DWC-06-0025

SUBCHAPTER A. Medical Reimbursement Policies
§134.1

SUBCHAPTER B. Miscellaneous Reimbursement
§§134.100, 134.110, 134.120, and 134.130

SUBCHAPTER I. Medical Bill Reporting
§134.802

The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts new §§134.1, 134.100, 134.110, 134.120, and 134.130, and amendments to §134.802, concerning medical billing reimbursements and reporting. The adopted rules will replace the emergency rules adopted by the Commissioner of the Division of Workers' Compensation on November 3, 2006, published in the November 18, 2005 issue of the *Texas Register* (30 TexReg 7621), with an extension, as published in the March 10, 2006 issue of the *Texas Register* (31 TexReg 1539). The new sections and the amended section are adopted with changes to the proposed text as published in the February 10, 2006 issue of the *Texas Register* (31 TexReg 808).

These adopted sections are necessary to implement, on a permanent basis portions of House Bill (HB) 7, enacted during the 79th Texas Legislature, Regular Session, effective September 1, 2005. The adopted sections are consistent with

statutory changes to the Labor Code §408.027, and also provide medical reimbursement direction for participants in a workers' compensation health care network established under Insurance Code Chapter 1305. These adopted sections do not apply to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

The adopted sections are designed to minimize micro-management of the system, utilize existing Medicare reimbursement structures, and incorporate concepts from Texas Department of Insurance (TDI) managed care rules for consistency and standardization. The adopted rules also accommodate eBill initiatives by identifying forms and processes compatible with both paper and electronic processes. Additionally, extensive reorganization of Chapter 134, in conjunction with revision of Chapter 133 as published elsewhere in this edition of the *Texas Register*, is provided for in these adopted sections to eliminate redundancies in existing rules and clarify billing and reimbursement procedures. This initiative includes the adopted repeal of several current billing, processing and reimbursement rules in Chapters 133 and 134, as published elsewhere in this edition of the *Texas Register*. The adopted rules consolidate reimbursement methodologies and miscellaneous reimbursement amounts previously located in both Chapters 133 and 134 to Chapter 134.

This adoption also organizes the rules regarding medical billing, processing, and reimbursement to clarify and streamline the process. This will enable system participants to easily access specific portions of the medical billing rules, which are now organized in the logical order of the billing and reimbursement process.

The adopted rules also minimize micro-management of this process by reducing specific, detailed instructions. This will allow system participants more flexibility in developing their medical billing and bill review processes. In addition, by eliminating many of the duplicative Division instructions and relying on the statutorily required Medicare reimbursement structures, and incorporating concepts from TDI managed care rules, the adopted rules provide consistency and standardization with other health care delivery systems.

The adopted sections clarify medical reimbursement and other miscellaneous reimbursement. The adopted sections also address insurance carrier medical bill reporting to the Division.

Minimal changes have been made to the proposed sections as published. However, none of the changes introduce new subject matter or affect additional persons other than those subject to the proposal as originally published.

Throughout the sections the Division makes editorial and grammatical changes for ease of reading and clarity as a result of public comment.

Adopted §134.1 clarifies that the Division medical fee guidelines do not apply to medical services provided through a workers' compensation health care network established under Insurance Code Chapter 1305, except for examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 which shall be reimbursed in accordance with §134.202. The adopted section also clarifies reimbursement for health care not provided through a workers' compensation health care network by specifically adding a reference to negotiated contracts and establishes the framework for fair and reasonable reimbursement.

Adopted §134.100 (which was previously addressed in repealed §134.5) establishes the reimbursement criteria for the treating doctor's attendance at a required medical examination. Adopted §134.110 (which was previously addressed in repealed §134.6) establishes criteria to determine reimbursement of the injured employee for travel expenses. Subsection (a)(1), establishes that an injured employee may be reimbursed for travel when the medical treatment for the compensable injury is not reasonably available and the injured employee travels more than 30 miles one way. Language has been changed to indicate

that the distance calculation shall be determined "from where the injured employee lives" rather than from "the injured employee's residence." This provides consistency between these rules and the workers' compensation health care network rules.

