Technical Advisory Committee on Claims Processing

Report on Activities

September 2008

Texas Department of Insurance

Mike Geeslin
Commissioner of Insurance

Texas Department of Insurance
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September 1, 2008

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 78768-2910

Dear Governors and Speaker:

This letter conveys the third report to the Legislature issued by the Technical Advisory Committee on Claims Processing (TACCP) in accordance with Senate Bill 418, 78th Regular Session. 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. The TACCP is charged with advising me on the technical aspects of claims processing.

Since passage of SB 418, the Department continues to see a downward trend in the number of complaints received, reflecting increased compliance with requirements for carriers' timely payments to providers. Many of the issues initially addressed by the TACCP have improved considerably. As a result, since its inception the Committee has shifted its focus from the basics of ensuring timely payment of claims to broader policy issues affecting providers and carriers.

This report outlines the history of prompt pay and the Committee's progress, along with updates on the most recent activities. It also includes prompt pay data and progress on issues from the first two reports. The TACCP made great strides to bridge the gap between carriers and providers and address issues that concern each group. The Department continues 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; Carol Cates, Director of Government Relations, at 463-6123; or Katrina Daniel, Acting Associate Commissioner of Life, Health & Licensing, at 322-4315. Thank you for your consideration.

Sincerely,

Mike Geeslin
Commissioner of Insurance

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Technical Advisory Committee on Claims Processing Overview

Texas law requires the Commissioner to appoint a Technical Advisory Committee on Claims Processing (TACCP) to consult before the adoption of any rules related to claims processing. The TACCP is charged with advising the Commissioner on:

- the technical aspects of coding health care services and claims development, submission, processing, adjudication, and payment;
- the impact of those processes of contractual requirements and relationships, including relationships among employers, health benefit plans, insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), electronic clearinghouses, physicians and other health care providers, third-party administrators, independent physician associations, and medical groups; and
- the implementation of standardized coding and bundling edits and logic. [1]

The current list of members and the organization or role they represent is included in the table, *TACCP Membership*.

TACCP Membership

Member	Representation
Gary Looney	Alamo Insurance Group
Robert Cook	Attorney
James Nelson	Attorney
Cathy Andrews	Austin Anesthesiology Group
Stacey Blankenship	Blue Cross and Blue Shield of Texas
Nathalie Woolfrey	CIGNA Healthcare of Texas Inc.
Mary McGuire	Covenant Management Systems, Mediview Division
Pat Harris	Harris County Medical Society
Denise Lydecker	HealthMarkets
Holly Brooke	HealthSouth
Brittney Powlesson	Hospital Corporation of America
Jenny Fowler	Humana
Gwendolyn Dalcour	Kelsey-Seybold Clinic
Lyle Ross	New Era Life Insurance Company
Karen Van Wagner, Ph.D.	North Texas Specialty Physicians
Aelia Khan Akhtar	Office of Public Insurance Counsel
Krista Crews	ProPath Associates
Cathy DeWitt	Texas Association of Business
Jared Wolfe	Texas Association of Health Plans
Mike Pollard	Texas Association of Life and Health Insurers
Patrick Smith	Texas Children's Hospital
Richard Schirmer	Texas Hospital Association
Teresa Devine	Texas Medical Association
Kristie Zamrazil	Texas Pharmacy Association
Melissa Eason	UniCare/WellPoint
James McNaughton	United Healthcare of Texas, Inc.
John Tietjen	University of Texas, MD Anderson Cancer Center

