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Catastrophic Events

Q: If a payor experiences a catastrophic event, is the payor required to notify physicians and providers?

A: It would seem to be a good business practice for plans to notify physicians and providers when events occur that will change claims processing timeframes and expectations. In addition, TDI will post notices regarding catastrophic events on its website.

Q: If a provider or payor experiences a catastrophic event, when is the provider or payor required to notify TDI? How should the provider or payor notify TDI?

A: The SB 418 rules state in 28 Texas Administrative Code §21.2819 (relating to Catastrophic Event) that a physician, provider, HMO, or preferred provider carrier must notify the Department if, due to a catastrophic event, the provider or payor is unable to meet certain deadlines set out in the rules. The provider or payor must send a notification to the Department within five days of the catastrophic event. This notification should be in writing and addressed to the Life/Health and HMO Filings Intake Section - Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104. In addition, within 10 days after the provider or payor returns to normal business operations, the provider or payor must send a certification to the Life/Health/HMO Filings Intake Division - Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104. The certification must be in the form of a sworn affidavit from a corporate officer or the corporate officer's designee and should

identify the specific nature and date of the catastrophic event, and the length of time the catastrophic event caused an interruption in the claims submission or processing activities of the physician, provider, HMO, or preferred provider carrier. A valid certification of a catastrophic event tolls the applicable statutory payment deadlines in 28 TAC §§21.2804, 21.2806, 21.2807, 21.2808, 21.2809, and 21.2815 for the number of days identified in the certification.

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Claim Filing Time Frames for Non-Contracted Providers

Q: Regarding 28 Texas Administrative Code §21.2824, which will take precedence for non-contracted providers submitting claims - the requirement for filing within 95 days or the Civil Practices and Remedies that allows 11 months from the date of service? How will non-contracted or out of state providers be made aware of the changed time frames?

A: The claim filing deadlines of Texas Insurance Code §§1301.102(a) and 843.337 apply to physicians and providers as defined in these statutes, who submit claims to a preferred provider benefit plan or an HMO, regardless of the physician's or provider's contracting status. Since these statutes are applicable only to a physician or provider who is licensed in this state, an out of state physician or provider would not be subject to the 95-day claim filing deadline. Claims filed for services rendered to persons who are not covered under a preferred provider benefit plan or an HMO are subject to the claim filing deadlines set forth in Chapter 146, Title 6, Civil Practices and Remedies Code. The Department and the stakeholder associations are making extensive educational efforts to inform all physicians and providers of the requirements of this law.

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Electronic Claims, Clearinghouses, and Payers

Q: If an electronic claim is submitted to the designated payment address, a clearinghouse, and the clearinghouse changes the electronic claim to paper then forwards it to the payer, what is the appropriate statutory deadline for payment - 30 days for an electronic claim, or 45 days for a paper claim?

A: If an electronic claim that is subject to SB 418 is submitted and received at the payer's designated claim address in a HIPAA-compliant electronic format, then the claim is subject to the 30-day prompt pay timeframe for electronic claims.

Q: I am a pharmacy provider and I received notice that the issuer of a health benefit plan intends to begin charging an adjudication fee for each electronic pharmacy claim that they process. Is this allowed?

A: No. The Texas prompt pay statute states that a health benefit plan issued by an insurer or a health maintenance organization may not directly or indirectly charge or hold a health care professional, health care facility, or person enrolled in a health benefit plan responsible for a fee for the adjudication of a claim.

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Filing Deadlines

Q: What is the filing deadline for an appeal? What is the filing deadline for a secondary claim?

A: The filing deadline for appealed claims is not addressed in SB 418 or the related rules. Providers should look to their provider contract or manual for guidance on this issue. TDI's rules provide that, for secondary claims, the timeframe for filing a clean claim to a secondary carrier begins when the provider learns of the amount paid by the primary carrier.

Q: What if an insured or enrollee does not inform a carrier of other insurance until after 95 days after

the date of service, but within the contracted filing deadline? Does the carrier lose its rights to coordination of benefits? Does the clock stop for prompt pay?

A: If your provider contract was not entered into or renewed after August 16, 2003, the timeframe for claim filing is governed by the terms of your provider contract. If your provider contract was entered into or renewed after August 16, 2003, you are required to file claims within 95 days of the date of service in the absence of a catastrophic event. Also, parties may agree by contract to a longer time. SB 418 states that an insurer shall accept as proof of timely filing information from another carrier showing that the claim was timely filed.

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Filing to the Wrong Carrier

Q: The rule states that if a claim is timely filed to the wrong carrier that proof of submission can be used as proof of timely filing. Does this apply to a worker's compensation claim?

A: The statute and the rule require Health Maintenance Organizations and Preferred Provider Benefit Plan carriers to accept as proof of timely filing a claim that was timely filed to another HMO or PPBP carrier. A clean claim timely filed to a workers' compensation or automobile carrier would not satisfy the requirement. In circumstances where a provider was unclear whether a claim should be filed under workers' compensation or under a HMO or PPBP plan, the provider may wish to file with both carriers at the same time.

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Mail Log

Q: 28 Texas Administrative Code §21.2816(h) - The rules have changed the wording from "must maintain" to "may choose to maintain a mail log". If the choice is made not to maintain a log, would the provider's computer-generated logs of claims filing now become acceptable proof of timely filing? What provisions are made for altered computer-generated logs?

A: If the provider's computer-generated printout is carrier-specific and contains all of the information required by 28 TAC §21.2816(h), the Department believes that the printout could suffice as a mail log and could establish a presumption of claims receipt if the log is submitted with the claim and faxed or electronically submitted to the carrier on the date of claim submission. The Department believes that an altered computer-generated log does not qualify as evidence of claim submission.

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Proof of Receipt

Q: The rule says that claims sent by first class mail are presumed received on the fifth day after submission. Does this mean that the 45-day clock starts after the fifth day? What happens if the provider does not use a mail log and the HMO says it never received the claim?

A: SB 418 states that "if a claim... is mailed, the claim is presumed to have been received by the carrier on the fifth day after the claim is mailed." While the Department is not requiring use of a mail log, in order to avoid disputes and to allow the Department to take action under these rules, there must be some documentation that the claim was actually mailed. If a provider has not used a mail log or other similar method, and has no other way to prove whether or when the claim was mailed, the received date would default to the carrier's received date stamp if the claim was received in the carrier's office. If the claim was not received at the carrier's office and no mail log or other agreed-upon method was used to document receipt of first class mail, then the provider would have no way to create a presumption of claims receipt. For this reason, the Department strongly encourages parties to make use of the mail log or agree to use a similarly reliable system for evidencing receipt of claims and other communications. Failure to do so may hinder the Department's efforts to assist the parties in claims dispute resolution.

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Requests for Additional Information

Q: How do you show proof of additional information being submitted and what system is in place to assure the clock has started again after the provider has sent requested information? (Insurance company responds regularly that they've never received the information.)

A: If the treating provider is responding to a request for additional information, the provider should, in accordance with 28 Texas Administrative Code (TAC) §21.2804(e), attach a copy of the carrier's request or include with the response the name of the patient, the patient identification number, any claim number provided by the carrier, the date of service, and the name of the treating provider. If the treating provider does not possess the requested information, the provider may submit a written response indicating the provider does not have the requested information.

Proof that either of these communications were submitted by the provider may be established by use of the mail log in 28 TAC §21.2816(h) or a similarly reliable method.

Q: Does the claim payment deadline stop when the insurance company asks for additional information?

A: If the request for additional information is made to the treating physician or provider, then the answer is yes. If the request is made to a third party, the answer is no.

Q: If a carrier requests additional information from the treating provider, and the treating provider never sends the information, what happens to the claim?

A: When a carrier requests additional information from the treating physician or provider, the payment deadline stops. Until the carrier receives the information requested or a response that the physician or provider does not have the requested information the claim may remain in a pended status. In such a circumstance, the carrier may elect to audit the claim by providing written notice of its intention to audit, a statement that a response to the request for information is due within 45 days of receipt of the request, and payment of 100 percent of the contracted rate. The provider's failure to respond timely to an information request during an audit causes the provider to forfeit the amount of the claim and permits the carrier to recover the amount previously paid.