Adopted §134.120 (which was previously addressed in repealed §133.106) establishes reimbursement for medical documentation. Adopted §134.130 (which was previously addressed in repealed §134.803) establishes interest for late payment on medical bills and refunds.

The adopted amendments to §134.802 make the language for insurance carrier medical bill reporting to the Division consistent with HB 7.

§134.1. Comment: A commenter recommends a language change to specifically note in the rule that Chapter 134 does not apply to political subdivisions with contractual relationships under §504.053(b)(2) of the Labor Code.

Agency Response: The Division declines to make this change as Labor Code §504.053 already addresses this situation. The Division attempts to avoid unnecessary repetition of statutory language; however, this clarification is added elsewhere in this adoption preamble.

§134.1. Comment: A commenter recommends §134.1 be amended to include that treating doctors will be paid even when the patient does not show up.

Agency Response: The Division declines to include language that would reimburse treating doctors for missed appointments. This approach would be contrary to the requirements §413.011(a) as it relates to Medicare reimbursement methodologies and payment policies relating to billing, coding and reporting.

§134.1(d). Comment: Commenters recommend language change to add a reference to Labor Code §415.005 which states a health care provider may not charge an amount greater than that normally charged for similar treatment to a payor outside the workers' compensation system, except for mandated or negotiated charges.

Agency Response: The Division declines to add this reference to the explanation of fair and reasonable reimbursement. This statutory reference deals with usual and customary charges and not reimbursement.

§134.1(d)(1). Comment: Commenters recommend language to add a reference to Labor Code §408.028 to the definition of fair and reasonable.

Agency Response: The Division declines to make the requested change. Section 413.011 provides requirements for guideline development. Section 408.028, regarding pharmaceutical services, does not add anything to the definition of fair and reasonable.

§134.1(e). Comment: Commenters recommend subsection 134.1(e) be amended to include that documentation pertaining to fair and reasonable reimbursement methodology shall retain its confidential and proprietary nature and shall not be subject to public disclosure.

Agency Response: The Division declines to make the requested change. The insurance carrier must make an assertion that a particular reimbursement methodology is proprietary and confidential. The Division cannot determine whether methodologies used by insurance carriers in calculating fair and reasonable reimbursement are confidential and/or proprietary. The Division has obligations under the Public Information Act to release information that is not excepted from disclosure. An exception based on a claim that information is proprietary must be asserted and substantiated by the owner of the information.

§134.1(e). Comment: A commenter recommends a language change to require insurance carriers to share their documented methodology with the health care provider upon request.

Agency Response: The Division declines to make this recommended change. A health care provider may file a medical fee dispute if dissatisfied with the reimbursement made by the insurance carrier. The Division may request the documentation of the reimbursement methodology from the insurance carrier if necessary to resolve the fee dispute. It is not necessary for the health care provider to receive this information in order to resolve the dispute.

§134.100(c). Comment: Commenters recommend the treating doctor's request for reimbursement for attendance at a required medical examination be in the form of an invoice and include adequate documentation. Another commenter recommends clarification that reimbursement under this subsection is a non-medical bill.

Agency Response: The Division declines to make this change. The treating doctor's attendance at a required medical examination is in a medical capacity for the injured employee's benefit. The Division considers the treating doctor's time for travel and attendance at a required medical examination, in accordance with §134.100, a medical service. The Division clarifies that health care provider travel not in accordance with §134.100 is not considered a medical service.

§134.110. Comment: A commenter recommends qualification requirement for travel reimbursement remain at 20 miles one way. The commenter states there is

no economic justification for imposing this hardship on injured employees. In addition, the cost of transportation has increased significantly in recent years and costs should not be borne by injured employees.