[1] Texas Insurance Code Ch. 1212

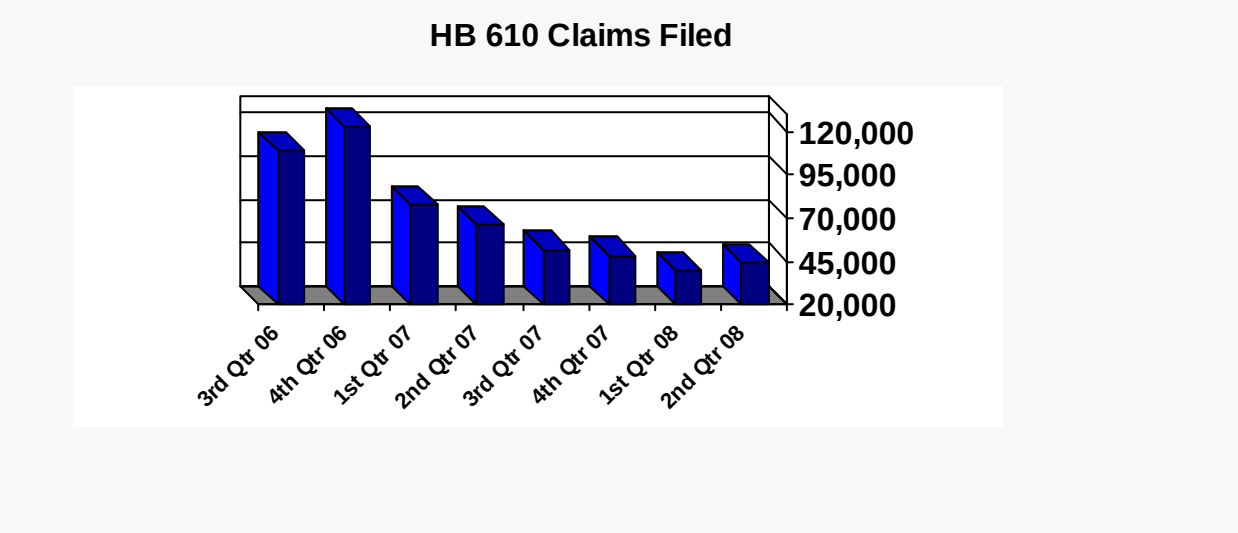
Prompt Pay Statutes and Rules Overview

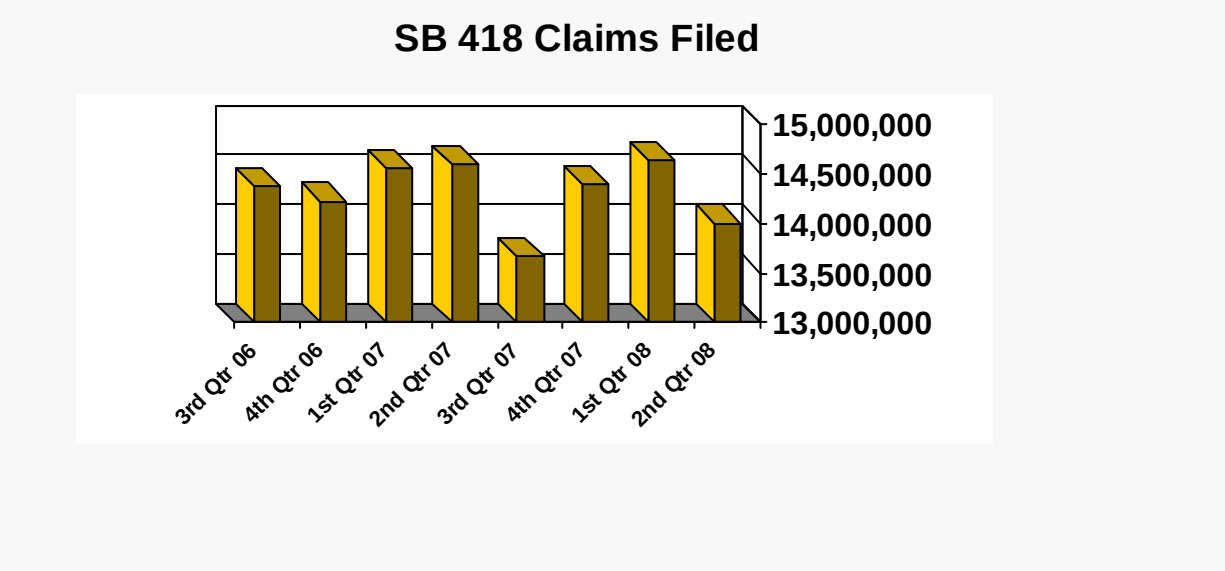
The primary body of law that relates to claims processing in Texas is the prompt payment statutes. Two pieces of legislation shape the prompt payment landscape in Texas today, House Bill (HB) 610, effective in 1999, and Senate Bill (SB) 418, effective in 2003. The table below, *Prompt Pay Statues and Rules Overview*, describes the history of these two bills, the subsequent rules adopted by the Commissioner of Insurance, and significant features of each.

Prompt Pay Statutes and Rules Overview		
	Senate Bill 418 (2003)	**House Bill 610 (1999)**
Statutory Reference	• Health Maintenance Organization (HMO) – Texas Insurance Code (TIC) §§ 843.336 – 843.353 • Preferred Provider Benefit Plan (PPBP) – TIC §§ 1301.101 – 1301.138	
Rules	28 Texas Administrative Code (TAC) §§ 3.3703 – 3.3707, 11.901, 19.1703, 19.1723, 19.1724, 21.2801 – 21.2809, and 21.2811 – 21.2826	28 TAC §§ 21.2801 – 21.2820
History and Purpose	• Passed in 2003, affecting claims filing and prompt payment processes. • Addresses certain prompt pay issues: 1) deadlines for claims payments; 2) clean claim requirements; 3) penalties for late paid claims, 4) overpayment refunds; 5) carrier compliance reporting requirements; 6) applicability to contracted providers and certain non-contracting providers; and 7) preauthorization and verification.	• Passed in 1999 to expedite HMO and preferred provider benefit plans clean claim payment to contracted providers; and • Required carriers to process clean claims within 45 days of receipt. • Required carriers to: 1) pay the total amount of the claim in accordance with the contract; or 2) deny the entire claim and notify the provider of the reason; or 3) audit the entire claim, paying 85 percent of the contracted rate, notifying 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. Required that electronically submitted and affirmatively adjudicated pharmacy claims were required to be processed in 21 days.
Applicability	Applies to: • Insured preferred provider benefit plans and HMO plans issued in Texas; • Contracts entered into or renewed on or after August 16, 2003; and • Specified provisions applicable to non-network emergency services in certain circumstances. Does not apply to certain plans, such as self-funded plans; workers´ compensation coverage; and government plans.	Applies to: • Insured preferred provider plans and HMO plans issued in Texas; and • Preferred provider contracts entered into or renewed prior to August 16, 2003.

SB 418 and HB 610 Claim Data

Since the passage of SB 418 in 2003, the number of claims governed by HB 610 has steadily declined to a minute portion of the claims subject to prompt pay laws. At publication, the most recent two quarters of the 2008 reporting period reflect that carriers reported fewer than 45,000 claims during each period were subject to HB 610 as compared to 14 million or more subject to SB 418. The two charts below, *HB 610 Claims Filed* and *SB 418 Claims Filed*, reflects the number of claims in each quarter since the third quarter of 2006. Claims regulated by SB 418 reach into the tens of millions, while claims regulated by HB 610 have reached as low as the tens of thousands.





TACCP Activities

Since the 2006 TACCP report to the legislature, the TACCP met five times on a quarterly schedule except during the legislative session. The meeting dates are shown in the table to the right. During that period, several new members joined the Committee, including a pharmacy representative, bringing new provider perspectives to the group. In addition, other stakeholders, dentists, chiropractors, and speech pathologists became more active through their attendance at meetings.

Meeting Dates

2006	November 16
2007	September 20
2008	January 30 April 30 July 30

The TACCP was created to guide the Department in the development of rules related to claims processing. At its inception, the Committee worked diligently over the course of two years to aid the Department in writing the rules that would help implement SB 418. However, unlike in its early days, this most recent biennium resulted in the need for the Committee to consider only one rule. Senate Bill 1884 (2007) passed, which adjusts the calculation for underpayment penalties under the prompt pay statutes. Accordingly, the Department conformed prompt pay rules to the new legislative language. The adoption order for the rule was signed on January 18, 2008.

In the absence of the large volume of rules considered by the Committee in the past, members discussed broader policy issues, such as coding and bundling claim charges and silent preferred provider organizations (PPOs). Despite its specific charge to make recommendations on issues such as implementation of standardized coding and bundling edits, the Committee has not reached a consensus on several issues. Three of these issues are discussed further in the *Ongoing Issues* section of this report.

In addition to the rule and broad issue consideration, the Department uses the Committee forum to keep members up-to-date on issues that may be of interest to them. The *Department Updates* section summarizes information Department staff provided to the TACCP.

