

Getting stiffed no longer needs to be a cost of doing business: Texas prompt pay provisions

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Despite the enactment of new “prompt pay” legislation in 2003, many health care providers still accept slow, low, or no reimbursement from a health maintenance organization (HMO) or preferred provider organizations (PPO) for their services. Some health care providers do so because they have been conditioned to accept this behavior as a cost of doing business. Others are fearful of retaliation by the HMO or PPO if they press for what they are entitled to. Texas law and the current posture of the Texas Board of Insurance are such that Texas health care providers no longer have to accept this mistreatment as a cost of doing business. In this regard, Texas’s current prompt pay statute is arguably one of the most provider-friendly statutes in the country considering the penalties and protections offered.

Current Texas prompt pay provisions come from two legislative enactments: House Bill (HB) 610, passed in 1999, and Senate Bill (SB) 418, passed in 2003. These provisions have been codified in Article 3.70-3C and Chapter 843 of the Texas Insurance Code. In addition, applicable provisions are set forth in the Texas Administrative Code (1).

ENTITIES COVERED

Texas’s prompt pay provisions apply to HMOs and PPOs funded by an insurer (2). In addition to covering payments to contracted providers, these provisions apply to physicians who have not contracted with the patient’s HMO/PPO if the care at issue was related to “an emergency or its attendant episode of care” under state or federal law or if the services were provided at the request of the HMO/PPO because the services were not reasonably available from an in-network physician (3). Texas’s prompt pay provisions do not apply to Medicaid, Medicare, self-funded ERISA plans, Health Select and Health Select Plus plans, federal employee plans, self-funded plans covering the University of Texas and Texas A&M University employees, Tri-Care (CHAMPUS), Texas Association of School Board coverages, the Children’s Health Insurance Program (CHIP), and worker’s compensation.

GOVERNING STATUTE

The more recent and more beneficial prompt pay provisions contained in SB 418 apply to HMO and PPO contracts that were renewed and under which services were provided after

October 5, 2003. In the event that some “evergreen” contracts are still in existence, meaning that they automatically renew, payment of those claims is governed by the less restrictive HB 610. At this late date, however, the likelihood is that SB 418 will apply.

HEALTH CARE PROVIDER DUTIES

To reap the benefits of the protections provided by SB 418, a “clean claim” must be submitted (2). One cannot overemphasize the importance of ensuring that clean claims are submitted, as most of the substantive rights extended to a provider under the statute are triggered on submitting a clean claim. To constitute a clean claim, the data elements required “must be complete, legible and accurate” (4). If the claim is submitted electronically, it “must us[e] the applicable format that complies with all federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements” to constitute a clean claim (5). Specifically, the claim must be submitted using the ACS X12N 837 format (6).

If the claim is nonelectronic, it must contain the data elements required on form CMS-1500 (08/05) (7). In the event the claim at issue was filed or refiled before July 18, 2007, the data elements required by CMS-1500 (12/90) are required (8). Nonelectronic claims submitted by institutional providers must contain the elements required by the UB-04 CMS-1450, unless the claim at issue was filed or refiled before July 18, 2007 (9). If that is the case, the elements within UB-92 CMS-1450 are required (10). The 43 elements needed for a nonelectronic dental clean claim are set forth within the statute (11). The fact that the information submitted contains information in addition to that required under statute does not render an otherwise clean claim deficient (12).

Clean claims must also be submitted in a timely fashion. Specifically, the claim must be submitted within 95 days after the services at issue were provided (13). Otherwise, unless physicians can establish that this failure was due to a

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“catastrophic event,” they forfeit their right to timely payment and associated penalties (14). Under statute, a catastrophic event is defined as an event “that cannot reasonably be controlled or avoided and that causes an interruption in the claims submission or processing activities for more than two consecutive business days” (15). Examples of events that would qualify as a catastrophic event include “acts of God, civil or military authority, acts of public enemy, war, accidents, fire, explosions, earthquake, windstorm, flood or organized labor stoppages” (15). The statute also provides for the process and timing through which one can certify that a catastrophic event has occurred (16).

HMO/PPO DUTIES

If the claim submitted is not a clean claim, the HMO/PPO must advise the provider of that fact. This must be done within 30 days of receipt of an electronic claim and within 45 days of receipt of a nonelectronic claim (17).

