DWC-06-0024

SUBCHAPTER A. General Rules for Medical Billing and Processing
§§133.1 - 133.3

SUBCHAPTER B. Health Care Provider Billing Procedures
§§133.10 and 133.20

SUBCHAPTER C. Medical Bill Processing/Audit by Insurance Carrier
§§133.200, 133.210, 133.230, 133.240, 133.250, 133.260, 133.270, and 133.280

The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts new §§133.1, 133.2, 133.3, 133.10, 133.20, 133.200, 133.210, 133.230, 133.240, 133.250, 133.260, 133.270, and 133.280 concerning medical billing and processing, including new medical billing timeframes. The new rules are adopted to implement, on a permanent basis, portions of House Bill (HB) 7, enacted during the 79th Legislature, Regular Session, effective September 1, 2005. The adopted rules permit compliance with statutory changes to the Labor Code §408.027 and new §408.0271, and also provide billing and processing direction for participants in a workers' compensation health care network established under Insurance Code Chapter 1305. These adopted rules do not apply to political subdivisions with contractual relationships under Labor Code §504.053(b)(2). The adopted rules will replace the emergency rules adopted by the Commissioner of Workers' Compensation on November 3, 2005, and 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 adopted rules 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, the Division has adopted an extensive reorganization of Chapter 133, in conjunction with the revision of Chapter 134 published elsewhere in this issue of the Texas Register, to eliminate redundancies in existing rules and clarify billing and processing procedures. The new rules are adopted with changes to the proposed text as published in the February 10, 2006 issue of the *Texas Register* (31 TexReg 798). This reorganization includes the adopted repeal of 20 billing, processing and reimbursement rules in Chapters 133 and 134, published elsewhere in this issue of the *Texas Register*.

The new rules are necessary to conform with changes by HB 7 to Labor Code §§408.027 and 408.0271. The adopted rules provide the following: for reimbursement, a health care provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service; insurance

carriers must pay, reduce, deny or determine to audit a health care provider's medical bill not later than the 45th day after receipt of the medical bill; an insurance carrier may request additional documentation necessary to clarify the health care provider's charges at any time during the 45-day review period and the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the insurance carrier's request; procedures and timeframes for audits performed by an insurance carrier; and procedures and timeframes for insurance carriers to request refunds from health care providers.

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

The adopted rules also minimize micro-management of the process by providing guidance and direction rather than specific, detailed instructions that require adherence. The new rules allow system participants more flexibility in developing their medical billing and bill review processes. In addition, the adoption relies on the statutorily required Medicare reimbursement structures, incorporates concepts from TDI managed care rules, and eliminates many of the

previous duplicative Division instructions, thus providing consistency and standardization with other health care delivery systems. The adopted rules also establish standards for reconsideration of medical bills and refunds of overpayments to health care providers.

A few changes are 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 Subchapter A, §§133.1 - 133.3, provides general provisions for medical billing and processing, including applicability of the chapter, definitions, and communications between health care providers and insurance carriers. No changes have been made to these rules as proposed.

Adopted Subchapter B sets out the billing procedures for health care providers by addressing the billing format, and submission of the medical bill. As a result of public comment, §133.10(b) was changed from the rule as proposed to allow a period of transition for pharmacists and pharmacy processing agents to change from billing form DWC-66 to the current National Council for Prescription Drug

Programs (NCPDP) Universal Claim Form (UCF). Section 133.20 (relating to Medical Bill Submission by Health Care Provider) subsection (e)(1) has been changed to reference Labor Code §415.005 (relating to Overcharging By Health Care Providers Prohibited; Administrative Violation) in addition to §413.011 (relating to Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols).

Adopted Subchapter C addresses medical bill processing and audits by insurance carriers. Section 133.200 sets out the procedures an insurance carrier should follow upon receipt of a medical bill from a health care provider. Section 133.210 addresses medical documentation. Section §133.230 provides procedures when an audit is conducted. Section §133.240 addresses medical payments and denials. As a result of public comment, proposed subsection (b)(2) of this section, which prohibited retrospective review of medical necessity of health care provided in accordance with Division-adopted treatment guidelines, has been deleted. Because treatment guidelines have not yet been adopted, it is more appropriate to address the application of treatment guidelines when they are adopted. Therefore, subsection (b)(2) was deleted and this issue will be addressed in the Disability Management rules when a treatment guideline or guidelines are adopted. Proposed subsection (e), regarding an insurance carrier provision of explanation of benefits (EOB) to health care providers and

injured employees, has been changed to reflect an insurance carrier is only required to send an EOB to the injured employee when a payment denial is based on lack of medical necessity, health care provided by a non-approved health care provider, or relatedness. As public comment pointed out, it is not necessary for injured employees to receive copies of all EOBs. Requiring that all EOBs be sent to the injured employee could cause confusion and adds unnecessary administrative costs. Therefore, the rule was changed to require that EOBs be sent to injured employees only when payment is denied for the listed reasons. This provision is consistent with previous Division rules. Subsection (f) has been changed to reflect that an insurance carrier is not required to document in a claim file the insurance carrier's fair and reasonable reimbursement methodology but rather the reimbursement should be in accordance with §134.1 (relating to Medical Reimbursement) which specifies how the insurance carrier should maintain such documentation. As a result of public comment, the Division determined documentation requirements reflected in §134.1 were sufficient. Subsections (h) and (i) have been changed to delete the references to the injured employee. The injured employee's reconsideration and medical dispute resolution processes are addressed by adopted §133.270 (relating to Injured Employee Reimbursement for Health Care Paid). Therefore, the references to injured employees in subsection (h) and (i) are not necessary. Subsection (j) has been changed to replace a reference made to subsection (e)

with a reference to §133.250 (relating to Reconsideration for Payment of Medical Bills). Section 133.250 describes the procedures for reconsideration of payment of medical bills. Section §133.260 addresses refunds. As a result of public comment, subsection (a) has been changed from proposal to delete the requirement that insurance carriers shall request a refund from a health care provider within 30 days from taking final action on a medical bill. Adopted subsection (a) requires an insurance carrier to request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when the insurance carrier determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided. This will allow the insurance carrier additional time to review services paid within 45 days, but still takes into consideration medical dispute resolution timeframes. Section §133.270 addresses when an injured employee may request reimbursement for health care for which the injured employee has paid. As a result of public comment, proposed subsection (c) has been changed from proposal. Adopted subsection (c) reflects that insurance carrier reimbursement to the injured employee shall be in accordance with §134.1 (relating to Medical Reimbursement). This change was made for consistency with changes made to §133.280 as a result of public comment. Proposed subsection (f) has also been changed to indicate that an injured

employee may, but is not required to submit a reconsideration request to the insurance carrier if reimbursement has been denied. An injured employee's reconsideration request is not required to be submitted in accordance with §134.250 (relating to Reconsideration for Payment of Medical Bills). Public comment indicated significant confusion regarding the injured employee's inclusion in §133.250 which focuses on reconsideration generated by a health care provider. The new language allows an injured employee and an insurance carrier to engage in a less structured non-mandatory reconsideration process if they choose, prior to an injured employee requesting medical dispute resolution in accordance §133.305. Section §133.280 describes the procedures for an employer to follow for reimbursement of health care paid. As a result of public comment, proposed subsection (b) has been changed to reflect that insurance carrier reimbursement shall be in accordance with §134.1. Adopted new subsection (c) indicates the employer may seek reimbursement for any payment made above the applicable Division fee guideline or contract amount from the health care provider who received the overpayment.

