SUBCHAPTER B. HEALTH CARE PROVIDER BILLING PROCEDURES
Amendments to
28 TAC §133.10
SUBCHAPTER G. ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION
Amendments to
28 TAC §133.500 and §133.501
Addition of
28 TAC §133.502

INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), the Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §§133.10, 133.500, and 133.501, concerning billing forms and formats, electronic formats for electronic medical bill processing, and processing of electronic medical bills, and adopts new §133.502, concerning supplemental data requirements for electronic medical bills. The amendments and new section are adopted with changes to the proposed text as published in the December 3, 2010, issue of the *Texas Register* (35 TexReg 10598).

The amendments and new section are necessary to ensure that workers' compensation medical billing requirements remain aligned, to the extent possible, with the billing requirements and standards adopted by the Centers for Medicare and Medicaid Services (CMS) as required by statutory provisions of Labor Code §413.011(a).

REASONED JUSTIFICATION. House Bill 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005 (HB 7), amended the Labor Code by adding new §408.0251, which relates to electronic billing. Labor Code §408.0251 requires the Commissioner to adopt rules regarding the electronic submission and processing of medical bills between health care providers and insurance carriers. Section 413.011(a) requires the Commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by CMS to achieve standardization, including applicable payment policies relating to coding, billing, and reporting and

with modifications to documentation requirements as needed for workers' compensation purposes.

The United States Department of Health and Human Services (HHS) modified the electronic medical billing transactions used by the CMS in the August 22, 2008 proposed rule (73 Federal Register 49745-49749) and the January 16, 2009 adopted rule (74 Federal Register 3296-3328), which included changes codified in 45 CFR §162.1102 and §162.1602. The Commissioner adopts specific electronic billing standards that are adopted by these Federal rules as listed in §133.500(a)(1) - (5) and (c)(1) - (5) to ensure that the Texas workers' compensation system remains, to the extent possible, aligned with the CMS coding and billing policies as statutorily required by Labor Code §413.011 and supports the business requirements of the workers' compensation system.

As part of the development process for these adopted rules, the Division posted informal working drafts of the sections on its website on September 15, 2008 and August 15, 2009 and received informal comments from system participants. The Division also solicited public input through five stakeholder meetings held on April 7, 2008; August 25, 2008; December 17, 2008; April 13, 2010; and May 10, 2010. The Division formally proposed amendments and new §133.502 in the *Texas Register* (35 TexReg 10598) which published on December 3, 2010. These adopted rules incorporate several recommendations offered in public comment.

In response to comments the Commissioner has adopted these sections with some changes to the proposal as published. In response to written comments on the published proposal, the Division has adopted the following changes to:

§133.10(f)(3), by adding "drug name and strength" as a required field;

§133.10(i), by adding "OP for Orthotists/Prosthetists" as a license type;

§§133.10, 133.500, 133.501 and 133.502 by adding a new subsection to each section to establish an effective date of August 1, 2011.

§133.10(j) is changed to state "a resubmission condition code may be reported" to clarify that resubmission codes are not required for paper medical bills.

§133.502 by adding new subsection(e) to state, "In reporting the resubmission condition code under this section, the resubmission condition codes shall have the definitions specified in §133.10(j) of this title" in order to clarify that the definitions for resubmission condition codes in §133.10(j) apply to the resubmission condition codes used in §133.502.

In order to clarify the rule, the Division has adopted non-substantive changes to:

§133.10 by modifying DWC-66 to DWC-066 to align with current Division form numbering style;

§133.10(f)(1)(L) by spelling out the acronym NPI as National Provider Identifier to conform to the proper form for the use of acronyms;

§133.10(h) by substituting the word "must" for "will" for standardization with existing rules and clarification purposes;

§133.500(i) by clarifying that the standards adopted by §133.500 are available for inspection at the Division's central office.

§133.502(a) and (c) by adding the term "hospital" to the term "institutional" for consistency in terminology with §133.500.

Any other adopted amendments to the rule text merely correct typographical, grammatical or punctuation errors in the previous rule text.

HOW THE SECTIONS WILL FUNCTION

Adopted amendment of §133.10:

Adopted §133.10(a) clarifies that health care providers are required to submit medical bills using the electronic formats adopted in §133.500 and §133.501 of this title unless either the health care provider or the billed insurance carrier is exempt from billing electronically under adopted §133.501 of this title. Adopted §133.10(a) further clarifies that health care providers covered by subsection (a) includes those providing services for certified workers' compensation health care networks as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

Adopted §133.10(b) requires health care providers that are exempt, as provided under adopted §133.10(a), to submit paper bills using standard forms prescribed by the Division. The Division requires the same standard forms for professional and institutional services used by CMS for Medicare services and the same standard form for dental services used by the Texas Medicaid and Healthcare Partnership (TMHP). The adopted amendment to §133.10(b) also clarifies that health care providers covered by subsection (b) includes those providing services for certified workers' compensation health care networks as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

Adopted §133.10(c) requires pharmacists and pharmacy processing agents billing for pharmacy services to bill using Division form DWC-066 for billing, but allows use of an alternative billing form if the insurance carrier approves its use prior to submission and the alternative billing form contains all of the information in the Division form DWC-066.

Adopted §133.10(d) requires dentists to bill for dental services on the current American Dental Association (ADA) claim form. The ADA 2006 Dental Claim Form is also used by the TMHP for Medicaid dental services.

Adopted §133.10(e) requires surgical implant providers to bill using a form prescribed by adopted §133.10(e)(1) if reimbursement is sought under §134.402 of this title (relating to Ambulatory Surgical Center Fee Guideline) or a form prescribed by adopted §133.10(e)(2) if the reimbursement is sought under either §134.403 or §133.404 of this title (relating to Hospital Facility Fee Guideline--Outpatient and Hospital Fee Guideline--Inpatient, respectively). These requirements have been included in adopted §133.10(e) at the request of stakeholders, in order to ensure the appropriate forms are used based on the facility at which the service was rendered.

Adopted §133.10(f) requires billing information submitted on paper forms be legible and conform to the instructions set forth in this section. It clarifies that the parenthetical information related to various terms applies to the corresponding field number on the applicable paper medical billing form. The data element requirement format used within this adopted subsection regarding the completion of the paper medical bills aligns with the format used by the Department concerning clean claim requirements for health care as contained in §21.2803 of this title (relating to Elements of a Clean Claim).

Adopted §133.10(f)(1) requires that medical bills filed or resubmitted for professional and noninstitutional services be filed using the CMS-1500 form and must include the data elements in this subsection.

Adopted §133.10(f)(2) requires that medical bills filed or resubmitted for institutional services be filed using the UB-04 form and must include the data elements in this subsection.

Adopted §133.10(f)(3) requires that medical bills filed or resubmitted for drugs or other pharmacy services must be filed on the Division's DWC-66 form or other form permitted under subsection (c), and must include the data elements in this subsection. It is noted that the substantive changes to the draft DWC-66 referenced in this adopted subsection include the requirement to include the National Provider Identification number (NPI number) and the

preauthorization number, when applicable. The addition of the NPI number is consistent with billing instructions used in the health care industry for services on and after May 23, 2008. The addition of the preauthorization number is intended to expedite payment processing for drugs that are not contained in the Division's closed formulary and to align the billing instructions with those provisions.

Adopted §133.10(f)(4) requires that medical bills filed or resubmitted for dental services be filed on the ADA 2006 Dental Claim Form and must include the data elements in this subsection.

Adopted §133.10(g) requires a default value of "999999999" to be used by a health care provider where an injured employee does not have a Social Security Number as required in subsection (f).

Adopted §133.10(h) provides the required format for state license numbers, other than facility state license numbers, submitted under subsection (f).

Adopted §133.10(i) provides the designators to be used in reporting the state license numbers as required by subsection (h) and the format for submissions where the health care provider has no state license number.

