TITLE 28. INSURANCE

**PART 2. TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION**

CHAPTER 134.- BENEFITS – GUIDELINES FOR MEDICAL SERVICES,

CHARGES, AND PAYMENTS

SUBCHAPTER I – MEDICAL BILL REPORTING

AMENDED: 28 TAC §134.803 and §134.807

ADOPTION

1. INTRODUCTION.

The Commissioner of Workers' Compensation (Commmissioner) of the Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §134.803 concerning Reporting Standards and §134.807 concerning State Specific Requirements. The amendments to §134.803 are adopted with a change to the proposed text as published in the November 9, 2012, issue of the *Texas Register* (37 TexReg 8923). The amendments to §134.807 are adopted without changes to the proposed text as published in the November 9, 2012, issue of the *Texas Register* (37 TexReg 8923).

The public comment period closed on December 10, 2012. The Division received three public comments. The Division did not receive a request for a public hearing. The Division published an informal draft of the proposed amendments on the Department's website from April 24, 2012, until May 24, 2012, and received ten informal comments on the informal draft rules.

Proposed §134.803 is adopted with a change to the proposed text in subsection (b). This change updates the date of the *Texas EDI Medical Difference Table*, Version 2.0 from October 2012 to January 2013. The adopted change is not substantive, does not materially

alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

2. REASONED JUSTIFCATION

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for this rule is set out in this order, which includes the preamble. The preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, the names of entities who commented and whether they were in support of or in opposition to the adoption of the rule, and the reasons why the Division agrees or disagrees with the comments and recommendations.

Federal regulations adopted by the Secretary of the Federal Department of Health and Human Services (HHS) in 45 Code of Federal Regulations (CFR) §162.1002 adopt standard medical data code sets that apply to the Medicare system which is regulated by the Centers for Medicare and Medicaid Services (CMS). Relevant to this adoption are the medical data code sets these federal rules adopt for medical diagnoses and inpatient procedures under 45 CFR §162.1002(b)(1). For the period on and after October 16, 2003, through September 30, 2014, the HHS Secretary requires the use of *International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM) Volumes 1 and 2* (including The Official ICD-9-CM Guidelines for Coding and Reporting), and for hospital inpatient procedure coding, *International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures* (including The Official ICD-9-CM Guidelines for Coding and Reporting)(ICD-9 code sets). For the periods on and after October 1, 2014, the HHS Secretary in 45 CFR §162.1002(c)(2) and (3) requires, for diagnosis coding, the use of *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* (including The Official ICD-10-

CM Guidelines for Coding and Reporting), and for hospital inpatient procedure coding, *International Classification of Diseases, 10th Revision Procedure Coding System (ICD-10-PCS)* (including The Official ICD-10-PCS Guidelines for Coding and Reporting) (ICD-10 code sets). The previous compliance date in these federal rules for the ICD-10 code sets was for the period on and after October 1, 2013; however recent, amendments to 45 CFR §162.1002(b) and (c) as published in the September 5, 2012, issue of the Federal Register, 77 FR 5420, extend the compliance date for the ICD-10 code sets for the period to October 1, 2014.

Labor Code §413.011 and corresponding Division rules require the Commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by CMS, including applicable payment policies relating to coding, billing, and reporting for use in the workers' compensation system. As a result, health care providers currently include appropriate ICD-9-CM codes on their medical bills to workers' compensation insurance carriers. Accordingly, once CMS requires the use of ICD-10-CM for diagnosis coding and ICD-10-PCS codes for inpatient procedure coding on medical bills for services rendered, health care providers in the workers' compensation system will begin using these codes to bill for medical services.

These adopted amendments affect Division rules in 28 Texas Administrative Code (TAC) Chapter 134, Subchapter I that implement the legislative directives in Labor Code §413.007 and §413.008 and that require insurance carriers to report to the Division specific billing and payment data for each medical bill submitted on a workers' compensation claim. Specifically, these adopted amendments make necessary modifications to §134.803 and §134.807 which will allow insurance carriers to include ICD-10 codes sets in their medical

billing and payment reports to the Division once health care providers initiate use of the ICD-10 code sets in their medical bills. Prior to these adopted amendments, these reporting rules only supported the submission of the ICD-9 code sets. As more fully described below, these adopted amendments will allow insurance carriers to include either the ICD-9 or ICD-10 code sets in their medical billing and payment reports, whichever is appropriate.

