Submission, Timelines and Prompt Pay of Clean Claims

Your determination on which rules apply will be based on provider contract status: Has the preferred provider's contract with the complained-of carrier been renewed on or after 8-16-03? If so, the column headed SB 418 and Related Rules will apply. If not, the column headed HB 610 and Related Rules will apply.

Please reference the rules for specific details. For any discrepancies between these reference materials and the rules, the rules prevail.

Topic	HB 610	SB 418
Applicability: Who has to comply?	Applies to HMOs and to preferred provider benefit plans issued by an insurer. **Does not apply to the following**: Self-funded ERISA plans, workers compensation coverage, government, school and church health plans, out-of-state insureds, Medicaid, Medicare + Choice HMOs, Medicare + Cost plans, Medicare Supplement plans, Health Select and Health Select Plus plans for state employees, federal employee plans, self-funded plans covering UT and A&M System employees, Tricare Standard (CHAMPUS), and Texas Association of School Boards coverages.	Applies to HMOs and to preferred provider benefit plans issued by an insurer. **Does not apply to the following**: Self-funded ERISA plans, workers compensation coverage, government, school and church health plans, out-of-state insureds, Medicaid, Medicare + Choice HMOs, Medicare + Cost plans, Medicare Supplement plans, Health Select and Health Select Plus plans for state employees, federal employee plans, self-funded plans covering UT and A&M System employees, Tricare Standard (CHAMPUS), and Texas Association of School Boards coverages, and the **Children's Health Insurance Program (CHIP)**
Claim Filing Deadline, Duplicate Claims	No provision	Must file claims within 95 days after provision of service. A physician or provider who fails to timely file forfeits right to payment unless prevented from filing by a catastrophic event (Refer to 28 TAC §21.2819, Catastrophic Event) - Applies to both preferred and non-preferred providers. For hospitals, 95 days starts on discharge date. Claims timely filed with another carrier satisfies this claim filing requirement and addresses issues of misdirected claims as well as claims filed late to a secondary carrier because a provider was awaiting processing by primary carrier. A physician or provider may not submit a duplicate claim prior to the 46th day, 31st day if filed electronically, or the 22nd day if for prescription drugs after the date the original claim is presumed to be received. If a duplicate is filed in contravention of this requirement, carrier is not subject to penalties with respect to the duplicate claim. ***28 Texas Administrative Code §21.2806***

Topic	HB 610	SB 418
Proof of receipt	Receipt of claims: The 45 day claim processing period begins on date of claim receipt. To create a rebuttable presumption of the receipt date providers may opt to use the claims mail log. A preferred provider must maintain a log that identifies each claim in a submission, include a copy of the log with the relevant submitted claim(s), fax or electronically send a copy of the log to the payor on the date of claim submission and maintain a copy of the fax acknowledgment or proof of electronic submission. If process is followed, claims sent by U.S. mail are presumed received on the **3rd business day** following mailing, claims sent by U.S. mail, return receipt requested or by overnight delivery are presumed received on date of signed receipt, claims sent by fax (if allowed) are presumed received on the fax date if the dated proof of transmission form is retained, electronically submitted claims are presumed received on date of electronic confirmation of receipt by the carrier or its clearinghouse. If no confirmation is given, the provider's clearinghouse may confirm so long as claim contained the correct payor ID. Hand-delivered claims are received on the delivery date. Receipt of other communication: Not Addressed	Receipt of claims & written communication: Communications and claims may be sent by U.S. mail first class or return receipt requested or by overnight delivery, electronically, fax transmission or hand delivery. Sender must maintain proof of any electronically submitted communication, fax transmission, or copy of the receipt of hand delivery. Communications and claims sent by first class mail are presumed received on the **5th calendar day.** Those sent via overnight delivery or U.S. mail return receipt requested are received on the delivery receipt date as are communications and claims that are hand delivered. A faxed claim is presumed received on the date of the transmission acknowledgement but a fax transmitted after a recipient's normal business hours is presumed received on the next business day. An electronically- submitted communication is presumed received on the submission date, while an electronically-submitted claim is presumed received on the date of electronic confirmation of receipt by the carrier or its clearinghouse. If no confirmation is given within 24 hours, the preferred provider's clearinghouse shall provide the confirmation if it can show that the claim contained the correct payor identification. To provide proof of submission and establish date of receipt the sender may chose to maintain a mail log. If used, the sender shall fax or electronically transmit a copy of the mail log at the time of submission and include a copy with the relevant communication (claim). The log shall identify each separate claim, request for information or response included in a batch communication and shall include the following information: claimant's name, address, telephone number, and federal tax ID number; name of addressee; carrier name; designated address; date of mailing or hand delivery; subscriber name and ID number; patient name; dates of service or occurrence; delivery method and claim number, if applicable. Carriers and providers can agree to any other method of establishing a presumption of claims receipt. ***28 TAC §21.2816***