Q: Does the insured's failure to provide information requested by a carrier stop the clock for claims payment?

A: A request for information from the insured does not stop the clock.

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Secondary Payor

Q: What if the payor is a secondary payor? Are they required to pay an electronic claim in 30 days, and do we have to file in the 30 days?

A: A provider must file a claim with a secondary carrier within 95 days after determining the amount paid by the primary carrier. The secondary carrier then has a 30-day period to process the claim if the claim is clean and filed electronically; or 45 days if the claim is clean and not filed electronically.

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Contract Cancellation and Notice to Members

Q: 28 Texas Administrative Code §11.901 (H) - If a provider may terminate the contract on or before the 30th day after the date the provider receives the requested information, how can the members be given adequate advance notice? Texas Insurance Code §843.309 does not specify a timeframe for reasonable advance notice. What will we use as a standard threshold?

A: A provider can obtain the protections regarding penalty and discrimination pursuant to 28 TAC §11.901(20)(H) (or, for PPO plans, 28 TAC §3.3703(a)(20)(H)) by serving notice of intention to terminate on or before the 30th day following the date the provider receives new or amended claims payment information. Once such notice of intention to terminate is given the carrier, the provider must still meet the requirements for reasonable notice to the covered persons under the provider's care (per TIC §843.309 for HMOs, and TIC §1301.160 for PPO plans).

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Deadlines

Q: Must carrier-provider contracts contain the time deadlines required by SB 418?

A: No. The SB 418 timelines apply to a contract entered into or renewed after August 16, 2003, whether they are restated in the contract or not. However, the parties may find it useful to re-state the deadlines in their contract.

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Effective Date and "Evergreen" Contracts

Q: Both SB 418 and the rules say they apply to contracts entered into or renewed on or after the effective date. However, many contracts have "evergreen" clauses that allow the contract to remain in force unless a party elects to terminate. Do the new law and rules apply to these contracts?

A: The Department is aware that certain physician and provider contracts may be "evergreen" contracts that do not renew. Whether a contract is an "evergreen" contract is a determination that must be made with reference to the specific language of each contract. However, if your contract does include a renewal provision, including an automatic renewal, SB 418 is applicable once the contract is renewed on or after August 16, 2003. The Department suggests that parties consult an attorney regarding a contract that appears to be "evergreen."

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Fee Schedule Change Notification

Q: Who do the carriers need to notify of a fee schedule change and how do they need to notify? mail? fax? certified mail? What happens if we do not receive notification of a fee schedule change?

A: Carriers are required to notify their contracting physicians or providers of any changes to their claims payment procedures, including fee schedules. The parties may agree by contract regarding to whom, specifically, such notices must be directed. The rules do not specify the method of such notice, other than that it must be in writing. It is reasonable to expect that such notices, like delivery of initial claims payment information upon a physician's or provider's request, may be made by any reasonable method. If a contracted provider fails to receive notice of a fee schedule change, the burden will be on the carrier to demonstrate that it provided the required notice to that physician or provider. Absent proof of having provided the required notice, the change cannot be put into effect.

Q: If an insurer contracts with a provider for rates that equal 100% of Medicare Resource-Based Relative Value Scale (RBRVS), is it necessary for the insurer to give 90 days notice if the rates, or the years, to which the rates are tied, changes?

A: Yes, with certain exceptions. The contracting requirements of the preferred provider benefit plan (PPBP) statute require 90 days notice of changes to coding guidelines and fee schedules. However, there may be an exception to this requirement if the rate change is based upon source information outside the control of the insurer.

Texas Insurance Code §1301.136(a)(3) requires that a contract between an insurer and a preferred provider provide that: "the insurer or the insurer's agent will provide notice of changes to the coding

guidelines and fee schedules that will result in a change of payment to the preferred provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules." 28 Texas Administrative Code (TAC) §3.3703(a)(20) provides further clarification of this disclosure requirement, specifying that "[a] contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract." (The entire subsection is available from the following link: [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=3&ti=28&pt=1](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=3&ti=28&pt=1); follow "Chapter 3 Life, Accident and Health Insurance and Annuities"; follow "Subchapter X Preferred Provider Plans"; follow "§3.3703 Contracting Requirements").

28 TAC §3.3703(a)(20)(B) states that:

[i]n the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer shall clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

Further, comments and responses in the September 18, 2002 adoption order amending 28 TAC §3.3703 specifically addressed the issue of notice requirements in the context of fee schedules based upon source information outside the carrier's control. TDI's position on the issue was clear:

The Department acknowledges the concerns regarding the timing of changes in coding and fee schedules but disagrees that the rule should be changed. Where parties have agreed to use source information outside the control of the carrier as the basis for the carrier's fee computation, the information the rule requires carriers to provide is the identity of the source and the procedure by which the physician or provider may readily access the source. A change to either of those items, or to any factor within the carrier's direct or indirect control, would trigger the 60-day notice requirement. Any change to the source information outside the control of the carrier, however, would not be a change to the carrier's claims payment policies or procedures or to the information required by this rule, and would not require 60 days notice under TIC §1301.106 and 28 TAC [§]3.3703(a)(20)(D). However, if the carrier [makes] a change to a claim processing or payment procedure (such as changing the fee payment from 120% of Medicare to 110%), that would require a 60-day notice in order to be effective. Although the rule does not require a carrier to provide notice of changes made by an outside source, the parties are free to create such a duty by contract, or to agree on effective dates different from those set by the outside source. The Department will continue to monitor this practice to determine if future rulemaking is warranted.

While notice requirements are now 90 days rather than 60 days, the Department has not otherwise amended the notice requirements with regard to external source data.

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Clearinghouse

Q: A large regional clearinghouse offers a service that allows physicians to transmit a flat data file to them, then they drop the information into a paper claim and mail the claim to the payer. In this case, do you have a suggestion about how a copy of the claims mail log can be included with these claims since the actual mailing of the claims is not being done by the provider?

A: Since the clearinghouse in this instance is acting as the provider's billing agent, the Department believes that the clearinghouse can prepare and submit the claims mail log in accordance with the rules. If this is not feasible, the provider should contact the carrier in order to agree on an alternative method.

Q: If you file paper claims to a clearinghouse, are the claims presumed to be mailed from the clearinghouse? Does the electronic log from the clearinghouse substantiate claim submission?

A: If the carrier has agreed to accept the clearinghouse's electronic log as proof of claim mailing, then the log will establish that proof. If you have no such agreement from the carrier, the electronic log would provide proof of claim mailing only if it contains all of the information set forth in 28 Texas Administrative Code §21.2816(h) and the clearinghouse encloses the log with the claim submission and faxes or electronically transmits the log to the carrier at the time the claim is submitted.

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Clearinghouse Error in Clean Claim

Q: What happens in situations where an electronic claim is sent to a clearinghouse and is received as a clean claim, but the clearinghouse transposes the data and the payer, therefore, processes the claim incorrectly? Must the HMO or PPBP plan pay a penalty for claims not paid (or underpaid) in accordance with statutory claims payment requirements?

A: Yes. If a claim that is subject to SB 418 is timely submitted and received at the payer's designated claim processing address as a clean claim, as defined in 28 Texas Administrative Code §21.2802(6), the HMO or PPBP plan must comply with applicable prompt pay obligations, including payment of any applicable penalty, regardless of whether the HMO or PPBP plan has identified a clearinghouse as the payer's designated claim processing address.

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Independent Practice Associations (IPAs)

Q: Does SB 418 apply to IPAs and third party payors?

A: Yes, to the extent these parties are contracted with Health Maintenance Organizations or insured Preferred Provider Benefit plans.

