SUBCHAPTER T. Submission of Clean Claims

28 TAC §§21.2802, 21.2807, 21.2815 and 21.2821

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to §§21.2802, 21.2807, 21.2815, and 21.2821 concerning submission of clean claims. These amendments: (1) ensure that carriers are aware of the responsibility to process a clean claim submitted together with deficient claims; (2) ensure that penalties are calculated consistently and in accordance with statutory requirements; and (3) provide consistency in reporting dates and clarify the reporting period for the required verification data report.

The proposed amendment to §21.2802 adds a definition of patient responsibility to clarify that the term does not include amounts that are not a portion of the contracted rate. Section 21.2802 also contains a proposed definition of “batch submission” to add clarity to the proposed amendments to §21.2807 that detail a carrier's obligations with respect to multiple claims submitted together. The proposed amendments to §21.2807 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 claims that are deficient. This is consistent with the statutory and regulatory requirements that, upon receiving an electronic clean claim at the designated address for claims receipt, a carrier must pay, deny or audit the claim within 30 days. The department recognizes that Senate Bill (SB) 50 (79th Regular Legislative Session) requires carriers to, upon

request, include 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, elsewhere in this edition of the Texas Register, proposed amendments to the contracting requirement rules in Chapters 3 and 11 that implement SB 50. The changes in law allow providers to be better aware of their rights under their contracts with health plans. The proposed changes to §21.2807 clarify that the requirement to process an electronic clean claim exists when the carrier receives the claim despite the claim being included among other claims that may or may not be clean. The requirement to process clean claims submitted together with deficient claims exists whether or not there is language in the contract addressing batch claim submissions. The proposed definition of "batch submission" identifies the intended consistency between the term and its usage in federal standardized electronic health care transactions by clarifying that the reference to a batch submission is a reference to existing federal standardized electronic health care transactions. Although the department has proposed language regarding the meaning of "batch submissions," carriers must avoid reading the language of SB 50 and the proposed language too narrowly. The language of the statute and the proposed amendment also apply to clean claims that are submitted "together with" claims that are deficient. This language is broader than the term "batch submission" and includes groups of claims that may or may not be properly classified as a batch submission for federal standardized transactions. Therefore, carriers should not unduly focus on whether claims that are

submitted together are in a batch submission that meets the federal regulatory definition. In addition, changes were made to this section to change specific references to more general references to reduce the need for frequent updating and revisions.

The proposed amendments to §21.2815 clarify the methodology for calculating a penalty when applicable patient responsibility under the terms of the health care plan is taken into consideration. The department has received inquiries regarding the particular issue of coinsurance responsibilities when calculating a penalty under the underpayment provisions of §21.2815. In seeking to address this issue, the department recognizes the need to address the penalty section as a whole to avoid any further confusion and has proposed amendments to both the late payment and underpayment sections of the penalty provisions in the subchapter.

For late payment penalties, the existing rule language and the statute provide that the basis for the penalty is the difference between billed charges and the contracted rate for the services. Because a single carrier may offer several different health plans that include varying levels of patient responsibility, the amount the carrier owes for a particular claim may vary. The design of the health plan's patient responsibility provisions will not affect the total amount the provider is due under the contract, but will affect the respective obligations of the carrier and patient. In order to consistently base prompt pay penalties on the difference between the provider's billed charges and the contracted rate for the services as required by the statute, the proposed amendments

clarify that the contracted rate is the total amount the provider is due under the terms of the contract, which includes patient responsibility.

To interpret “contracted rate” in a late payment penalty calculation to include only the amount owed by the carrier would allow penalty amounts to vary based upon patient responsibility. This would actually increase penalties as the carrier’s responsibility for a particular claim decreases. For example, assume the billed charge for a service is $1,500, and the contracted rate for the services is $1,000. If the patient owes $950 due to an unpaid deductible, the carrier will owe only a small amount ($50) for the claim. If the carrier fails to pay the $50 within the statutory claims payment period, the penalty will be $1,500 minus $1,000, or $500. If the amount owed by the carrier is used as the contracted rate, the penalty increases to $1,500 minus $50, or $1,450. To avoid this potential and inappropriate result, the amendments to §21.2815(b)(1) clarify that patient financial responsibility is included in the contracted rate used for calculating a penalty.