Adopted §133.10(j) provides definitions for resubmission condition codes reported under subsection (f).

Adopted §133.10(k) provides that where a resubmitted medical bill complies with the requirements of §133.250 of this title (relating to Reconsideration of Payment of Medical Bills), the inclusion of the appropriate resubmission condition code and the original reference number is sufficient to identify the resubmission as a request for reconsideration.

Adopted §133.10(l) establishes that this section is effective August 1, 2011.

Adopted amendment of §133.500:

Adopted §133.500(a) provides billing standards for transactions occurring before January 1, 2012. Specifically, subsection (a)(1) contains the standards for professional billing, subsection (a)(2) contains the standards for institutional/hospital billing, subsection (a)(3) contains the standards for dental billing, subsection (a)(4) contains the standards for retail pharmacy billing, and subsection (a)(5) contains the standards for remittance advice.

Adopted §133.500(b) applies to medical bill processing transactions submitted before January 1, 2012. Specifically, subsection (b)(1) contains the standards for acknowledgments and responses to submitted electronic medical and pharmacy medical bills. Subsection (b)(2) contains the standards for documentation submitted with an electronic medical bill for professional, institutional/hospital, dental, and retail pharmacy services.

Adopted §133.500(c) provides billing standards for transactions occurring on or after January 1, 2012. Specifically, subsection (c)(1) contains the standards for professional billing, subsection (c)(2) contains the billing standards for institutional/hospital billing, subsection (c)(3) contains the billing standards for dental billing, subsection (c)(4) contains the billing standards for retail pharmacy billing, and subsection (c)(5) contains the standards for remittance advice.

Adopted §133.500(d) applies to medical bill processing transactions submitted on and after January 1, 2012. Subsection (d)(1) contains the standards for acknowledgments or responses to submitted electronic medical and pharmacy medical bills. Subsection (d)(2) contains the standards for documentation submitted with an electronic medical bill for professional, institutional/hospital, dental, and retail pharmacy services.

Adopted §133.500(e) requires an electronic medical bill transaction contain all the required fields set out in the standards adopted under §133.500(a) or (c) plus the supplemental data

requirements in adopted §133.502 of this title (relating to Electronic Medical Billing Supplemental Data Requirements). Subsection (e) also requires that the submitted values be current and valid.

Adopted §133.500(f) allows insurance carriers and health care providers to exchange electronic data in non-standard formats provided that there is mutual agreement between the two parties and all the data elements in the Division's prescribed format are present in the non-standard format.

Adopted §133.500(g) and (h) provide directions on how to obtain copies of the adopted standards. Adopted §133.500(i) provides directions on how to review the adopted standards at the Division's office. These provisions are included in the rule consistent with the requirements contained in 1 Texas Administrative Code §91.40 (relating to How to File Adoption by Reference (ABR) Material).

Adopted §133.500(j) establishes that this section is effective August 1, 2011.

Adopted amendments of §133.501:

Adopted §133.501(a)(1) clarifies that the section applies to the exchange of electronic medical bill data under §133.500 for professional, institutional/hospital, pharmacy and dental services, including transactions for medical services rendered to certified workers' compensation health care networks as defined in Insurance Code Chapter 1305 or rendered to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

Adopted §133.501(a)(2) clarifies that insurance carriers are required to accept electronic medical bills submitted by health care providers under §133.500, unless the insurance carrier is exempt under adopted subsection (b) of this section.

Adopted §133.501(a)(3) clarifies that the health care provider is required to submit its electronic medical bills to the insurance carrier under §133.500 unless either the health care provider or the insurance carrier is exempt under adopted subsection (b) of this section.

Adopted §133.501(b)(1) provides the exemptions available to health care providers for the submission of electronic medical bills to the insurance carriers. Labor Code §413.011 requires the Commissioner to adopt rules that align with the coding and billing policies used by the CMS. The Administrative Simplification Compliance Act (ASCA, Section 3 of Pub. L. 107-105, 42 CFR 424.32) requires that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003. These provisions provide an exemption for "(a) physician, practitioner, facility, or supplier with fewer than 10 full-time equivalent employees." Based on these statutory and regulatory provisions, the subsection adopts this same threshold for workers' compensation electronic medical bill submission. The adopted subsection also adds a new exemption related to the number of injured employees receiving services by the health care provider. In June 2010, the Workers' Compensation Research and Evaluation Group, Texas Department of Insurance published a research report entitled *Access to Medical Care in the Texas Workers' Compensation System, 1998 - 2008.* This report found, in pertinent part, that the top 20% of physicians were responsible for more than 80% of the market's key activities and treated between 32 and 41 patients per year. Accordingly, physicians who treat less than this number of patients are individually responsible for a relatively small percentage of the medical bills submitted each year. This additional metric provides an objective basis for health care providers that do not provide services to many injured employees, but do not meet the other exemption requirements. This exemption is designed to mitigate some of the connectivity challenges that exist for certain micro-businesses that have more than ten employees, but whose existing

processes, practice management systems, and clearinghouses have limited connectivity to workers' compensation payers.

Adopted §133.501(b)(2) provides that health care providers that claim an exemption to electronic medical bill submission must provide supporting documentation to the Division within 15 days of a request for that information. This subsection enables the Division to take prompt action in the event a complaint is received and enables prompt resolution of the issue.

Adopted §133.501(b)(3) provides the exemptions available to insurance carriers for the reception of electronic medical bills submitted by the health care providers. The adopted subsection includes several new exemptions based on the reasons given by insurance carriers requesting exemptions over the last couple of years. These exemptions are based on objective criteria that can be easily determined by the requesting insurance carrier and will assist in streamlining the review process.

Adopted §133.501(b)(4) requires insurance carriers to notify the Division prior to the beginning of each calendar year if the insurance carrier will assert an exemption from the requirement to accept electronic medical records and details the information required in the notice. In practice, the Division has granted insurance carrier exemptions on an annual basis. However, the requirement to request the exemption on an annual basis is not contained in the existing rule. The addition of this requirement, along with basic contact information, will help ensure that insurance carriers understand the annual notification requirement and provide the Division with the information necessary to ask clarifying questions, if needed.

Adopted §133.501(c) provides that health care providers and insurance carriers may contract with other entities to handle the electronic medical billing process but that the health care providers and insurance carriers are responsible for any acts or omissions of their agents in

performing those duties. This subsection contains similar information as existing §133.501(a)(4), but has been moved due to formatting changes.

Adopted §133.501(d)(1) defines an electronic medical bill as a medical bill submitted electronically by a health care provider or its agent. The definition of a "complete" electronic medical bill has been deleted to avoid any potential conflicts with other definitions contained in this title. The term "complete medical bill" is defined in §133.2 of this title (relating to Definitions) and applies to both electronic and paper medical bills.

Adopted §133.501(d)(2) provides that an insurance carrier must take final action on a complete electronic medical bill within 45 days after the date the complete electronic medical bill is received by the insurance carrier. The nature of electronic medical billing introduces complexities due to the number of health care information clearinghouses that may be involved in transmitting or exchanging electronic medical bills. This provision applies strictly to medical bill processing by the insurance carrier and ensures that the insurance carrier is afforded the time frame required by Labor Code §408.027(b), excluding potential delays between transmission intermediaries.