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Third Party Administrator (TPA)

Q: If a TPA does not verify or preauthorize benefits, do they still have to provide a toll-free number and weekend staff? Does Section 3J, Applicability of Article to Entities Contracting with Insurer, apply to a TPA? Sections 3A-3I of this article apply to a person with whom an insurer contracts to:

(1) process or pay claims; (2) obtain the services of physicians and providers to provide health care services to insureds; or (3) issue verifications or preauthorizations.

A: The carrier remains ultimately responsible for ensuring that the verification and preauthorization requirements, including the toll-free number and weekend and holiday staffing, are complied with. If any other entity, such as a TPA, will be responsible for responding to requests for verification or preauthorization, then the carrier should advise physicians and providers to whom the request should be sent. In general, one of the parties in the contractual chain must comply so that the physicians who are providing services to patients who are insured by the carrier have the ability to request preauthorization and verification.

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Date of Current Illness

Q: Is this date required for Preventative Medicine? Example: code 99396.

A: If your provider contract was not entered into or renewed on or after August 16, 2003, this field (Field 14 on the CMS 1500) is required. For preventive medicine services you should enter the date of service in this field. If your provider contract was entered into or renewed on or after August 16, 2003, the date of injury is required if the service was due to an accident. Otherwise, this field is no longer required in

order to file a clean claim.

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Facility-Based Providers

Q: 28 Texas Administrative Code §21.2803 (K) and (M) - The rules do not exclude neonatologists or hospitalists as facility based providers. While these providers do have direct patient contact, they may not have access to this information. Since they are not specifically excluded, would their claims be clean if there is a "NA" in the fields?

A: No, the claim would not be considered clean. Only those types of physicians that are specifically listed in the rules--radiologists, anesthesiologists and pathologists--are allowed to use the "NA" response in those fields.

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Field 10D

Q: Regarding Field 10D, if a practice receives a verbal denial of claim receipt before the end of the statutory claims payment period and the provider wishes to send another claim, do they need to put "D" in this field?

A: No. A clean claim must be processed as required by the rules. A carrier's indication during the statutory claims payment period that it has not received a claim will not present a problem if the submitting physician or provider has made use of the mail log or a similarly reliable method for evidencing submission. If there is no proof of claims submission and the carrier indicates that the claim was not received, the second claim is not a duplicate and instead is a new claim requiring the beginning of a new statutory claims payment period. If the submitting physician or provider does have proof of submission, the carrier's request for a duplicate claim does not require the physician or provider to indicate on the second claim that the second claim is a duplicate. The Department has clarified in the definition of a duplicate claim that a requested copy of a claim is not a duplicate claim.

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Field 19

Q: An anesthesiology practice states that they often include the number of minutes in Field 19. Even though the rule doesn't specifically allow anesthesia minutes for this field, can they continue to put minutes in this field?

A: Yes.

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Field 29

Q: Regarding Field 29, the rule says that when filing a secondary claim this field should be completed with the amount paid by the primary plan. However, secondary plans often base their payment on the primary plan's "allowed amount" rather than the amount the physician was actually paid. Which amount should be submitted in Field 29?

A: The rule says when filing a secondary claim, the provider completes Field 29 with the amount paid by the primary plan. If a carrier needs to know a primary plan's allowed amount, the carrier can request this information from the treating provider in accordance with 28 Texas Administrative Code §21.2804, or from the primary plan in accordance with 28 TAC §21.2805.

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Centers for Medicaid and Medicare Services (CMS) 1500 - Field 33

Q: If I am billing for a Group number in Box 33 and use the same tax ID number in Box 25, where do I put the individual provider numbers? In the past, we put them in Box 24-K.

A: While the individual provider number is no longer required for a claim to be considered "clean," the health plans have indicated that they would prefer that physicians include this information in Box 24-K to facilitate processing. If it is not included, the plans may likely request it.

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CMS-1500 (08/05), Fields 17a and 17b

Q: After May 23, 2008, if Field 17 includes the name of a referring physician or provider, must both Fields 17a and Field 17b be completed if the physician or provider is eligible for a National Provider Identification (NPI) Number in order for the claim to be considered "clean"? After May 23, 2008, physicians and providers newly licensed or certified may have never been issued an identifier other than the NPI.

A: Yes. If a referring physician is noted in Field 17, 28 Texas Administrative Code §21.2803(b)(1)(V) requires submission of the ID Number of the referring primary care physician, specialty physician, or hospital in Field 17a and does not contemplate a contingent date component. Further, if a referring physician is noted in Field 17 for claims filed or re-filed on or after May 23, 2008, 28 TAC §21.2803(b)(1)(W) requires submission of the NPI number of the referring primary care physician, specialty physician, or hospital, if the referring physician is eligible for an NPI number, in Field 17b. The Department intends to monitor the need for the ID Number data element set forth in 28 TAC §21.2803(b)(1)(V) as use of the NPI progresses and will consider future rulemaking as appropriate. With regard to physicians who have not been issued an identifier other than the NPI, please note that "ID Number" is not a defined term. As stated in the adoption order, entry of the ID Number is necessary to allow a payer to identify a provider without reference to the NPI. Because the rule does not specify anything more specific than "the ID Number" for use in this field, the Life, Health & Licensing Program's position is that the rule does not preclude the physician from duplicating its NPI in the field if there is not a payer-assigned ID number in place.

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CMS-1500 (08/05), Fields 19 and 24

Q: CMS-1500 (08/05), Field 19 continues to be a conditional field to be completed when a physician uses an unlisted or not classified procedure code or a National Drug Code. In this regard, would the submission of supplemental information in Field 24 consistent with the NUCC Manual instruction render a claim deficient?

A: The use of Field 24 on the CMS-1500 (08/05) form in a manner consistent with the NUCC Manual Instruction for that field would not, in and of itself, render a claim deficient. 28 Texas Administrative Code §21.2803(h) clarifies that the submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under the section shall not render the claim deficient.

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Children's Health Insurance Program (CHIP)

Q: Why is CHIP exempt from prompt pay?

A: SB 418 requires the Commissioner of Insurance to exempt CHIP if, after consulting with the Commissioner of Health and Human Services, he determines the provisions of SB 418 would have a negative fiscal impact on CHIP. The Commissioner of Health and Human Services has indicated the bill would have a negative fiscal impact.

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Exclusive Provider Organizations (EPOs)

Q: Are EPOs subject to prompt pay?

A: It depends. Fully insured Exclusive Provider Benefit Plans that are issued in Texas by insurers in the commercial market are subject to the prompt pay statutes and rules.

Exclusive Provider Plans, as described at 28 Texas Administrative Code §3.9201, are limited to the Statewide Rural Healthcare System, Medicaid and CHIP. The Statewide Rural Healthcare System was created to sponsor, arrange for or provide services in rural areas of Texas, and is not currently a licensed carrier. Medicaid and CHIP are exempt from the requirements of SB 418; however, they are subject to contractual payment requirements from Health and Human Services Commission.

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Legal Holidays

Q: The statute and rules require that a carrier maintain a toll-free telephone number to receive requests for verification and preauthorization on Saturdays, Sundays and legal holidays. What constitutes a legal holiday?

A: While the statute does not define the term "legal holiday," it would be fair to consider the term to include the legal holidays listed in the Texas Government Code Sec. 662.003 that are actually taken by the carrier. The holidays are:

(a) National holidays: (1) First day of January, New Year's Day (2) The third Monday in January, Martin Luther King Jr. Day (3) The third Monday in February, Presidents' Day (4) The last Monday in May, Memorial Day (5) The fourth of July, Independence Day (6) The first Monday in September, Labor Day (7) The 11th of November, Veterans Day (8) The fourth Thursday in November, Thanksgiving Day (9) The 25th of December, Christmas Day. (b) State holidays: (1) The 19th of January, Confederate Heroes Day (2) The second day of March, Texas Independence Day (3) The 21st day of April, San Jacinto Day (4) The 19th day of June, Emancipation Day in Texas (5) The 27th day of August, Lyndon Baines Johnson Day (6) The Friday after Thanksgiving Day (7) The 24th of December, and (8) The 26th of December. (c) An optional holiday includes only the days on which Rosh Hashanah, Yom Kippur, or Good Friday falls.