The proposed amendments to §21.2815(d) clarify the method for calculating a penalty on an underpaid claim. The statute requires the carrier to calculate “the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to the billed charges.” This results in the carrier paying the billed charges rate for the portion of the claim the carrier failed to pay on time. The proposal includes an example that clarifies how coinsurance or other patient responsibility should be treated when calculating an underpayment penalty. The proposal also clarifies that the ratio used in the calculation should be the balance the carrier owes on the claim to the total amount

the provider is due under the contract with the health plan. This represents the percentage of the claim that was left unpaid after the carrier's initial payment. This is consistent with the statutory directive that the carrier must pay "a penalty on the amount not timely paid." (Insurance Code Article 3.70-3C §3I(d) and §843.342(d).) This percentage is then applied to the billed charges so that the penalty is based upon the specific portion of the claim that was paid late. The proposed amendments provide examples that include patient responsibility amounts so that providers and carriers are better aware of the correct calculation methods.

The department has also proposed an amendment to subsection (e) to clarify penalty calculations for claims that are subject to coordination of benefits for multiple carriers. The proposed amendment indicates that the overall percentage of the claim owed by the secondary carrier will impact the penalty calculations such that the contracted rate and billed charges amounts are both reduced to be consistent with the secondary carrier's obligation on the claim.

The proposed amendments to §21.2821 change the deadline for the annual verification reporting requirement and clarify the time period for which reporting is required. The proposed reporting date has been changed to August 15 to make it consistent with one of the existing dates for quarterly reporting of claims data. The proposed amendment to the reporting time period establishes the 12-month period for reporting as July 1 of the prior year through June 31 of the current year.

The department will consider the adoption of the proposed amendments in a public hearing under Docket No. 2617 scheduled for September 7, 2005, at 10:00 a.m. in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street in Austin, Texas.

2. FISCAL NOTE. Kimberly Stokes, Senior Associate Commissioner for Life, Health and Licensing, has determined that for each year of the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Stokes has determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of the proposed amendments will be the clarification of a carrier's obligation to pay all properly submitted clean claims regardless of whether they are submitted together with claims that are deficient. This will avoid improper denials of clean claims and the unnecessary delays and penalties that result from those denials. In addition, the proposed amendments will add clarity and consistency to the calculation of prompt pay penalties. The proposed amendments also specify a reporting period for verification request data so that carriers will be better aware of the requirements for collecting data. Finally, the proposed amendments provide greater efficiency by consolidating reporting

dates for annual verification reporting with the second quarter claims data reporting requirement. Any cost to persons required to comply with these proposed amendments for each year of the first five years the amendments will be in effect is the result of the enactment of Senate Bill 418 (SB 418) (78th Regular Legislative Session) and not the result of the adoption, enforcement, or administration of the amendments. The proposed amendments clarify existing requirements under this subchapter and do not create new obligations or processes for persons required to comply with the rules. Consistent with SB 418, the proposed amendment to §21.2807 explains the application of the requirement to process a clean claim in a timely manner to circumstances in which clean claims are submitted together with deficient claims, an obligation that existed prior to the proposed amendments. The proposed amendments to §21.2815 provide clarifying language and examples to better enable carriers to calculate penalties and do not create any new obligations not already required under the existing rules or SB 418. The proposed amendments to §21.2821 include minor changes to existing reporting requirements and do not impose any additional costs. Ms. Stokes has determined that there is no adverse economic impact on entities that qualify as a small business or micro-business under Government Code §2006.001 as a result of the proposed amendments. In addition, the department believes it is neither legal nor feasible to waive the provisions of the proposed amendments for small or micro businesses since all carriers, regardless of size, are subject to the statutory penalty

requirements and will benefit from the additional guidance provided in the proposed amendments.

4. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 6, 2005, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Kimberly Stokes, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

5. STATUTORY AUTHORITY. The amendments are proposed under Insurance Code Articles 3.70-3C §3A(e), 3.70-3C §3I, and 21.52Y, and §§843.342, 843.338, and 36.001. Article 3.70-3C §3A(e) and §843.338 require carriers to pay clean claims upon receipt and within the statutory claims payment period. Article 3.70-3C §3I and §843.342 provide for the calculation of penalties for violations of prompt pay requirements. Article 21.52Y creates the Technical Advisory Committee on Claims Processing (TACCP) to advise the commissioner on claims processing, payment and adjudication. The statute requires the TACCP to submit a biannual report to the legislature concerning the activities of the committee. The reporting requirements in this subchapter are necessary to provide information to the TACCP in fulfilling its statutory role. Section 36.001 provides that the Commissioner of Insurance may adopt any rules

necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

6. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§§21.2802, 21.2807, 21.2815 and 21.2821	Insurance Code Articles 3.70-3C §3A(e), 3.70-3C §3I, and 21.52Y, and §§843.342 and 843.338

7. TEXT.

§21.2802. Definitions. The following words and terms when used in this subchapter shall have the following meanings:

(1) (No change.)

(2) Batch submission--A group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.

(3) [~~(2)~~] Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider. For purposes of this subchapter, billed charges must comply with all other applicable requirements of law,

including Texas Health and Safety Code §311.0025, Texas Occupations Code §105.002, and Texas Insurance Code Art. 21.79F.

(4) [~~(3)~~] CMS--The Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(5) [~~(4)~~] Catastrophic event--An event, including acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, windstorm, flood or organized labor stoppages, that cannot reasonably be controlled or avoided and that causes an interruption in the claims submission or processing activities of an entity for more than two consecutive business days.

(6) [~~(5)~~] Clean claim--

(A) For non-electronic claims, a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy that includes:

(i) the required data elements set forth in §21.2803(b) of this title (relating to Elements of a Clean Claim); and

(ii) if applicable, the amount paid by the primary plan or other valid coverage pursuant to §21.2803(c) of this title (relating to Elements of a Clean Claim);

(B) For electronic claims, a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy using the ASC X12N 837

format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

(7) [~~(6)~~] Condition code--The code utilized by CMS to identify conditions that may affect processing of the claim.

(8) [~~(7)~~] Contracted rate--Fee or reimbursement amount for a preferred provider's services, treatments, or supplies as established by agreement between the preferred provider and the HMO or preferred provider carrier.

(9) [~~(8)~~] Corrected claim--A claim containing clarifying or additional information necessary to correct a previously submitted claim.

(10) [~~(9)~~] Deficient claim--A submitted claim that does not comply with the requirements of §21.2803(b),(c) or (e) of this title.

(11) [~~(10)~~] Diagnosis code--Numeric or alphanumeric codes from the International Classification of Diseases (ICD-9-CM), Diagnostic and Statistical Manual (DSM-IV), or their successors, valid at the time of service.

(12) [~~(11)~~] Duplicate claim--Any claim submitted by a physician or provider for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. The term does not include corrected claims, or claims submitted by a physician or provider at the request of the HMO or preferred provider carrier.

(13) [~~(12)~~] HMO--A health maintenance organization as defined by Insurance Code §843.002(14).

(14) [~~(13)~~] HMO delivery network--As defined by Insurance Code §843.002(15).

(15) [~~(14)~~] Institutional provider--An institution providing health care services, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers and residential treatment centers.

(16) [~~(15)~~] Occurrence span code--The code utilized by CMS to define a specific event relating to the billing period.

(17) [~~(16)~~] Patient control number--A unique alphanumeric identifier assigned by the institutional provider to facilitate retrieval of individual financial records and posting of payment.

(18) Patient responsibility--Any portion of the contracted rate for which the patient is responsible. Patient responsibility does not include amounts due from a patient in addition to the contracted fee or reimbursement amount for the specific services, treatments, or supplies.

(19) [~~(17)~~] Patient-status-at-discharge code--The code utilized by CMS to indicate the patient's status at time of discharge or billing.

(20) [~~(18)~~] Physician--Anyone licensed to practice medicine in this state.

(21) [~~(19)~~] Place of service code--The codes utilized by CMS that identify the place at which the service was rendered.

(22) [~~(20)~~] Preferred provider--

(A) with regard to a preferred provider carrier, a preferred provider as defined by Insurance Code Article 3.70-3C, §1(10) (Preferred Provider Benefit Plans) or Article 3.70-3C, §1(1) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans).

