

## New Billing Disclosures Required

Two new laws went into effect Sept. 1, 2007. Both affect your billing procedures and policies. The new laws are a result of Texas Senate Bills 1731 and 1832. Here is what you need to do.

**SB 1731** The spirit of the bill is to ensure Texas patients, whether insured or uninsured, have access to important information so they can make better health care decisions. The bill imposes transparency requirements on all — physicians, hospitals, and health plans.

### All physicians must:

- Post a notice in your waiting room to inform patients they can request a copy of your billing policies.
- Adopt billing policies and procedures that inform patients:
  1. About possible patient discounts for charity care and the uninsured,
  2. Whether late payments will incur interest, and
  3. About your billing complaint process and procedures.

### Physicians treating out-of-network and uninsured patients must follow these requirements:

- Patients can request a written estimate of their out-of-pocket expenses (due within 10 days). The estimate can list these disclaimers:
  1. Charges may vary based on the patient's condition.
  2. The request can delay the scheduling of care.
  3. The actual charges may differ from the amount paid by the third-party payer.
  4. The patient is personally liable for the services not paid by health insurance.
- Health plans must estimate the amount an insured patient will pay for proposed services if requested. For in-network services, direct patients to their health plan.
- Patients can request an itemized statement of the charges within one year. You have 10 business days to comply.
- Your patient can request up to two additional statements for free.
- You must refund a patient overpayment within 30 days.

### Facility-based physicians\* billing an insured patient for out-of-network services must disclose:

- Itemized services and supplies,
- Date services were provided, and
- Clear statements that:
  1. You are not in the patient's health plan.
  2. The health plan does not cover your total charge.
  3. The patient can call to discuss billing arrangements.
  4. If a payment arrangement is made, you will not report the patient to a collection agency if he or she makes payments according to the agreement.
- You also must provide billing phone number and information on how to file a complaint with the Texas Medical Board (TMB), along with TMB's mailing address and telephone complaint number.

\* Includes radiologists, anesthesiologists, pathologists, emergency physicians, and neonatologists.

**SB 1832** The intent of this bill is to provide transparency and disclosure for anatomical pathology services. It applies only to a physician or entity that bills for the service but neither performs nor supervises the service.

The disclosure requirements affect only **anatomical** pathology services.

### Disclosure requirement:

- If you bill for an anatomical pathology service and do not perform or supervise the service, you must disclose:
  1. The **price** you paid for the service, and
  2. The **physician or lab** that actually performed the service.
- The law allows the billing physician to provide written disclosure to either the patient or the patient's health plan.

### Disclosure via claim can be done the following way:

- Physicians may submit information relating to purchased diagnostic services on both the non-electronic CMS 1500 claim form and the electronic 837P.
- On the CMS 1500 claim form, the fields that would communicate that a physician is billing for purchased diagnostic services are Fields 20 and Field 32. See below for the instructions from p. 26 of the NUCC 1500 manual. Note the instruction for Field 32 on p. 46 of the manual. It requires that when more than one supplier is used, a separate 1500 claim form must be used. Essentially this instruction means that if a physician is billing for purchased diagnostic services, those must be billed separately from the services the physician provides directly.
- On the electronic 837P, information related to Purchased Services is entered in Loop 2310C (p. 298), 2310D (p.303), and 2400 (p. 489). See the pages indicated in the 837P Implementation Guide. Loops 2310C and 2310D are claim level loops, which means the information applies to the entire claim. Loop 2400 is a service level loop and would be used on service lines involving purchased services/tests if different from the information given at the claim level.

*Texas Medical Board has rules regarding implementation of both of these laws.*