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Medicaid Health Maintenance Organizations (HMOs)

Q: Does the prompt pay statute and rules apply to Medicaid HMOs?

A: SB 418 requires the Commissioner of Insurance to exempt Medicaid if, after consulting with the Commissioner of Health and Human Services (HHSC), he determines that the provisions of SB 418 would have a negative fiscal impact on the Medicaid program. The Commissioner of HHSC has indicated that the bill would have a negative fiscal impact. Consequently, the Commissioner of Insurance has adopted rules exempting Medicaid, both traditional Medicaid and Medicaid HMO plans, from the provisions of SB 418.

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Prompt Pay and Potential Fraud

Q: As a payer, my concern is that the Texas prompt pay statutes and rules require me to pay clean claims that have triggered an investigation for potential fraud or clean claims that I suspect may be fraudulent. Am I required to pay claims that I am investigating for potential fraud or suspect may be fraudulent? What other actions can I take on these claims?

A: In the adoption order for the SB 418 rules, TDI recognized these concerns and encouraged physicians, providers, consumers, and insurers to file complaints with the department concerning allegations of fraudulent or unreasonable charges. The TDI Fraud Unit may investigate and/or refer such matters to the appropriate authority, including the Texas Medical Board (TMB), other state agencies regulating healing art professions, a district attorney's office, the Office of the Attorney General or the federal government. In addition, Subsection (f) was added to 28 Texas Administrative Code (TAC) §21.2818 to make clear that the provisions of this section do not affect a carrier's ability to recover an overpayment in the case of fraud or material misrepresentation. While recovery of overpayments where fraud is confirmed may be problematic, recovery efforts under such circumstances are not subject to the 180-day deadline that is otherwise applicable.

From the information currently available to the Department, it appears that a very small number of claims submitted by a few physicians or providers are suspected to be fraudulent or potentially fraudulent. How payers decide to treat these claims is a business decision. Some possible scenarios are listed below:

- A payer could make use of the request for additional information allowed by 28 TAC §21.2804 in order to further investigate the claim. The 28 TAC §21.2804 request can be used by a payer to require a provider to submit additional information that a payer may find useful in investigating a potentially fraudulent claim. Furthermore, a request for additional information under 28 TAC § 21.2804 tolls the applicable statutory claims payment period from the time of the request until receipt of a response from the provider. This gives payers additional time to investigate a potentially fraudulent claim without concern for the payment deadlines.
- A payer could notice the claim for audit, pay the required 100 percent of the contracted rate, and continue its investigation of the suspected fraudulent claim. Additional information from the provider could be requested through the audit process. If the provider fails to tender the requested information during the audit, after appropriate notice the provider forfeits the entire claim amount.
- A payer that is concerned about fraud related to inflated billed charges on a claim form should be aware that TDI's rules related to the definition of billed charges indicate that the amount billed on a claim form must comply with applicable requirements of law, including Texas Health and Safety Code §311.0025 (A hospital, treatment facility, mental health facility, or health care professional may not submit a bill for a treatment that the hospital, facility, or professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary), Texas Occupations Code §105.002 (Unprofessional conduct includes knowingly presenting or causing to be presented a false or fraudulent claim for the payment of a loss under an insurance policy), and Texas Insurance Code §552.003 (A person commits an offense if the person intentionally or knowingly charges two different prices for providing the same product or service, where the higher price is based on the fact that an insurer will pay all or part of the price of the product or service).
- A payer that suspects fraud may file a complaint with the Texas Medical Board (TMB) . The TMB's enforcement process is complaint-driven and anyone can file a complaint. Each complaint is evaluated within 30 days. If the TMB opens an investigation, most are completed within 180 days. TMB can subpoena records but must have patient names in order to do so. Investigations and the documentation are confidential; finalized disciplinary actions are public and can be used in criminal cases. Some Texas agencies prohibit improper billing practices by regulation. For example, the Texas Board of Chiropractic Examiners and the Texas State Board of Dental Examiners have, respectively, placed their prohibitions at 22 Texas Administrative Code §75.1(a) and §108.2 (e).

In any of these scenarios, TDI encourages payers to report these actions to TDI so that the Department can take appropriate action. A payer may decide to deny a claim it determines to be fraudulent after undertaking a reasonable investigation as required by Texas Insurance Code (TIC) §541.060. In such case, as with any other suspected insurance fraud, payers are reminded that TIC §701.051 states "Not later than the 30th day after the date the person makes the determination or reasonably suspects that a fraudulent insurance act has been or is about to be committed in this state, the person shall report the

information in writing to the insurance fraud unit...and may also report the information to another authorized governmental agency."

In addition, it is important to note that the prompt pay statutes and rules apply to contracted claims, that is, HMOs and insured PPO plans. The prompt pay statutes and rules do not apply to self-funded ERISA plans, indemnity plans, Medicaid, Medicare, Medicare supplement, government and school plans, and CHIP. SB 418 requires HMOs and insurers who write preferred provider health benefit plans to report quarterly to TDI certain data about clean claims. SB 418 also sets out a 98 percent compliance threshold for paying clean claims within the 21-, 30-, or 45-day period. If the number of clean claims paid "late" falls below the 98 percent compliance threshold, then TDI may assess administrative penalties. Payers with concerns about claims paid late due to suspected fraud are encouraged to maintain records concerning the payer's actions related to the specific claim and report the matter to TDI. Payers with additional concerns related to fraudulent claims should contact the TDI Fraud Unit at 512-463-6492 to further discuss this matter.

Hypothetical Question: After a reasonable investigation of a claim, and in good faith, the carrier forwarded a provider claim subject to SB 418 prompt pay requirements to its Special Investigative Unit to further review suspicions of fraud. The claim was timely denied. Following a year-long investigation, it was determined that there was not sufficient evidence to establish fraudulent behavior on the part of the provider. What does the carrier owe the provider? Will the carrier be subject to an administrative penalty under SB 418?

Response: The carrier owes penalties to the provider as set forth in TIC §§843.342 and 1301.137. While various administrative penalties and remedies also exist for violation of the Texas Insurance Code (TIC), SB 418 establishes specific penalty provisions within certain parameters. SB 418 specifically provides for a penalty of up to \$1,000 per day for each unpaid claim if the carrier processes more than two percent of its claims in violation of the prompt pay requirements. The Commissioner has discretion whether to assess an administrative penalty in this context and the amount of such penalty. Additionally, the Commissioner has discretion to assess an administrative penalty authorized by other provisions of the TIC.

A carrier may submit information relative to the fraud investigation explaining why the claim was not paid timely so that this may be taken into account when exercising discretion regarding possible enforcement options. Of particular note would be information regarding the referral of such claims to TDI or to an authorized governmental agency as referenced in the Texas Insurance Code §701.051. For those penalties specifically authorized in SB 418, the carrier is subject to the \$1,000 per day per claim penalty only if the carrier processes more than two percent of its clean claims late. Compliance is based on quarterly reporting and claims are categorized as non-institutional and institutional. The penalty per day may not exceed \$1,000 for each claim that remains unpaid in violation of the prompt pay statutes.

Information available to TDI suggests that the number of potentially fraudulent claims subject to SB 418 is low. Further, the number of claims paid late following an investigation for fraud is even lower. In addition, carriers self-report that they are generally paying more than 98 percent of claims timely. A carrier may submit information to the department regarding its fraud investigations of specific clean claims that were ultimately paid late and other matters to explain the reasons the carrier did not process 98 percent of clean claims timely.

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Carrier Quarterly Compliance Data Call

Q: Do I need to respond to the quarterly data calls and annual declinations report, if my company does not write preferred provider health plan coverage and is not a health maintenance organization?

A: The data call is only applicable to carriers that are selling managed care plans in Texas. The managed care plan may be a preferred provider benefit plan or a health maintenance organization (HMO). If you do not have any PPBP forms filed with the department and your company is not a HMO, then you do not need to respond to the data call.