Agency Response: The Division acknowledges the commenters concerns regarding the change from the previous rule. The Texas Insurance Code through the network rules establishes the distance of 30 miles as a standard for the network service area. Since travel expenses are not considered medical benefits they will be reimbursed under the same rules in both the network and non-network systems. Consequently, it is important that this statutorily indicated distance be maintained for consistency.

§134.110(a). Comment: A commenter recommends subsection 134.110(a) be amended to allow an injured employee to request travel reimbursement only when the medical services provided are medically necessary and related to the compensable injury.

Agency Response: The Division declines to make this change. Subsection 134.110(a)(1) limits an injured employee's request for reimbursement from the insurance carrier for incurred travel expenses when the medical treatment is for a compensable injury and is not reasonably available within 30 miles from where the injured employee lives. An injured employee's medical treatment is provided at the direction of a health care provider and the injured employee likely has little

knowledge of medical necessity or reasonableness. Since injured employees have limited responsibility to pay medical expenses and associated costs in the Texas Workers' Compensation System, it is appropriate that injured employees not be limited in their opportunity to recover out-of-pocket expenses.

§134.110(a)(1). Comment: Commenters recommend a language change to state "where the employee lives" rather than "employees' residence" to provide consistency with workers' compensation health care network rules.

Agency Response: The Division agrees with the recommended language and the rule has been changed for consistency purposes.

§134.110(b). Comment: Commenters recommend a language change to the timeframe an injured employee has to submit a travel reimbursement request from one year to 95 days.

Agency Response: The Division declines to make the recommended change in timeframes. The timeframe for a health care provider to submit a medical bill to the insurance carrier is specifically set at 95 days from the date of service by Labor Code §408.027. The Labor Code does not extend this limitation to injured employees seeking reimbursement for travel expenses. The timeframe is set at 12 months from the date of service to allow injured employees an extended period of time to attempt to recover out-of-pocket travel expenses. This is

extremely important due to the relative infrequency of injured employees seeking travel expenses from the insurance carrier and the injured employee may need the additional time to gather the information necessary to submit the request.

§134.110(d). Comment: A commenter recommends subsection 134.110(d) be amended to specify that total reimbursement mileage is based on round trip mileage to the nearest location where medical treatment is reasonably available.

Agency Response: The Division declines to make this change. While injured employees subject to a workers' compensation health care network must choose a treating doctor in accordance with network rules, an injured employee in the non-network system is entitled to choose any treating doctor on the Division's Approved Doctor List. The question of treatment not being reasonably available within 30 miles or outside 30 miles is a question of circumstance and fact not able to be specifically addressed by this rule. If an insurance carrier disputes the reasonable availability of health care, a dispute regarding the requested travel reimbursement may be made and resolved through the benefit review process.

§134.120(d). Comment: A commenter recommends language change to provide that if an insurance carrier has denied benefits based on lack of documentation and such documentation can be produced, the injured employee

may request such documentation and the insurance carrier should be responsible for the costs.

Agency Response: The Division declines to make this change. The Division clarifies the health care provider is required to provide the injured employee, or the injured employee's representative, an initial copy of any existing medical documentation without charge. However, the injured employee, or the injured employee's representative, is required to reimburse the health care provider for subsequent requests for the same medical documentation. Further, the Division believes it to be appropriate for the workers' compensation system for an injured employee, or the injured employee's representative, requesting creation of medical documentation, such as a medical narrative, to be required to reimburse the health care provider for this additional information.

§134.120(e). Comment: A commenter recommends language change to require documentation be provided by the health care provider to the Office of Injured Employee Counsel upon request.

Agency Response: The Division declines to make this change. The Division believes such a directive to be more appropriate within future Office of Injured Employee Counsel rules. Although Chapter 404 of the Labor Code provides broad access to information in the hands of the Division it does not provide for access to information held by health care providers.

§134.120(g). Comment: A commenter recommends subsection 134.120(g) be amended to specify the insurance carrier should only be liable for claim-specific narrative information specifically applicable to the compensable injury and directed towards the specific request made by the insurance carrier or the Division.