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Effect of filing a clean claim	Upon receipt of clean claim at designated address 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 85% of contracted rate and notify the provider that claim is being audited, (4) pay a portion of the claim and deny or audit the remainder, paying 85% of the audited portion. For electronically-submitted and electronically-paid prescription claims, carrier must pay within 21 calendar days after clean claim is adjudicated. ***28 TAC §21.2807***	Upon receipt of clean claim at designated address and within the statutory claim payment period the carrier must: (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% of contracted rate and notify the provider that claim is being audited, (4) pay a portion of the claim and deny or audit the remainder, paying 100% of the audited portion. For electronically-submitted prescription claims, carrier must pay within 21 calendar days after clean claim is adjudicated. ***28 TAC §21.2807***
Deficient Claims	Must notify provider of deficient claim within 45 days of receipt and within 21 days of receipt of deficient pharmacy claim. ***28 TAC §21.2808***	Must notify preferred provider of deficient claim within 45 days of receipt of claim, within 30 days of receipt of electronic claim and within 21 days of receipt of deficient pharmacy claim. ***28 TAC §21.2808***
Statutory Claim Payment Period	45 days for payment, denial, or audit of non-pharmacy clean claim 21 days for payment of pharmacy claims. ***28 TAC §21.2802(25)***	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; 21 days from affirmative adjudication for payment of pharmacy claims. ***28 TAC §21.2802(28)***
Clean Claim, Defined	A clean claim consists of: data elements on HCFA 1500 and UB92 claim forms that are required or conditionally required by TDI rules. It must also include properly-noticed additional data elements and attachments. Claims to secondary carriers must disclose amounts paid by the primary carrier. Data elements must be	A clean claim consists <u>only</u> of: data elements on CMS 1500 and UB 92* claim forms that are required or conditionally required by TDI rules for non-electronic claims. Claims to secondary carriers must disclose amounts paid by the primary carrier. Electronic claims must comply with all federal laws applicable to electronic claims, implementation guides, companion

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Clean Claim, Defined (continued)	complete, legible and accurate. Additional data elements or information does not render the claim deficient. ***28 TAC §21.2803***	guides, and trading partner agreements. Data elements must be complete, legible and accurate. Additional data elements or information does not render the claim deficient. *Not all data elements on these forms are required for all providers. Refer to rule language for these exceptions. ***28 TAC §21.2803***
Coordination or non-duplication of Benefits	For policies that contain a coordination or nonduplication of benefits provision or a variable deductible provision, the amount paid by the primary carrier is a clean claim element for a claim submitted to a secondary carrier. ***28 TAC §21.2803(e)***	For policies that contain a coordination or nonduplication of benefits provision or a variable deductible provision, the amount paid by the primary carrier is a clean claim element for a claim submitted to a secondary carrier. Carriers can require that providers maintain and furnish updated information about a patient's coverage under other health benefit plans. **(SB 418)** Carriers cannot otherwise require a preferred provider to investigate COB of other health benefit plan coverage. When filing an electronic claim requiring COB the secondary payor shall rely on the primary payor's information submitted on the claim. Primary payors may submit information electronically to secondary payors using the ASC X12N 837 format and in compliance with 28 TAC §21.2803(e). ***28 TAC §21.2803(c)& (e)***
Additional information requested from treating provider	No provision	Carrier is allowed one request to a treating preferred provider for additional information within 30 days of clean claims receipt. Request must be written, specific to claim or related episode of care, specifically describe the clinical and other information requested, be relevant and necessary for claim resolution, and be for information contained or in the process of being incorporated in to patient's medical or billing record maintained by the preferred provider. Request for additional information stops the claim clock until the carrier receives (1) the requested information or (2) the provider's response that information is not in provider's medical/billing record. Upon receiving response, carrier must act on the claim on or before the later of the 15th day after receiving response or the latest date for adjudicating claim under 28 TAC §21.2807 (Effect of filing clean claim).