Q: What if my company has preferred provider plans filed with the Department, but is not marketing the product? Do we need to respond to the data calls?

A: If your company has no lives insured in Texas and are no longer paying claims from any runoff business, then you are not required to report data. You do need to let the Department know that you are exempt from the data call and let us know the reason why. At this time, you may notify the Department by email at PromptPay@tdi.texas.gov. We suggest you monitor the Department's bulletins [here](#) in the event the method of notification changes.

Q: My company writes managed care plan coverage but it is only Medicare, Medicaid, and CHIP plans. Do we need to respond to the quarterly data call?

A: The prompt pay laws and the quarterly data calls are not applicable to self-funded ERISA plans; workers compensation coverage; government, school, and church health plans; out-of-state plans; Medicaid; Medicare Advantage Plans ; Medicare + Cost plans; Medicare Supplement plans; the Health Select plan for state employees; federal employee plans; self-funded plans covering UT and A&M System employees; Tricare Standard (CHAMPUS); Texas Association of School Boards coverages; and the Children's Health Insurance Program (CHIP). If your company only sells these types of plans, then you are not required to respond to the quarterly data call. If your company sells commercial managed care plans in addition to these types of plans, then you will need to report the data from the commercial business.

Q: My company is a delegated entity reporting the quarterly data for a carrier. Do I need to show my company's TDI ID number when logging into the online database?

A: You will need to login using the insurance company's or HMO's TDI ID number. The second screen that opens will allow you to enter your company's name. Make sure you enter your company's business name and not the contact or data entry person's name.

Q: Why does the database require us to enter the same data twice? There are fields for reporting the number of clean claims paid within the applicable statutory period, then it asks us to report the number of claims paid within 1 - 45 days.

A: There are no duplications in the requested data. The fields asking you to report the number of clean claims paid within the applicable statutory payment period are for those claims that were paid on time. The next three groups of fields are used for reporting data on claims that were paid late in increments of 1 - 45 days, 46 - 90 days, and 91 or more days past the statutory deadline for paying claims.

Q: Must the late payment data that is required in the Quarterly Provider Claims Data Reports include underpaid claims? Must underpaid claims data be included with late payment data if there was no underpayment penalty payable to the provider or if some claims data would be reported in more than one quarter?

A: Late payment data must include data on underpayments regardless of whether an underpayment penalty is payable to the provider or whether certain claims data would be reported in more than one quarter. TDI needs all of this information in order to accurately assess a carrier's compliance with the prompt pay requirements. Even though an underpayment penalty may not be payable to a provider, TDI may review claims payment activities to determine whether disciplinary action, up to and including administrative penalties, is appropriate.

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Charge for Records Requested to Process Claims

Q: Can a physician or provider charge a carrier for records requested to process claims?

A: Yes, unless prohibited by your contract. According to the Texas Medical Board , reasonable fees for medical records maintained by a physician are as follows. You also may wish to check their [website](#).

Board rule 165.1 defines a reasonable fee to be a charge of no more than \$25 for the first twenty pages

and \$.50 per page for every copy thereafter. For x-rays, \$8.00 per film. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. The physician shall be entitled to payment of a reasonable fee prior to release of the information unless the information is requested by a licensed Texas health care provider or physician, if requested for purposes of emergency or acute medical care. In the event payment is not included with the request, within ten calendar days from receiving a request for the release of records for reasons other than emergency or acute medical care, the physician shall notify the requesting party in writing of the need for payment and may withhold the information until payment of a reasonable fee is received.

The Department of State Health Services (DSHS) licenses general and special hospitals in accordance with the Health and Safety Code, Chapter 241. DSHS is required by Health and Safety Code §241.154(e) to annually adjust the fees that hospitals may charge for providing a patient's health care information to reflect the most recent changes to the consumer price index as published by the Bureau of Labor Statistics (BLS) of the U. S. Department of Labor, The BLS measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers.

Information on current fees may be obtained by contacting:

Department of State Health Services
Facility Licensing Group
1100 West 49th Street
P. O. Box 149347
Austin, TX 78714-9034
(512) 834-6648

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Definition of Emergency Room (ER) Services

Q: How are ER services defined for purposes of SB 418 non-contracted doctors?

A: Emergency care is defined in both Texas Insurance Code §§1301.155(a) and 843.002(7) as "...health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of a bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus."

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ID Card

Q: Is there a way for a physician or provider to reliably determine which insurance plans are truly self-funded ERISA plans and which ones are governed by state law?

A: 28 Texas Administrative Code §21.2820 requires ID cards issued by health plans regulated by TDI to prominently display either "TDI" or "DOI" on the front of the card.

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Medicare Supplement and Medicare Select Plans

Q: Do the clean claim rules under SB 418 apply to Medicare supplement or Medicare Select plans?

A: They do not. Medicare supplement plans do not use a provider network. While Medicare Select plans do use a provider network, there is no out-of-network benefit so they do not meet the definition of a

Preferred Provider Benefit Plan.

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Provider Records

Q: 28 Texas Administrative Code §11.901(11) - How frequently must a provider update their records for additional health coverage?

A: While the frequency of update of provider records for additional health coverage is not addressed in this rule, the Department notes that 28 TAC 21.2803(b)(1)(Q)(ii) requires that a physician or provider have on file a statement signed by the patient or authorized representative within the past 12 months that there is no other health coverage.

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Billed Charges

Q: Please clarify the definition of billed charges. Will providers be stuck in the argument over usual, customary and reasonable (UCR) charges versus billed charges in the calculation of penalty amounts due?

A: If the provider's contract was issued/renewed after August 16, 2003, only billed charges can be used in the calculation of penalty amounts. However, billed charges must not be "unreasonable," as discussed below.

Q: What is considered an unreasonable billed charge? What do you mean by material misrepresentation under fraud?

A: While the Department does not regulate the amount a physician or provider can charge for a particular service, it will remain alert to allegations of abuse in this area. In connection with these expressed concerns, the definition of billed charges states that, for purposes of the 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 Chapter 552. In addition, physicians, providers, consumers, and carriers are encouraged to file complaints with the Department regarding allegations of fraudulent or unreasonable charges. The TDI Fraud Unit, when it believes there has been a violation of a law, refers such matters, as appropriate, to the Texas Medical Board, a district attorney's office, the Office of the Attorney General or the federal government. Moreover, the Department has launched an aggressive education campaign to inform all stakeholders of the various prompt pay provisions, and will record information to track concerns regarding timely payment of clean claims, billed charge penalties paid, medical inflation, and fraud referrals. The Department will consult with the Technical Advisory Committee on Claims Processing regarding aggregate information. The Department also notes that where a claim is paid correctly and promptly, the carrier's liability will be limited to the contracted amount, and the issue of the definition of billed charges does not arise.

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Calculation of Underpayment Penalties

Q: Should a carrier calculate underpayment penalties to a provider by using the particular services on the claim that were underpaid?

A: Neither the statute nor the rules explicitly state that calculations of underpayment penalties should be performed on a line item basis. However, TDI has consistently maintained in the past that line item calculations are appropriate and that penalty calculations should not include services that were correctly and timely paid.

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Date of Receipt of Payment

Q: Does 28 Texas Administrative Code §21.2816, "Date of Receipt," apply to receipt of payment as well as receipt of claim? If not, where is receipt of payment defined?

A: 28 TAC §21.2810, Date of Claim Payment, defines the date of receipt of payment, with reference to the modes of transmitting such payment, for purposes of compliance with the statutory claims payment period.

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Duplicate Claims

Q: SB 418 prohibits providers from submitting a duplicate bill within 46 days of the original submission. If the provider submits a duplicate bill resulting in a duplicate payment, does the health plan only have 180 days to recoup?

A: In order to recover an overpayment, including one caused by the provider's having submitted a duplicate claim, the carrier must give a provider notice of the overpayment within 180 days from the date the overpayment was received except in the case of fraud or material misrepresentation.

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Non-Contracted Providers

Q: What is the expected reimbursement from a payor for non-contracted providers who provide emergency and referral services?