Upon receipt of a clean claim, the carrier has four options:

1. Pay the total amount of the claim as provided for in its contract with the physician.
2. Deny the entire claim and advise the provider why the claim has not been paid.
3. Audit the claim, paying the full contracted rate and notifying the provider that the claim is being audited.
4. Pay a portion of the claim and deny or audit the remainder, while paying the full contracted rate of the audited portion of the claim (18).

The carrier has 30 days within which to exercise these options if the claim is electronic. If the claim is nonelectronic, the deadline is 45 days (19).

If the carrier elects to audit a claim, the audit must be completed within 180 days (20). In the event that the audit reveals that a refund is in order, the carrier must explain the specific claim, amount, and reasons a refund is requested, advise the provider of the right to appeal, and describe how the carrier intends to recover the refund (21). The provider must provide the carrier the refund by the later of 30 days after notification of the audit results or 30 days after exhaustion of appeal rights (22).

Carriers are allowed one request to a submitting provider for additional information when evaluating a claim (23). This request must be made within 30 days of the carrier’s receipt of a clean claim (23). If a proper request is made, the time within which the carrier has to pay the claim is tolled until the provider either provides the requested information or advises the carrier that he or she does not have the information requested (24). Once the provider gives this information to the carrier, the carrier must act on the claim by the later of 15 days after receiving the response or the latest date for resolution of a claim under statute (24).

Table. Carrier penalties if a claim is not paid on time*

Contracted amount paid	Date paid after deadline	Penalty (the lesser amount of the two options)
None	Day ≤45	50% of the difference between the billed charges and the contracted rate or \$100,000
	Day 46–90	100% of the difference between the billed charges and the contracted rate or \$200,000
	Day ≥91	100% of the difference between the billed charges and the contracted rate or \$200,000, plus 18% annual interest on the penalty amount [†]
Portion	Day ≤45	50% of the underpaid amount [‡] or \$100,000
	Day 46–90	100% of the underpaid amount [‡] or \$200,000
	Day ≥91	100% of the underpaid amount [‡] or \$200,000, plus 18% annual interest on the penalty amount [†]

*On time is defined as 30 days for electronic claims and 45 days for nonelectronic claims (17).

[†]Interest begins to accrue on the date the carrier was required to pay the claim and ends on the date the claim and the amount of penalty are paid in full.

[‡]The underpaid amount is the percentage the carrier underpaid the claim multiplied by the difference between the billed charges and the contracted rate (32). See text for explanation and examples.

For a request for additional information to be proper, it must be written, be specific to the claim or the care rendered in connection with the claim, specifically describe the information to be contained in response to the request, be relevant and necessary to resolve the claim, and request information that is contained in or in the process of being incorporated into the billing or medical records maintained on the patient by the provider (25). To be proper and to restart the claims payment clock, any response the provider gives must also include a copy of the carrier’s request for additional information along with the patient’s name, identification number, the carrier’s claim number, the date of service, and the name of the treating provider (26).

A carrier is also allowed to request information from someone other than the submitting provider (27). If it does so, the carrier must notify the submitting provider. Unlike a request for additional information to the submitting provider, a request for information to someone other than the submitting provider does not toll the deadlines within which the carrier must act in responding to submission of a clean claim (27).

If the carrier overpays a claim (in contrast to an audited claim), the carrier can obtain a refund of its overpayment using the process described above to recover a payment made pending an audit (21). In this particular circumstance, the carrier must advise the provider of the overpayment no later than the 180th day after the provider’s receipt of the overpayment (21). Providing that the proper statutory steps are followed, the provider must reimburse the carrier for the overpayment by the later of 45 days after notification of the overpayment or 45 days after exhaustion of appeal rights (28).

PENALTIES FOR FAILURE TO COMPLY

If a carrier fails to timely pay the full amount on a clean claim, the penalties owed the provider differ depending upon when the claim is paid (*Table*) (29–32). For example, if the

difference between the billed charges and the contracted rate for those charges is \$5000, the penalty under the first scenario is \$2500, the penalty under the second scenario is \$5000, and the penalty under the third scenario is \$5000 plus 18% annual interest that accrues from the time the claim should have been paid (30).