Ongoing Issues for the Committee

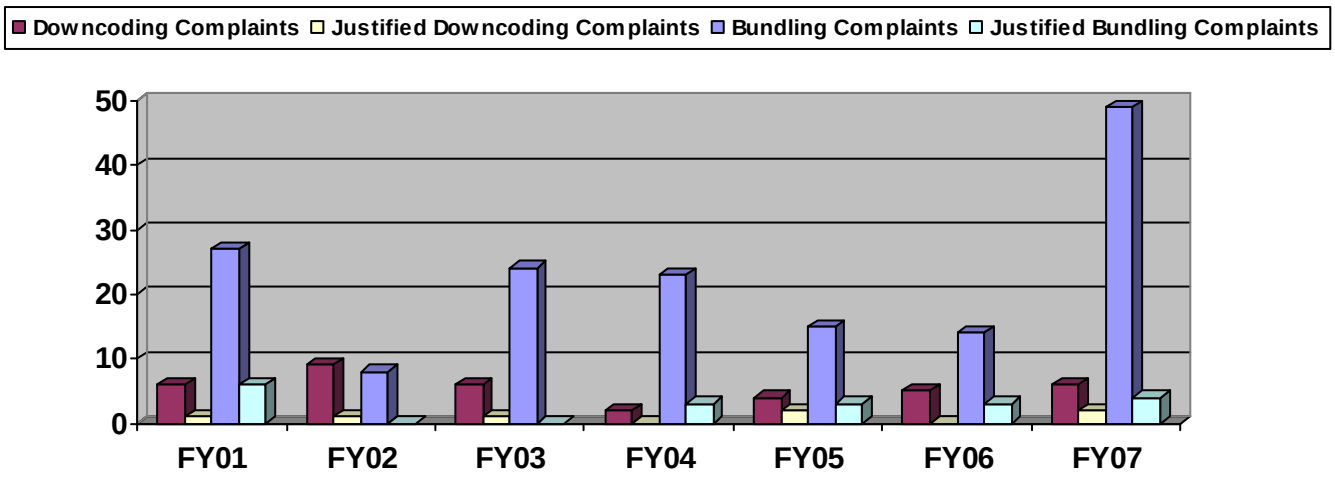
In the biennium since the last report, the TACCP primarily discussed three issues: coding and bundling, silent PPOs, and recovery of overpayments. Below is a summary of each issue followed by differing perspectives from the members. These issues are generally high-level policy issues on which the Committee has not been able to reach consensus. As a result, no clear recommendation is made to the Commissioner or Legislature. Rather, a discussion of the issues is reflected with wide ranging opinions.

Coding and Bundling

Overview

Coding, the use of standard alphanumeric codes on an insurance claim, describes specific elements necessary for reimbursement for provider services. While codes are assigned to describe the service performed by the provider, billing activities also affect reimbursement. Payors, generally insurance carriers, HMOs or their designees, use proprietary electronic adjudication systems based on complex computer programs to process and pay claims. If a physician or provider participates in Medicare or a third party payor network, then pricing is established through a contractual fee agreement.

To estimate the magnitude of this issue in Texas, the Texas Department of Insurance (TDI) examined the number of complaints related to bundling and coding. The graph below shows the number of complaints the Department has received since FY01 related to bundling and downcoding and how many of each were justified. In 2007, while the number of complaints for bundling reached nearly 50, fewer than five were determined to be justified.



Coding Standards

Accurate coding is essential to ensure proper billing and payment. The Health Insurance Portability and Accountability Act (HIPAA) provisions set out standards for the electronic exchange of healthcare data: the Common Procedure Terminology (CPT), developed and maintained by the American Medical Association (AMA), and the Healthcare Common Procedure Coding System (HCPCS), developed and maintained by the Centers for Medicare and Medicaid Services (CMS). In addition to the primary codes, modifier codes communicate variable situations that affect reimbursement.

While payors are required to use the standard code sets, they process claims using proprietary software. CPT and HCPCS manuals contain guidelines for correct coding methods; however, the nature of these policies is highly technical.

Bundling and Other Practices

Bundling occurs when the payor combines two or more procedure codes reported separately by the provider and pays only one of the combined procedure codes. Payment policies like this vary considerably among health plans, and the AMA believes that many bundling policies are inconsistent with standard CPT guidelines. Providers are adamant that bundling policies withhold payment for services provided to enrollees in good faith and carriers report that some providers bill for procedures separately to maximize reimbursement in defense of bundling policies. While unbundling services can occur because of the complexity of coding, it is sometimes an indicator of fraud. In recent years, reports from the Office of the Inspector General (OIG) have found substantial numbers of claims – 5.1 percent – to be inappropriately coded in the Medicare fee-for-service (FFS) program, though it does not estimate whether any portion of the error rate is attributable to fraud. The two most prevalent types of unbundling found were fragmenting one service into separate component parts and reporting separate codes for related services in one comprehensive code.

A provider that bills for a service not supported by proper documentation engages in the practice of upcoding. Conversely, downcoding occurs when a payor denies or changes codes submitted on a medical claim. All parties agree that coding errors resulting in either practice are inevitable due to the complexity of coding. However, intentional upcoding by a physician or provider to generate higher reimbursement is viewed as unethical and as an indicator of potential fraud. Intentional downcoding by a payor that results in a payment less than the contracted rate may be a deceptive trade practice and may constitute a violation of their contract with the provider.

TACCP DISCUSSION

Federal Guidance

In the previous biennium, TDI staff contacted CMS and found that no federal provision would prohibit the Department from adopting rules on standards related to bundling and coding procedures for commercial insurance claims in Texas. CMS authority over Medicare and Medicaid claims 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, no prohibition exists for 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.

TACCP Member Perspectives

Carrier representatives urge the Department not to consider adopting standardized edits since 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. However, the Texas Medical Association counters that the coding issues addressed in the multi-state litigation settlement agreements with the largest health plans in the United States can be a foundation to use in creating a standard. Health plans that agreed to the settlement's coding provisions included: Aetna, Blue Cross Blue Shield of Texas, CIGNA, Humana, and WellPoint, which does business in Texas as UniCare. These agreements are time limited and include an expiration date.

Consistent with the 2006 TACCP report, 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.

Silent PPO

Overview

Although the Texas Insurance Code does not define a PPO, several commonly accepted definitions exist. One such definition of PPO is "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."[2] This stable volume of patients is often referred to as steerage.

Silent PPOs buy, sell, lease or otherwise transfer provider discounts without regard for steerage of patients toward contracted 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. The term “Silent PPO” can be used to describe the business practice where a carrier may take a discount from a provider’s charge based upon the purchase or lease of the purported right to the discount under a contract between the physician and some other party that is either invalid or may not exist. Silent PPO transactions are not legitimate business arrangements. Legitimate PPO discounts are based on a contractual agreement and are not referred to as Silent PPOs.

Rental PPOs differ from silent PPOs in that the PPO will contract with providers to create a "panel" that is “sold” to a payor 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. The PPO re-prices the claim and sends it on to the payor who adjudicates and pays the claim. In this model, the provider is aware of the discount.

Patients and providers are hurt the most by the silent PPO practice. Patients may not get the benefit of the silent PPO unauthorized discount and may be held responsible for higher costs than anticipated. Physicians and providers are harmed because an unauthorized discount is taken where the physician does not have a direct contractual relationship or the provider is paid less than the amount for which the provider contracted or, if not contracted, is paid at a rate the provider had no part in negotiating. Additionally, a patient may get caught in a payment dispute between the provider and payor.