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Additional information requested from treating provider (continued from previous page)	No provision	Either response must be accompanied by (1) a copy of the carrier's request for additional information or (2) the patient's name and ID number, the carrier's claim number, date of service and name of treating preferred provider. Either response is subject to 28 TAC §21.2816 (Date of Receipt). If the request is submitted per federal electronic transaction requirements, the preferred provider must respond in accordance with the requirements to resume the payment period. ***28 TAC §21.2804***
Additional information requested from sources other than treating provider	No provision	Carrier can request information from a source other than the treating provider but must disclose the source's name to the treating provider. This request does not stop the claim clock. A response under this section is subject to 28 TAC §21.2816 (Date of Receipt.) ***28 TAC §21.2805***
Audit Procedures	If claims determination cannot be made within 45 days after clean claim receipt, carrier must pay 85% of claim at contracted rate and notify provider that claim is being audited. Upon completion, if additional payment is due, the carrier must pay within 30 days after completing the audit. ***28 TAC §21.2809***	If claims determination cannot be made within the applicable statutory claims payment period, carrier must pay 100% of contracted rate (less copayments, deductibles, etc.) before expiration of applicable payment period and must notify provider on the EOB that claim is being audited. Carrier can request additional information and continue investigation. ***28 TAC §21.2809***
Audit Period	Carrier can continue investigation for 180 days after claim is received. If still cannot adjudicate claim, carrier must pay remaining 15% but can continue to investigate claim and obtain refund if it is determined that the claim was not payable. ***28 TAC §21.2809***	Carrier must complete audit in 180 days and give written notice of audit results and list specific claims paid and not paid as well as a list of specific claims and amounts for which refund is due. Carrier must give basis and specific reasons for refund request. Carrier is entitled to complete refund if preferred provider fails to timely respond to a request for additional information. ***28 TAC §21.2809***

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Time frames for Refunds	If audit reveals claim is not payable, provider must refund payment within 30 days after later of (1) notification of audit results or (2) expiration of patient/subscriber appeal rights if appeal is filed before expiration of the 30 day refund period. Chargebacks are allowed but audit notification must state that carrier will charge back unless provider contacts carrier to make arrangements for alternative reimbursement. ***28 TAC §21.2809***	If audit reveals that a refund is due from the preferred provider, the carrier must furnish the preferred provider with a refund request and an appeal opportunity pursuant to §21.2818 (Overpayment of Claims). The refund is due in 30 days after the later of the date that (1) the physician or provider receives notice of the audit results; or (2) any appeal rights of the provider are exhausted. ***28 TAC §21.2809***
Overpayment of claims	Refunds of audit payments are addressed in 28 TAC §21.2809 (Time Frames for Refunds). HB 610 did not address other types of refunds.	Carriers may recover refunds due to overpayments or audit payments but must give notice by the 180th day after overpayment was made or give earlier notice of audit results as required by 28 TAC §21.2809. Notice must be in writing, for specific amounts, give notice of appeal rights, and describe methods by which carrier intends to recover the refund. A provider has 45 days to file a written dispute with the carrier's refund request which will trigger the appeal process. Carrier cannot recover overpayments until later of (1) 45 days after notification (30th day after notification for audits) or (2) the date provider appeal rights have been exhausted, if physician has not made prior arrangements for repayment. **Note:** If a carrier is a secondary payor but inadvertently pays as primary, it must seek a refund from HMO or insurer who is the primary carrier. However, if the correct primary carrier is a self-funded ERISA plan or other non-insured plan, the carrier may seek a refund of overpayment from the provider who received the incorrect payment. The provisions of 28 TAC §21.2818 do not affect a carrier's ability to recover overpayment in case of a provider's fraud or material misrepresentation. ***28 TAC §21.2818***
Claims procedures	Carrier must disclose mailing and physical address and phone number where claims are to be sent for processing. Also applies if claims processing is delegated. Must give 60 days advance notice in writing to preferred providers of any changes to claim processors or claim filing address. ***28 TAC §21.2811***	Carrier must disclose mailing and physical address and phone number where claims are to be sent for processing. Also applies if claims processing is delegated. Must give 60 days advance notice in writing to preferred providers of any changes to claim processors or claim filing address. ***28 TAC §21.2811***