The penalties that apply if only a portion of a clean claim is paid are also shown in the Table. This process is more complicated because “the underpaid amount is calculated based on the ratio of the balance owed by the carrier to the total contracted rate . . . as applied to an amount equal to billed charges minus the contracted rate” (32). In determining the correct penalty, a five-step process is required:

1. Determine the amount underpaid by the carrier on the contracted rate (e.g., carrier owes a balance of \$200 on a contracted \$1000 claim).
2. Determine the percentage the carrier underpaid the claim (e.g., if the carrier owes \$200 on a contracted \$1000 claim, the carrier underpaid the claim by 20%).
3. Determine the difference between the billed charges and the contracted rate (e.g., if the billed charges were \$1500 and the contracted rate was \$1000, this number would be \$500).
4. Multiply the percentage the carrier underpaid the claim by the difference between the billed charges and the contracted rate (e.g., in our example, 20% × \$500 = \$100).
5. Determine the amount of the penalty by multiplying the answer to step 4 by the applicable penalty (50%, 100%, or 100% plus subsequent applicable interest) (32).

Using our example above, and assuming that the balance was paid on or before the 30th day after the applicable payment period expired, the penalty would be \$50 (\$100 × 50%) (32). If the balance was not paid until the 90th day after expiration of the applicable payment period, the penalty would be \$100 (100% of the underpaid amount).

If there is a certified catastrophic event, these penalties do not apply (33). In addition, these penalties do not apply if the carrier is not notified of the underpayment until after the 270th day following the provider’s receipt of the underpayment and the carrier pays the balance of the claim on or before the 30th day after the date it receives notice of the underpayment (34). Under no circumstance is the carrier relieved of the obligation to pay any remaining unpaid balance owed under contract to the provider (35).

PROTECTIONS AGAINST RETALIATION

The belief that claims payment difficulties should be accepted to avoid possible retaliation is not well founded. Both the Texas Insurance Code and the Texas Administrative Code provide protections against carrier retaliation. Legislation in 2001 and 2003 added provisions to the Texas Insurance Code that expressly forbid HMOs from retaliatory action (cancellation, refusal to renew, or termination) against providers and their groups for filing a complaint against an HMO or appealing the decision of an HMO (36). In addition, the Texas Administrative Code expressly requires that the contracts with physicians and providers not only contain the provisions regarding retaliation from the Texas Insurance Code but also contain prompt pay provisions (37).

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1. 28 Tex Admin Code §21.2801–22.2826.
 2. 28 Tex Admin Code §21.2801.
 3. 28 Tex Admin Code §21.2823.
 4. 28 Tex Admin Code §21.2803(g).
 5. 28 Tex Admin Code §21.2803(e).
 6. 28 Tex Admin Code §21.2802(6)(B).
 7. 28 Tex Admin Code §21.2803(b)(1).
 8. 28 Tex Admin Code §21.2803(b)(2).
 9. 28 Tex Admin Code §21.2803(b)(3).
 10. 28 Tex Admin Code §21.2803(b)(4).
 11. 28 Tex Admin Code §21.2803(c).
 12. 28 Tex Admin Code §21.2803(h).
 13. 28 Tex Admin Code §21.2806(a).
 14. 28 Tex Admin Code §21.2806(b).
 15. 28 Tex Admin Code §21.2802(5).
 16. 28 Tex Admin Code §21.2819.
 17. 28 Tex Admin Code §21.2808.
 18. 28 Tex Admin Code §21.2807(b).
 19. 28 Tex Admin Code §21.2802(31).
 20. 28 Tex Admin Code §21.2809(c).
 21. 28 Tex Admin Code §21.2818(a), (b).
 22. 28 Tex Admin Code §21.2818(d)(2).
 23. 28 Tex Admin Code §21.2804(a).
 24. 28 Tex Admin Code §21.2804(c).
 25. 28 Tex Admin Code §21.2804(b).
 26. 28 Tex Admin Code §21.2804(e).
 27. 28 Tex Admin Code §21.2805.
 28. 28 Tex Admin Code §21.2818(d)(1).
 29. 28 Tex Admin Code §21.2815(a).
 30. 28 Tex Admin Code §21.2815(b).
 31. 28 Tex Admin Code §21.2815(c).
 32. 28 Tex Admin Code §21.2815(e).
 33. 28 Tex Admin Code §21.2815(f)(1).
 34. 28 Tex Admin Code §21.2815(f)(2).
 35. 28 Tex Admin Code §21.2815(g).
 36. Tex Ins Code §843.281 (Vernon’s Supp 2008).
 37. 28 Tex Admin Code §11.901(a)(2) and (8).