A: The HMO Act requires that carriers reimburse non-contracted providers who furnish emergency services and authorized referral services at a usual and customary or agreed rate. Texas Insurance Code §1301.155(b) pertaining to preferred provider benefit plans requires that carriers pay non-contracted providers at the preferred provider rate or percentage if services are not available from preferred providers in the service area or if an insured cannot reasonably reach a preferred provider to receive emergency care.

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Overpayments

Q: Does the 180-day limit on notice of and subsequent refund of overpayment apply to overpayments made prior to August 16, 2003, or only those overpayments subsequently made under a contract that was entered into or renewed after that date?

A: The 180-day timeframe for the refund of an overpayment applies only to those overpayments made under a contract that was entered into or renewed after August 16, 2003. For services performed under a contract entered into or last renewed prior to August 16, 2003, the HB 610 rules continue to apply.

Q: For overpayment and underpayment notices, do the deadlines run from the date of service, the date the claim was filed, or the date the claim was received by payor?

A: None of the above. For overpayment and underpayment notices the deadlines run from the date the overpayment or underpayment was received.

Q: When calculating the 180 days notice for an overpayment request, how do you determine the payment receipt date? Does it differ based on how the payment was made, for example, mailed, electronic, hand-delivery, etc.?

A: 28 Texas Administrative Code §21.2810, "Date of Claim Payment," provides that, in determining compliance with the statutory claims payment period, payment is considered to have been made on the date of:

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By Chris Tighe at 12:15 pm, Oct 15, 2014

(1) the postmark, if a claim payment is delivered by the United States Postal Service; (2) electronic transmission, if a claim payment is made electronically; (3) delivery of the claim payment to a commercial carrier, such as UPS or Federal Express; or (4) receipt by the physician or provider, if a claim payment is made other than as provided in (1), (2), or (3), above (e.g., hand-delivery).

Q: If the provider notifies the carrier of an overpayment and the carrier does not respond, or it is after 180 days, can the provider refuse to return the money? Is the provider required to notify the carrier at all?

A: You are entitled to the correct contracted rate and appropriate penalty, if any. Should you receive an amount in excess of these figures, responsible business practices suggest that you return that excess amount. However, SB 418 imposes no obligation that you do so, absent a timely written request from the carrier. Under 28 TAC §21.2818, the carrier has 180 days from the date the payment was received to request your return of an overpayment.

Q: Can a carrier recoup a payment electronically without the provider receiving any other notification?

A: No. Under 28 TAC §21.2818 the carrier must give written notice of overpayment, including the specific claims and amounts for which refund is due and for each claim the reasons and basis for the refund request. The notice must also disclose the provider's appeal rights and describe the methods by which the carrier intends to recover the refund.

Q: What remedy does a carrier have when it pays, and did not dispute, a claim within the required time frames, but later determines after 180 days that an overpayment has been made? Some examples of how this might occur include:

- A fee schedule was loaded improperly in the health plan's system; or
- The federal government provides clarification on a Medicare payment methodology, such as Ambulatory Procedure Categories (APC), that is followed throughout the industry.

A: In order to recover an overpayment, a carrier must notify the provider within 180 days of the date the provider received the overpayment. The statute and rules provide no remedies or exceptions to this time frame except in the case of fraud or material misrepresentation.

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Penalty Payments

Q: Who requests the insurance company to pay penalties, the physician or provider, or TDI? How can a physician or provider get a carrier that does not pay claims timely to pay the required penalties?

A: If the provider believes the company has not paid a claim in compliance with 28 TAC §21.2807, the provider should contact the company and assert rights to penalty payments. If a provider feels he or she is owed a penalty payment after contacting the company, the provider should file a complaint with TDI.

Q: Are maximum penalties per claim/per patient, or per insurance plan, or per doctor?

A: Penalties are calculated per claim.

Q: Regarding payment penalty, the calculations begin with "billed charges." If I bill at the contracted rate, do I forfeit the opportunity for a penalty?

A: If there's no difference between the contracted rate and your billed charges, there's no difference upon which to compute a penalty.

Q: A payer misses the statutory claims payment period deadline and is in the 1-45 day penalty period. According to 28 TAC §21.2815(a)(1), "if the claim is paid on or before the 45th day after the end of the applicable 21-, 30- or 45-day statutory claims payment period, pay to the preferred provider, in addition to the contracted rate owed on the claim, a penalty in the amount of the lesser of: ..." Does the

language "in addition to" require that the payer pay the penalty at the same time that the late claim is paid? What if the payer pays the contracted rate owed on the claim but does not pay the penalty at the same time? Does any additional penalty accrue until such time as the payer pays the penalty amount? Is there a violation if a payer elects to pay penalties periodically, say once a quarter for instance, rather than at the time the claims are paid? What position would the Department take in this scenario? Would the Department consider levying administrative fines for a demonstrated pattern of behavior under this scenario?

A: SB 418 (Texas Insurance Code §§1301.137(j) and 843.342(j)), and the related rule (28 TAC §21.2815(g)) require a carrier to "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", which suggests that the claim payment and penalty payment should be made at the same time. Thus, a carrier that fails to pay the penalty at the time the claim is paid may be in violation of the prompt payment rules. However, there is no language in the statute or rules which suggests that additional penalties accrue to the physician or provider in such a scenario. Rather, a carrier that fails to pay the penalty payment in compliance with the referenced provisions may be subject to administrative penalties. In exercising his discretion regarding the imposition of such penalties, the Commissioner may take into consideration various factors, including a carrier's penalty payment policies and pattern of behavior.

Q: What are a carrier's prompt pay obligations in situations in which the insured does not provide certain information required to process the claim? 28 TAC §21.2804 of the rules allows the carrier to delay the statutory claims payment period while waiting for a reply to a request sent to the treating provider. However, a carrier sometimes needs certain information from the insured, and the insurance contract requires the insured to submit the information in order for the claim to be payable. If the carrier denies the clean claim in a timely manner, has the carrier met its statutory and regulatory obligations?

A: Carriers that choose to deny a claim at the end of the applicable statutory claims payment period due to a lack of information thought to be necessary for adjudication of the claim should be mindful of the statutory requirement to pay a payable clean claim within the applicable statutory claims payment period (see Texas Insurance Code §§1301.137(a) and 843.342(a)) and the provisions of Texas Insurance Code §541.060 and Chapter 542 Subchapter A regarding unfair claims settlement practices. The prompt pay requirements dictate that a carrier must, within the applicable statutory claims payment period, make a determination of whether the claim is payable and either pay, deny or audit the claim. If a carrier is waiting for information from a party other than the treating provider and cannot determine whether the claim is payable according to the terms of the insurance policy or evidence of coverage by the end of the applicable statutory claims payment period, the carrier may choose to audit the claim by paying 100 percent of the claim amount and attaching a notification that the claim is being audited. Upon receiving the necessary information that indicates whether the claim is payable, the carrier is obligated to notify the physician or provider of the results of the audit and, if applicable, request a refund of the claim amount in accordance with the recovery procedures detailed in 28 TAC §21.2818.

If information required from the insured under the terms of the policy is not received, or if a carrier can otherwise determine that the claim is not payable according to the terms of the insurance policy or evidence of coverage, the carrier may deny the claim and satisfy its statutory and regulatory obligations. A claim that was timely but improperly denied in violation of these statutes may result in administrative action by the Department.

Q: If a carrier incorrectly denies a clean claim and subsequently receives information that the claim should have been paid, does the carrier owe prompt pay penalties?

A: A timely, but improper, denial will result in the carrier owing prompt pay penalties. If a carrier denies a clean claim in a manner that is either incorrect or inconsistent with the terms of the insurance policy or evidence of coverage, the carrier will be subject to administrative penalties, including, if applicable, prompt pay penalties.