(B) with regard to an HMO,

(i) a physician, as defined by Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined by Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(23) [~~(21)~~] Preferred provider carrier--An insurer that issues a preferred provider benefit plan as provided by Insurance Code Article 3.70-3C, Section 2 (Preferred Provider Benefit Plans).

(24) [~~(22)~~] Primary plan--As defined in §3.3506 of this title (relating to Use of the Terms "Plan," "Primary Plan," "Secondary Plan," and "This Plan" in Policies, Certificates and Contracts).

(25) [~~(23)~~] Procedure code--Any alphanumeric code representing a service or treatment that is part of a medical code set that is adopted by CMS as required by federal statute and valid at the time of service. In the absence of an existing federal code, and for non-electronic claims only, this definition may also include local

codes developed specifically by Medicaid, Medicare, an HMO, or a preferred provider carrier to describe a specific service or procedure.

(26) [~~(24)~~] Provider--Any practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician.

(27) [~~(25)~~] Revenue code--The code assigned by CMS to each cost center for which a separate charge is billed.

(28) [~~(26)~~] Secondary plan--As defined in §3.3506 of this title.

(29) [~~(27)~~] Source of admission code--The code utilized by CMS to indicate the source of an inpatient admission.

(30) [~~(28)~~] Statutory claims payment period--

(A) the 45-calendar-day period in which an HMO or preferred provider carrier shall make claim payment or denial, in whole or in part, after receipt of a non-electronic clean claim pursuant to Insurance Code Article 3.70-3C, §3A (Preferred Provider Benefit Plans) and Chapter 843;

(B) the 30-calendar-day period in which an HMO or preferred provider carrier shall make claim payment or denial, in whole or in part, after receipt of an electronically submitted clean claim pursuant to Insurance Code Article 3.70-3C, §3A (Preferred Provider Benefit Plans) and Chapter 843; or

(C) the 21-calendar-day period in which an HMO or preferred provider carrier shall make claim payment after affirmative adjudication of an

electronically submitted clean claim for a prescription benefit pursuant to Insurance Code Article 3.70-3C, §3A(f) (Preferred Provider Benefit Plans) and §843.339, and §21.2814 of this title (relating to Electronic Adjudication of Prescription Benefits).

(31) [~~(29)~~] Subscriber--If individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO or preferred provider carrier; or if group coverage, the individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in a group health benefit plan issued by the HMO or the preferred provider carrier.

(32) [~~(30)~~] Type of bill code--The three-digit alphanumeric code utilized by CMS to identify the type of facility, the type of care, and the sequence of the bill in a particular episode of care.

§21.2807. Effect of Filing a Clean Claim.

(a) (No change.)

(b) After receipt of a clean claim, prior to the expiration of the applicable statutory claims payment period specified in §21.2802 [~~§21.2802(28)~~] of this title (relating to Definitions), an HMO or preferred provider carrier shall:

(1) - (4) (No change.)

(c) With regard to a clean claim for a prescription benefit subject to the statutory claims payment period specified in §21.2802 [~~§21.2802(28)(C)~~] of this title[~~(relating to~~

~~Definitions)~~], an HMO or preferred provider carrier shall, after receipt of an electronically submitted clean claim for a prescription benefit that is affirmatively adjudicated pursuant to Insurance Code Article 3.70-3C, §3A(f) (Preferred Provider Benefit Plans) and Insurance Code §843.339, pay the prescription benefit claim within 21 calendar days after the clean claim is adjudicated.

(d) An HMO or preferred provider carrier or an HMO's or preferred provider carrier's clearinghouse that receives an electronic clean claim is subject to the requirements of this subchapter regardless of whether the claim is submitted together with, or in a batch submission with, a claim that is deficient.

§21.2815. Failure to Meet the Statutory Claims Payment Period.

(a) (No change.)