In addition to the adopted amendments that implement the reporting of ICD-9 code sets or ICD-10 code sets under Subchapter I of Chapter 134 of this title, the Division has also adopted nonsubstantive changes that are designed to provide increased clarity and readability in Division rules. These other adopted amendments are described below.

3. HOW THE SECTIONS WILL FUNCTION.

Amended §134.803.

The adopted amendments to §134.803(b) adopt by reference the *Texas EDI Medical Difference Table*, Version 2.0, dated January 2013. This new table contains changes to the previously adopted difference table which are necessary to delineate the difference in which the Division implemented the IAIABC EDI Implementation Guide with regard to the reporting of diagnosis and procedure codes. The *Texas EDI Medical Difference Table*, Version 2.0 includes the Texas segment/elements that need to be populated with the ICD-9 code sets or ICD-10 code sets contained on medical bills.

Specifically, the adopted difference table documents how insurance carriers are to report data for data elements HI01-2, HI02-2, HI03-2, HI04-2, and HI05-2 in the HI segment. (See pages 4 and 5 of the adopted *Texas EDI Medical Difference Table*, Version 2.0, dated January 2013). These changes are necessary because they will require insurance carriers to submit ICD-10 code sets in a medical EDI record once health care providers begin submitting

these codes on medical bills. Furthermore, the adopted difference table clarifies that each of those specified data elements can be populated with the ICD-9 or ICD-10 CM code, or ICD-9 or ICD-10 PCS code, when the appropriate code is contained on the medical bill.

This adopted difference table also makes nonsubstantive revisions to the previously adopted difference table for purposes of improved clarity and readability. These revisions include a new column titled "Row Type" which contains a general description of each row. Also, the CAS segment on the table is titled "Claims Adjustment."

The adopted amendments to subsection (c) are necessary to update the Division's website address to read http://www.tdi.texas.gov/wc/indexwc.html.

Finally, the adopted amendments to §134.803 delete subsection (e) concerning the September 1, 2011, effective date because that effective date provision is no longer necessary. In accordance with Government Code §2001.036, the effective date for this amended rule will be 20 days after the date it is filed with the Office of the Secretary of State.

Amended §134.807

Section 134.807 concerns state specific requirements. The two changes in the adopted amendments relate to subsections (f) and (g). The adopted change in amended subsection (f) is the addition of (f)(4) which states: *(4) When ICD-10-CM and ICD-10-PCS codes are contained on the medical bill, the insurance carrier must report these codes in the associated ICD-9-CM data elements using the ICD-9-CM code qualifiers*. The instruction is necessary to provide guidance to insurance carriers and their trading partners so that they will know how to populate ICD-10-CM and ICD-10-PCS code in the ICD-9 data elements when appropriate. These segment/elements are specified in the adopted *Texas EDI Medical Difference Table*, Version 2.0, dated January 2013 on pages 4 and 5, Loop Identifier 2300, Segment/Element HI.

The adopted amendments to §134.807 also delete subsection (g) concerning the September 1, 2011 effective date because that effective date is no longer necessary. In accordance with Government Code §2001.036, the effective date of the amended rule will be 20 days after the date it is filed with the Office of the Secretary of State.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES

General: Commenter supports the approach taken by the Division which retains the use of the *IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0 (July 4, 2002)* while requiring insurance carriers to populate the ICD-10 codes in the ICD-9 data elements when appropriate through the use of the *Texas EDI Difference Table, Version 2.0 (April 2012)*.

Agency Response: The Division appreciates the supportive comment.

General: Two commenters oppose these rule amendments and urge the Division to adopt the IAIABC Workers' Compensation Medical Bill Data Reporting EDI Implementation Guide, Release 2, dated February 1, 2012, (Release 2) as well as the ASC X12 5010 standard code sets which support the reporting of ICD-10CM and ICD-10-PCS codes. One commenter states that North Carolina has already adopted Release 2 and that California and Oregon have indicated their intent to adopt Release 2. The commenter states the Division's approach in modifying Release 1 will require entities operating in these other states to maintain three separate platforms, EDI Release 1.1, the Texas approach, and Release 2. The commenter states this approach negates the value of having standardized reporting platforms and adds cost to the overall system for any entity operating in multiple states with no overall system benefit or savings. Another commenter states that insurance carriers would have two years to convert their systems, and it would be more efficient and less costly in the long run to simply

adapt systems to the new Release 2 standard rather than maintain a unique Release 1 system with Texas-only modifications. The commenter states that while adoption of a Release 1 with Texas-only modifications may seem less intensive and less costly, maintaining a Texas only standard would add complexity and duplicative processes and, in the long term, be more costly both in terms of expenses and personnel hours.

Agency Response: The Division disagrees with adopting Release 2 and the ASC X12 5010 standard code sets at this time. The Division also disagrees that by not adopting Release 2, complexity, duplicative processes, and greater costs are added to the system. During the development of these rule amendments designed to accommodate ICD-10 codes in medical bill and payment reporting, the Division did consider adopting Release 2 as an alternative approach. However, after considering the feasibility, timeframes, and costs of implementing Release 2 for all system participants the Division elected to maintain the system currently in place with a few modifications at this time for several reasons.

First, Release 2 is only recently available and has not been implemented for mandatory use by other jurisdictions. Additionally, adopting Release 2 would require a much longer implementation period. The longer implementation period for Release 2 will not allow the Division and impacted system participants sufficient time to make the necessary technology changes and also undergo the required testing to fully implement Release 2 by October 1, 2014. Instead, the decision to adopt these amendments is prudent and less complex because it provides the necessary time for the Division and impacted system participants in the Texas workers' compensation system to conduct thorough testing to avoid costly obstacles that could otherwise emerge with the immediate full implementation of Release 2. Lastly, these adopted amendments make only minimal changes to the current

Release 1 platform already implemented and used by the Division and system participants. These minimal changes set forth in these adopted amendments are necessary so the Division can meet its data collection needs with regard to ICD-10 code sets. The costs imposed by these changes are nominal and relate only to those modifications that will allow for the submission and collection of ICD-10 code sets in medical EDI records. At this time, the better approach is to implement the minimal changes set forth in these amendments in order to collect the new ICD-10 code sets when appropriate.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL

For: Property Casualty Insurers Association of America

For, with changes: None

Against: Healthesystems and American Insurance Association

Neither for or Against: None

6. STATUTORY AUTHORITY.

The amendments are adopted under the Labor Code §§413.007, 413.008, 413.011, 413.0511, 413.0512, 402.075, and 405.0025 and under the general authority of §§402.00111, 402.00128, and 402.061, and Government Code §2001.0036.

Labor Code §413.007 requires the Division to maintain a statewide data base of medical charges, actual payments, and treatment protocols that may be used by the Commissioner in adopting medical policies and fee guidelines and the Division in administering the medical policies, fee guidelines, or sections. Labor Code §413.007, also requires that the Division ensure that the data base contains information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols that can

be used in a meaningful way to allow the Division to control medical costs as provided by Texas Workers' Compensation Act.

Labor Code §413.008 provides that on request from the Division for specific information, an insurance carrier shall provide to the Division any information in the insurance carrier's possession, custody, or control that reasonably relates to the Division's duties under the Act and to health care treatment, services, fees, and charges.

Labor Code §413.011 in relevant part, requires the Commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by CMS, including applicable coding, billing, and reporting policies, and to adopt rules that remain aligned, to the extent possible, with CMS coding, billing, and reporting policies.

Labor Code §413.0511 and §413.0512 require the Division's Medical Advisor and Medical Quality Review Panel to monitor the quality of health care and recommend appropriate actions regarding doctors, other health care providers, insurance carriers, utilization review agents, and independent review organizations. Medical bill reporting data collected from the statewide data base contain information that assist the Division Medical Advisor and the Medical Quality Review Panel in performing their duties under §413.0511 and §413.0512.

Labor Code §402.075 requires the Commissioner of Workers' Compensation to assess, at least biennially, the performance of insurance carriers and health care providers in meeting key regulatory goals

Labor Code §405.0025 requires the Workers' Compensation Research and Evaluation Group to conduct professional studies on the quality and cost of medical benefits and to produce a biennial report on the impact of certified networks.

Labor Code §402.00111 provides that the Commissioner shall exercise all executive authority, including rulemaking authority, under Title 5, Labor Code. Labor Code §402.00128 lists the general powers of the Commissioner including the power to hold hearings and the authority to assess and enforce penalties as authorized by Title 5, Labor Code. Section 402.061 provides the Commissioner the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

Government Code §2001.036, provides in relevant part, that a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State, except that if a later date is specified in the rule, the later date is the effective date.

