

TEXAS STATUTES AND CODES

CIVIL PRACTICE AND REMEDIES CODE
TITLE 6. MISCELLANEOUS PROVISIONS
CHAPTER 146. CERTAIN CLAIMS BY HEALTH CARE SERVICE PROVIDERS BARRED

Tex. Civ. Prac. & Rem. Code § 146.001 (2000)

§ 146.001. Definitions

In this chapter:

(1) "Health benefit plan" means a plan or arrangement under which medical or surgical expenses are paid for or reimbursed or health care services are arranged for or provided. The term includes:

(A) an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract;

(B) an evidence of coverage or group subscriber contract issued by a health maintenance organization or an approved nonprofit health corporation;

(C) a benefit plan provided by a multiple employer welfare arrangement or another analogous benefit arrangement;

(D) a workers' compensation insurance policy; or

(E) a motor vehicle insurance policy, to the extent the policy provides personal injury protection or medical payments coverage.

(2) "Health care service provider" means a person who, under a license or other grant of authority issued by this state, provides health care services the costs of which may be paid for or reimbursed under a health benefit plan.

§ 146.002. Timely Billing Required

(a) Except as provided by Subsection (b) or (c), a health care service provider shall bill a patient or other responsible person for services provided to the patient not later than the first day of the 11th month after the date the services are provided.

(b) If the health care service provider is required or authorized to directly bill the issuer of a health benefit plan for services provided to a patient, the health care service provider shall bill the issuer of the plan not later than:

(1) the date required under any contract between the health care service provider and the issuer of the health benefit plan; or

(2) if there is no contract between the health care service provider

and the issuer of the health benefit plan, the first day of the 11th month after the date the services are provided.

(c) If the health care service provider is required or authorized to directly bill a third party payor operating under federal or state law, including Medicare and the state Medicaid program, the health care service provider shall bill the third party payor not later than:

(1) the date required under any contract between the health care service provider and the third party payor or the date required by federal regulation or state rule, as applicable; or

(2) if there is no contract between the health care service provider and the third party payor and there is no applicable federal regulation or state rule, the first day of the 11th month after the date the services are provided.

(d) For purposes of this section, the date of billing is the date on which the health care service provider's bill is:

(1) mailed to the patient or responsible person, postage prepaid, at the address of the patient or responsible person as shown on the health care service provider's records; or

(2) mailed or otherwise submitted to the issuer of the health benefit plan or third party payor as required by the health benefit plan or third party payor.

§ 146.003. Certain Claims Barred

(a) A health care service provider who violates Section **146.002** may not recover from the patient any amount that the patient would have been entitled to receive as payment or reimbursement under a health benefit plan or that the patient would not otherwise have been obligated to pay had the provider complied with Section **146.002**.

(b) If recovery from a patient is barred under this section, the health care service provider may not recover from any other individual who, because of a family or other personal relationship with the patient, would otherwise be responsible for the debt.