Insurance Code Chapter 1305 establishes that a medical bill for services provided through a workers' compensation health care network shall be paid, reduced, denied or audited in accordance with Labor Code §408.027. The adopted rules clarify that the medical billing and bill reviewing processes,

including coding and reporting requirements, apply to services provided to an injured employee subject to a workers' compensation health care network as established under Insurance Code Chapter 1305, with any exceptions noted.

§133.1. Comment: A commenter recommends a language change to specifically note in the rule that Chapter 133 does not apply to a political subdivision 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.

§133.1. Comment: A commenter recommends language to clarify the applicability to workers' compensation health care networks.

Agency Response: The Division declines to make this change. The rule clearly lays out applicability and specifically identifies the portions of Chapter 133 that do not apply to health care services provided to injured employees subject to workers' compensation health care networks established under Insurance Code Chapter 1305.

§133.2. Comment: A commenter recommends defining the term "reasonable health care."

Agency Response: The Division declines to extend the definition beyond the statute. The Labor Code definition for "health care reasonably required" provides adequate clarity to all interested parties, and is clear and understandable.

§133.2. Comment: Commenters recommend the terms "audit," "incomplete bill" and "corrected bill" be defined, as this will provide greater clarity regarding the use of these terms throughout the chapter.

Agency Response: The Division declines to make the requested changes. The terms are commonly used and well understood in the medical billing and reimbursement process and definition is not necessary.

§133.2(2). Comment: Commenters recommend alternative language to include that a medical bill is considered received when it meets the requirements of a complete medical bill.

Agency Response: The Division declines to make the change. The definition of a complete medical bill is consistent with the definitions included in Subchapter F of this chapter (relating to Electronic Medical Billing, Reimbursement, and Documentation). The suggested language incorrectly implies that the paper

billing process and the electronic billing process are analogous. Receipt of a paper medical bill does not necessarily indicate completeness.

§133.2(3). Comment: Commenters suggest that the prudent layperson standard be added to the definition of emergency to be consistent with other managed care products.

Agency Response: The Division acknowledges that other managed care systems utilize the "the prudent layperson" concept. However, the definition included in the rule mirrors the statutory language at Insurance Code §1305.004 (13) and (15). When appropriate, as with these rules, it is the Division's intent to remain parallel with workers' compensation network rules to provide consistency in the workers' compensation system and leaving the definition as it is accomplishes that purpose.

§133.2(4). Comment: A commenter recommends the definition of final action be amended to prevent insurance carriers from circumventing the 45-day deadline by denying just one charge and leaving the others pending. The commenter also recommends the definition repeat language in §134.1 in addition to referencing §134.1. The commenter recommends the definition be amended to include denying "payment" rather than "charge" on a medical bill for final action.

Agency Response: The Division declines to make these changes. Section 133.210(c) prohibits insurance carriers from separating charges on a medical bill and a denial of a charge on a medical bill constitutes final action on the entire bill. Additionally, the Division declines to repeat language included by reference to §134.1 since it is unnecessarily redundant.

§133.2(5). Comment: Commenters express concern that subsection §133.2(5) extends authority to all health care provider agents as the statute does for pharmacy processing agents in Labor Code §413.0111 and as reflected in §133.2(7).

Agency Response: The Division clarifies that the definition of health care provider agents is intended to address billing practices already in place in the workers' compensation system. The definition does not extend any new authority to health care provider agents but clarifies that they must act within the confines of the Labor Code and Division rules. Pharmacy processing agents are a specific subset of health care provider agents and as such have unique authority and responsibilities through §413.0111 and are separately addressed in §133.2 (7).

§133.2(8). Comment: A commenter recommends the definition of retrospective review be consistent with the definition in Insurance Code §1305.352.

Agency Response: The definition is consistent with existing definitions of retrospective review, appearing in 28 TAC §19.2003. The Division also notes that Insurance Code §1305.352 actually addresses standards for retrospective review rather than a definition. The standards set out in this provision of the Insurance Code are accepted standards and system participants are expected to comply with those standards.

§133.3. Comment: A commenter suggests additional language to cite §402.021 and mandate communication and interaction between health care providers, insurance carriers, and case managers.

Agency Response: The Division declines to make the requested changes to further regulate the communication process between health care providers and insurance carriers. The Labor Code and Division rules already outline the interaction between system participants and anticipates a good faith effort from all system participants to actively communicate to foster appropriate return to work efforts.

§133.3. Comment: A commenter expressed support for subsection 133.3.

Agency Response: The Division acknowledges and appreciates the support.

§133.3 (b) & (c). Comment: A commenter recommends communication by mail or personal delivery be certified and that "all" communication related to medical bill processing be documented.

Agency Response: The Division acknowledges the commenter's suggestion but feels the proposed language is more aligned with the Division's paperless communication initiative. Further, such a requirement is likely to impose unnecessary micro-management and potentially increase costs to the system. If system participants want to utilize certified mail and document all communication on medical bill processing, they are able to do so.

§133.10. Comment: A commenter recommends the effective date of medical billing rules be postponed until all insurance carriers are set up to receive electronic claims from pharmacists that are non-network or do not use third party billing agents. The commenter asserts Texas pharmacists must continue to have the option of using the paper claim forms currently required. The commenter believes these rules need to address both electronic and paper billing procedures. The commenter states pharmacies do not use, and should not be required to use, a third party billing agent to bill workers' compensation claims. Additionally, the commenter believes some pharmacies will be waived from the electronic billing requirements and must have a means to file workers' compensation claims.

Agency Response: The Division declines to make this change. The effective dates of Subchapter F of this chapter (relating to Electronic Medical Billing, Reimbursement, and Documentation) will dictate the timeframes for implementation of the electronic medical billing process. However, these rules do apply to both electronic and paper medical billing. Section 133.10 directs electronic formats be in accordance with Subchapter F of this chapter. Until the electronic billing process is implemented, the National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) will be the standard paper form for pharmacy billing beginning January 1, 2007. This supports the standardization concept included in §413.011 and assists in the transition to electronic billing. Additionally, there are no requirements that pharmacies use third party billing agents to process workers' compensation claims.

§133.10(b). Comment: A commenter recommended subsection §133.10(b) be amended to allow pharmacy bills be submitted on either the National Council for Prescription Drug Programs (NCPDP) form or the Division form DWC-66.

