late		
	P	I	NI	P	I	NI	P	I	NI	P	I	NI
July-September 2004	6,817,640	638,890	3,400,191	93.79	99.31	99.40	451,580	4,423	20,666	6.21	0.69	0.60
October-December 2004	7,794,443	662,937	4,007,550	94.29	99.13	99.4	471,928	5,828	24,284	5.71	0.87	0.60
January-March 2005	7,707,511	783,502	5,132,400	95.52	99.05	98.31	361,379	7,549	88,245	4.48	0.95	1.69
April - June 2005	7,860,183	705,516	5,020,132	99.9	99.13	98.52	7,530	6,197	75,219	0.10	0.87	1.48
July-September 2005	7,304,303	683,198	4,111,335	99.94	99.24	99.15	4,289	5,220	35,438	0.06	0.76	0.85
October-December 2005	8,380,994	631,675	4,111,739	99.97	99.56	99.64	2,112	2,761	14,656	0.03	0.44	0.36
January-March 2006	7,465,770	715,631	4,231,231	99.88	99.75	99.79	9,086	1,810	9,042	0.12	0.25	0.21
April-June 2006	7,933,899	765,290	4,510,147	99.88	99.64	99.16	9,702	2,789	38,330	0.12	0.36	0.84

P = Pharmacy claims
I = Institutional/hospital claims
NI = Non-institutional/physician or professional claims

Table 2: Electronic vs. Non-Electronic Claims – SB 418 Claims Data
Source: TDI SB 418 Provider Claims Data Calls – July 2004 – June 2006

	Electronic Institutional Claims	Electronic Non-Institutional Claims	Electronic Pharmacy Claims	Non-Electronic Institutional Claims	Non-Electronic Non-Institutional Claims	Total Reported Claims
July-September 2004	461,265 (4%)	2,567,565 (22%)	7,269,220 (64%)	182,048 (2%)	858,739 (8%)	11,338,837 (100%)
October-December 2004	532,693 (4%)	3,143,192 (24%)	8,266,371 (64%)	136,072 (1%)	888,642 (7%)	12,966,970 (100%)
January-March 2005	598,638 (4.3%)	4,078,649 (29%)	8,068,890 (57.3%)	192,413 (1.4%)	1,141,996 (8%)	14,080,586 (100%)
April-June 2005	577,589 (4%)	4,111,977 (30%)	7,867,713 (58%)	134,124 (1%)	983,374 (7%)	13,674,777 (100%)
July-September 2005	562,705 (5%)	3,261,407 (27%)	7,308,592 (60%)	125,713 (1%)	885,366 (7%)	12,143,783 (100%)
October-December 2005	522,497 (4%)	3,371,336 (26%)	8,383,106 (64%)	111,939 (1%)	755,059 (5%)	13,143,937 (100%)
January-March 2006	601,040 (5%)	3,629,914 (29%)	7,474,856 (60%)	116,401 (1%)	610,359 (5%)	12,432,570 (100%)
April-June 2006	607,745 (5%)	3,910,406 (29%)	7,933,899 (60%)	160,334 (1%)	638,071 (5%)	13,250,455 (100%)

Table 3: HB 610 Data
Source: TDI SB 418 Provider Claims Data Calls – July 2004 – June 2006

Reporting Period	Clean Claims Paid Timely	Percentage Paid Timely	Clean Claims Paid Late	Percentage Paid Late
July-September 2004	329,189	99.32	2,240	0.68
October-December 2004	188,214	99.25	1,423	0.75
January-March 2005	194,851	99.53	912	0.47
April-June 2005	75,109	99.14	950	0.86
July-September 2005	56,750	99.45	316	0.55
October-December 2005	64,688	99.84	106	0.16
January-March 2006	61,568	99.87	79	0.13
April-June 2006	63,667	99.11	571	0.89

Table 4: Requests for Verifications

Source: TDI SB 418 Provider Claims Data Calls – July 2004 – June 2006

Reporting Period	Requests for Verification	Verifications Issued	Verifications Declined
July - September 2004	11,106	5,623	5,483
October - December 2004	7,774	4,772	2,994
January - March 2005	8,122	5,399	2,719
April - June 2005	7,845	5,308	2,533
July - September 2005	7,381	5,900	1,481
October - December 2005	16,065	14,596	1,469
January - March 2006	18,264	14,127	4,138
April - June 2006	18,300	14,749	3,551

NOTE: TDI is verifying self-reported data from a few carriers regarding discrepancies between total verification requests, and the sum of verifications issued and declined.

Table 5: Annual Report of Reasons for Declinations

July 2004 – June 2005 (2005) and July 2005 – June 2006 (2006)
Source: SB 418 Annual Reasons for Declination Report

Reason for Declination	2005 Totals	2006 Totals
Declinations due to premium payment time frames that prevent verifying eligibility for a 30-Day Period	5,122	2,589
Declinations due to policy deductibles, specific benefit limitations or annual benefit maximums	10,139	13,986
Number of declinations due to benefit exclusions	13,344	17,202
Number of declinations due to no coverage or change in membership eligibility, including individuals not eligible, not yet effective, or membership cancelled	5,834	8,704
Declinations due to pre-existing condition limitations	2,040	1,118
Declinations due to other policy or contract limitations	8,854	10,342
Declinations due to lack of information from the requesting physician or provider	9,174	13,136
Declinations due to lack of information from other physician or provider	416	276
Declinations due to lack of information from any other person	1,043	4,352
Declinations due to other reasons	9,763	15,302

NOTE: Includes declinations issued from July 2004 through June 2006 as of 8/25/2006. Carriers may have reported more than one reason for a declination.

Provider Complaints

The table below reports the complaints from physicians and providers received by TDI from fiscal 2000 through August 23, 2006. The number of complaints received as well as the number of justified complaints has decreased. 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
FY 2000 through August 23, 2006
Source: TDI Complaints Inquiry System (CIS) database
Note: This table includes all TDI complaints received from a physician or a provider.

FY	TOTAL PROVIDER COMPLAINTS RECEIVED	JUSTIFIED COMPLAINTS	PERCENTAGE JUSTIFIED
2000	10,150	3,777	37.21%
2001	14,865	5,767	38.80%
2002	19,511	5,950	30.50%
2003	19,652	4,132	21.03%
2004	11,718	2,280	19.46%
2005	10,821	2,059	19.03%
2006 YTD	8,032	1,398	17.41%