Adopted §133.501(e)(1) provides that an insurance carrier must acknowledge receipt of an electronic medical bill within two working days of receipt and that the timeframe for returning an incomplete medical bill set out in §133.200 of this title does not apply to electronic medical bills. Subparagraph (A) provides that when an electronic medical bill does not meet the definition of a complete medical bill or does not meet the edits defined in the applicable standards, the notice of rejection will be transmitted in an acknowledgement. Subparagraph (B) provides that a health care provider may not resubmit a duplicate electronic medical bill within 45 days from the date the insurance carrier acknowledges receipt of the original complete medical bill but may submit a corrected electronic medical bill after receiving notification of rejection. The corrected bill will be submitted as a new, original bill. The information contained in the existing rule regarding detailed

and functional acknowledgments has been removed because the information can be conveyed and contained in four different acknowledgment processes: interchange, functional, implementation, or application level. The adopted standards explain the use and purpose of each of the transaction sets and additional specificity is not needed in the context of these rules. The processing timeframe has been expanded from one to two days based on stakeholder feedback, the complexities of connectivity, and other issues associated with electronic medical billing.

Adopted §133.501(e)(2) provides that acknowledgement is not an admission of liability by an insurance carrier and the insurance carrier may subsequently deny the accepted electronic medical bill for lack of coverage or liability issues. The revisions to this section are required due to the current statutory language and the industry use of the Application Advice (004010X161) transaction set, which is required by the existing rule and adopted §133.500(b)(1) for transactions conducted before January 1, 2012. Labor Code §408.027(b) specifically requires the insurance carrier to "pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim." This statutory provision does not condition the receipt of a medical bill based on the existence of liability issues. The Application Advice transaction set is designed to respond to an incoming health care claim transaction and is not intended to be used as an unsolicited response. Based on these issues, the previous language regarding rejections has been removed and replaced with language that aligns with both industry practices and the regulatory requirements regarding denying medical bills within the 45 days from receipt.

Adopted §133.501(f) provides that an electronic remittance notification is an explanation of benefits (EOB) concerning payment or denial of a medical bill, a recoupment request, or a receipt of refund. Insurance carriers must provide an electronic remittance notification no later than 45 days after receipt of a complete electronic medical bill or within five days of generating a payment.

Adopted language clarifies that the requirements in subsection (f) do not modify the medical bill processing timeframes in Labor Code §408.027.

Adopted §133.501(g) defines electronic documentation as consisting of medical documentation submitted electronically that is related to an electronic medical bill. The additional language contained in the existing subsection (e) has been removed to avoid conflicts with other regulatory provisions. For example, §133.501(d) already provides for mutually agreed upon formats and alternate mechanisms are allowed without restating those provisions. In addition, the required information necessary to match electronic documentation to an electronic medical bill is clearly explained in the adopted standards and is required to be included without listed a subset of the required information. With the implementation of electronic medical records and electronic file uploads, other mechanisms to ensure the transfer of complete medical documentation are already available and limiting the mechanism or data is not beneficial to efficient processing. Finally, stakeholders have commented that this timeframe creates additional delays and problems associated with electronic medical bill processing. The removal of the seven day period is intended to improve the timeliness of medical bill matching processes.

Adopted §133.501(h) establishes that this section is effective August 1, 2011.

Adopted new §133.502:

Adopted §133.502(a) sets out Texas-specific data elements required for all professional, institutional, and dental electronic medical bills submitted before January 1, 2012, that are in addition to the data requirements adopted under §133.500(a) of this title.

Adopted §133.502(b) requires the injured employee Social Security Number and the health care provider state license numbers required in §133.502(a) to be submitted following the content

and format requirements contained in adopted §133.10 of this title (relating to Required Billing Forms/Formats).

Adopted §133.502(c) sets out Texas-specific data elements required for all professional, institutional, and dental electronic medical bills submitted on or after January 1, 2012, that are in addition to the data requirements adopted under §133.500(c) of this title.

Adopted §133.502(d) sets out Texas-specific data elements required for all pharmacy electronic medical bills that are in addition to the standards adopted under §133.500 of this title. The source documents related to these electronic transaction standards are published and maintained by Data Standard Maintenance Organizations, including the Accredited Standards Committee (ASC X12) and the National Council for Prescription Drug Programs (NCPDP). The historical approach used by the Division required stakeholders to review the ASC X12 or NCPDP standards, compare them with the contents of the rules, and perform another comparison with the Division's instructions. By adopting the national standards and incorporating the data differences within the content of the rule, certain review inefficiencies are reduced and Division instruction errors are eliminated. The Division will review the ASC X12 or NCPDP standards on an ongoing basis and, if revisions to standards or rules are necessary, will initiate the rulemaking process in accordance with the Government Code, to inform stakeholders about any potential changes and provide them a public comment period. This approach improves stakeholder understanding of the current data requirements and improves the stability of the system by ensuring all potential changes are thoroughly reviewed prior to implementation. Lastly, it is noted that two lists of data requirements are contained in this rule due to the two different sets of electronic medical billing transaction versions that are adopted.

Adopted §133.502(e) provides that in reporting resubmission condition codes under this section, the resubmission condition codes have the definitions specified in §133.10(j).

Adopted §133.502(f) provides that this section does not apply to paper medical bills submitted for payment under §133.10(b).

Adopted §133.502(g) establishes that this section is effective August 1, 2011.

SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

General: Commenters support the proposed rule specifications for the billing form requirements, data usage, and data values to be used in connection with medical bills in the Texas workers' compensation system. Commenters indicate the defined requirements will enhance the bill review process and improve the acceptance rate for medical bills.

Agency Response: The Division appreciates the supportive comments and agrees that the additional clarification on medical billing forms, formats and data requirements will improve processing efficiency.

General: A commenter opined that requiring preauthorization for prescription medications is not beneficial to the Texas workers' compensation system.

Agency Response: The Division disagrees and clarifies that the scope of these rules relates to medical bill processing and does not add or reduce any preauthorization requirements contained in other Division rules.

General: A commenter requested clarification regarding the medical documentation that must be submitted with a medical bill.

Agency Response: The Division notes that §133.210, regarding Medical Documentation, is outside the scope of this rule initiative. The Division clarifies that the scope of these rules relates to medical bill processing and does not add or reduce any documentation requirements.

General: Commenters requested clarification regarding the effective date of the proposed rules and the use of the new form DWC-066, Statement of Pharmacy Services. Commenters indicated that the modifications to the form and data content requirements will require some programming time in order to accommodate the new changes.

Agency Response: The Division agrees and has added a new subsection containing an effective date of August 1, 2011 for §§133.10, 133.500, 133.501 and 133.502. The Division notes that this new effective date provides health care providers and insurance carriers six months to accommodate system changes.

§133.10(b): A commenter requested that proposed subsection (b) be modified to require health care providers to bill on the form type as prescribed by Medicare payment policies.

Agency Response: The Division disagrees. The Division notes that certain workers' compensation services are not valued or billable under the Medicare payment policies. In addition, the adopted rules provide the necessary clarification in other subsections. The forms to be used by surgical implant providers is specifically addressed in adopted §133.10(e). The forms to be used by other health care providers is dictated by the type of services rendered: subsection (f)(1) addresses the form requirement for a professional or non-institutional medical bill, subsection (f)(2) addresses the form requirement for an institutional medical bill, subsection (f)(4) addresses the form requirement for a pharmacy medical bill, and subsection (k) addresses the form requirement for a dental medical bill. In addition, the Division notes that requiring the form type to align with Medicare payment policies will introduce conflicts with existing reimbursement provisions. For example, home health services are reimbursed based on the Texas Medicaid Fee Schedule instead of the Medicare prospective payment system methodology. Depending on the situation, it may be appropriate for home health care to be billed on either the CMS-1500 or the

UB-04, as opposed to the Medicare requirement of solely the UB-04. Stakeholders may use the Medicare payment policies as a source to help determine the billing form that is appropriate in most situations, but must use judgment and consider the provisions of §133.10 before making their final decision.

§133.10(e): A commenter supports the specific billing form requirements for surgical implant providers requesting separate reimbursement for implantable devices and opines that this requirement will minimize disputes.

Agency Response: The Division appreciates the supportive comments.