Agency Response: The Division declines to make this change requesting a transition period that would allow use of both forms. The rule has been amended to require the use of the DWC-66 until December 31, 2006 and postpones the implementation of the NCPDP form until January 1, 2007. This change will allow adequate time for health care providers and insurance carriers to integrate these

forms into their processes. To implement the concepts of §413.011 regarding health care reimbursement policies that reflect standardized reimbursement structures in other health care delivery systems, the Division has adopted the forms commonly used for medical billing including the NCPDP form. Continued use of a Division designed form hinders the transition to standardization with the other health care delivery systems. To allow bills to be submitted on either form would require insurance carriers to maintain dual processing systems and add to bill processing costs. In addition, for clarification purposes, the Division has added language to subsection (b) regarding pharmacy processing agents.

§133.20. Comment: A commenter recommends new subsections be added to specifically state that rules pertaining to a health care provider or an insurance carrier also pertain to their agent and are limited to the services the agent is performing on behalf of the health care provider or insurance carrier.

Agency Response: The Division declines to further address the rights and responsibilities of health care provider and insurance carrier agents in these rules. The roles of health care provider agents and insurance carrier agents as they relate to the billing and reimbursement process are adequately addressed in these rules.

§133.20(e)(1). Comment: A commenter recommends the deletion of the terms "usual and customary" as this is not consistent with and is not defined by Labor Code §413.011. In addition, the commenter believes the deletion would help conform this rule to pharmacy reimbursement as established by Labor Code §408.028. The commenter asserts the subsection as written also does not conform to §134.1.

Agency Response: The Division declines to make this change. The adopted rule is consistent with the Medicare payment policies as required in §413.011 and with §134.1 which required health care providers to bill in accordance with the fee guidelines established by the Division. The adopted rule is also consistent with §415.005, which provides that it is a violation for a health care provider to charge an insurance carrier an amount greater than that normally charged for similar treatment to a payor outside the workers' compensation system, except for mandated or negotiated charges. Section 408.028 does not address requirements for submitting bills.

§133.20(e)(1). Comment: Commenters recommended subsection §133.20(e)(1) be amended to repeat language included in Labor Code §415.005(a), as well as a reference to §415.005.

Agency Response: The Division agrees with the recommendation to add the statutory reference to §415.005 and believes the reference is sufficient to further clarify the health care providers' billing responsibilities.

§133.20(e)(1). Comment: A commenter recommends this subsection be amended to allow health care providers to bill more than their usual and customary charge when the reimbursement in the applicable fee guideline is greater than the usual and customary charge.

Agency Response: The Division declines to make the requested change. Such a change would be contrary to the intent of Labor Code §415.005(a), which states a health care provider commits a violation if the person charges an insurance carrier an amount greater than that normally charged for similar treatment to a payor outside the workers' compensation system, except for mandated or negotiated charges.

§133.20(i). Comment: A commenter requested clarification regarding how to indicate on the claim form that additional documentation is being submitted with the medical bill.

Agency Response: The Division declines to make this change. Directions such as this are generally included in the Division's instructions on how to fill out

medical billing forms and not by rule. Any necessary changes will be included in the next revision of those billing instructions.

§133.20 (j). Comment: A commenter states the offer by the employer to pay medical bills should be required to be in writing and the employer should also waive any protections they might have. The commenter opines this subsection could be construed as price fixing. The commenter states that if a health care provider must waive the provisions of prompt pay when billing an employer then adherence to a fee schedule should also be waived.

Agency Response: The Division acknowledges the commenter's concerns but feels the suggestion would be unduly restrictive. Billing the employer, instead of an insurance carrier, for medical services is an agreement reached between the health care provider and the employer. It is unclear what protection or benefits an employer derives from this arrangement, whereas, it may be a benefit to the health care provider. Generally, the Division does not dictate contractual arrangements. However, §133.280 establishes that the insurance carrier will reimburse the employer in accordance with §134.1 in order to preserve medical cost control.

§133.20(j). Comment: A commenter recommends subsection §133.20(j) be amended to except health care providers from waiving their rights when billing

the employer if the employer refuses to provide their insurance carrier information.

Agency Response: The Division declines to make this change. The Labor Code at §415.008 prohibits a person from knowingly or intentionally misrepresenting or concealing a material fact to obtain or deny a payment of a worker's compensation benefit. If this does occur, a health care provider should report this to the Division.

§133.20(l). Comment: A commenter expresses concern regarding the adequacy of 28 TAC §134.504 but will address this issue in future pharmacy reimbursement rules.

Agency Response: The Division agrees that questions related to pharmacy reimbursement amounts should be addressed in rulemaking specifically related to pharmacy reimbursement policies.

§133.200. Comment: A commenter recommends the rule include a provision that requires insurance carriers to notify health care providers within five working days of the insurance carrier's receipt of a medical bill.

Agency Response: The Division declines to make the change since this would add another administrative requirement to the billing process. The anticipated electronic billing process includes an electronic acknowledgement. The adopted

rules include various checkpoints and time requirements that allow health care providers to follow the progress of a medical bill submission. Health care providers may always submit paper billings via certified mail or hand delivery if they choose.

§133.200(a)(1). Comment: A commenter recommends the subsection be amended to state a medical bill may also be returned if it belongs to another insurance carrier.

Agency Response: The Division declines to make the requested change. Such micro-management is contrary to the intent of these rules. However, the Division acknowledges that the insurance carrier should follow good business practices in communicating with health care providers and return a medical bill that is not related to one of their policies.

§133.200(a)(2)(B). Comment: Commenters recommend subsection (a)(2)(B) be amended to allow the insurance carrier to return a bill as incomplete if the required documentation is not submitted with the medical bill.

Agency Response: The Division declines to make the change. Section 133.2, regarding Definitions, defines a "complete medical bill" and §133.210 establishes documentation requirements. The health care provider is required to submit a complete medical bill and should include required documentation. If a health

care provider fails to include required documentation, insurance carrier medical billing processes allow insurance carriers to request any necessary documentation or deny medical bills for lack of documentation.

§133.200(d). Comment: Commenters recommend subsection §133.200(d) be applied to returned incomplete bills only. Commenters stated some system limits may impact the number of line items that may be entered on a single bill.

Agency Response: The Division declines to make this change. An insurance carrier combining or separating bills is contrary to the concept of adopted §133.240, regarding Medical Payments and Denials, which directs an insurance carrier to not change a health care provider's bill. In addition, this provision enhances the proper application of payment policies relating to coding, billing, and reporting. Processing health care provider bills differently than submitted may result in unintended consequences, for example the reconsideration process may directly be affected by this practice.

§133.230(a). Comment: Commenters recommend deletion of language in subsection §133.230(a) that allows audits only prior to final action because this will prevent insurance carriers from performing audits associated with fraud investigations and for reasons other than to determine medical necessity.