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Denial prohibited for change of address	After change of address or change in claim processors, carrier cannot premise denial on failure to timely file unless carrier has given the notice as required by 28 TAC §21.2811. ***28 TAC §21.2812***	After change of address or change in claim processors, carrier cannot premise denial on failure to timely file unless carrier has given the notice as required by 28 TAC §21.2811. ***28 TAC §21.2812***
Requirements applicable to other contracting entities	A carrier's responsibility to comply with all requirements cannot be limited or diminished by any contract or delegation agreement for processing of claims or for issuing preauthorizations. ***28 TAC §21.2813***	A carrier's responsibility to comply with all requirements is not limited or diminished by any contract or delegation agreement for processing of claims or for issuing verifications or preauthorizations. ***28 TAC §21.2813***
Penalties **Applicable Statutory Claim Payment Period is:** ***21 days for pharmacy claim*** ***30 days for electronic claim*** ***45 days for paper claim***	Carriers who fail to correctly pay or audit claim within the statutory claim payment period are liable for 100% of billed charges (as defined) or the contracted penalty rate. (Amounts already paid and amounts for non-covered services may be deducted from the penalty.) Carrier may also be subject to administrative penalties of up to $1,000 per day for each day a claim remains unpaid. ***28 TAC §21.2815***	<u>Late payment penalties:</u> (1) If claim is paid on or before 45th day after ***applicable statutory claim payment period*** (as defined) carrier must pay: contracted rate plus the lesser of 50% of difference between contracted rate and billed charges or $100,000. (2) If claim is paid on or after the 46th day but before 91st day after ***applicable statutory claims payment period***, carrier must pay: the contracted rate plus the lesser of 100% of the difference between contracted and billed charge or $200,000. (3) If claim is paid on or after the 91st day after the ***applicable statutory claim payment period***, carrier must pay the contracted rate plus the penalty specified in paragraph 2 plus 18% interest on the penalty amount. <u>Underpayment penalties:</u> (1) If balance of claim is paid on or before the 45th day after ***applicable statutory claim payment period***, carrier must pay contracted amount owed plus the lesser of 50% of the underpaid amount or $100,000. (2) If balance of claim is paid on or after the 46th day but before the 91st day after the ***applicable statutory claim payment period***, carrier must pay contracted amount owed plus the lesser of 100% of the underpaid amount or $200,000.