§133.10(f)(1) and (2): A commenter supports the requirements associated with the preauthorization number and three commenters support the instructions on requesting separate reimbursement for implantable devices on professional and institutional medical bills. One commenter opines that providing a specified list of code values to be used in submitting the request may be beneficial to medical bill processing.

Agency Response: The Division appreciates the supportive comments. The Division declines to develop and publish a proprietary list that would be used exclusively for Texas workers' compensation purposes. The Division notes that various Data Standard Maintenance Organizations (DSMOs) maintain the code lists used in the health care industry medical billing process, including the National Uniform Claims Committee, the National Uniform Billing Committee, and the Accredited Standard Committee (ASC X12). These DSMOs have established procedures related to adding and maintaining the various medical billing code lists along with the instructions on how these codes are populated on the various billing forms or formats. The Division notes that the industry can work with the DSMOs independently, or with organizations

such as the International Association of Industrial Accident Boards and Commissions, to secure the requested code values.

§133.10(f)(2): Two commenters requested that the Division require institutional inpatient medical bills to contain the Diagnosis Related Group (DRG) code as a required field. The commenters noted that §134.404 of this title (relating to Hospital Facility Fee Guideline--Inpatient), is based on Medicare reimbursement policies which use the DRG methodology in determining the reimbursement amount.

Agency Response: The Division disagrees. The DRG methodology is limited to acute care inpatient admissions and does not apply to all inpatient hospital bills. In addition, the Division notes that the *Medicare Claims Processing Manual*, Chapter 25, related to Completing and Processing the CMS-1450 Data Set, does not require the DRG code to be populated. The Division also notes that the National Uniform Billing Committee's *Official UB-04 Data Specifications Manual 2011,* dated July 2010, and the ASC X12 Standards for Electronic Data Interchange, Technical Report Type 3, Health Care Claim: Institutional (837), May 2006, ASC X12, 005010X233, requires the DRG to be reported only when a contract exists between the hospital and the payer which requires this field to be populated. The other data requirements contained on the institutional medical bill contain sufficient information for the insurance carriers to use the appropriate software to derive the DRG code and ensure that the reimbursement is in accordance with the established fee guidelines. While hospitals may choose to populate the DRG code on their medical bills, requiring hospitals to populate the DRG code on all institutional inpatient medical bills would not be consistent with the Medicare and national billing standards.

§133.10(f)(2): A commenter requested the Division expand the requirements contained in proposed §133.10(f)(2)(V) to include Health Insurance Prospective Payment System (HIPPS) rate

codes. The commenter notes that Medicare requires certain institutional service medical bills to include the HIPPS rate codes, including inpatient rehabilitation facilities and skilled nursing facilities.

Agency Response: The Division disagrees. The Division notes that none of the current fee guidelines adopted by the Division use prospective payment methodologies which require the use of HIPPS rate codes. The Medicare prospective payment systems that require HIPPS rate codes specify one revenue code in each system to allow the reporting of a CMS maintained HIPPS rate codes. These HIPPS rate codes are structured and designed for these particular reimbursement methodologies. For example, the HIPPS rate codes for skilled nursing facilities include an assessment indicator showing the timing of the assessment and whether it was for Medicare or TRICARE. In addition, the Division notes that the fee guideline for home health services is based on Medicaid reimbursement methodologies as opposed to the HIPPS based Medicare prospective payment system, which may introduce confusion on billing and reimbursement requirements. However, institutional providers may populate this field if they believe that it will assist in the bill review process.

§133.10(f)(3): Two commenters support the requirement associated with the preauthorization number on pharmacy medical bills associated with medications which are not on the closed formulary.

Agency Response: The Division appreciates the supportive comments.

§133.10(f)(3): Two commenters requested that the Division include "Refills Remaining" as a required data element on pharmacy medical bills.

Agency Response: The Division disagrees. While the number of refills remaining may provide certain information to a payer on potential future exposure, it does not impact the reimbursement amount that is due on the billed medication. The Division notes that the National Council for Prescription Drug Programs (NCPDP) Workers' Compensation/Property & Casualty Universal Claim Form and the Telecommunication Standard Implementation Guide, Version D, Release 0, do not support "refills remaining" as data that is included on pharmacy bills. However, these national standards do provide the ability to report the "fill number." In order to improve alignment with the national billing standards, the Division will modify the name of this field on the DWC-066 from "refills remaining" to "fill number." The pharmacy or pharmacy processing agent may populate this field if they believe that it will assist in the bill review process.

§133.10(f)(3): Two commenters requested that the Division include "Drug Name and Strength" as a required data element on pharmacy medical bills.

Agency Response: The Division agrees and has amended the rule to add "drug name and strength". In the Texas workers' compensation system, pharmacies may bill for controlled medication or over-the-counter medication. The Division notes that certain items, such as over-the-counter medication, may not have a National Drug Code (NDC) and will have to be identified using a health related item (HRI) or universal product code (UPC). Requiring the "Drug Name and Strength" allows the insurance carrier to perform further validation on the code (NDC/HRI/UPC) being submitted for reimbursement in field 21 or 22 compared with the description of the actual product that was dispensed, reducing the likelihood of an inaccurate reimbursement amount.

§133.10(f)(4): Two commenters requested that the Division include "Description" as a required data element on dental medical bills.

Agency Response: The Division disagrees. The American Dental Association (ADA) Dental Claim form requires the dentist to include ADA procedure codes. These codes are also included in the Health Care Procedural Coding System (HCPCS) Level 2 codes and are readily available for bill processors. These codes are maintained by the ADA, specify the services that are being billed, and are updated on an annual basis. Given that the reimbursement for dental services are based off the ADA Codes and the consistency of that data set, it does not appear necessary to require the description that is associated with the ADA Code. However, dentists may populate this field if they believe that it will assist in the bill review process.

§133.10(f)(4): A commenter supports the requirement associated with the preauthorization number on dental medical bills.

Agency Response: The Division appreciates the supportive comments.

§133.10(f) and (i): A commenter recommends the requirement to include medical license numbers be removed. The commenter notes that the NPI numbers were created to eliminate the use of other identifying information and license numbers are not required for any other form of medical billing. The commenter notes that requiring the state license number is an administrative burden on physicians and their offices without clear benefit to the Texas workers' compensation system.

Agency Response: The Division disagrees. The Division acknowledges the trend toward a single identifier in health plans subject to the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and the adopted rules follow this framework for electronic medical billing transactions submitted on or after January 1, 2012. However, the Division has retained the state license number requirement for all paper medical bills and pre-2012 electronic medical billing transactions to improve research efforts related to treatment rendered by health care providers.

The Division requires the state license number to be reported by the insurance carrier in data submissions related to medical bill and payment records and has used this identifier extensively in performing system research and monitoring functions. The Division believes it is premature to move to a NPI-centric framework at this point in time. Retaining the state license number on paper medical bills submitted on or after January 1, 2012 assists in the transition to the new identification method and provides an incentive for health care providers to submit medical bills using the adopted electronic transactions.

§133.10(g): Two commenters recommended replacing the social security number default value of '999999999' with a default value of '999' plus the date of injury or date of birth. The commenters noted that the Division accepts these default values in claims electronic data interchange (Claims EDI) reporting from the insurance carrier.

Agency Response: The Division disagrees. The concept of using the same values as the Claims EDI framework was contained in the previous informal working drafts posted by the Division. Health care providers responded that the standard in the health care industry for this type of situation is to use '999999999' instead of some value comprised of other data elements already contained on the medical bill. The use of this default value is simply designed to trigger an insurance carrier investigation into the medical bill and the associated workers' compensation claim. Requiring a combined value will increase the automation requirements on health care providers, without providing any realistic value to the insurance carrier. If the insurance carrier's first notice of injury is the medical bill, the use of '999999999' should be sufficient to trigger the investigation, establish a claim, and take the appropriate action associated with processing the medical bill.