Agency Response: The Division declines to make the recommended change. Labor Code §408.027 requires audits to be processed within 160 days of receipt of the medical bill. Section 408.027 establishes that insurance carriers pay, reduce, or deny a medical bill within 45 days of receipt of a complete medical bill. Insurance carriers additionally have the opportunity to audit medical bills prior to taking final action. Once an insurance carrier takes final action there should be no need to conduct an additional bill review and audit. Additionally, a health care provider is entitled to closure on a medical bill after the insurance carrier has had an opportunity to audit the medical bill and taken final action on the medical bill. These provisions deal directly with medical bill processing and should not be construed to limit activities not directly related to bills on which the insurance carrier is taking final action. Investigations of fraud are generally outside the scope of a standard bill review and audit conducted to determine the accuracy of a medical bill. Investigations of fraud should continue to be conducted as usual in coordination with the agency's fraud, compliance and regulation activities.

§133.230(d). Comment: Commenters recommend an amendment to §133.230(d) to incorporate a requirement that the health care provider provide any documentation necessary for the insurance carrier to complete the audit rather than documentation relating to the billings subject to audit.

Agency Response: The Division declines to add the recommended language. Adopted §133.230(d) already requires the health care provider to provide any documentation related to the billing(s) subject to audit. This requirement should not be construed that it allows insurance carriers to pursue information not related to the billings subject to audit.

§133.240. Comment: A commenter recommends adding peer review requirements to the billing and reimbursement rules.

Agency Response: The Division declines to address peer review requirements in these rules. Peer review standards and sanctions are addressed in other Division rules.

§133.240. Comment: Commenters recommend the term "final action" as it is used in this section be defined.

Agency Response: The Division declines to add a second definition. A definition of final action is included in §133.2(4) and is applicable throughout Chapter 133.

§133.240(a). Comment: A commenter requested clarification that bill review does not extend the insurance carriers responsibility to take final action within 45 days of the receipt of the medical bill.

Agency Response: The insurance carrier may request documentation at any time prior to the 45th day after receipt of a complete medical bill. The insurance carrier must take final action or determine to audit the medical bill by the 45th day after the receipt of a complete medical bill. The 45-day timeframe to make or deny payment is not extended by a request for documentation. This is clearly stated in §133.240(a).

§133.240(a). Comment: A commenter states concern regarding the insurance carrier's 45-day timeframe to process a medical bill.

Agency Response: The 45-day timeframe to pay, reduce, deny or determine to audit is a statutory requirement of §408.027.

§133.240(b). Comment: A commenter agrees with the use of treatment guidelines as a standard of reasonable health care and states this would improve the system.

Agency Response: The Division appreciates the comment.

§133.240(b)(2). Comment: Commenters recommended deletion of §133.240(b)(2) as the Division does not have the statutory authority to adopt this provision, which is contrary to HB 7 goals. A commenter questions whether services may be disputed if an insurance carrier or utilization review agent

disagrees with the health care provider regarding the provision of care in accordance with Division-adopted treatment guidelines.

Agency Response: Subsection (b)(2) has been deleted because it is more appropriate to address the application of the treatment guidelines with the adoption of that guideline. The application of this concept is an integral portion of the Disability Management rules, which will likely include specific instructions for the use of treatment and return to work guidelines and the treatment planning process. Likewise, the Division will address statutory authority necessary to adopt treatment planning and other disability management rules when those rules are proposed and adopted.

§133.240(b)(2). Comment: A commenter supports this subsection but recommends additional language to specify an insurance carrier shall not deny payment on a medical bill based solely on the failure of a health care provider to adhere to Division-adopted treatment guidelines.

Agency Response: The Division appreciates the comment. However, subsection (b)(2) has been deleted. The application and use of treatment guidelines will be addressed in future disability management rule making efforts.

§133.240(c). Comment: A commenter expresses concern regarding subsection (c) as this mandate may result in an insurance carrier being forced to pay a

claim, regardless of whether it was accurately submitted, thus increasing health care costs.

Agency Response: The Division clarifies the adopted rules allow insurance carriers to deny payment, audit, or request additional information to clarify a medical bill prior to issuing a payment. There is no indication that these requirements would result in incorrect payments or denials or increase health care costs.

§133.240(c). Comment: A commenter recommends subsection (c) be amended to prohibit an insurance carrier from changing a billing code with the intent to deny payment.

Agency Response: The Division declines to make the requested change. The most current Medicare payment policies, including Correct Coding Initiatives (CCI), are required to be used in the Texas Workers' Compensation system by §413.011; therefore, no additional direction is necessary. Adding the language suggested by the commenter would make the provision difficult to enforce.

§133.240(d). Comment: Commenters recommended language change to §133.240(d) to allow insurance carriers to request documentation at any time.

Agency Response: The Division declines to add the recommended language as Labor Code §408.027 specifies a 45-day timeframe.

§133.240(d). Comment: A commenter states that this requirement will force insurance carriers to deny bills because of an inability to request and receive clarification and documentation from the health care provider.

Agency Response: The timeframes to request additional documentation are set statutorily. Insurance carriers must pay, reduce, deny or determine to audit not later that the 45th after receipt of the health care provider's claim per Labor Code §408.027.

§133.240(d). Comment: A commenter recommends language to limit the insurance carrier to a one-time request for documentation.

Agency Response: The Division declines to make this change. The Labor Code at §408.027 specifically allows insurance carriers to request additional documentation any time during the 45 days after the receipt of a medical bill. The statute does not put a limit on the number of requests that can be made within that 45-day period.

§133.240(e). Comment: Commenters recommend that in subsection §133.240(e) the injured employee be removed from the requirement to receive an explanation of benefits (EOB). A commenter states that it is only when the payment is denied on the basis of compensability, liability, or coverage issues

that notice to the injured employee should be provided and this is already required by subsection (g). Another commenter states that this requirement will result in confusion and needlessly increases administrative costs. A commenter recommended the injured employee receive an explanation of benefits when a medical bill is being denied for relatedness.

Agency Response: The Division agrees that sending copies of all EOBs to the injured employee could confuse the injured employee. Since the health care provider has access to the medical dispute process there is no need for the injured employee to receive notification of all denials and no need for the injured employee to receive notification of paid medical bills. Requiring these EOBs to be sent to injured employees would have increased administrative costs with minimal quantifiable benefit to the injured employee. Consequently, §133.240 has been changed to require an EOB be sent to the injured employee only when payment is denied for a series of reasons related to medical necessity, approved doctors, or compensability/relatedness. The adopted rule closely reflects the requirements of the previous medical billing and reimbursement rules.

§133.240(f). Comment: Commenters recommend subsection §133.240(f) be amended so that the method the insurance carrier uses to calculate the payment be required to be documented in a reproducible format rather than in the claim file.

Agency Response: The Division agrees to delete the requirement to document the reimbursement methodology in the claim file. The rule has been changed to reference §134.1, regarding Medical Reimbursement, which requires that reimbursement methodologies be documented.

§133.240(g). Comment: Commenters recommended deletion of subsection §133.240(g).

Agency Response: The Division declines to make the recommended change. If billed health care services are denied due to compensability or extent of injury, the insurance carrier should have filed or concurrently file the applicable notice required by Labor Code §409.021. This requirement was contained in the previous medical billing rules and is not new to the workers' compensation system.