Agency Response: The Division declines to make this change. The Division clarifies narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee and created at the written request of the insurance carrier or the Division. As such, it is an insurance carrier's prerogative to reimburse for narrative reports requested and submitted in accordance with this rule and that specifically address the issues brought forward. Additionally, it is a health care provider's responsibility to submit narrative reports in accordance with this rule and specifically address the issues brought forward. Further, the rule provides additional guidance as to what shall be submitted as a narrative report.

For with changes: Flahive, Ogden & Latson, Texas Medical Association, American Insurance Association, Office of Injured Employee Counsel, Baker Botts, LLP, The Boeing Company, Texas Mutual Insurance Company, Hospital Corporation of America, Texas Pharmacy Association, Insurance Council of

Texas, Association of Fire & Casualty Insurers of Texas, Property Casualty

Insurers of America

Subchapter A. MEDICAL REIMBURSEMENT POLICIES

28 TAC §134.1

The section is adopted under Labor Code §§401.023, 408.004, 408.0041, 408.021, 408.025, 408.027, 408.151, 413.007, 413.011, 413.019, 413.053, 402.00111, and 402.061. Section 401.023 provides for the computation of an interest rate used in the calculation of interest due on late payments. Section 408.004 provides for required medical examinations and reimbursement of both injured employee expenses incident to the examination and those of the doctor selected by the employee to attend. Section 408.0041 provides for designated doctor examinations and reimbursement of both injured employee expenses incident to the examination and those of the doctor selected by the employee to attend. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Section 408.025 requires the Commissioner to adopt requirements for reports and records required to be filed within the Workers' Compensation System. Section 408.027 establishes the timeframe for a health care provider's claim submission, the timeframes for an insurance carrier's

processing of a claim including requests for additional documentation and audit, the reimbursement during the pendency of an audit, and the section's applicability to all delivered health care whether or not subject to a workers' compensation health care network. Section 408.151 provides for required medical examinations and designated doctor examinations during supplemental income benefits. Section 413.007 requires the division to maintain a statewide database of medical charges, actual payments, and treatment protocols. Section 413.011 requires the Commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet other statutory requirements. Section 413.019 provides for the accrual of interest on late payments by the insurance carrier or health care provider beginning on the 60th day after the date the health care provider submits the bill to the insurance carrier until the bill is paid, or the health care provider receives notice of alleged overpayment from the insurance carrier. Section 413.053 authorizes the Commissioner to establish standards for reporting and billing, governing both form and content. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Act. Section

402.061 authorizes the Commissioner to adopt rules necessary to administer the Act.

Chapter 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

Subchapter A. MEDICAL REIMBURSEMENT POLICIES

§134.1. Medical Reimbursement.

(a) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsection (b) of this section.

(b) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.202 of this chapter (relating to Medical Fee Guideline).

(c) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(1) the Division's fee guidelines;

(2) a negotiated contract; or

(3) subsection (d) of this section in the absence of an applicable fee guideline.

(d) Fair and reasonable reimbursement:

(1) is consistent with the criteria of Labor Code §413.011;

(2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.

(e) The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts. Upon request of the Division, an insurance carrier shall provide copies of such documentation.

Subchapter B. MISCELLANEOUS REIMBURSEMENT
28 TAC §§134.100, 134.110, 134.120, 134.130

The sections are adopted under Labor Code §§401.023, 408.004, 408.0041, 408.021, 408.025, 408.027, 408.151, 413.007, 413.011, 413.019, 413.053, 402.00111, and 402.061. Section 401.023 provides for the computation of an interest rate used in the calculation of interest due on late payments. Section 408.004 provides for required medical examinations and reimbursement of both injured employee expenses incident to the examination and those of the doctor