§133.10(i): Two commenters recommended adding "OP for Orthotists/Prosthetists" in the list of license types. The commenters note that all Orthotists and Prosthetists have a unique license number assigned by the Texas Board of Orthotics and Prosthetics.

Agency Response: The Division agrees and has amended the rule to add "OP for Orthotists/Prosthetists" in this subsection.

§133.10(i): Two commenters recommended adding "NP for Nurse Practitioner" in the list of license types.

Agency Response: The Division disagrees. A Nurse Practitioner is a Registered Nurse with advanced education and clinical expertise in a health care specialty. While the Texas Board of Nursing has specific rules regarding the education and experience necessary to be designated an "Advanced Practice Nurse", such as a Nurse Practitioner, the license issued by the Texas Board of Nursing to these individuals is a Registered Nurse license. In the proposed rules, the Division added "RN for Registered Nurse" and this prefix should be used in transmitting the license number of Advanced Practice Nurses.

§133.10(i): A commenter opined that the list of abbreviations of license types are inconsistent with the definitions of health care providers in Insurance Code §1451.001. The commenter recommended additional clarification that the use of a particular license type does not imply eligibility for reimbursement.

Agency Response: The Division agrees that the list of license types in the proposed rules are different than the list of health care providers in that section of the Insurance Code, but the Division disagrees that additional clarification is needed in the adopted rule. The Division notes that the list of health care practitioners listed in Insurance Code §1451.001 is a subset of the health care providers and health care practitioners authorized to provide treatment and receive

reimbursement the in Texas workers' compensation system. The list of license types is intended to reflect those health care providers that typically submit medical bills in the Texas workers' compensation system in order to help identify the health care provider. The Division agrees that having or including a particular license type in a medical bill does not guarantee that the services will be reimbursed. Likewise, the fact that a license type is not included on the list does not preclude reimbursement for medical services. Each medical bill must be reviewed by the insurance carrier considering many different issues, including the compensability of the claim, fee guideline requirements, coding requirements, and other payment policies.

§133.10(j) and (k): Two commenters recommended that the reconsideration condition codes be listed as a required data element on paper medical bills and three commenters requested clarification about the use of reconsideration condition codes on paper medical bills.

Agency Response: The Division disagrees that reconsideration condition codes should be a required data element on paper medical bills. The requirements for requests for reconsideration are contained in §133.250, related to Reconsideration for Payment of Medical Bills and paper submissions that comply with those provisions provide sufficient information to the insurance carrier to identify the package as a request for reconsideration. The resubmission condition codes were adopted by the National Uniform Billing Committee to be effective on and after October 1, 2008. While these codes were adopted for use by the workers' compensation industry, they are currently not heavily used by health care providers other than electronic submitters. The primary purpose these codes were added is to facilitate the identification of duplicate and appeal transactions in the electronic medical billing processes, as opposed to filing a paper appeal on a medical bill that was initially submitted electronically. The resubmission condition codes serve simply as an identification mechanism for the insurance carrier. Adding the definitions into the

rule allow for this identification mechanism to be used and provides efficiency to the initial screening of incoming medical bills performed by insurance carriers and their eBill agents. However, the Division disagrees that they should be required data elements on paper medical bills at this point in time. The Division agrees that clarification is necessary for paper medical billing and amends §133.10(j) to "a resubmission condition code may be reported" to clarify that resubmission condition codes are not required for paper medical bills.

§133.502(a)(11) and (c)(5): Two commenters recommended including the code value and definition of a duplicate submission in both these subsections and listing the reconsideration condition code values in these subsections.

Agency Response: The Division agrees that a clarification is necessary and adds new §133.502(e) to incorporate the definitions specified in §133.10(j).

NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: Pathfinder Consulting

For, with changes: Allen Orthotics & Prosthetics, Healthesystems, MK Prosthetic & Orthotic Services, Property Casualty Insurers Association of America, Texas Mutual Insurance Company, Insurance Council of Texas, and Texas Medical Association.

Against: None

Neither for or Against: One individual.

STATUTORY AUTHORITY.

SUBCHAPTER B – HEALTHCARE PROVIDER BILLING PROCEDURES

The amendments and new section are adopted under the Labor Code §§402.00111, 402.061, 408.0251, and 413.011. Labor Code §408.0251 requires the Commissioner of Workers' Compensation to adopt rules related to electronic billing requirements. Labor Code §413.011 requires the Commissioner of Workers' Compensation to adopt rules that remain aligned, to the extent possible, with Centers for Medicare and Medicaid Services coding and billing policies.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under Labor Code Title 5. Labor Code §402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §504.002 provides that the above referenced sections of the Texas Workers' Compensation Act, and Commissioner rules adopted under those chapters, are applicable to political subdivisions and health care providers contracted with political subdivisions under §504.053(b)(2).

Insurance Code §1305.153(d) provides that the billing requirements of the Texas Workers' Compensation Act and Commissioner rules are applicable to network and out-of-network health care providers.

SUBCHAPTER G – ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

The amendments and new section are adopted under the Labor Code §§402.00111, 402.061, 408.0251, and 413.011. Labor Code §408.0251 requires the Commissioner of Workers' Compensation to adopt rules related to electronic billing requirements. Labor Code §413.011 requires the Commissioner of Workers' Compensation to adopt rules that remain aligned, to the extent possible, with Centers for Medicare and Medicaid Services coding and billing policies.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code. Labor Code §402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §504.002 provides that the above referenced sections of the Texas Workers' Compensation Act, and Commissioner rules adopted under those chapters, are applicable to political subdivisions and health care providers contracted with political subdivisions under §504.053(b)(2).

Insurance Code §1305.153(d) provides that the billing requirements of the Texas Workers' Compensation Act and Commissioner rules are applicable to network and out-of-network health care providers.

7. TEXT.

SUBCHAPTER B – HEALTHCARE PROVIDER BILLING PROCEDURES

§133.10. Required Billing Forms/Formats.

(a) Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.

(b) Except as provided in subsection (a) of this section, health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance

Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit paper medical bills for payment on:

(1) the 1500 Health Insurance Claim Form Version 08/05 (CMS-1500);

(2) the Uniform Bill 04 (UB-04); or

(3) applicable forms prescribed for pharmacists, dentists, and surgical implant providers specified in subsections (c), (d) and (e) of this section.

(c) Pharmacists and pharmacy processing agents shall submit bills using the Division form DWC-066. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:

(1) the insurance carrier has approved the alternate billing form prior to submission by the pharmacist or pharmacy processing agent; and

(2) the alternate billing form provides all information required on the Division form DWC-066.

(d) Dentists shall submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.

(e) Surgical implant providers requesting separate reimbursement for implantable devices shall submit bills using:

(1) the form prescribed in subsection (b)(1) of this section when the implantable device reimbursement is sought under §134.402 of this title (relating to Ambulatory Surgical Center Fee Guideline); or

(2) the form prescribed in subsection (b)(2) of this section when the implantable device reimbursement is sought under §134.403 or §134.404 of this title (relating to Hospital Facility Fee Guideline--Outpatient and Hospital Facility Fee Guideline--Inpatient).

(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care:

(A) patient's Social Security Number (CMS-1500/field 1a) is required;

(B) patient's name (CMS-1500/field 2) is required;

(C) patient's date of birth and gender (CMS-1500/field 3) is required;

(D) employer's name (CMS-1500/field 4) is required;

(E) patient's address (CMS-1500/field 5) is required;

(F) patient's relationship to subscriber (CMS-1500, field 6) is required;

(G) employer's address (CMS-1500, field 7) is required;

(H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known, the billing provider shall enter 'UNKNOWN' if the workers' compensation claim number is not known by the billing provider;

(I) date of injury (CMS-1500, field 14) is required;

(J) name of referring provider or other source (CMS-1500, field 17) is required when another health care provider referred the patient for the services;

(K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number;

(M) diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code must be present;

(N) prior authorization number (CMS-1500/field 23) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the requesting health care provider;

(O) date(s) of service (CMS-1500, field 24A) is required;

(P) place of service code(s) (CMS-1500, field 24B) is required;

(Q) procedure/modifier code (CMS-1500, field 24D) is required;

(R) diagnosis pointer (CMS-1500, field 24E) is required;

(S) charges for each listed service (CMS-1500, field 24F) is required;

(T) number of days or units (CMS-1500, field 24G) is required;

(U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number;

(W) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line;

(X) billing provider's federal tax ID number (CMS-1500/field 25) is required;

(Y) total charge (CMS-1500/field 28) is required;

(Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier;

(AA) service facility location information (CMS-1500/field 32) is required;

(BB) service facility NPI number (CMS-1500/field 32a) is required when the facility is eligible for an NPI number;

(CC) billing provider name, address and telephone number (CMS-1500/field 33) is required;

(DD) billing provider's NPI number (CMS-1500/Field 33a) is required when the billing provider is eligible for an NPI number; and

(EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX').

(2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:

(A) billing provider's name, address, and telephone number (UB-04/field 01) is required;

(B) patient control number (UB-04/field 03a) is required;

(C) type of bill (UB-04/field 04) is required;

(D) billing provider's federal tax ID number (UB-04/field 05) is required;

(E) statement covers period (UB-04/field 06) is required;

(F) patient's name (UB-04/field 08) is required;

(G) patient's address (UB-04/field 09) is required;

(H) patient's date of birth (UB-04/field 10) is required;

(I) patient's gender (UB-04/field 11) is required;

(J) date of admission (UB-04/field 12) is required when billing for inpatient services;

(K) admission hour (UB-04/field 13) is required when billing for inpatient services other than skilled nursing inpatient services;

(L) priority (type) of admission or visit (UB-04/field 14) is required;

(M) point of origin for admission or visit (UB-04/field 15) is required;

(N) discharge hour (UB-04/field 16) is required when billing for inpatient services with a frequency code of "1" or "4" other than skilled nursing inpatient services;

(O) patient discharge status (UB-04/field 17) is required;

(P) condition codes (UB-04/fields 18 - 28) are required when there is a condition code that applies to the medical bill;

(Q) occurrence codes and dates (UB-04/fields 31 - 34) are required when there is an occurrence code that applies to the medical bill;

(R) occurrence span codes and dates (UB-04/fields 35 and 36) are required when there is an occurrence span code that applies to the medical bill;

(S) value codes and amounts (UB-04/fields 39 - 41) are required when there is a value code that applies to the medical bill;

(T) revenue codes (UB-04/field 42) are required;

(U) revenue description (UB-04/field 43) is required;

(V) HCPCS/Rates (UB-04/field 44):

(i) HCPCS codes are required when billing for outpatient services and an appropriate HCPCS code exists for the service line item; and

(ii) accommodation rates are required when a room and board revenue code is reported;

(W) service date (UB-04/field 45) is required when billing for outpatient services;

(X) service units (UB-04/field 46) is required;

(Y) total charge (UB-04/field 47) is required;

(Z) date bill submitted, page numbers, and total charges (UB-04/field 45/line 23) is required;

(AA) insurance carrier name (UB-04/field 50) is required;

(BB) billing provider NPI number (UB-04/field 56) is required when the billing provider is eligible to receive an NPI number;

(CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider shall enter the license number and jurisdiction code (for example, '123TX');

(DD) employer's name (UB-04/field 58) is required;

(EE) patient's relationship to subscriber (UB-04/field 59) is required;

(FF) patient's Social Security Number (UB-04/field 60) is required;

(GG) workers' compensation claim number assigned by the insurance carrier (UB-04/field 62) is required when known, the billing provider shall enter 'UNKNOWN' if the workers' compensation claim number is not known by the billing provider;

(HH) preauthorization number (UB-04/field 63) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider;

(II) principal diagnosis code and present on admission indicator (UB-04/field 67) are required;

(JJ) other diagnosis codes (UB-04/field 67A- 67Q) are required when there conditions exist or subsequently develop during the patient's treatment;

(KK) admitting diagnosis code (UB-04/field 69) is required when the medical bill involves an inpatient admission;

(LL) patient's reason for visit (UB-04/field 70) is required when submitting an outpatient medical bill for an unscheduled outpatient visit;

(MM) principal procedure code and date (UB-04/field 74) is required when submitting an inpatient medical bill and a procedure was performed;

(NN) other procedure codes and dates (UB-04/fields 74A- 74E) are required when submitting an inpatient medical bill and other procedures were performed;

(OO) attending provider's name and identifiers (UB-04/field 76) are required for any services other than nonscheduled transportation services, the billing provider shall report the NPI number for an attending provider eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(PP) operating physician's name and identifiers (UB-04/field 77) are required when a surgical procedure code is included on the medical bill, the billing provider shall report the NPI number for an operating physician eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

(QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

(3) The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care:

(A) dispensing pharmacy's name and address (DWC-066/field 1) is required;

(B) date of billing (DWC-066/field 2) is required;

(C) dispensing pharmacy's National Provider Identification (NPI) number (DWC-066/field 3) is required;

(D) billing pharmacy's or pharmacy processing agent's name and address (DWC-066/field 4) is required when different from the dispensing pharmacy (DWC-066/field 1);

(E) invoice number (DWC-066/field 5) is required;

(F) payee's federal employer identification number (DWC-066/field 6) is required;

(G) insurance carrier's name (DWC-066/field 7) is required;

(H) employer's name and address (DWC-066/field 8) is required;

(I) injured employee's name and address (DWC-066/field 9) is required;

(J) injured employee's Social Security Number (DWC-066/field 10) is required;

(K) date of injury (DWC-066/field 11) is required;

(L) injured employee's date of birth (DWC-066/field 12) is required;

(M) prescribing doctor's name and address (DWC-066/field 13) is required;

(N) prescribing doctor's NPI number (DWC-066/field 14) is required;

(O) workers' compensation claim number assigned by the insurance carrier (DWC-066/field 15) is required when known, the billing provider shall enter 'UNKNOWN' if the workers' compensation claim number is not known by the billing provider;

(P) dispensed as written code (DWC-066/field 19) is required;

(Q) date filled (DWC-066/field 20) is required;

(R) generic National Drug Code (NDC) code (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19;

(S) name brand NDC code (DWC-066/field 22) is required when a name brand drug is dispensed;

(T) quantity (DWC-066/field 23) is required;

(U) days supply (DWC-066/field 24) is required;

(V) amount paid by the injured employee (DWC-066/field 26) is required if applicable;

(W) drug name and strength (DWC-066/field 27) is required;

(X) prescription number (DWC-066/field 28) is required;

(Y) amount billed (DWC-066/field 29) is required; and

(Z) preauthorization number (DWC-066/field 30) is required when preauthorization, voluntary certification, or an agreement was approved and the insurance carrier provided an approval number to the requesting health care provider.