If the carrier's initial denial of the claim was both timely and proper according to the terms of the insurance policy or evidence of coverage, the carrier does not owe a penalty for late payment of the

claim as it satisfied its prompt payment obligation by making a proper and timely determination when it denied the claim. If the carrier subsequently receives information that enables it to reverse that decision and pay the claim, then no penalties are owed, provided the carrier pays the correct amount owed within the appropriate time payment deadline.

Q: Can a Health Maintenance Organization (HMO) or Preferred Provider Benefit Plan (PPBP) plan avoid payment of provider penalties for late paid and underpaid claims through waiver or agreement of the provider?

A: No. The penalties required under SB 418 for late paid claims cannot be waived by contract. The penalty requirement is set forth in Texas Insurance Code §§843.342 and 1301.137 and 28 Texas Administrative Code §21.2815. SB 418 eliminated the ability of parties to contract for penalties for claims subject to SB 418. Further, Commissioner's Bulletin No. B-0008-05 (February 24, 2005) advises carriers that the Department "expects that all carriers subject to the prompt payment requirements will pay penalties concurrently with late claims or balances of underpaid claims."

Q: May an out-of-network provider of emergency services recover a penalty from an HMO or preferred provider carrier for late payment of a clean claim?

A: No. While 28 TAC §21.2823 clarifies that the carrier must promptly pay the out-of-network provider within the period provided in TIC §843.338 or §1301.103 and 28 TAC §21.2807, the carrier is liable only to a preferred provider for a late payment penalty under TIC §843.342 or §1301.107 and TAC §21.2815.

If, however, the carrier fails to pay within the period required by TIC §843.338 or §1301.103 and 28 TAC §21.2807, the out-of-network provider may file a complaint with the agency, and the agency may elect to take administrative action against the carrier, including assessment of an administrative penalty.

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Auditing Claims

Q: How long can a carrier take to audit a claim?

A: A carrier that intends to audit a clean claim must give notice of the audit and pay 100% of the contracted rate to the preferred provider before expiration of the statutory claim payment period. The carrier must complete the audit within 180 days from the date the carrier received the claim and provide written notice of the audit results. The notice must list the specific claims that were paid and not paid as a result of the audit along with a listing of claims and amounts for which a refund is due and the basis for the refund request. The carrier may recover a refund due upon completion of an audit but must notify the preferred provider that an overpayment exists not later than the 180th day after the provider received the payment. The notice must also disclose the provider's appeal rights and describe the methods by which the carrier intends to recover the refund.

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Claim Processing Timelines

Q. Do the time periods for a carrier to act on a clean claim begin on the day the carrier receives the clean claim from a preferred provider or does it begin on the day after the claim is received?

A. Texas Insurance Code §§843.338 and 1301.103 provide for payment not later than the 45th day after the date a non-electronic clean claim is received, and not later than the 30th day after an electronic clean claim is received. Texas Insurance Code §§843.339 and 1301.104 provide for payment not later than the 21st day after an electronic pharmacy claim is adjudicated. The first day of the statutorily provided period is the day following the carrier's receipt of the clean claim.

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Patient's Responsibility

Q: My doctor told me that due to new insurance laws I must pay for the services he will perform because my carrier will not "verify" the services. I thought I had insurance coverage. What happened? What should I do?

A: Senate Bill 418 includes provisions that allow physicians and providers to request from a health plan verification that the plan will guarantee payment for the services the physician or provider proposes to perform. In some cases, a health plan may decline to issue a verification. However, this does not necessarily mean that your coverage under the health plan has terminated or that the proposed service is not covered. Even without a verification, you are still entitled to the covered services under your insurance policy; contact your carrier if you have additional questions. If you are covered under an HMO plan, your doctor's demand for payment from you may violate the terms of his contract with the HMO.

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Preauthorization and Verification

Q: My company uses a claims scrubber software in the routine claims adjudication process. During one part of the process, various claims are processed through the software to determine reimbursements for multiple surgeries, for example, what CPT codes are incidental or mutually exclusive, and what percent those procedures should be reimbursed based on primary, secondary and tertiary procedures (100%-20%). The current process does not include submitting preauthorization requests (referrals) to determine or obtain a review of payment reimbursement. The preauthorization/authorization has already taken place prior to the review. SB 418 leads us to believe that in order to avoid denying or reducing payment in error based on medical necessity or appropriateness, when the actual claim comes in we would need to run preauthorizations through the claim scrubber software. Is our understanding correct?

A: If you give a preauthorization, you cannot deny or reduce payment for the reasons of medical necessity or appropriateness, which would be a determination made by the utilization review staff during their clinical review. The utilization review is not the same as the claims adjudication process. You would still be free, after preauthorizing, to run the claim through a claims scrubber software and to bundle codes at that time.

Q: If a physician or provider has received a SB 418 verification from a carrier, does the physician or provider still have to file a clean claim in order to be paid?

A: Regardless of whether a physician or provider has received a verification for services, he or she must still timely submit a clean claim in order to be paid for those services in accordance with these rules. There are several reasons for this conclusion. First, nothing in the statute indicates that the verification and claim filing processes are mutually exclusive, and nothing exempts a verified service from the clean claim requirements. Second, the adopted rule makes the verification number a required element of a clean claim, a change that was supported by most parties that commented on this provision. Third, a carrier may not deny or reduce payment for a claim for verified services that were timely provided, except in the case of material misrepresentation or substantial failure to perform the proposed services. The information on a claim form may assist a carrier in determining that these situations do not exist. And, as the statute makes clear, a verification does not apply in the case of a material misrepresentation or substantial failure to perform. The Department notes, however, that many carriers have paid claims that did not precisely include all required elements, so long as the carrier was satisfied that it had sufficient information to process and pay the claim. The rules do not preclude carriers from continuing to do so, including cases where the claim is for a verified service.

Q: Can insurers elect not to provide preauthorization at all?

A: Pursuant to SB 418, a physician or provider can request a preauthorization only where the carrier has determined that certain services require preauthorization. That carrier, having established the requirement, does not have to issue a preauthorization for proposed services.

Q: Suppose an HMO requires preauthorization for all hospital stays. An enrollee needing surgery is referred by his doctor or the HMO to a non-contracting specialist because that type of surgeon is not available in-network. The surgeon requests verification of the surgery and the HMO declines. Since SB 418 does not give a non-contracted referral doctor access to the preauthorization process, does he have any recourse to prevent denial of payment due to no preauthorization?

A: In this situation, the surgeon has asked for verification but the plan declined, so verification is no longer an option in this instance. He doesn't have access to the SB 418 preauthorization process. Therefore, the process that remains for the surgeon to utilize is the process in 28 Texas Administrative Code §§19.1710 - 19.1712, that was in effect prior to SB 418 and continues in effect for those who are not subject to SB 418's preauthorization process.

Q: What if the patient's diagnosis changes from the time of authorization to the time of treatment? For example, we obtain a preauthorization for an admitting diagnosis of a myocardial infarction but after tests are done the diagnosis is changed to gastritis. Can the carrier deny payment for services performed to treat the final diagnosis? Can they refuse to pay for some of the inpatient days they initially authorized?

A: Preauthorization is a determination of whether proposed services are medically necessary and is issued based on the patient's diagnosis. If that diagnosis changes, the provider should contact the carrier or its utilization review agent and request a new authorization for the correct diagnosis. The provider should not expect a carrier to pay for all services or all hospital days that were initially authorized to treat a condition that ultimately was determined not to exist.

Q: Can insurers elect not to provide verification at all?

A: The SB 418 statutory language makes clear that all carriers subject to SB 418 must make a good faith effort to entertain requests for verification rather than adopting a corporate policy of no verifications. If the carrier is unable to verify, it may decline so long as it states the specific reason for the declination. Such reason, according to the statute, must be specific to the request for the proposed service rather than a blanket refusal.

Q: A doctor called for verification for a cholecystectomy (gall bladder removal). While performing that procedure, the doctor discovered a severely inflamed diverticulum on the patient's intestine that required removal in order to prevent rupture. Will the verification include the intestinal surgery?