§133.240(g). Comment: A commenter offers alternative language related to an insurance carrier's rationale for denials in order to file notices as required by Labor Code §409.021, and §§124.2 and 124.3.

Agency Response: The Division declines to make this change. The adopted language is consistent with the previous rule, which has not been confusing to system participants in the past.

§133.240(h)&(i). Comment: Commenters state that injured employees should not be allowed to request medical dispute resolution over a fee dispute between the health care provider and the insurance carrier.

Agency Response: The Division agrees that an injured employee should not be inserted into fee disputes between a health care provider and the insurance carrier. The rule has been changed to clarify that a health care provider may file for reconsideration and proceed to medical dispute resolution if dissatisfied with the insurance carrier's final action. The Division further clarifies that injured employee reimbursement processes are addressed by §133.270, regarding Injured Employee Reimbursement for Health Care Paid.

§133.240(j). Comment: A commenter recommends that subsection §133.240(j) be amended to specifically state the insurance carrier is not required to respond to a resubmission in violation of this subsection.

Agency Response: The Division declines to make this change. The Division clarifies that insurance carriers are not required to review medical bills resubmitted after final action has been taken.

§133.240(k). Comment: A commenter recommends language be amended in subsection §133.240(k) to delete the requirement that interest payments be paid at the same time as the medical bill payment.

Agency Response: The Division declines to make the recommended change. The Labor Code at §408.027 establishes the timeframes for an insurance carrier to reimburse health care providers for a medical bill. Additionally, §413.019 of the Labor Code establishes the timeframe when interest accrues. Health care providers are entitled to know when they will be reimbursed for interest payments. The interest is due at the time of the medical payment and not at some future date. Further, for consistency in the data collection and monitoring processes, interest payments are required to be identified and processed on a bill-by-bill basis.

§133.240(k). Comment: A commenter recommends language to allow insurance carriers and health care providers to negotiate, and contract for additional penalties for untimely payment of medical bills.

Agency Response: The Division declines to add language that would encourage an informal penalties structure or additional punitive payments outside those that are required by the Labor Code.

§133.240(k). Comment: A commenter states concern regarding the provision that interest begins to accumulate on or after the 60th day rather than after the 45th day from the date the insurance carrier originally received the complete medical bill.

Agency Response: The Division declines to make this change because the timeframes for calculating interest are established by statute in Labor Code §413.019. The adopted language is consistent with the Labor Code and other Division rules related to the calculation and payment of interest.

§133.240(l). Comment: A commenter recommends subsection 133.240(l) be amended to allow all health care provider agents to remit a net amount to the health care provider that is less than the insurance carrier's full payment to the health care provider's agent; this would be parallel to subsection 133.240(m) regarding pharmacy processing agents.

Agency Response: The Division declines to make the suggested change. The suggested change would extend to all health care agents authority consistent with pharmacy provider agents. Labor Code §413.0111 is applicable only to pharmacy processing agents and specifically requires rules adopted for reimbursement of prescription medical services to allow pharmacies to use agents as assignees to process claims under contractual terms. There is not a similar requirement for other health care providers in the statute.

§133.240(m). Comment: A commenter recommends this subsection be deleted, as it is confusing and unnecessary.

Agency Response: The Division declines to make this change. This provision is necessary to clarify that reimbursement procedures and requirements for pharmacy processing agents, as noted in §413.0111 of the Labor Code, differ from those applicable to all other health care provider agents.

§133.250. Comment: Commenter states that proposed §133.250 does not address injured employees with respect to requests for reconsiderations.

Agency Response: The Division clarifies §133.250 is applicable to health care providers only and §133.270 regarding Injured Employee Reimbursement for Health Care Paid addresses the injured employee's medical billing processes.

§133.250(b). Comment: Commenters recommend the timeframe in subsection 133.250(b) be changed from eleven months to six months from date of service, as the proposed timeframe seems unnecessarily long.

Agency Response: The Division declines to make the requested change. The timeframe for reconsideration is set at eleven months from the date of service in order to allow health care providers as much opportunity as possible to access the medical dispute resolution since that process requires a dispute to be filed within one year of the date of service. Previously, the reconsideration process did not include any time restrictions and consequently was inconsistent with the requirements of the medical dispute resolution process. Additionally, all health

care provider medical bills must go through the reconsideration process prior to filing a medical dispute. If the reconsideration timeframe was less than eleven months, it would effectively change the timeframes for the medical dispute resolution process to coincide with the reconsideration process.

§133.250(b). Comment: A commenter recommends the health care provider's timeframe for requesting reconsideration be extended as subsections (e),(f) and (g) create additional time periods for the reconsideration process that may extend the entire process past the one-year deadline to request medical dispute resolution.

Agency Response: The Division declines to make any changes to the timeframes associated with the reconsideration process. Timeframes have been included in the reconsideration process in order to speed the resolution of accounts and to coordinate the reconsideration and medical dispute resolution processes.

§133.250(c)(1). Comment: A commenter states subsection 133.250(c)(1) is in direct conflict with subsection (g).

Agency Response: The Division declines to make the requested change. The two subsections are not in conflict because subsection (c) pertains to the original submission of a reconsideration request by the health care provider and

subsection (g) provides direction for resubmission of the reconsideration request by the health care provider if an insurance carrier response has not been received.

§133.250 (d). Comment: A commenter recommends a stamped "REQUEST FOR RECONSIDERATION" notation for all reconsideration requests be reinstated as in current §133.304.

Agency Response: The Division declines to make the requested change because such an administrative requirement would impose unnecessary regulatory requirements and potentially add costs to the system. However, system participants may utilize this business practice if they wish.

§133.250(d). Comment: A commenter recommends language change to limit documentation requirements to those instances in which the insurance carrier has taken final action.

Agency Response: The Division declines to make the requested change since documentation requirements apply to all phases of the billing and reimbursement process and cannot be limited to a specific type of medical bill or situation pursuant to Labor Code §408.027.

§133.250(d)(1). Comment: Commenters recommend subsection 133.250(d)(1) be amended to require modifiers and number of units in addition to the original billing codes.

Agency Response: The Division declines to make the requested change. A reconsideration request may include corrections relating to modifiers and/or number of units. For this reason, a request for reconsideration may include changes in the number of units or modifiers from that in the original bill for proper processing and payment of the bill.

§133.250(d)(2). Comment: Commenters recommend subsection 133.250(d)(2) should require the original explanation of benefits always be submitted.

Agency Response: The Division declines to make this change. A health care provider may not always have received an explanation of benefits from the insurance carrier as the rule allows a reconsideration request to be submitted if a health care provider has not received notification by the insurance carrier of final action on a medical bill.

§133.250(e). Comment: A commenter recommends the seven day timeframe for an insurance carrier to review a reconsideration request for completeness be extended to 30 days. The commenter infers that the rule requires seven days to process a reconsideration request.