TDI Regulation of PPOs

TDI does not regulate PPOs, rather, it regulates certain insurance carriers and third party administrators (TPAs) that contract with PPOs.[3] The Insurance Code addresses silent PPOs through its regulation of preferred provider benefit plans (PPBPs).[4] 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.[5]

The Texas Legislature addressed this issue in SB 130 (1999) with provisions that require agreement from a provider before he or she is reimbursed on a discounted basis. The statute prohibits an insurer or TPA from reimbursing a physician or provider on a discounted fee basis unless:

[2] Robert W. Strain, Insurance Words and Their Meanings 99, 1987.
[3] TIC §§ 1301.001(5) and 4151.001(1)
[4] TIC § 1301.004
[5] TIC § 1301.001(9)

- 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; or
- The insurer or TPA agreed to provide coverage for health care services under the insurance policy.[6]

Based on this authority in 2007, the Department has taken enforcement actions against four entities for Silent PPO practices.[7]

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. In 2007, the Department received 40 complaints regarding silent PPOs.

In an attempt to address PPO regulation in November 2006, TDI drafted an informal rule for comment. The rule would have required a carrier to furnish a provider, at the time the carrier takes the discount, with proof of underlying contracts that permit the discount. Comments received to date reflect the opposing perspectives of providers and carriers. The Department ultimately withdrew the draft.

The Department has 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.

In its self-evaluation report to the Texas Sunset Commission, TDI recommended that it be given additional authority to regulate PPOs, including authorizing TDI to require the registration of PPOs. In response, the Sunset Advisory Commission Staff Report concluded that the prevalence of this type of healthcare delivery system, combined with the potential consumer harm that can result, argued for regulation of PPOs by the State. As a result, Sunset staff recommended requiring PPOs to obtain a certificate of authority to operate in Texas to ensure that TDI has information about these entities, and could take enforcement action against them if necessary. This minimal regulatory process would also allow the State to look more closely at the problems that can occur among PPOs, providers, insurers, and consumers. TDI also encouraged the Sunset Advisory Commission to consider principles that must be adhered to as a condition of maintaining a PPO certificate of authority.

TACCP Member Perspectives

Carrier representatives maintain that more evidence of the silent PPO practice should be presented to TDI before any rule is proposed or considered. To date, little exists and the low number of complaints does not suggest a significant problem in Texas.

Additionally, health plans believe that TIC § 1301.056(b) sufficiently addresses the silent PPO issue and vests TDI with enforcement authority. The bill analysis of SB 130 states that the law "will hold insurers in violation of an unfair act or deceptive practice under the Insurance Code, if the insurers knowingly mislead a provider into giving them discounts to which the insurers are not entitled." TDI

[6] TIC § 1301.056(a)

[7] Great-West Life & Annuity Insurance Company, Humana Insurance Company, Metropolitan Life Insurance Company, and Unicare Life & Health Insurance Company.

has taken enforcement actions against at least three health plans for the application of a discount without a contract, which suggests that TDI already has sufficient authority to regulate this practice.

Likewise, physician representatives point out that TDI recently has agreed to consent orders with three health plans for silent PPO activity. These consent orders addressed violations of TIC §1301.056 in which health insurers applied discounts to out-of-network claims when the insurer was not contractually entitled to do so, was not given express authority to access discount information, or did not give prior notification to such providers before taking discounts. Additionally, insurers were fined for taking advantage of contractual discounts with PPOs in which providers were to receive patient steerage in exchange for the discount and no steerage was provided.

Finally, the Texas Legislature attempted to address this issue through legislation (HB 839 - Eiland) during the 80th Legislature, but the bill did not pass. Regulation of the secondary discount market is an issue that the National Conference of Insurance Legislators has been working to address for at least two years. Numerous other states including Ohio and Florida have recently passed legislation to address the issue of inappropriate use of provider discounts.

Recovery of Overpayment

Overview

Subsection (f) of TAC § 21.2818 of the TDI prompt payment regulations provides that an insurer may recover a refund due to an overpayment or completion of an audit if it notifies the physician or provider of completion of the audit or provides notification of the overpayment within 180 days of receipt. The carrier must provide an opportunity for appeal before recovering a refund. The rule does "not affect a carrier's ability to recover an overpayment in the case of fraud or a material misrepresentation by a physician or provider."

Absent fraud or a material misrepresentation by the provider, carriers may not recover overpayments if notice has not been given within the timeframes established by the rule. However, the rule does not limit the time in which a carrier may investigate a claim in order to determine whether fraud or a material misrepresentation may have occurred.

As with all prompt pay laws, including recovery of overpayments, state regulation is limited to those plans that fall within TDI's jurisdiction. As a result, providers who experience notice of payment recovery outside of the 180 days may be dealing with a plan that is not subject to Texas prompt pay laws.

TACCP Member Perspectives

Hospital providers say that it is not uncommon for health plans or, more often, third party auditing firms retained by health plans, to request bill audits on multiple accounts. Often, the requests by third party auditing firms are for 50 to 100 (or more) accounts from multiple health plans. The requests are often for any accounts over a certain billed charge threshold or for any account that hits a stop-loss provision. Unless there is proof of fraud or material misrepresentation, or the health plan can establish and provide evidence of a pattern of fraud or material misrepresentation by a particular provider, a blanket request to audit multiple accounts outside of the established time frame is not permitted by the regulation. Further, the submission of an incorrect bill does not constitute fraud or a material misrepresentation nor should it form the basis for an audit or recovery of overpayments beyond the 180-day timeframe.

Physicians state that a material misrepresentation can, and usually does, have an element of intention. A material misrepresentation is made when the person making the representation knows

it is likely to induce another to assent.[8] However, another meaning is that the false representation is likely to induce a reasonable person to assent. A mere error anywhere on the claim form is insufficient to fall under the definition of a material misrepresentation. The misrepresentation must address an item of import upon the claim form such that a reasonable person (which may differ from the perspective of an insurer) would find the distinction meaningful to the decision. Physicians report that TDI has emphasized the former approach (that the maker of the statement knows the misrepresentation will induce assent) rather than the latter approach. This interpretation, physicians say, carries out the intent of the legislation and ensures the 180-day audit timeframe is given meaningful effect.

Carriers indicate that providers complain about attempts to audit or investigate claims more than 180 days after the receipt of the claim payment. However, carriers go on to say say, the rule does not apply and does not "affect a carrier's ability to recover an overpayment in the case of fraud or a material misrepresentation by a physician or provider." This issue often arises in the context of a requested hospital bill audit, to determine the validity of one or more submitted claims, which may take place at the facility location and require scheduling with hospital personnel. If the results of such a hospital bill audit indicate that the facility incorrectly billed for services or supplies that were not provided to the insurer's member, the claim for those services or supplies would fall within the exception for "a material misrepresentation" by the provider (regardless of intent), and the restrictions of TAC § 21.2818 would not apply. Because recovery of the overpayment would not be prohibited in this situation, the regulation must reasonably be read to permit insurers to perform necessary audits to discover such overpayments.