(b) The following examples demonstrate how to calculate penalty amounts under subsection (a) of this section:

(1) If the contracted rate, including any patient financial responsibility, [~~owed by the HMO or preferred provider carrier~~] is $10,000 and the billed charges are $15,000, and the HMO or preferred provider carrier pays the claim [~~is paid~~] on or before the 45th day after the end of the applicable statutory claims payment period, the HMO or preferred provider carrier shall pay, in addition to the amount [~~contracted rate~~] owed on the claim, 50% of the difference between the billed charges ($15,000) and the contracted rate ($10,000) or $2,500. The basis for the penalty is the difference between

the total contracted amount, including any patient responsibility, and the provider's billed charges;

(2) - (3) (No change.)

(c) (No change.)

(d) For the purposes of subsection (c) of this section, the underpaid amount is calculated on the ratio of the balance owed by the carrier [~~amount underpaid on the contracted rate~~] to the total contracted rate, including any patient financial responsibility, [~~contracted rate~~] as applied to the billed charges. For example, a claim for a contracted rate of $1,000.00 and billed charges of $1,500.00 is initially underpaid at $600.00, with the insured owing $200.00 and the HMO or preferred provider carrier owing a balance of $200.00. [~~$800.00~~] The HMO or preferred provider carrier pays the [~~and the~~] $200.00 balance [~~is paid~~] on the 30th day after the end of the applicable statutory claims payment period. The amount the HMO or preferred provider carrier initially underpaid, $200.00, is 20% of the contracted rate. To [~~In order to~~] determine the penalty, the HMO or preferred provider carrier must calculate 20% of the billed charges, which is $300.00. This amount represents the underpaid amount for subsection (c)(1) of this section. Therefore, the HMO or preferred provider carrier must pay, as a penalty, 50% of $300.00, or $150.00.

(e) For purposes of calculating a penalty when an HMO or preferred provider carrier is a secondary carrier for a claim, 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 following example illustrates this method: Carrier A pays 80% of a claim for a contracted rate of $1,000 and billed charges of $1,500, leaving $200 unpaid as the patient's responsibility. The patient has coverage through Carrier B that is secondary and Carrier B will owe the $200 balance. If Carrier B fails to pay the $200 within the applicable statutory claims payment period, Carrier B will pay a penalty based on the percentage of the claim that it owed. The contracted rate for Carrier B will therefore be $200 (20% of $1,000), and the billed charges will be $300 (20% of $1,500).

(f) [~~(e)~~] An HMO or preferred provider carrier is not liable for a penalty under this section:

(1) if the failure to pay the claim in accordance with the applicable statutory claims payment period is a result of a catastrophic event that the HMO or preferred provider carrier certified according to the provisions of §21.2819 of this title (relating to Catastrophic Event); or

(2) if the claim was paid in accordance with §21.2807 of this title, but for less than the contracted rate, and:

(A) the preferred provider notifies the HMO or preferred provider carrier of the underpayment after the 180th day after the date the underpayment was received; and

(B) the HMO or preferred provider carrier pays the balance of the claim on or before the 45th day after the date the insurer receives the notice of underpayment.

(g) [~~(f)~~] Subsection (f) [~~(e)~~] of this section does not relieve the HMO or preferred provider carrier of the obligation to pay the remaining unpaid contracted rate owed the preferred provider.

(h) [~~(g)~~] An HMO or preferred provider carrier that pays a penalty under this section shall clearly indicate on the explanation of payment the amount of the contracted rate paid, the amount of the billed charges as submitted by the physician or provider and the amount paid as a penalty. A non-electronic explanation of payment complies with this requirement if it clearly and prominently identifies the notice of the penalty amount.

§21.2821. Reporting Requirements.

(a) - (d) (No change.)

(e) An HMO or preferred provider carrier shall annually submit to the department, on or before August 15th [~~July 31~~], at a minimum, information related to the number of declinations of requests for verifications from July 1st of the prior year to June 30th of the current year, in the following categories:

(1) policy or contract limitations:

(A) premium payment timeframes that prevent verifying eligibility for 30-day period;

(B) policy deductible, specific benefit limitations or annual benefit maximum;

(C) benefit exclusions;

(D) no coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership cancelled;

(E) pre-existing condition limitations; and

(F) other.

(2) declinations due to inability to obtain necessary information in order to verify requested services from the following persons:

(A) the requesting physician or provider;

(B) any other physician or provider; and

(C) any other person.

8. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2005.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance