CHAPTER 133. GENERAL MEDICAL PROVISIONS
SUBCHAPTER B. HEALTH CARE PROVIDER BILLING PROCEDURES
28 TAC §§133.10 and 133.20

SUBCHAPTER C. MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER
28 TAC §133.200

SUBCHAPTER G. ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION
28 TAC §133.502

TEXT.

§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), must[~~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), must[~~shall~~] submit paper medical bills for payment on:

(1) the 1500 Health Insurance Claim Form Version 02/12 (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 must[~~shall~~] submit bills using the division[~~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[~~Division~~] form DWC-066.

(d) Dentists must[~~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 must[~~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[~~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 must[~~shall~~] leave the field blank if the workers' compensation claim number is not known by the billing provider;

(I) date of injury and "431" qualifier (CMS-1500, field 14) are required;

(J) name of referring provider or other source is required when another health care provider referred the patient for the services; no[~~No~~] qualifier indicating the role of the provider is required (CMS-1500, field 17);

(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 must[~~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 and the applicable ICD indicator must be present;

(N) prior authorization number (CMS-1500/field 23) is required in the following situations:[~~when preauthorization,~~]

(i) Preauthorization, concurrent review, or voluntary certification was approved and the insurance carrier provided an approval number to the requesting health care provider. Include the approval number in the prior authorization field (CMS-1500/field 23).[~~;~~]

(ii) The division ordered a designated doctor examination and provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23).

(iii) The designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23).

(O) date or dates[~~date(s)~~] of service (CMS-1500, field 24A) is required;

(i) If the designated doctor referred the injured employee for additional testing or evaluation, the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation.

(ii) If the designated doctor did not refer the injured employee for additional testing or evaluation, the "From" and "To" dates are the date of the designated doctor examination.

(P) place of service code or codes[~~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 must[~~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

must[~~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 must[~~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[~~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 must[~~shall~~] leave the field blank if the workers' compensation claim number is not known by the billing provider;

(HH) preauthorization number (UB-04/field 63) is required when:

(i) preauthorization, concurrent review, or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider; or

(ii) a designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number to the designated doctor.

(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 these[~~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 must[~~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 must[~~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[~~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 must[~~shall~~] leave the field blank 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;

(Z) preauthorization number (DWC-066/field 30) is required when:

(i) preauthorization, voluntary certification, or an agreement was approved and the insurance carrier provided an approval number to the requesting health care provider; or[~~and~~]

(ii) a designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number to the designated doctor.

(AA) for billing of compound drugs refer to the requirements in §134.502 of this title (relating to Pharmaceutical Services).

(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:

(i) preauthorization, concurrent review, or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider; or

(ii) a designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number to the designated doctor.

(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 must[~~shall~~] leave the field blank 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[~~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 or numbers or letter or letters[~~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 must[~~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 must[~~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 must[~~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[~~Number~~] as required in subsection (f) of this section, the health care provider must leave the field blank.

(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[~~Independent Review Organization~~], or a network[~~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 for medical bills submitted on or after (NEW DATE)[~~April 1, 2014~~].

§133.20. Medical Bill Submission by Health Care Provider

(a) The health care provider must[~~shall~~] submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider must[~~shall~~] not submit a medical bill later than the 95th day after the date the services are provided.

(1) If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title, the 95-day period for timely submission of the bill begins on the date of service of the additional testing or evaluation.

(2) In accordance with subsection (c) of the statute, the health care provider must[~~shall~~] submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

(3) A health care provider who submits a medical bill to the correct workers' compensation insurance carrier must[~~shall~~] include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A)-(H)[~~§133.307(c)(2)(A) - (H)~~] of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

(c) A health care provider must[~~shall~~] include correct billing codes from the applicable division[~~Division~~] fee guidelines in effect on the date or dates[~~date(s)~~] of service when submitting medical bills.