Fraud requires a showing of intent; a material misrepresentation does not. A material misrepresentation included on a claim submitted by a provider would fall within this exception, regardless of intent. A misrepresentation that results in a carrier overpaying a claim or paying for a service or supply that was not actually provided may be considered material.

Pharmacies have a different experience with recovery of overpayments. They report that they receive requests from pharmacy benefit managers (PBMs) for claims information in excess of the 180-day look-back limit provided by law, often justified by an allegation of "material misrepresentation" or "fraud." Additionally, some PBMs have told pharmacies that they do not have to comply with the audit provisions ascribed in law. Pharmacists report that PBMs recoup payments that were based on audit findings of clerical or administrative errors or practices unrelated to plan benefits or coverage.

Chapter 4151 requires persons holding themselves out or acting as a TPA to hold a certificate of authority under that chapter. An administrator is defined as a person who, in connection with annuities or life benefits, health benefits, accident benefits, *pharmacy benefits***,** or workers' compensation benefits, collects premiums or contributions from or *adjusts or settles* claims for residents of this state**.**

What is not clear is:

- whether all PBMs that adjudicate and audit pharmacy claims are licensed as TPAs under Chapter 4151 or are regulated by other parts of the TIC;
- whether the term "adjusts or settles claims" includes claim adjudication, which to pharmacists mean that the claim was clean and the patient and prescribed drugs were eligible for coverage;
- whether the state holds sufficient enforcement authority and staff to take action against PBMs who violate state law and regulations, especially regarding claim payments and audits.

[8] Black's Law Dictionary 1022 (8th Ed.)

Department Updates to the Committee

In addition to discussing ongoing issues, the Department keeps the TACCP informed on bills and other issues that affect or might be of interest to committee members. Below is a list of updates on bill implementation efforts and other issues for which the Department provided information to the Committee.

Bills

The Department updated members on the bills below that were enacted by the 80th Texas Legislature. The Department kept members up to date on activities related to these bills and summaries of those updates are included below. More detailed information on these bills can be found on the TDI website.

House Bill 472 Relates to the regulation of TPAs, including administrators with delegated duties in the workers' compensation system. The Department held a stakeholder meeting in October 2007 to discuss rulemaking and posted an informal rule on its website in November 2007. The Department is preparing the final text and anticipates publishing a formal proposed rule in the Texas Register near the time of this report's publication. The Department is also developing two other rules to implement HB 472 that have a smaller scope.

House Bill 522 Requires the Commissioner to appoint an advisory committee and the Department to develop a pilot program to create electronic identification cards that contain health insurance eligibility information. In anticipation of legislative implementation, three carriers created pilots for electronic health data cards. The committee is developing recommendations for the legislature and anticipates releasing the report in the fall.

House Bill 1594 Aimed at helping medical groups expedite credentialing for new providers. However, the definition of medical group set forth in the bill significantly limits the types of medical groups affected. The bill author clarified the intent through a written letter and many health plans have agreed to comply with the spirit of the law.

Senate Bill 1731 Requires providers to provide patients with notice of billing practices. Also, requires the Department to collect data on health care reimbursement rates, create user-friendly 'report cards' to allow consumers to compare PPO and HMO plans, and evaluate health network adequacy. For the reimbursement rate portion of the legislation, the Department will collect data on several hundred procedure and diagnosis codes, and informal draft rules have not yet been released due to ongoing contract negotiations with the American Medical Association to allow the Department to utilize the AMA's copyrighted Current Procedure Technology codes. The target date for the first data submission will be determined during the rulemaking process. The HMO and PPO 'report card' sections of the legislation will have staggered implementation dates, and the Department plans to issue draft rules later this year. The Department is working with the Network Adequacy Advisory Committee (NAAC) to collect and evaluate information on health network adequacy, and informal working draft rules were issued in July 2008.

Issues Relevant to Stakeholders

The Department updated TACCP members on issues most relevant to stakeholders including workers' compensation, Medicare Advantage marketing, and claim coding systems.

Workers' Compensation: Find a Doctor Brochure

Because the approved doctors' list was abolished, the TDI Division of Workers' Compensation (DWC) developed a "Find a Doctor" brochure aimed at educating injured workers who are not part of a network on how to find a doctor who accepts workers' compensation claims. Detailed information about the doctors who may be eligible and willing to treat workers' compensation injured employees may be accessed on the TDI website. Doctors previously removed or denied admission to the Division's former Approved Doctor List are excluded from providing any service within the Texas Workers' Compensation system (except in an emergency situation).

Medicare Advantage Marketing

TDI staff updated the TACCP regarding issues relating to the marketing of Medicare-related products (e.g., Medicare Advantage, Medicare Part D, Medicare supplements). TDI signed a memorandum of understanding on August 1, 2007, with CMS to facilitate the sharing of information and has participated in monthly conference calls with the CMS Dallas Regional office.

Updating Claim Coding Systems: Implementation of ICD-10-CM 9

Payors, such as commercial health insurance carriers and CMS, and providers, such as physicians, other health care professionals, hospitals, and other facilities, use a system of codes on health care claims to reflect diagnosis and procedures. These codes allow a provider to communicate specific billing information to the payor. A list of coding categories is defined in the textbox: *Claim Coding Definitions*.

Claim Coding Definitions

International Classification of Diseases (ICD) – Developed by the World Health Organization, the international standard diagnostic classification for many health management purposes, including health insurance claims.

Diagnosis-related group (DRG) – a system to classify hospital cases into one of approximately 500 groups expected to have similar hospital resource use.

Current Procedural Terminology (CPT) – developed and maintained by the American Medical Association, is used in the United States to code professional services on claims of physicians and other non-inpatient providers.

These coding systems must be updated periodically and the TACCP discussed impending updates for the International Classification of Diseases (ICD). First developed by the World Health Assembly in 1948, ICD codes are the basis for payment to physicians, health care facilities, and other health care providers, and are used to classify diseases and other health problems recorded on many types of health records, including health care claims. [10] Because ICD coding captures diagnostic and procedural information, advances in health care create the need to update the system to obtain greater clinical accuracy.

The current standard coding system for identifying diagnoses in the United States is the ICD, 9th Revision, Clinical Modification (ICD-9-CM). In 1994, World Health Organization (WHO) Member States (representing 99 countries) began using the ICD, 10th Revision, Clinical Modification (ICD-10-CM) as the standard to replace ICD-9-CM.

Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures.

[9] Teresa B. Devine, CAE, Director, Payment Advocacy Department, Texas Medical Association
[10] "International Classification of Diseases." World Health Organization. <www.who.int>.

ICD-10-CM has been used for vital statistics reporting in the United States since 1999 and has been implemented throughout much of the rest of the world for reporting diagnoses in health care settings.[11] Carrying out this update in clinical settings in the United States, however, will involve significant electronic systems changes. A study by the Rand Corporation estimates the total cost for implementation will be approximately $425 million to $1.15 billion in one-time costs for system changes and training for physicians and providers, payers and vendors, plus between $5 and $40 million per year in lost productivity. Rand estimates benefits between $700 million and $7.7 billion.

The Department of Health and Human Services (HHS) on August 15, 2008 announced a long-awaited proposed regulation that would replace the ICD-9-CM code sets with the greatly expanded ICD-10 code sets, effective October 1, 2011. In a separate proposed regulation, HHS proposed adopting the updated X12 standard, version 5010, and the National Council for Prescription Drug Programs standard, version D.0, for electronic transactions, such as healthcare claims. Version 5010 is essential to use of the ICD-10 codes.

Under the updated transaction standards proposed rule, compliance with version 5010 (health care transactions) and Version D.0 (pharmacy claims) would be required by April 1, 2010. Comments on both proposed rules are due by October 21, 2008.

As the health care industry moves toward adoption of updated transactions and code sets, the TACCP will play an important role in advising TDI on how these changes will impact healthcare transactions for which TDI has oversight.

[11] Lumpkin, MD, MPH, John. "National Committee on Vital and Health Statistics Letter to Sec. Thompson Re: ICD-10 Recommendations." 05 Nov. 2003.

Appendices

Appendix A - Resolved Issues

The table below lists examples of issues that were covered in previous reports and were addressed by the TACCP before this reporting period. The table serves to show the effectiveness and accomplishments of the Committee to date.

Issue	Background	Resolution Summary
Clearinghouses		
Clearinghouses convert data submitted by a health care provider to a payor and can be public or private entities, including billing services or re-pricing companies.	Federal HIPAA provisions require clearinghouses to conduct standard transactions where enacted. However, clearinghouses are free to use their own transaction methods. As a result, some processes reject entire batches of claims in addition to the deficient claims. CMS has not specified whether claims may be rejected at the "batch level" or must be the individual claim level". Providers indicated that "batch rejection" requires significant review of individual claims to determine which claim(s) caused the rejection. Providers believe 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 batch rejection.	In response, the Legislature enacted SB 50 (2005), which requires carriers to include, if requested, a provision in the provider's contract indicating that the carrier will not deny or refuse to process a clean claim submitted in a batch that may contain deficient claims. The Department has adopted amendments to rules in TAC Chapters. 3 and 11 to implement SB 50 (TAC § 21.2807). These amendments are 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. Additionally, TDI clarified 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"), the payor remains subject to electronic claim timeframes.
Disclosure of Fee Schedules		
SB 418 allows contracted providers the right to request certain claims payment information, including fee schedules, payment methodologies, and coding and bundling rules or processes. In addition, payors must give 90 days written notice prior to instituting any changes to the claims processing information.	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 ensure 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.

Issue	Background	Resolution Summary
Some health plans reported they have received more than 100,000 provider requests while others indicated they received no requests.		
National Provider Identifier (NPI)		
On May 28, 2008, CMS implemented new claim forms and required providers to use a new National Provider Identifier number on claim forms. As a result, providers needed to obtain NPI numbers from CMS and carriers needed to prepare to accept claims using the NPI as the provider identifier.	The NPI is a HIPAA standard and is a unique identification number for health care providers. Beginning May 23, 2007 (May 23, 2008, for small health plans), CMS required Medicare health care providers, health plans, and clearinghouses to use the NPIs in administrative and financial transactions in lieu of legacy provider identifiers in the HIPAA standards transactions. To implement these standards, CMS implemented new claim forms, which are used in commercial transactions as well. CMS delays in implementing the forms created challenges for providers and carriers to transition to the new forms and NPI requirements.	Throughout implementation, TDI worked with carrier and provider representatives to encourage preparedness by May 2008. In addition, the Department modified clean claim rules to implement the new claim forms and included flexibility in the rule to accommodate the shifting implementation dates. In addition, the Department worked closely with carriers to ensure that contingency plans were in place to ease the transition during the initial phases.
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. Under SB 418, health carriers must pay penalties for claims paid timely but incorrectly. In certain situations, the formula contained in the TDI rule results in a total payment to the provider, including the penalty, which exceeds billed charges. Under the late payment penalty structure, the maximum penalty is billed charges. The underpayment penalty formula under TAC § 21.2815(d) is: Underpaid Amount/Contracted Rate X Billed Charges = Penalty Payment.	During the 81st Legislative Session, a carrier proposed 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. 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.	The Legislature passed Senate Bill 1884 (2007) passed, which adjusts the calculation for underpayment penalties under the prompt pay statutes. Accordingly, the Department conformed prompt pay rules to the new legislative language. The adoption order for the rule was signed on January 18, 2008.

Requests for Verification		
Verification is a statutorily established process that allows providers to verify a patient's coverage for specific services. It can be used regardless of whether preauthorization is required. A carrier must respond to a verification request within certain specified time frames. If approved, 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 is a guarantee of payment. Although not a guarantee of payment, once a service is preauthorized a carrier may not deny or reduce payment based on medical necessity or appropriateness of care.	Some carrier representatives indicate that the personnel costs associated with weekend and holiday staffing are significant and excessive considering the number of requests for verification submitted. They recommend that the statute governing verification be amended to remove the requirement that carriers have staff available during these times. In contrast, provider members have indicated the frequency of declinations and the strict requirements necessary for a verification request have discouraged providers from using the process.	TDI collects data quarterly on carrier declinations of provider verification requests. This report contains some of that information in Appendix C. In addition, as the Department notices unexpectedly high rates of declinations or low rates of verification requests, the Department contacts the carrier to ensure compliance with the statute. If necessary, the Department has authority to take enforcement actions for a carriers failure to comply this prompt pay statute.

Appendix B – Department Provider Ombudsman Activities

Department's Role in Assisting Providers

Provider Ombudsman	The role of the Provider Ombudsman is to assist health care providers in dealing with insurance carriers. The Provider Ombudsman expedites resolution of provider complaints and analyzes complaint data for patterns or particularly serious violations that require corrective action. In some cases the Provider Ombudsman suggests changes in TDI rules if necessary to improve compliance with insurance laws. The program was developed in 2001 following prompt payment for medical insurance claims legislation. In the fall of 2006, the Commissioner transferred the function from the Consumer Protection Program to the Life, Health and Licensing Program. The change was driven by a shift from the previously high number of complaints to monitoring prompt pay trends and issues that arise from evolution of the health care industry. Mission: To assist providers on matters involving prompt payment of claims. Duties include: • Monitor complaints in aggregate to determine trends that identify new issues or carrier-specific issues; • Collect and analyze quarterly prompt pay data for compliance with prompt pay laws; • Plan and conduct quarterly and ad hoc meetings of the Technical Advisory Committee on Claims; • Develop rules necessary to enforce prompt payment; • Partner with the Consumer Protection Program as needed on specific complaints; and • Partner with the Enforcement Program to ensure compliance with prompt pay laws.

Outreach and Education

Department staff responds to requests and invitations to speak on issues important to various groups and travels throughout Texas. Staff responds to interview requests from different types of media sources. The table on the next several pages includes speaking engagements and interviews for fiscal year 2007 and 2008. From September 2006 through August 2008, TDI, including DWC staff, has presented, or interviewed on numerous occasions at organizations or media outlets on health or workers' compensation related issues.

In response to a request by chiropractors for more involvement, the Department began holding quarterly meetings to provide a platform for their concerns and questions. In addition, TDI staff created a Chiropractors Resource Page on the Department website that includes quarterly meeting summaries, a mini conference video, and frequently asked questions and answers.

The Department also increased its outreach to pharmacists, including a representative on the TACCP. In addition, based on concerns raised by pharmacy representatives, the Department conducted special efforts to educate pharmacists on filing complaints

The table on the next page shows a sample of the speaking and informational requests to which the Department responds to educate consumers, providers, and carriers.

Speeches, Presentations and Interviews 2007 to 2008

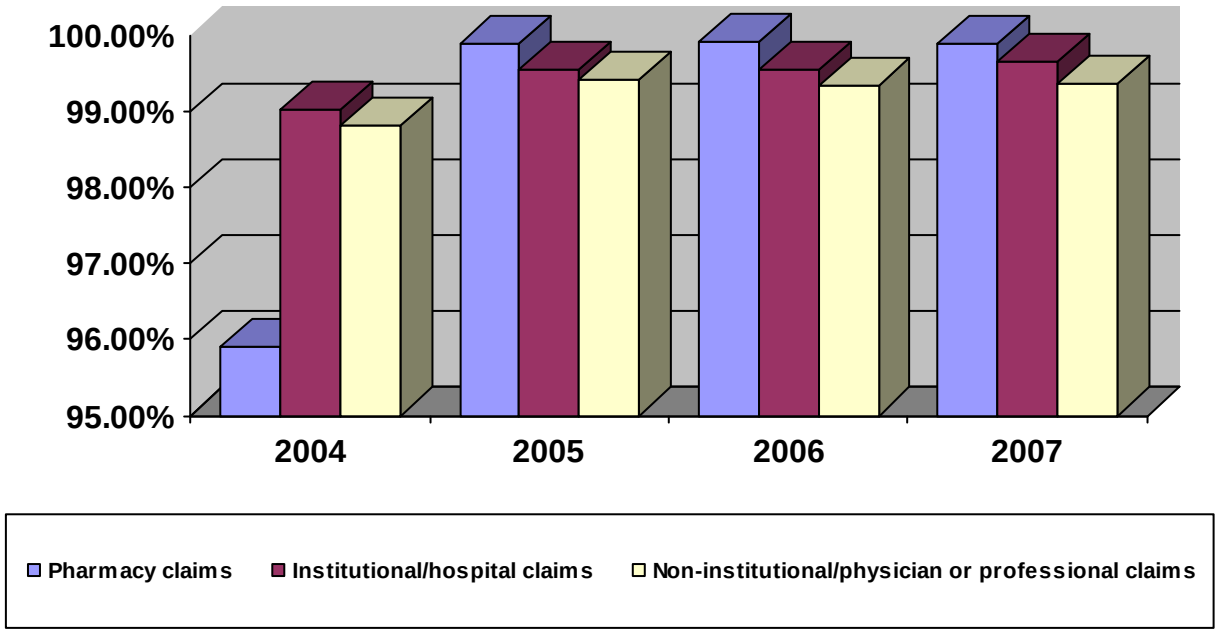
Topic	Requesting Organization, Media or Event	City
Compliance issues	2006 TDI Employer Health Coverage Compliance Conference	Austin
	2006 TDI Property and Casualty Compliance Conference	
	2006 TDI Life, Health & Licensing Compliance Conference	
	2006 DWC Compliance Seminar	
Department Update/Overview TDI and/or DWC	Texas Orthopaedic Association	Austin
	Lubbock Health Underwriters Symposium	Lubbock
	Texas Self Insurance Association	Galveston
Disaster Planning and/or Recovery Efforts	TDI: Texas State Disaster Coalition	Austin
Fraud	TDI: 9th Annual Fraud Conference	Austin
	TDI 10th Annual Fraud Conference	
Health Insurance	Texas Association of Business Health Care Conference	Austin
Legislative Update or Specific Bill Update/Discussion	Texas Medical Association: Patient - Physician Advocacy Committee	San Antonio
	Texas Medicine Magazine	Austin
	Texas Association of Public and Nonprofit Hospitals	Dallas
	Anesthesia Administrators of Texas 20th Annual Educators Conference	Grapevine
Long-Term Care Insurance	Houston Chronicle	Houston
	Montgomery Courier	Montgomery
Medicare Advantage Plans	(H) EPCC-TV, Channel 14	El Paso
	(H) KFOX-TV, Channel 14	
	New York Times	Washington, DC
Mental Health Benefits	Houston Chronicle	Houston
Prompt Pay	2007 Orthopedic Symposium	Houston
	Texas Osteopathic Medical Association	Dallas
	Genesis Physicians Group (2 events)	
		Plano
		Frisco
		Carrollton
	Presbyterian Managers Association	Dallas
	Texas Medicine Magazine (2 interviews)	Austin
	Texas Medical Group Management Association	
	Department of Aging and Rehabilitative Services - Early Childhood Intervention Program	
	Texas Speech Language Hearing Association	San Antonio
	San Angelo Assn. of Insurance and Financial Advisors	San Angelo
	Texas Society of Anesthesiologists	Bastrop
Regulatory Issues/Updates	Texas Ambulatory Surgery Center Society Conference Texas Chiropractic Association Texas Public Policy Foundation	Austin
	Texas Chiropractic Association Mid-Winter Seminar	Ft. Worth
	Association of Insurance Compliance Professionals (AICP)	Portland
Regulatory Process	Texas Chiropractic Association Annual Convention	San Antonio
Silent PPOs	Texas Medical Association	Austin

Topic	Requesting Organization, Media or Event	City
Workers' Compensation	San Antonio Claims Association Workers' Compensation Health Care Networks Employer Workshop Workers' Compensation Health Care Networks Provider Workshop	San Antonio
	TWC Texas Business Conference	Dallas
	Texas Association of Business	Wichita Falls
	Texas Medicine Magazine	Austin
	Texas Association of Business	Midland
	Victoria Professional Association of Health Care Office Managers	Victoria
	AFL-CIO Texas Labor-Management Conference	San Antonio
	Texas Association of Business	Gainesville
	Texas Association of Business	Wichita Falls
	TDI Workers' Compensation Health Care Network Workshop	Austin
	Texas Medicine Magazine	

Appendix C – Compliance Oversight

Timeliness of Provider Claims Payments

This graph represents the percentage of clean claims paid timely.