(4) The following data content or data elements are required for a complete dental medical bill related to Texas workers' compensation health care:

(A) type of transaction (ADA 2006 Dental Claim Form/field 1);

(B) preauthorization number (ADA 2006 Dental Claim Form/field 2) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider;

(C) insurance carrier name and address (ADA 2006 Dental Claim Form/field 3) is required;

(D) employer's name and address (ADA 2006 Dental Claim Form/field 12) is required;

(E) workers' compensation claim number assigned by the insurance carrier (ADA 2006 Dental Claim Form/field 15) is required when known, the billing provider shall enter 'UNKNOWN' if the workers' compensation claim number is not known by the billing provider;

(F) patient's name and address (ADA 2006 Dental Claim Form/field 20) is required;

(G) patient's date of birth (ADA 2006 Dental Claim Form/field 21) is required;

(H) patient's gender (ADA 2006 Dental Claim Form/field 22) is required;

(I) patient's Social Security Number (ADA 2006 Dental Claim Form/field 23) is required;

(J) procedure date (ADA 2006 Dental Claim Form/field 24) is required;

(K) tooth number(s) or letter(s) (ADA 2006 Dental Claim Form/field 27) is required;

(L) procedure code (ADA 2006 Dental Claim Form/field 29) is required;

(M) fee (ADA 2006 Dental Claim Form/field 31) is required;

(N) total fee (ADA 2006 Dental Claim Form/field 33) is required;

(O) place of treatment (ADA 2006 Dental Claim Form/field 38) is required;

(P) treatment resulting from (ADA 2006 Dental Claim Form/field 45) is required, the provider shall check the box for occupational illness/injury;

(Q) date of injury (ADA 2006 Dental Claim Form/field 46) is required;

(R) billing provider's name and address (ADA 2006 Dental Claim Form/field 48) is required;

(S) billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) is required if the billing provider is eligible for an NPI number;

(T) billing provider's state license number (ADA 2006 Dental Claim Form/field 50) is required when the billing provider is a licensed health care provider; the billing provider shall enter the license type, license number, and jurisdiction code (for example, 'DS1234TX');

(U) billing provider's federal tax ID number (ADA 2006 Dental Claim Form/field 51) is required;

(V) rendering dentist's NPI number (ADA 2006 Dental Claim Form/field 54) is required when different than the billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) and the rendering dentist is eligible for an NPI number;

(W) rendering dentist's state license number (ADA 2006 Dental Claim Form/field 55) is required when different than the billing provider's state license number (ADA 2006 Dental Claim Form/field 50), the billing provider shall enter the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

(X) rendering provider's and treatment location address (ADA 2006 Dental Claim Form/field 56) is required when different from the billing provider's address (ADA Dental Claim Form/field 48).

(g) If the injured employee does not have a Social Security Number as required in subsection (f) of this section, the health care provider must use a default value of '999999999'.

(h) Except for facility state license numbers, state license numbers submitted under subsection (f) of this section must be in the following format: license type, license number, and jurisdiction state code (for example 'MDF1234TX').

(i) In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services

they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:

(1) AC for Acupuncturist;

(2) AM for Ambulance Services;

(3) AS for Ambulatory Surgery Center;

(4) AU for Audiologist;

(5) CN for Clinical Nurse Specialist;

(6) CP for Clinical Psychologist;

(7) CR for Certified Registered Nurse Anesthetist;

(8) CS for Clinical Social Worker;

(9) DC for Doctor of Chiropractic;

(10) DM for Durable Medical Equipment Supplier;

(11) DO for Doctor of Osteopathy;

(12) DP for Doctor of Podiatric Medicine;

(13) DS for Dentist;

(14) IL for Independent Laboratory;

(15) LP for Licensed Professional Counselor;

(16) LS for Licensed Surgical Assistant;

(17) MD for Doctor of Medicine;

(18) MS for Licensed Master Social Worker;

(19) MT for Massage Therapist;

(20) NF for Nurse First Assistant;

(21) OD for Doctor of Optometry;

(22) OP for Orthotist/Prosthetist;

(23) OT for Occupational Therapist;

(24) PA for Physician Assistant;

(25) PM for Pain Management Clinic;

(26) PS for Psychologist;

(27) PT for Physical Therapist;

(28) RA for Radiology Facility; or

(29) RN for Registered Nurse.

(j) When resubmitting a medical bill under subsection (f) of this section, a resubmission condition code may be reported. In reporting a resubmission condition code, the following definitions apply to the resubmission condition codes established by the Uniform National Billing Committee:

(1) W3 - Level 1 Appeal means a request for reconsideration under §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) or an appeal of an adverse determination under Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage);

(2) W4 - Level 2 Appeal means a request for reimbursement as a result of a decision issued by the division, an Independent Review Organization, or a Network complaint process; and

(3) W5 - Level 3 Appeal means a request for reimbursement as a result of a decision issued by an administrative law judge or judicial review.

(k) The inclusion of the appropriate resubmission condition code and the original reference number is sufficient to identify a resubmitted medical bill as a request for reconsideration under §133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title provided the resubmitted medical bill complies with the other requirements contained in the appropriate section.

(l) This section is effective August 1, 2011.

SUBCHAPTER G. ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

§133.500. Electronic Formats for Electronic Medical Bill Processing.

(a) For electronic transactions conducted before January 1, 2012, the division adopts by reference the following electronic medical bill processing standards as adopted by the United States Department of Health and Human Services in 45 CFR §162.1102(b) and §162.1602(b):

(1) Professional Billing--the ASC X12N 837, Health Care Claim: Professional, Volumes 1 and 2, Version 004010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.

(2) Institutional/Hospital Billing--the ASC X12N 837, Health Care Claim: Institutional, Volumes 1 and 2, Version 004010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1.

(3) Dental Billing--the ASC X12N 837, Health Care Claim: Dental, Version 004010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

(4) Retail Pharmacy Billing--the Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1

(Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(5) Remittance--the ASC X12N 835, Health Care Claim Payment/Advice, Version 004010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.

(b) For electronic transactions conducted before January 1, 2012, the division adopts by reference the following electronic medical bill processing standards:

(1) Acknowledgment:

(A) Electronic responses to ASC X12N 837 transactions:

(i) the TA1 Interchange Acknowledgment contained in the standards adopted under subsection (a) of this section;

(ii) the 997 Functional Acknowledgment contained in the standards adopted under subsection (a) of this section; and

(iii) the ASC X12N 824--Application Advice, Version 004010, February 2006, Washington Publishing Company, 004010X161.

(B) Electronic responses to National Council for Prescription Drug Programs (NCPDP) transactions, the Response contained in the standards adopted under subsection (a) of this section.

(2) Documentation submitted with an electronic medical bill: ASC X12N 275--Additional Information to Support a Health Claim or Encounter, Version 004050, May 2004, Washington Publishing Company, 004050X151.

(c) For electronic transactions conducted on or after January 1, 2012, the division adopts by reference the following electronic medical bill processing standards as adopted by the United States Department of Health and Human Services in 45 CFR §162.1102(c) and §162.1602(c):

(1) Professional Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222 and Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

(2) Institutional/Hospital Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837), May 2006, ASC X12, 005010X223, Type 1 Errata to Health Care Claim: Institutional (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12, 005010X223A1, and Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

(3) Dental Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Dental (837), May 2006, ASC X12, 005010X224, Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12, 005010X224A1, and Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

(4) Retail Pharmacy Billing--the Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, National Council for Prescription Drug Programs.

(5) Remittance--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835), April 2006, ASC X12, 005010X221, and Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

(d) For electronic transactions conducted on or after January 1, 2012, the division adopts by reference the following electronic medical bill processing standards:

(1) Acknowledgment:

(A) Electronic responses to ASC X12N 837 transactions:

(i) the ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subsection (c) of this section;

(ii) the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Implementation Acknowledgment for Health Care Insurance (999), June 2007, ASC X12, 005010X231; and

(iii) the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12, 005010X214.

(B) Electronic responses to NCPDP transactions, the Response contained in the standards adopted under subsection (c) of this section.

(2) Documentation submitted with an electronic medical bill: ASC X12N 275 - Additional Information to Support a Health Claim or Encounter, Version 005010, February 2008, Washington Publishing Company, 005010X210.

(e) Electronic medical billing transactions must:

(1) contain all fields required in the applicable standard as set forth in subsection (a) or (c) of this section and the data requirements contained in §133.502 of this title (relating to Electronic Medical Billing Supplemental Data Requirements); and

(2) be populated with current and valid values defined in the applicable standard as set forth in subsection (a) or (c) of this section, Chapter 134 of this title (relating to Benefits--Guidelines

for Medical Services, Charges, and Payments), and the data requirements contained in §133.502 of this title.