A: The SB 418 rules say the provider can furnish a description of the proposed procedure(s) or the procedure code(s). The verification and preauthorization procedures are prospective in nature. The statute and rules provide no method or procedure for obtaining a verification or preauthorization after a service has been furnished. In the example above, the verification will only apply to the cholecystectomy. The fact that the intestinal surgery is not verified does not preclude payment for the procedure.

Q: Must a verification be requested for each service, or can there be a general verification, for example, for office visits over the next three months during an illness?

A: Providers are not required to request verification for any service. If a provider wishes to request verification for a global service or for an extended series of services, he or she may request such verification. The carrier may either verify or decline to verify the services as requested.

Q: If a provider requests verification on multiple procedures and it is determined during the review that not all of the services are appropriate, can the entire verification request be declined or should a partial approval/declination be given?

A: The health plan should verify that portion of the requested services that it is able to verify and issue a declination of the remainder of the services, with specific reasons for the declination.

Q: A carrier has had a few instances where a provider requested a verification for services to be performed later that same day. The carrier declined to verify, based on the rationale that a carrier must respond without delay but no later than five days after the request has been made. In these cases, the

date of service will have already passed by the time the carrier makes their determination. Is this correct?

A: The rule makes clear that a carrier must provide a response to a verification request "without delay, and as appropriate to the circumstances of the particular request, but not later than five days after the date of receipt of the request for verification." Depending upon the circumstances, it is possible that a carrier could process a request on the same day the service was to be provided. However, other services will require a greater amount of time to verify. Because the law defines verification as a reliable representation that a carrier will pay for a proposed medical or health care service, a carrier is not required to retrospectively verify a service that has already been performed.

Q: If a physician or provider receives a verification on the last day of the month (example: September 30) for services to be performed on a future date (example: October 7), is the carrier still liable for payment even if the carrier subsequently learns that the insured was terminated earlier that month (example: on September 1)?

A: If the provider has requested and received a verification in compliance with 28 Texas Administrative Code §19.1724, the carrier is liable for payment unless the services were not performed or there has been material misrepresentation.

Q: I requested a verification from a payer for a procedure and the carrier responded with a verification related to a specific CPT code. However, when I submitted the claim, the payer bundled the verified code into another code that was billed and denied the verified code as incidental. Can they do this?

A: Yes. Processing a verified claim includes the opportunity to apply the provider contract, but not the insurance contract, to the claim. The provider contract, with its associated bundling edits and logic, should continue to be applicable as the parties have agreed that the document represents how the provider will be paid.

Q: SB 418 and the rules seem to indicate that preauthorization and verification are two separate processes. However, some carriers and providers use the words "preauthorization," "precertification," and "verification" to mean the same thing. Can verification ever include preauthorization?

A: Once a carrier has issued a SB 418 verification pursuant to the requirements of the statute and rules, the claim resulting from those services may not be denied or reduced unless there was a material misrepresentation in the request for verification or a failure to substantially perform the verified services. Therefore, a carrier may not deny or reduce a previously verified claim due to the medical necessity or appropriateness of the services. In that sense, a verification does include preauthorization because a carrier that issues a verification has eliminated its ability to deny the claim for medical necessity or appropriateness.

Q: Although the statute and rules say a carrier must respond to a request for verification, does it have to respond to a request for preauthorization if the carrier does not require preauthorization for that particular service?

A: Because a physician or provider, pursuant to SB 418, can request a preauthorization only where the carrier has determined that certain services require preauthorization, that carrier, having established the requirement, does not have to issue a preauthorization for proposed services. Where a carrier issues a verification, the verification is inclusive of a medical necessity determination.

Q: When does the time limit start to run on a request for verification that is received after hours? For example, if a call requesting verification for post-stabilization care is received by a carrier's answering machine or service at night, does the one hour deadline for response start to run the next day?

A: The adopted rules state that the clock begins ticking on a request received after the mandated telephone times upon the beginning of the next mandated telephone time. Accordingly, a request for verification involving post-stabilization care services received Saturday at 11 p.m. must be answered by 10 a.m. on Sunday (next mandated telephone time plus one hour).

Q: A provider requested a verification in accordance with SB 418 and 28 TAC 19.1724 and the carrier issued a verification pursuant to this request. Subsequently, the carrier learned that the insured made a material misrepresentation on the insured's application for the coverage. Would the material misrepresentation on the application void the verification of payment to the provider?

A: No. Pursuant to SB 418, if a carrier provides a verification to a physician or provider for proposed services, the carrier may not deny or reduce payment for those services if provided on or before the 30th day after the verification was provided unless the physician or provider has materially misrepresented or substantially failed to perform the proposed health services. SB 418 contains no provisions that would permit a carrier to deny or reduce payment for verified services because of an insured's material misrepresentation on the application for coverage.

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Texas Plan/Texas Patient/Out of State Provider

Q: If an out of state provider calls to verify/preauthorize benefits on a Texas resident who has a Texas plan, do insurers have to verify/preauthorize in that situation? Do the provisions of the law apply to a Texas resident obtaining medical services out of state when that person has a Texas-based plan?

A: No. Both §§1301.001 and 843.002, Texas Insurance Code, define physician, provider, and health care provider as persons who are licensed in Texas. Therefore, the prompt pay provisions would apply to out of state physicians and providers only if they were also licensed in Texas.

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Texas Plan/Out of State Patient/Out of State Provider

Q: If an out of state patient covered by a Texas plan receives treatment from an out of state provider, will the Texas prompt pay rules apply?

A: No. The term "physician" is defined in the prompt pay rules as a person licensed to practice medicine in the state (28 Texas Administrative Code §21.28002(18)). "Provider" is defined as an entity that is licensed or otherwise authorized to practice in this state (28 TAC §21.2802(24)). Consequently, the prompt pay rules do not apply to out of state providers that are not licensed or otherwise authorized to practice in Texas.

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Out of State Plan/Texas Patient/Texas Provider

Q: If a Texas provider calls to verify/preauthorize benefits on a Texas resident who is covered by a plan that was issued in another state, do insurers have to verify/preauthorize in that situation? Do the provisions of the law apply to a Texas resident obtaining and Texas provider rendering medical services under a policy that was issued in another state?

A: No. The Texas prompt pay provisions do not apply to preferred provider health benefit and HMO plans that are issued in another state.

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Texas Plan/Out of State Patient/Texas Provider

Q: If an out of state patient covered by a Texas plan receives treatment from a Texas provider, will the Texas prompt pay rules apply?

A: Yes. As noted in the FAQs above, the prompt pay rules apply to preferred provider health benefit and HMO plans that are issued in Texas, and to claims from physicians and providers licensed or otherwise authorized to practice in Texas. The residence of the patient is not a determining factor as to whether the Texas prompt pay rules do or do not apply.

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Protected Health Information/Health Insurance Portability and Accountability Act Privacy

Q: SB 418 and the rules provide that if a carrier requests an attachment or other information from someone other than the preferred provider who submitted the claim, the carrier must give the preferred provider notice of the physician or provider from whom the carrier is requesting the information. Does this conflict with privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPAA)?

A: No. In many instances, the physician filing the claim will have provided the name of the other physician to the carrier, so there will be no disclosure. Even where a disclosure might occur, the disclosure is a part of a carrier's health care operations, as well as an act necessary to receive payment, both of which are excepted from the HIPAA authorization requirement.

Q: If a provider requests verification on a non-member/participant, is it necessary for the HMO or PPO carrier to decline to verify and send a declination letter to the provider? If so, how much member information must be provided in the letter?

A: The HMO or PPO carrier must always respond appropriately. The HIPAA rules include a general exception from the requirement to obtain specific consent when private health information is disclosed by or among covered entities for treatment, payment or health care operations. 45 Code of Federal Regulations §164.506(a). However, that exception includes qualifiers, so that the exception does not apply to all covered entities in all circumstances. Therefore, the carrier should consult with its own legal counsel regarding HIPAA privacy rule questions, such as how much member information to include in the declination letter.

For more information contact: ConsumerProtection@tdi.texas.gov or 1-800-252-3439

Last updated: 09/06/2014

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