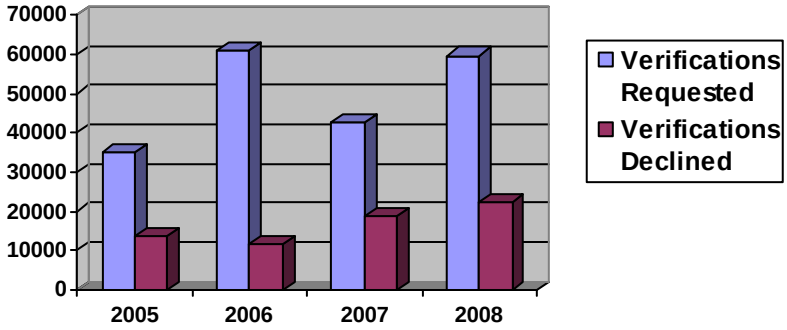


Source: TDI SB 418 Provider Claims Data Calls - July 2004 - June 2008

Note: Each year illustrated in the graph begins in July of that year and runs through June of the following year. (2004 = July 2004 to June 2005)

Verification Requests

This graph compares the number of verification of benefit requests by providers to the number of declines for verification by carriers.



Note: Each year illustrated in the graph begins in July of that year and runs through June of the following year. (2005 = July 2004 to June 2005)

Source: TDI SB 418 Provider Claims Data Calls - July 2004 - June 2008

Reasons for Verification Declinations

Carriers also report to the Department reasons for declining to verify benefits and the chart below shows the reasons and number of times those reasons were given in the previous four years.

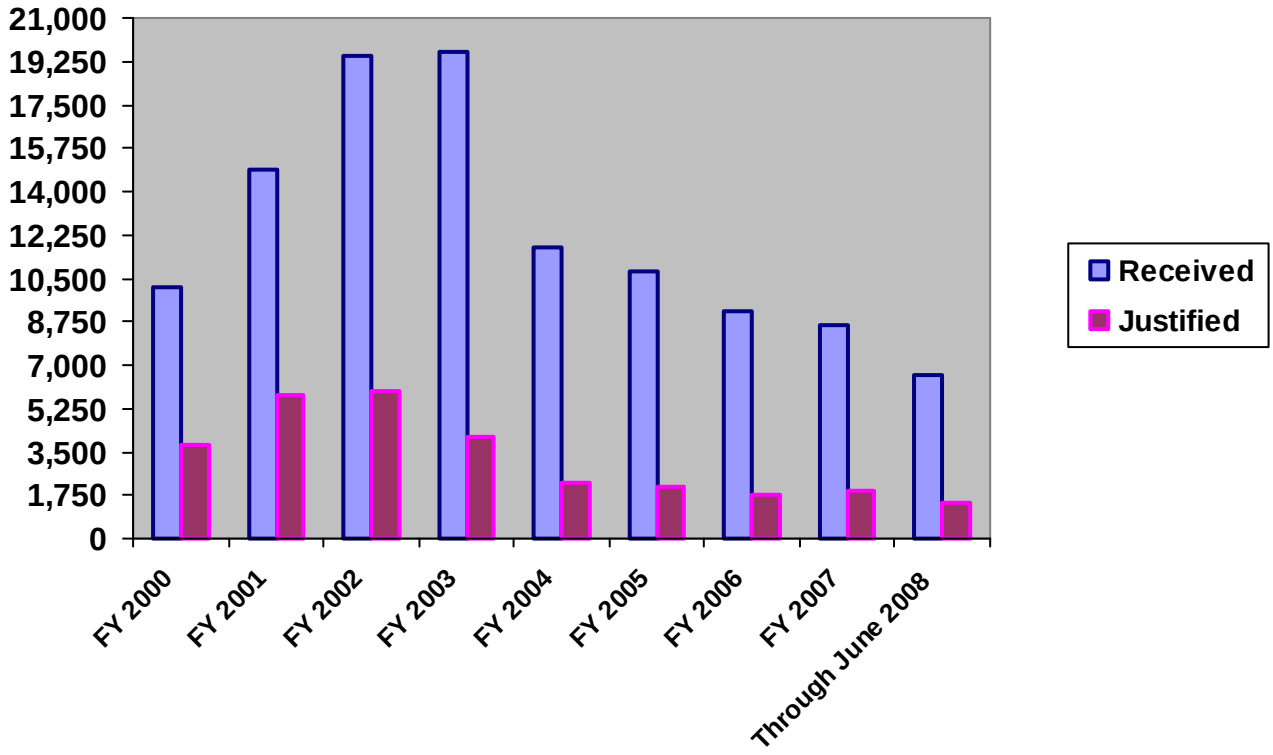
Note: Carriers may have reported more than one reason for a declination. Each year illustrated in the graph begins in July of that year and runs through June of the following year. (2005 = July 2004 to June 2005)

Reason for Declination	2005	2006	2007	2008
Declinations due to premium payment time frames that prevent verifying eligibility for a 30-Day Period	5,353	2,589	2,717	1,500
Declinations due to policy deductibles, specific benefit limitations or annual benefit maximums	10,648	13,986	26,564	10,566
Number of declinations due to benefit exclusions	13,583	17,202	24,515	12,913
Number of declinations due to no coverage or change in membership eligibility, including individuals not eligible, not yet effective, or membership cancelled	6,064	8,704	6,693	13,843
Declinations due to pre-existing condition limitations	2,995	1,118	2,102	3,037
Declinations due to other policy or contract limitations	8,954	10,342	3,079	12,344
Declinations due to lack of information from the requesting physician or provider	9,208	13,136	2,971	25,113
Declinations due to lack of information from other physician or provider	422	276	166	1,276
Declinations due to lack of information from any other person	1,042	4,352	5,769	1,538
Declinations due to other reasons	9,763	15,302	16,238	18,352

Source: SB 418 Annual Reasons for Declination Report - July 2004 - June 2008

Complaints Received from Physicians and Providers: FY 2000 through June, 2008

The graph below illustrates that since SB 418 was passed by Legislature in 2003, the number of complaints dropped dramatically in 2004 and has steadily declined since. The number of justified complaints has also declined after the passing of SB 418 and has been about the same during the last several years. Received complaints include all complaints received by TDI from a physician or a provider. A justified complaint involves 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.



Source: TDI Complaints Inquiry System (CIS) database

The electronic version of this report is available on the TDI website at:
http://www.tdi.state.tx.us/reports/report5.html