(f) Insurance carriers and health care providers may exchange electronic data in a non-prescribed format by mutual agreement. All data elements required in the division prescribed formats must be present in a mutually agreed upon format.

(g) The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; Telephone (703) 970-4480; and FAX (703) 970-4488. They are also available through the internet at *http://www.X12.org.* A fee is charged for all implementation specifications.

(h) The implementation specifications for the retail pharmacy standards may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260. Telephone (480) 477-1000; FAX (480) 767-1042. They are also available through the Internet at *http://www.ncpdp.org.* A fee is charged for all implementation specifications.

(i) The electronic medical bill processing standards adopted in this section are available for inspection at the main office of the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, TX 78744 or any subsequent address of the division's main office.

(j) This section is effective August 1, 2011.

§133.501. Electronic Medical Bill Processing.

(a) Applicability.

(1) This section applies to the exchange of electronic medical bill data in accordance with §133.500 of this title (relating to Electronic Formats for Electronic Medical Bill Processing) for

professional, institutional/hospital, pharmacy, and dental services. This section applies to all electronic medical bill processing, including transactions for medical services rendered under the provisions of Insurance Code Chapter 1305 or rendered to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

(2) Insurance carriers shall accept electronic medical bills from health care providers transmitted in accordance with §133.500 of this title unless the insurance carrier is exempt from the process in accordance with subsection (b) of this section.

(3) Health care providers shall submit electronic medical bills to insurance carriers in accordance with §133.500 of this title unless the health care provider or the billed insurance carrier is exempt from the process in accordance with subsection (b) of this section.

(b) Exemptions.

(1) A health care provider is exempt from the requirement to submit medical bills electronically to an insurance carrier if:

(A) the health care provider employs fewer than 10 full time employees;

(B) the health care provider provided services to 32 or fewer injured employees during the preceding calendar year; or

(C) the health care provider can sufficiently demonstrate electronic medical bill implementation will create an unreasonable financial hardship and can provide supporting documentation such as financial statements and other documentation which reflect the cost of implementation.

(2) A health care provider who asserts an exemption under this section must provide all supporting documentation to the division within 15 days of a division request for documentation.

(3) An insurance carrier is exempt from the requirement to receive medical bills electronically from health care providers if:

(A) the insurance carrier is placed in receivership;

(B) the insurance carrier was issued an initial license to write workers' compensation insurance by the Texas Department of Insurance during the current or preceding calendar year;

(C) the insurance carrier had less than 32 workers' compensation claims for which income or medical benefits were paid during the preceding calendar year;

(D) the insurance carrier no longer writes workers' compensation insurance in Texas and is only handling runoff claims;

(E) the insurance carrier was a certified self-insured employer under Labor Code, Chapter 407, or a self-insured group under Labor Code, Chapter 407A, which has withdrawn from the certified self-insurance program or group self-insurance; or

(F) the insurance carrier submits a request to the division with supporting documentation such as financial statements and other documents which reflect cost of implementation and sufficiently demonstrates that electronic medical bill implementation will create an unreasonable financial hardship and the Commissioner approves the request.

(4) An insurance carrier who asserts an exemption under this subsection must provide all supporting documentation to the division within 15 days of a division request for documentation.

(5) Insurance carriers shall submit notification to the division prior to the beginning of each calendar year for which they will assert an exemption to the electronic medical bill processing requirements. The required notification must include:

(A) federal tax identification number of the insurance carrier;

(B) contact information, including but not limited to the name, physical address, and telephone number; and

(C) a description regarding facts related to the exemption under paragraph (3) of this subsection asserted by the insurance carrier.

(c) Agents. Health care providers and insurance carriers may contract with other entities for electronic medical bill processing. Insurance carriers and health care providers are responsible for the acts or omissions of their agents executed in the performance of services for the insurance carrier or health care provider.

(d) Electronic medical bill.

(1) An electronic medical bill is a medical bill submitted electronically by a health care provider or its agent.

(2) An insurance carrier shall take final action not later than the 45th day after the date the insurance carrier received a complete electronic medical bill.

(e) Acknowledgment.

(1) An insurance carrier must acknowledge receipt of an electronic medical bill by returning an acknowledgment within two working days of receipt of the electronic submission. The time frame for returning an incomplete medical bill contained in §133.200 of this title (relating to Insurance Carrier Receipt of Medical Bills from Health Care Providers) does not apply to an electronic medical bill.

(A) Notification of a rejection is transmitted in an acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable standard.

(B) A health care provider may not submit a duplicate electronic medical bill earlier than 45 days from the date submitted if an insurance carrier acknowledged receipt of the original complete electronic medical bill. A health care provider may submit a corrected medical bill

electronically to the insurance carrier after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

(2) Acknowledgment of a medical bill is not an admission of liability by the insurance carrier. The insurance carrier may subsequently deny a medical bill for liability or other issues within the 45-day medical bill processing timeframe contained in Labor Code §408.027.

(f) Electronic remittance notification.

(1) An electronic remittance notification is an explanation of benefits (EOB), submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

(2) An insurance carrier must provide an electronic remittance notification no later than 45 days after receipt of a complete electronic medical bill or within 5 days of generating a payment. This requirement applies only to the date the electronic remittance is sent and does not modify the medical bill processing timeframes contained in Labor Code §408.027.

(g) Electronic documentation. Electronic documentation consists of medical documentation submitted electronically that is related to an electronic medical bill.

(h) This section is effective August 1, 2011.

§133.502. Electronic Medical Billing Supplemental Data Requirements.

(a) In addition to the data requirements and standards adopted under §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional/hospital, and dental electronic medical bills submitted before January 1, 2012 must contain:

(1) the telephone number of the submitter;

(2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN";

(3) the injured employee's Social Security Number as the subscriber member identification number;

(4) the injured employee's date of injury;

(5) the rendering health care provider's state provider license number;

(6) the referring health care provider's state provider license number;

(7) the billing provider's state provider license number, if the billing provider has a state provider license number;

(8) the attending physician's state medical license number, when applicable;

(9) the operating physician's state medical license number, when applicable;

(10) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and

(11) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.

(b) In reporting the injured employee Social Security Number and the state license numbers under subsection (a) of this section, health care providers must follow the data content and format requirements contained in §133.10 of this title (relating to Required Billing Forms/Formats).

(c) In addition to the data requirements contained in the standards adopted under §133.500(c) of this title, all professional, institutional/hospital, and dental electronic medical bills submitted on or after January 1, 2012 must contain:

(1) the telephone number of the submitter;

(2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN";

(3) the injured employee's date of injury;

(4) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and

(5) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.

(d) In addition to the data requirements contained in the standards adopted under §133.500 of this title, all pharmacy electronic medical bills must contain:

(1) the dispensing pharmacy's National Provider Identification number; and

(2) the prescribing doctor's National Provider Identification number.

(e) In reporting the resubmission condition code under this section, the resubmission condition codes shall have the definitions specified in §133.10(j) of this title.

(f) This section does not apply to paper medical bills submitted for payment under §133.10(b) of this title.

(g) This section is effective August 1, 2011.

8. CERTIFICATION. This agency hereby certifies that the adopted amendments to §§133.10, 133.500, and 133.501 and the adopted addition of §133.502 have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas on February 3, 2011.

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Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to §§133.10, 133.500, and 133.501 concerning billing forms and formats, electronic formats for electronic medical bill processing, and processing of electronic medical bills, and the addition of §133.502 concerning supplemental data requirements for electronic medical bills, specified herein, are adopted.

AND IT IS SO ORDERED

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ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

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Dirk Johnson
General Counsel

COMMISSIONER'S ORDER NO.