Agency Response: The Division declines to make the change. The seven day timeframe is established for an insurance carrier to determine if a reconsideration request is submitted according to rule requirements. Subsection (f) establishes that the insurance carrier has 21 days to actually process a complete reconsideration request and take final action.

§133.250(f). Comment: A commenter recommends the timeframe in subsection 133.250(f) be changed from 21 days to 21 business days to provide adequate time.

Agency Response: The Division declines to make the suggested change. The use of days rather than business days is consistent with the other Division rules and provides adequate time for the insurance carrier to take action on a request for reconsideration.

§133.250(g). Comment: A commenter believes subsection §133.250(g) is in conflict with subsection §133.240(j) and requests clarification.

Agency Response: The Division clarifies subsection §133.240(j) pertains to the original submission of medical bills for payment and the timeframe reflected in §133.250(g) pertains to the submission of medical bills for reconsideration of payment. Therefore, they are not in conflict.

§133.250(g). Comment: A commenter recommends clarification of subsection 133.250(g) as the health care provider should only have one opportunity for reconsideration before going to medical dispute resolution and this subsection seems to state otherwise.

Agency Response: The Division clarifies that subsection §133.250(g) provides direction for resubmission of the reconsideration request by the health care provider only if an insurance carrier response is not received within 26 days.

§133.260. Comment: A commenter recommends a language change to require the insurance carrier, not the health care provider, to request medical dispute resolution in the event of a refund request.

Agency Response: The Division declines to make this change. The Labor Code at §408.0271 requires the health care provider to reimburse the insurance carrier for payments received by the health care provider for inappropriate charges not later than the 45th day after the date of the insurance carrier's notice. The insurance carrier does not have an incentive to file medical dispute resolution if there is a disagreement because they have already received the refund.

§133.260(a). Comment: Commenters disagree with the insurance carrier 30-day time limit for requesting refunds. Other commenters recommended deletion of the 30-day timeframe in subsection §133.260(a).

Agency Response: The Division agrees to change this provision, however, declines to remove all timeframes for requesting a refund. Section 408.0271 requires the health care provider to submit a request for medical dispute resolution if the health care provider disagrees with the insurance carrier's request for refund. Further, §133.307 (relating to Medical Dispute Resolution of a Medical Fee Dispute) establishes that requests for medical dispute resolution must be filed no later than one year after the date of service. Because of these requirements, the medical dispute timeframes must be considered in establishing an insurance carrier refund timeframe. Consequently, the timeframe has been changed to 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later. The filing requirements established in the medical billing and reimbursement process were taken into consideration in establishing the 240 day and 30 day post audit timeframes. This will allow the insurance carrier additional time to review services paid within 45 days after receipt of a complete medical bill but still takes into consideration medical dispute resolution timeframes. The Division clarifies that in developing these timeframes

the health care provider's appeal was considered equivalent to a reconsideration request.

§133.260(a). Comment: A commenter supports this subsection but recommends additional language to state that an insurance carrier waives any claim to an overpayment after the 30 days has expired.

Agency Response: The Division clarifies the timeframe in this provision has been changed. However, the Division declines to make the requested change because the recommended language is unnecessary. The timeframes established in the subsection limits requests for refunds. In addition, §133.260(f) requires the health care provider to submit a refund to the insurance carrier whenever the overpayment is identified by the health care provider even though the insurance carrier has not requested a refund.

§133.260(g). Comment: Commenters recommend subsection 133.260(g) be amended to clarify the health care provider shall include a copy of the insurance carrier's original request for refund if requested and always provide the original explanation of benefits containing the overpayment.

Agency Response: The Division declines to make this change. The Division clarifies a copy of the original explanation of benefits containing the overpayment may not be available to the health care provider, especially if the health care

provider reimburses the insurance carrier a refund in accordance with subsection (f). The section requires a detailed explanation itemizing the refund and should identify all necessary information, including the name of the health care providers who billed and rendered the services and the injured employee. In addition, the detailed explanation is required to specify the total dollar amount being refunded and itemized by dollar amount, line item, date of service, and the amount of interest paid, if any, and the number of days on which interest was calculated.

§133.270. Comment: Commenters recommend the rule be amended to include a 95-day timeframe for injured employees to submit a request for reimbursement to the insurance carrier. Another recommended a 12-month timeframe.

Agency Response: The Division declines to specify a timeframe for an injured employee to submit a request for reimbursement. 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 medical expenses. Consequently, no provision has been included to limit an injured employee's time to attempt to recover out-of-pocket medical expenses. This is extremely important due to the relative infrequency of injured employees seeking reimbursement for medical expenses from the insurance carrier. The injured employee may need an extended period of time to understand the

process and to submit a request for reimbursement. Since injured employees have limited responsibility to pay medical expenses in the Texas Workers' Compensation System, it is appropriate that injured employees not be limited in their opportunity to recover out-of-pocket medical expenses.

§133.270. Comment: A commenter recommends injured employees be required, and not just allowed, to seek reimbursement for overpayments from health care providers.

Agency Response: The Division declines to require the injured employee to seek reimbursement for overpayments. Injured employees are fully capable of making decisions concerning overpayments without Division intervention.

§133.270(d). Comment: A commenter recommends subsection 133.270(d) be amended to include a 95-day timeframe for injured employees to submit a request to health care provider for overpayment.

Agency Response: The Division declines to specify a timeframe for an injured employee. 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 medical expenses. Consequently, no provision has been included to limit an injured employee's time to attempt to

recover out-of-pocket medical expenses. This is extremely important due to the relative infrequency of injured employees seeking reimbursement for medical expenses from the insurance carrier. The injured employee may need an extended period of time to understand the process and to submit a request for reimbursement. Since injured employees have limited responsibility to pay medical expenses in the Texas Workers' Compensation System, it is appropriate that injured employees not be limited in their opportunity to recover out-of-pocket medical expenses.

§133.270(d). Comment: A commenter recommends the subsection be amended to require the insurance carrier, rather than the injured employee, to obtain overpayments from the health care provider.

Agency Response: The Division declines to make this change. The transaction originally transpired between the injured employee and the health care provider. If an individual pays for health care services and is later determined to have overpaid based on his or her insurance coverage the appropriate result is that the individual seek refund of the overpayment from the health care provider. Additionally, the injured employee is only required to submit to the insurance carrier a request that includes documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider. This limited information may hinder an insurance carrier from properly requesting a

refund from a health care provider and it is redundant and unnecessary for insurance carriers to be involved in the process.

§133.270(f). Comment: A commenter identifies a potential inconsistency between §§133.240, 133.250, and 133.270.

Agency Response: The Division agrees clarification was necessary and §§133.240, 133.250, and 133.270 have been changed for improved rule coordination. References to the injured employee have been removed from §133.240 and a reference to §133.250 has been removed from §133.270. This clarifies that injured employee reimbursement processes are addressed by §133.270.

§133.280(a). Comment: Commenters recommend the rule be amended to include a 95-day timeframe for employers to submit a request for reimbursement.

