Texas Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

## As required by Tex. Ins. Code Ann. § 1458.101(b), Provider has been notified of and authorizes the Contracting Entity to sell, lease or otherwise transfer information regarding the payment or reimbursement terms of the Agreement.

## As required by Tex. Ins. Code Ann. § 1458.101(c), the Contracting Entity may contract with a person to provide access to the Contracting Entity's rights and responsibilities under the Agreement.

## As required by Tex. Ins. Code Ann. § 1458.101(d), upon request of the Provider, the Contracting Entity will provide information necessary to determine whether a particular person has been authorized to access the Provider's health care services and contractual discounts.

## As required by Tex. Ins. Code Ann. § 1458.102, if a Contracting Entity provides a person access to health care services or contractual discounts under the Agreement, the Contracting Entity shall require the person to comply with all applicable terms, limitations, and conditions of the Agreement.

# **General Insurance Laws**

## As required by Tex. Ins. Code Ann. § 1301.055 and 28 Tex. Admin. Code § 3.3703(a)(8), the Agreement incorporates the mechanism for resolving complaints initiated by an insured or a Provider contained in the Provider Manual, Tex. Ins. Code Ann. § 1301.053(b), or 28 Tex. Admin. Code § 3.3706(b)(2), as appropriate.

## As required by Tex. Ins. Code Ann. § 1301.056(b), contracting parties to the Agreement expressly authorize and are notified of the fact that the preferred provider organization can sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the Agreement.

## As required by Tex. Ins. Code Ann. § 1301.064, payment to the Provider for health care services and benefits provided to an insured under the Agreement and to which the insurer is entitled under the terms of the contract must be made no later than: (i) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or (ii) if applicable, within the number of calendar days specified in the Agreement.

## As required by Tex. Ins. Code Ann. § 1301.152(c), the Agreement incorporates the Provider Manual with respect to the procedure for resolving disputes regarding the necessity for continued treatment by the Provider.

## As required by Tex. Ins. Code Ann. § 1301.153(b), termination of the physician's or Provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, does not: (i) release the physician or health care Provider from the generally recognized obligation to: (1) treat an insured whom the physician or Provider is currently treating; and (2) cooperate in arranging for appropriate referrals; or (ii) release the insurer from the obligation to reimburse the physician or health care Provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or Provider's participation is terminated, an insured whom the physician or Provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

## As required by 28 Tex. Admin. Code § 3.3703(a)(10), if a preferred Provider is compensated by the insurer on a discounted fee basis, such preferred Provider agrees to bill the insured only on the discounted fee and not the full charge.

## As required by 28 Tex. Admin. Code § 3.3703(a)(11), the insurer is required to comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the Provider for covered services rendered to insureds.

## As required by 28 Tex. Admin. Code § 3.3703(a)(12), the Provider is required to comply with Tex. Ins. Code Ann. §§ 1301.152-1301.154, which relates to continuity of care.

## As required by 28 Tex. Admin. Code § 3.3703(a)(14), the insurer may be required to comply with Tex. Ins. Code. Ann. § 1301.058.

## As required by 28 Tex. Admin. Code § 3.3703(a)(15) and Tex. Ins. Code Ann. § 1301.059(b), to the extent the Agreement requires quality assessments, the Agreement requires the insurer to engage in quality assessment only through a panel of at least 3 physicians selected from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer.

## As required by 28 Tex. Admin. Code § 3.3703(a)(18), if Provider voluntarily terminates the Agreement, then the Provider must provide reasonable notice to the insured, and must require the insurer to provide assistance to the Provider as set forth in the Tex. Ins. Code Ann. § 301.160(b).

## As required by 28 Tex. Admin. Code § 3.3703(a)(19), the insurer is required to provide Provider with written notice on termination of the Agreement by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the Provider's right to request a review, as specified in 28 Tex. Admin. Code § 3.3706(d).

## As required by 28 Tex. Admin. Code § 3.3703(a)(20), the preferred Provider is entitled upon request to all information necessary to determine that the preferred Provider is being compensated in accordance with the Agreement.

## As required by 28 Tex. Admin. Code § 3.3703(a)(25), the preferred Provider must comply with all applicable requirements of Tex. Ins. Code Ann. § 1661.005.

## As required by 28 Tex. Admin. Code § 3.3703(a)(26), if the Agreement is between an insurer and a facility, the facility must give notice to the insurer of the termination of the a contract between the facility and a facility-based physician group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the 5th business day following termination of the contract.

## As required by 28 Tex. Admin. Code § 3.3703(a)(27), except for instances of emergency care as defined under Tex. Ins. Code Ann. § 1301.155(a), a physician or Provider referring an insured to a facility for surgery must: (i) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; (ii) notify the insurer that surgery has been recommended; and (iii) notify the insurer of the facility that has been recommended for the surgery.