(d) The health care provider that provided the health care must[~~shall~~] submit its own bill, unless:

(1) the health care was provided as part of a return-to-work[~~return to work~~] rehabilitation program in accordance with the division[~~Division~~] fee guidelines in effect for the dates of service;

(2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider must[~~shall~~] submit the bill;

(3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or

(4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill.

(e) A medical bill must be submitted:

(1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and

(2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

(f) Health care providers must[~~shall~~] not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

(h) Not later than the 15th day after receipt of a request for additional medical documentation, a health care provider must[~~shall~~] submit to the insurance carrier:

(1) any requested additional medical documentation related to the charges for health care rendered; or

(2) a notice the health care provider does not possess requested medical documentation.

(i) The health care provider must[~~shall~~] indicate on the medical bill if documentation is submitted related to the medical bill.

(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill or bills[~~bill(s)~~]. Such billing is subject to the following:

(1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

(A) prompt payment, as provided by Labor Code §408.027;

(B) interest for delayed payment as provided by Labor Code §413.019; and

(C) medical dispute resolution as provided by Labor Code §413.031.

(2) When a health care provider bills the employer, the health care provider must[~~shall~~] submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier.

(3) When a health care provider bills the employer, the health care provider must bill in accordance with the division's[~~Division's~~] fee guidelines and §133.10 of this chapter (relating to Required Billing Forms/Formats).

(4) A health care provider must[~~shall~~] not submit a medical bill to an employer for charges an insurance carrier has reduced, denied, or disputed.

(k) A health care provider must[~~shall~~] not submit a medical bill to an injured employee for all or part of the charge for any of the health care provided, except as an informational copy clearly indicated on the bill, or in accordance with subsection (l) of this section. The information copy must[~~shall~~] not request payment.

(l) The health care provider may only submit a bill for payment to the injured employee in accordance with:

(1) Labor Code §413.042;

(2) Insurance Code §1305.451; or

(3) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

(m) A designated doctor must include the assignment number on the medical bill in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).

(n) A designated doctor who refers the injured employee for additional testing or evaluation under §127.10 must provide the assignment number to the health care provider performing the testing. The health care provider performing the testing must include the assignment number on the medical bill in accordance with §133.10.

(o) This section is effective for medical bills submitted on or after (NEW DATE).

§133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers

(a) On[~~Upon~~] receipt of medical bills submitted in accordance with §133.10[~~(a)(1) and (2)~~] of this chapter (relating to Required Billing[~~Medical~~] Forms/Formats), an insurance carrier must[~~shall~~] evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).

(1) Insurance carriers must[~~shall~~] not return medical bills that are complete, unless the bill is a duplicate bill.

(2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier must[~~shall~~]:

(A) complete the bill by adding missing information already known to the insurance carrier, except for the following:

(i) dates of service;

(ii) procedure or modifier[~~procedure/modifier~~] codes;

(iii) number of units; and

(iv) charges; or

(B) return the bill to the sender, in accordance with subsection (c) of this section.

(3) The insurance carrier may contact the sender to get[~~obtain~~] the information necessary to make the bill complete, including the information specified in paragraph (2)(A)(i)-(iv)[~~(2)(A)(i) - (iv)~~] of this subsection. If the insurance carrier gets[~~obtains~~] the missing information and completes the bill, the insurance carrier must[~~shall~~] document the name and telephone number of the person who supplied the information.

(b) An insurance carrier must[~~shall~~] not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier must[~~shall~~] include a document identifying the reasons[~~reason(s)~~] for returning the bill.

The reasons[~~reason(s)~~] related to the procedure or modifier codes must[~~code(s) shall~~] identify the reasons[~~reason(s)~~] by line item.

(c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill.

(d) An insurance carrier must[~~shall~~] not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.

§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 or hospital[~~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[~~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[~~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 or hospital[~~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; and

(6) for a designated doctor and a health care provider performing a designated doctor referral examination, include the assignment number in the prior authorization field (CMS-1500/field 23).

(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 must[~~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 DATE[~~August 1, 2011~~].