Agency Response: The Division declines to restrict the time period for employers to submit a request for reimbursement. The Division believes that in this instance employers and insurance carriers are best suited to determine the parameters for reimbursement timeframes.

§133.280(b). Comment: Commenters recommended language change to 133.280(b) to also reflect contract amount in addition to Division fee guideline

amount. Commenters also recommended allowing the employer reimbursement for overpayment from the health care provider consistent with 133.270(d).

Agency Response: The Division agrees with the recommended language change. Subsection (b) has been amended to direct reimbursement to the employer be in accordance with §134.1 which specifies medical reimbursement, and incorporates the contract amount as well as the applicable Division fee guideline amount. New subsection (c) has been added to allow the employer to seek reimbursement for overpayment from the health care provider.

For, with changes: Texas Medical Association, Broadspire, McKesson Health Solutions, Zenith Insurance, Flahive, Ogden & Latson, Medtronic, Inc., American Insurance Association, Office of Injured Employee Counsel, State Office of Risk Management, Baker Botts, LLP, The Boeing Company, Texas Mutual Insurance Company, Lockheed Martin Aeronautics Company, Texas Association of School Boards Risk Management Fund, Hospital Corporation of America, Texas Pharmacy Association, Insurance Council of Texas, Property Casualty Insurers of America, and Association of Fire & Casualty Insurers of Texas

Neither For Nor Against: Fair Isaac Corporation

Subchapter A. GENERAL RULES FOR MEDICAL BILLING AND PROCESSING

28 TAC §§133.1 - 133.3

The new sections are adopted under Labor Code §§401.023, 401.024, 406.010, 408.003, 408.025, 408.0251, 408.027, 408.0271, 413.007, 413.011, 413.0111, 413.015, 413.019, 413.042, 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 401.024 authorizes the Commissioner by rule to permit or require the transmission of information through electronic means. Section 406.010 authorizes the Commissioner to adopt rules necessary to specify the requirements for insurance carriers to provide claims service. Section 408.003 requires the insurance carrier to reimburse an employer for the amount of benefits paid directly to an injured employee to which the employee was entitled. Section 408.025 requires the Commissioner to adopt requirements for reports and records required to be filed within the Workers' Compensation System. Section 408.0251 requires the Commissioner to adopt rules regarding the electronic submission and processing of medical bills. 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 408.0271 permits insurance carriers to request refunds from health care providers upon the insurance carrier's determination that rendered health care services were

inappropriate, permits health care providers to appeal that determination to the insurance carrier, and requires health care providers to remit payment upon final adverse determination by the insurance carrier. 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 413.0111 provides for the contractual use of agents and assignees by pharmacies to process claims and act on behalf of the pharmacies. Section 413.015 permits an insurance carrier to contract with another entity to forward payments for medical services. 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 413.042 specifies the limited circumstances under which a health care provider may seek reimbursement from an injured employee. 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.

§133.1. Applicability of Medical Billing and Processing.

(a) This chapter applies to medical billing and processing for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305, and to injured employees not subject to such networks, with the following exceptions pertaining only to health care services provided to an injured employee subject to a workers' compensation health care network established under Chapter 1305:

(1) Subchapter D of this chapter (relating to Dispute of Medical Bills);

(2) §133.210(f) of this chapter (relating to Medical Documentation); and

(3) §133.240(b) and (i) of this chapter (relating to Medical Payments and Denials).

(b) This chapter applies to all health care provided on or after May 2, 2006. For health care provided prior to May 2, 2006, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

§133.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Bill review--Review of any aspect of a medical bill, including retrospective review, in accordance with the Act, rules, and the appropriate Division fee and treatment guidelines.

(2) Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms), or as specified for electronic medical bills in Chapter 135 of this title (relating to Electronic Medical Billing, Reimbursement, and Documentation).

(3) Emergency--Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(4) Final action on a medical bill--

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(5) Health care provider agent--A person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for medical bill processing under the Labor Code or Division rules.

(6) Insurance carrier agent--A person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims services or fulfilling the insurance carrier's obligations for medical bill processing under the Labor Code or Division rules.

(7) Pharmacy processing agent--A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request

reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Retrospective review--The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

§133.3. Communication Between Health Care Providers and Insurance Carriers.

(a) Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

(b) Communication between the health care provider and insurance carrier related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

(c) Health care providers and insurance carriers shall maintain, in a reproducible format, documentation of communications related to medical bill processing.

Subchapter B. HEALTH CARE PROVIDER BILLING PROCEDURES

28 TAC §133.10, §133.20

The new sections are proposed under Labor Code §§401.023, 401.024, 406.010, 408.003, 408.025, 408.0251, 408.027, 408.0271, 413.007, 413.011, 413.0111, 413.015, 413.019, 413.042, 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 401.024 authorizes the Commissioner by rule to permit or require the transmission of information through electronic means. Section 406.010 authorizes the Commissioner to adopt rules necessary to specify the requirements for insurance carriers to provide claims service. Section 408.003 requires the insurance carrier to reimburse an employer for the amount of benefits paid directly to an injured employee to which the employee was entitled. Section 408.025 requires the Commissioner to adopt requirements for reports and records required to be filed within the Workers' Compensation System. Section 408.0251 requires the Commissioner to adopt rules regarding the electronic submission and processing of medical bills. Section 408.027 establishes the timeframe for a 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 408.0271 permits insurance carriers to request refunds from health care providers upon the insurance carrier's determination that rendered health care services were inappropriate, permits health care providers to appeal that determination to the insurance carrier, and requires health care providers to remit payment upon final adverse determination by the insurance carrier. 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 413.0111 provides for the contractual use of agents and assignees by pharmacies to process claims and act on behalf of the pharmacies. Section 413.015 permits an insurance carrier to contract with another entity to forward payments for medical services. 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 413.042 specifies the limited circumstances under which a health care provider may seek reimbursement from an injured employee. 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.

§133.10. Required Billing Forms/Formats.

(a) Health care providers shall submit medical bills for payment:

(1) on standard forms used by the Centers for Medicare and Medicaid Services (CMS);

(2) on applicable forms prescribed for pharmacists and dentists specified in subsections (b) and (c) of this section; or

(3) in electronic format in accordance with Subchapter F of this chapter (relating to Electronic Medical Billing, Reimbursement, and Documentation).

(b) Pharmacists and pharmacy processing agents shall submit bills using the current National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) for health care provided on or after January 1, 2007.

Pharmacists and pharmacy processing agents shall use the Division form DWC-66 for health care provided on or before December 31, 2006.

(c) Dentists shall submit bills using the current American Dental Association claim form.

(d) All information submitted on required billing forms must be legible and completed in accordance with Division instructions.

§133.20. Medical Bill Submission by Health Care Provider.

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

(b) A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

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

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

(1) the health care was provided as part of a return to work rehabilitation program in accordance with the 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 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 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 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 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(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 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 fee guidelines and §133.10 of this chapter (relating to Required Billing Forms/Formats).