selected by the employee to attend. Section 408.0041 provides for designated doctor examinations and reimbursement of both injured employee expenses incident to the examination and those of the doctor selected by the employee to attend. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Section 408.025 requires the Commissioner to adopt requirements for reports and records required to be filed within the Workers' Compensation System. Section 408.027 establishes the timeframe for a health care provider's claim submission, the timeframes for an insurance carrier's processing of a claim including requests for additional documentation and audit, the reimbursement during the pendency of an audit, and the section's applicability to all delivered health care whether or not subject to a workers' compensation health care network. Section 408.151 provides for required medical examinations and designated doctor examinations during supplemental income benefits. Section 413.007 requires the division to maintain a statewide database of medical charges, actual payments, and treatment protocols. Section 413.011 requires the Commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet other statutory requirements. Section 413.019 provides for the

accrual of interest on late payments by the insurance carrier or health care provider beginning on the 60th day after the date the health care provider submits the bill to the insurance carrier until the bill is paid, or the health care provider receives notice of alleged overpayment from the insurance carrier. Section 413.053 authorizes the Commissioner to establish standards for reporting and billing, governing both form and content. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Act. Section 402.061 authorizes the Commissioner to adopt rules necessary to administer the Act.

§134.100. Reimbursement of Treating Doctor for Attendance at Required Medical Examination.

(a) When an injured employee's treating doctor is present at a required medical examination in accordance with §126.6 of this title (relating to Required Medical Examination), the insurance carrier shall reimburse the treating doctor for time as follows:

(1) at a rate of $100 an hour limited to four hours, unless the insurance carrier pre-approves extended time; and

(2) in quarter hour increments with any amount over 10 minutes considered an additional quarter hour.

(b) Reimbursement is limited to the time required to travel from the treating doctor's usual place of business to the place of the examination. In addition, it includes the duration of the examination and the time required to return from the examination location to the treating doctor's usual place of business. The travel shall be by the most direct route. This time does not include time spent for meals or other elective activities engaged in by the doctor.

(c) The treating doctor shall submit a request for reimbursement in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).

(d) The injured employee's treating doctor shall be the only doctor permitted to attend and charge for the attendance at the examination.

(e) This section shall apply to all dates of travel on or after May 2, 2006.

§134.110. Reimbursement of Injured Employee for Travel Expenses Incurred.

(a) An injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when:

(1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives; and

(2) the distance traveled to secure medical treatment is greater than 30 miles, one-way.

(b) The injured employee shall submit the request for reimbursement to the insurance carrier within one year of the date the injured employee incurred the expenses.

(c) The injured employee's request for reimbursement shall be in the form and manner required by the Division and shall include documentation or evidence (such as itemized receipts) of the amount of the expense the injured employee incurred.

(d) The insurance carrier shall reimburse the injured employee based on the travel rate for state employees on the date travel occurred, using mileage for the shortest reasonable route.

(1) Travel mileage is measured from the actual point of departure to the health care provider's location when the point of departure is:

(A) the employee's home; or

(B) the employee's place of employment.

(2) If the point of departure is not the employee's home or place of employment, then travel mileage shall be measured from the health care provider's location to the nearest of the following locations:

(A) the employee's home;

(B) the place of employment; or

(C) the actual point of departure.

(3) Total reimbursable mileage is based on round trip mileage.

(4) When an injured employee's travel expenses reasonably include food and lodging, the insurance carrier shall reimburse for the actual expenses not to exceed the current rate for state employees on the date the expense is incurred.

(e) The insurance carrier shall pay or deny the injured employee's request for reimbursement submitted in accordance with subsection (c) of this section within 45 days of receipt.

(f) If the insurance carrier does not reimburse the full amount requested, partial payment or denial of payment shall include a plain language explanation of the reason(s) for the reduction or denial. The insurance carrier shall inform the injured employee of the injured employee's right to request a benefit review conference in accordance with §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

(g) This section shall apply to all dates of travel on or after May 2, 2006.

§134.120. Reimbursement for Medical Documentation.

(a) An insurance carrier is not required to reimburse initial medical documentation provided to the insurance carrier in accordance with §133.210 of this title (relating to Medical Documentation).

(b) An insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title.