7. TEXT.

§134.803 *Reporting Standards*

(a) Except as provided in this subchapter, the commissioner adopts by reference the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002 (IAIABC EDI Implementation Guide) published by the International Association of Industrial Accident Boards and Commissions (IAIABC).

(b) The commissioner adopts by reference the *Texas EDI Medical Data Element Requirement Table*, Version 1.0, dated June 2011, the *Texas EDI Medical Data Element Edits Table*, Version 1.0, dated June 2011, and the *Texas EDI Medical Difference Table*, Version 2.0, dated January 2013. All tables are published by the division.

(c) Information on how to obtain or inspect copies of the IAIABC EDI Implementation Guide and the adopted division tables may be found on the division's website: http://www.tdi.texas.gov/wc/indexwc.html.

(d) In the event of a conflict between the IAIABC EDI Implementation Guide and the Labor Code or division rules, the Labor Code or division rules shall prevail.

§134.807 *State Specific Requirements*

(a) A medical EDI transmission shall not exceed a file size of 1.5 megabytes. A transaction set shall not contain more than 100 medical EDI records in a claimant hierarchical loop.

(b) Insurance carriers shall submit medical EDI transactions using Secure File Transfer Protocol (SFTP). All alphabetic characters used in the SFTP file name must be lower case and the file must be compressed/zipped. Files that do not comply with these requirements or the naming convention may be rejected and placed in appropriate failure folders. Insurance carriers must monitor these folders for file failures and make corrections in accordance with §134.804(e) of this title (relating to Reporting Requirements).

(c) SFTP files must comply with the following naming convention:

(1) Two digit alphanumeric state indicator of 'tx';

(2) Nine digit trading partner Federal Employer Identification Number (FEIN);

(3) Nine digit trading partner postal code;

(4) Nine digit insurance carrier FEIN or 'xxxxxxxxx' if the file contains medical EDI transactions from different insurance carriers;

(5) Three digit record type '837';

(6) One character Test/Production indicator ('t' or 'p');

(7) Eight digit date file sent 'CCYYMMDD';

(8) Six digit time file sent 'HHMMSS';

(9) One character standard extension delimiter of '.'; and

(10) Three digit alphanumeric standard file extension of 'zip' or 'txt'.

(d) The transaction types accepted by the division include '00' original, '01' cancel, and '05' replacement.

(e) Insurance carriers are required to use the following delimiters:

(1) Date Element Separator--'*' asterisk;

(2) Sub-element Separator--':' colon; and

(3) Segment Terminator--'~' tilde.

(f) In addition to the requirements adopted under §134.803 of this title (relating to Reporting Standards), state reporting of medical EDI transactions shall comply with the following formatting requirements:

(1) Loop 2400 Service Line Information must not contain more than one type of service. Only one of the following data segments may be contained in an iteration of this loop: SV1 Professional Service, SV2 Institutional Service, SV3 Dental Service or SV4 Pharmacy Service.

(2) When reporting compound medications, Loop 2400 Service Line Information SV4 Pharmacy Drug Service must include a separate line for each reimbursable component of the compound medication. The compounding fee must be reported using a default NDC number equal to '99999999999' as a separate service line.

(3) When reporting pharmacy medical EDI records, the following data element definition clarifications apply:

(A) DN501 Total Charge Per Bill is the total amount charged by the pharmacy or pharmacy processing agent;

(B) DN511 Date Insurer Received Bill is the date the insurance carrier received the bill;

(C) DN512 Date Insurer Paid Bill is the date the insurance carrier paid the pharmacy or pharmacy processing agent;

(D) DN638 Rendering Bill Provider Last/Group Name is the name of the dispensing pharmacy;

(E) DN690 Referring Provider Last/Group Name is the last name of the prescribing doctor; and

(F) DN691 Referring Provider First Name is the first name of the prescribing doctor.

(4) When ICD-10-CM and ICD-10-PCS codes are contained on the medical bill, the insurance carrier must report these codes in the associated ICD-9-CM data elements using the ICD-9-CM code qualifiers.

8. CERTIFICATION.

This agency hereby certifies that the amendments have been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2013.

X _____

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 28 TAC §134.803 concerning Reporting Standards and 28 TAC §134.807 concerning State Specific Requirements are adopted.

AND IT IS SO ORDERED.

X_____

ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

X_____

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