## As required by 28 Tex. Admin. Code § 3.3703(a)(28), if the Agreement is between an insurer and a facility, except for instances of emergency care as defined under Tex. Ins. Code Ann. § 1301.155(a), that the facility, when scheduling surgery must: (i) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and (ii) notify the insurer that surgery has been scheduled.

## As required by Tex. Ins. Code Ann. § 1301.136, if the Agreement is between an insurer and a preferred Provider then: (i) the preferred Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the preferred Provider will receive under the Agreement; (ii) the insurer or the insurer's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the insurer receives the request; (iii) 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; and (iv) the Agreement may be terminated by the preferred Provider on or before the 30th day after the date the preferred Provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

# **Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws**

## As required by Tex. Ins. Code Ann. § 843.321, the Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the physician or Provider will receive under the contract. The HMO or the HMO's agent must provide the coding guidelines and fee schedules not later than the 30th day after the date the HMO receives the request. The HMO or the health HMO’s agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the physician or 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. The Agreement may be terminated by the physician or Provider on or before the 30th day after the date the physician or Provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

## As required by Tex. Ins. Code Ann. § 843.361, a physician or Provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

## As required by Tex. Ins. Code Ann. § 1272.302(b), a physician or Provider must: (i) require that reasonable advance notice be given to an enrollee of an impending termination from the network or entity of a physician or Provider who is currently treating the enrollee; and (ii) provide that the termination of the physician's or Provider's contract, except for reason of medical competence or professional behavior, does not release the network or entity from the obligation to reimburse the physician or Provider for treatment of an enrollee who has a special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of the enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

## As required by Tex. Ins. Code Ann. § 1272.302(f), the Agreement incorporates the Provider Manual with respect to the procedure for resolving disputes regarding the necessity for continued treatment by the Provider.

## As required by 28 Tex. Admin. Code § 11.901(a) and Tex. Ins. Code Ann. § 843.361, the following language is included in the Agreement:

Provider hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency, or breach of this agreement, may Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided under this agreement. This provision does not prohibit collection of supplemental charges or copayments made in compliance with the terms of (applicable agreement) between HMO and subscriber or enrollee. Provider further agrees that:

(A) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and must be construed to be for the benefit of the HMO subscriber or enrollee; and

(B) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of the proposed changes.

## As required by 28 Tex. Admin. Code § 11.901(b) the Agreement: (i) prohibits retaliation as contained in Tex. Ins. Code Ann. § 843.281; (ii) requires continuity of treatment, if applicable, as described in Tex. Ins. Code Ann. §§ 843.309 and 843.362; (iii) requires notification to enrollees receiving care from a physician or Provider whose participation in the Agreement has been terminated, in compliance with Tex. Ins. Code Ann. §§ 843.308 and 843.309; (iv) requires posting of complaint notices in physician or Provider offices as described in Tex. Ins. Code Ann. § 843.283, provided that a representative notice that complies with this requirement may be obtained from the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or the department's website at [www.tdi.texas.gov](http://www.tdi.texas.gov); (v) provides indemnification of the HMO as allowed in Tex. Ins. Code Ann. § 843.310; (vi) requires prompt payment of claims as described in Tex. Ins. Code Ann. §§ 542 Subchapter B and 1271.005, and all applicable statutes and rules pertaining to prompt payment of clean claims, including Tex. Ins. Code Ann. § 843 Subchapter J and 28 Tex. Admin. Code 21 Subchapter T, with respect to payment to the physician or Provider for covered services rendered to enrollees; (vii) if applicable, payment of capitation as described in Tex. Ins. Code Ann. §§ 843.315 and 843.316; (viii) provides for selection of a primary care physician or Provider, if applicable, as described in Tex. Ins. Code Ann. § 843.203; (ix) provides that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish X-rays and non-prefabricated orthotics covered by the evidence of coverage as described in Tex. Ins. Code Ann. § 843.311; (x) complies with the electronic claims filing requirements of 28 Tex. Admin. Code § 21.3701, if applicable; (xi) requires the preferred Provider to comply with all applicable requirements of Tex. Ins. Code Ann. § 1661.005; and (xii) a contracting physician or Provider is required to retain in the contracting physician's or Provider's records updated information concerning a patient's other health benefit plan coverage.

## As required by 28 Tex. Admin. Code § 11.901(c), the Provider is entitled, upon request, to all information necessary to determine that the physician or provider is being compensated in compliance with the Agreement.

## As required by 28 Tex. Admin. Code § 11.901(d), the Agreement incorporates written notification of termination to a physician or Provider provisions in compliance with Tex. Ins. Code Ann §§ 843.306 and § 843.307, and requires that: (i) the HMO must provide notice of termination by the HMO to the physician or Provider at least 90 days before the effective date of the termination; (ii) not later than 30 days following receipt of the written notification of termination, a physician or Provider may request a review by the HMO's advisory review panel except in a case involving: (1) imminent harm to patient health; (2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or Provider's ability to practice medicine, dentistry, or another profession; or (3) fraud or malfeasance; and (iii) within 60 days after receipt of the physician or Provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or Provider.