(c) Upon request, the health care provider shall provide the injured employee, or the injured employee's representative, an initial copy of the medical documentation without charge. The requestor shall reimburse the health care provider for subsequent requests of the same medical documentation.

(d) If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information.

(e) The health care provider shall provide copies of any requested or required documentation to the Division at no charge.

(f) The reimbursements for medical documentation are:

(1) copies of medical documentation--$.50 per page;

(2) copies of hospital records--an initial fee of $5.00 plus $.50 per page for the first 20 pages, then $.30 per page for records over 20 pages;

(3) microfilm--$.50 per page;

(4) copies of X-ray films--$8.00 per film;

(5) narrative reports:

(A) one to two pages--$100;

(B) each page after two pages--$40 per page.

(g) Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.

§134.130. Interest for Late Payment on Medical Bills and Refunds.

(a) Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.340 of this title (relating to Medical Payments and Denials).

(b) Health care providers shall pay interest to insurance carriers on requests for refunds paid later than the 60th day after the date the health care provider received the request for refund, in accordance with §133.260 of this title (relating to Refunds).

(c) The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made.

(d) Interest shall be calculated as follows:

(1) multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest);

(2) divide the annual amount of interest by 365 (to determine the daily interest amount); then

(3) multiply the daily interest amount by the number of days of interest to which the recipient is entitled under subsection (a) or (b) of this section.

(e) The percentage of interest for each quarter may be obtained by accessing the Texas Department of Insurance's website, www.tdi.state.tx.us.

(f) This section shall apply to all dates of service on or after May 2, 2006.

Subchapter I. MEDICAL BILL REPORTING

28 TAC §134.802

The amendments are adopted under Labor Code §§401.023, 408.004, 408.0041, 408.021, 408.025, 408.027, 408.151, 413.007, 413.011, 413.019, 413.053, 402.00111, and 402.061. Section 401.023 provides for the computation of an interest rate used in the calculation of interest due on late payments. Section 408.004 provides for required medical examinations and reimbursement of both injured employee expenses incident to the examination and those of the doctor selected by the employee to attend. Section 408.0041 provides for designated

doctor examinations and reimbursement of both injured employee expenses incident to the examination and those of the doctor selected by the employee to attend. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Section 408.025 requires the Commissioner to adopt requirements for reports and records required to be filed within the Workers' Compensation System. Section 408.027 establishes the timeframe for a health care provider's claim submission, the timeframes for an insurance carrier's processing of a claim including requests for additional documentation and audit, the reimbursement during the pendency of an audit, and the section's applicability to all delivered health care whether or not subject to a workers' compensation health care network. Section 408.151 provides for required medical examinations and designated doctor examinations during supplemental income benefits. Section 413.007 requires the division to maintain a statewide database of medical charges, actual payments, and treatment protocols. Section 413.011 requires the Commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet other statutory requirements. Section 413.019 provides for the accrual of interest on late payments by the insurance carrier or health care

provider beginning on the 60th day after the date the health care provider submits the bill to the insurance carrier until the bill is paid, or the health care provider receives notice of alleged overpayment from the insurance carrier. Section 413.053 authorizes the Commissioner to establish standards for reporting and billing, governing both form and content. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Act. Section 402.061 authorizes the Commissioner to adopt rules necessary to administer the Act.

§134.802. Insurance Carrier Medical Electronic Data Interchange to the Division.

(a) The insurance carrier shall submit medical bill and payment data to the Division within 30 days after the insurance carrier makes payment, denies payment, or receives a refund of overpayment on a medical bill.

(b) Insurance carriers shall submit medical bill and payment data electronically in the form and format prescribed by the Division.

(c) The Division shall prescribe the form, format, and content of the required medical bill and payment data submission.

(d) This section shall apply to all dates of service on or after July 15, 2000, for facility and professional medical services except pharmacy and dental services.

(e) This section shall apply to all dates of service on or after January 1, 2005, for pharmacy and dental services in addition to the already required facility and professional medical services.