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Penalties (continued from previous page)		(3) If balance of claim is paid on or after the 91st day after the ***applicable statutory claim payment period***, carrier must pay the contracted rate plus the penalty specified in paragraph 2 plus 18% annual interest on the penalty amount. The Underpaid Amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate. See the rule for an example of this calculation. A carrier is not liable for a penalty under this section if failure to timely pay was due to a certified catastrophic event. When a catastrophic event precludes the timely payment of a claim, the statutory payment deadline is extended only for the amount of time a certified catastrophe interrupted business operations. A carrier is not liable for a penalty under this section if the claim was paid per 28 TAC §21.2807 but for less than the contracted rate and (1) the provider notifies the carrier of the underpayment more than 270 days after the payment receipt date and (2) the carrier pays the balance within 30 days after receiving notice of the underpayment. The EOB shall indicate the amount of the contracted rate paid, the amount of billed charges, and the amount paid as a penalty. ***28 TAC §21.2815***
SB 418 example of the penalty calculation for a clean claim that is paid on or before the 45th day after the end of the applicable statutory claim payment period	For this example, pharmacy claims, late payment = days 22-66; electronic claims = days 31-75; paper claims = days 46-90) If amount of contracted rate = $10,000 and billed charges = $15,000, then: $15000-$10000 = $5000 **X** 50% = $2500	
SB 418 Penalty for underpayments calculation of underpaid amounts	$\left(\frac{\text{amount underpaid on contracted rate}}{\text{amount of contracted rate}}\right) \text{X} \left(\text{billed charges - contracted rate}\right) = \text{underpaid amount}$ If amount of contracted rate = $1,000, billed charges = $1,500, amount paid timely = $800 and amount underpaid on contracted rate = $200 (paid 30 days after statutory claims period expires) then: $200/$1000 (or 20%) **X** ($1500-$1000) = $100 - Company owes a penalty of 50% of the $100 underpaid or $50	

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I. D. Cards	No provision	***Emergency Rules still apply until I.D Card rules are adopted. They are:*** I D card or other similar document must include the name of enrollee or insured, first date of eligibility under plan or toll free number for obtaining this information, and a symbol (star with "TDI" in the middle) displayed on the front. The effective date of this provision is January 1, 2004, for plans issued or renewed on or after that date. ***28 TAC* §21.2820**
Catastrophic event	No provision	If carrier or physician or provider is unable to meet regulatory deadlines due to a catastrophic event (see definition at 28 TAC §21.2802(4)), entity must notify TDI within 5 days of the event. Within 10 days after return to normal business operations, entity must provide certification in form of a sworn affidavit, identify nature of event, and the length of interruption of claims submission or processing. A valid certification under this section tolls the deadlines stated in 28 TAC §21.2804, §21.2806, §21.2808, §21.2809 and §21.2815 for the number of days identified in the certification. ***28 TAC §21.2819***
Terms of Contracts	Contracts cannot contain provisions that extend stated time frames or waive a physician or provider's right to recover attorney's fees. **28 TAC §*21.2817***	Unless otherwise set forth in rules, contracts cannot contain provisions that extend stated time frames or that waive a provider's right to recover attorney's fees and court costs. ***28 TAC §21.2817***
Reporting requirements	No provision	Sets forth requirements for reporting to TDI. Refer to rule for details. ***28 TAC §21.2821***
Applicability to Certain Non-Contracting Physicians and Providers	No provision	Provisions relating to Verification and Effect of filing a Clean Claim apply to a physician or provider who furnishes to an HMO or PPO enrollee or insured (1) emergency care or its attendant episode of care as required by state or federal law; or (2) care at the request of a carrier, physician or provider because services are not reasonably available from a network provider. ***28 TAC §21.2823***

Topic	HB 610	SB 418
Verification	NA	Routine - 5 days Concurrent Hospitalization - 24 hours Post stabilization or Life-threatening - 1 hour
Validity of Verification	NA	At least 30 days
Preauthorization For approvals	Routine - 2 working days after receipt of all information necessary to make the decision Concurrent Hospitalization - 24 hours Post Stabilization or Life Threatening - 1 hour	Routine - 3rd calendar day after receipt of request Concurrent Hospitalization - 24 hours Post Stabilization or Life Threatening - 1 hour
Preauthorization For adverse determinations	Routine - Within 3 working days after receipt of all necessary information Concurrent Hospitalization - Within 1 working day Post Stabilization or Life Threatening - Within 1 hour	Routine - 3rd calendar day after receipt of request Concurrent Hospitalization - 24 hours Post Stabilization or Life Threatening - 1 hour