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

(k) A health care provider 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 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).

Subchapter C. MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER

28 TAC §§133.200, 133.210, 133.230, 133.240, 133.250, 133.260, 133.270, 133.280

The new sections are proposed under Labor Code §§401.023, 401.024, 406.010, 408.003, 408.025, 408.0251, 408.027, 408.0271, 413.007, 413.011, 413.0111, 413.015, 413.019, 413.042, 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 401.024 authorizes the Commissioner by rule to permit or require the transmission of information through electronic means. Section 406.010 authorizes the Commissioner to adopt rules necessary to specify the requirements for insurance carriers to provide claims service. Section 408.003 requires the insurance carrier to reimburse an employer for the amount of benefits paid directly to an injured employee to which the employee was entitled. Section 408.025 requires the Commissioner to adopt requirements for reports and records required to be filed within the Workers' Compensation System. Section 408.0251 requires the Commissioner to adopt rules regarding the electronic submission and processing of medical bills. 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 408.0271

permits insurance carriers to request refunds from health care providers upon the insurance carrier's determination that rendered health care services were inappropriate, permits health care providers to appeal that determination to the insurance carrier, and requires health care providers to remit payment upon final adverse determination by the insurance carrier. 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 413.0111 provides for the contractual use of agents and assignees by pharmacies to process claims and act on behalf of the pharmacies. Section 413.015 permits an insurance carrier to contract with another entity to forward payments for medical services. 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 413.042 specifies the limited circumstances under which a health care provider may seek reimbursement from an injured employee. 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.

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

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

(1) Insurance carriers 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 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/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 obtain the information necessary to make the bill complete, including the information specified in paragraph (2)(A)(i) - (iv) of this subsection. If the insurance carrier obtains the missing information and completes the bill, the insurance carrier shall document the name and telephone number of the person who supplied the information.

(b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the 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 shall not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.

§133.210. Medical Documentation.

(a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

(b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

(1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

(2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

(3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;

(4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and

(5) for hospital services: an itemized statement of charges.

(d) Any request by the insurance carrier for additional documentation to process a medical bill shall:

(1) be in writing;

(2) be specific to the bill or the bill's related episode of care;

(3) describe with specificity the clinical and other information to be included in the response;

(4) be relevant and necessary for the resolution of the bill;

(5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;

(6) indicate the specific reason for which the insurance carrier is requesting the information; and

(7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

(e) It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division

considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

(f) Workers' compensation health care networks established under Insurance Code Chapter 1305 may decrease the documentation requirements of this section.

§133.230. Insurance Carrier Audit of a Medical Bill.

(a) An insurance carrier may perform an audit of a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. The insurance carrier may not audit a medical bill upon which it has taken final action.

(b) If an insurance carrier decides to conduct an audit of a medical bill, the insurance carrier shall:

(1) provide notice to the health care provider no later than the 45th day after the date the insurance carrier received the complete medical bill. For onsite audits, provide notice in accordance with subsection (c) of this section;

(2) pay to the health care provider no later than the 45th day after receipt of the health care provider's medical bill, for the health care being audited:

(A) for a workers' compensation health care network established under Insurance Code Chapter 1305, 85 percent of the applicable contracted amount; or

(B) for services not provided under Insurance Code Chapter 1305, 85 percent of:

(i) the maximum allowable reimbursement amounts established under the applicable Division fee guidelines;

(ii) the contracted amount for services not addressed by Division fee guidelines; or

(iii) the fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) for services not addressed by clause (i) or (ii) of this subparagraph;

(3) make a determination regarding the relationship of the health care services provided for the compensable injury, the extent of the injury, and the medical necessity of the services provided; and

(4) complete the audit and pay, reduce, or deny in accordance with §133.240 of this chapter (relating to Medical Payments and Denials) no later than the 160th day after receipt of the complete medical bill.

(c) If the insurance carrier intends to perform an onsite audit, the notice shall include the following information for each medical bill that is subject to audit:

(1) employee's full name, address, and Social Security number;

(2) date of injury;

(3) date(s) of service for which the audit is being performed;

(4) insurance carrier's name and address;

(5) a proposed date and time for the audit, subject to mutual agreement; and

(6) name and telephone number of the person who will perform the onsite audit, has the authority to act on behalf of the insurance carrier, and shall personally appear for the onsite audit at the scheduled date and time.

(d) During the insurance carrier's onsite audit, the health care provider shall:

(1) make available to the insurance carrier: all notes, reports, test results, narratives, and other documentation the health care provider has relating to the billing(s) subject to audit; and

(2) designate one person with authority to: negotiate a resolution, serve as the liaison between the health care provider and the insurance carrier, and be available to the insurance carrier's representative.

(e) On the last day of the onsite audit, the health care provider's liaison and the insurance carrier's representative shall meet for an exit interview. The insurance carrier's representative shall present to the health care provider's liaison a list of unresolved issues related to the health care provided and the billed charges. The health care provider's liaison and the insurance carrier's representative shall discuss and attempt to resolve the issues.

§133.240. Medical Payments and Denials.

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)

(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

(d) The insurance carrier may request additional documentation, in accordance with §133.210 of this chapter (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division and indicate any interest amount paid,

and the number of days on which interest was calculated. The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and

(2) the injured employee when payment is denied because the health care was:

(A) determined to be unreasonable and/or unnecessary;

(B) provided by a health care provider other than

(i) the treating doctor selected in accordance with §408.022 of the Texas Labor Code,

(ii) a health care provider that the treating doctor has chosen as a consulting or referral health care provider,

(iii) a doctor performing a required medical examination in accordance with §126.5 of this title (relating to Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Order for Required Medical Examination), or

(iv) a doctor performing a designated doctor examination in accordance with §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings); or

(C) unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(f) When the insurance carrier pays a health care provider for health care for which the Division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.1 (relating to Medical Reimbursement).

(g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

(1) the injury is not compensable;

(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the health care was provided was not related to the compensable injury.

(h) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

(i) If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(j) Health care providers, injured employees, employers, attorneys, and other participants in the system 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 as provided in §133.250 and §133.305 of this chapter.

(k) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds), without any action taken by the Division. The interest payment shall be paid at the same time as the medical bill payment.

(l) When an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the full amount that the insurance carrier reimburses.

(m) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(n) An insurance carrier commits an administrative violation if the insurance carrier fails to pay, reduce, deny, or notify the health care provider of the intent to audit a medical bill in accordance with Labor Code §408.027 and Division rules.

§133.250. Reconsideration for Payment of Medical Bills.

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action.

(b) The health care provider shall submit the request for reconsideration no later than eleven months from the date of service.

(c) A health care provider shall not submit a request for reconsideration until:

(1) the insurance carrier has taken final action on a medical bill; or

(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

(d) The request for reconsideration shall:

(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;

(2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;

(3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and

(4) include a bill-specific, substantive explanation in accordance with §133.3 of this chapter (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

(e) An insurance carrier shall review all reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its request to the insurance carrier.

(f) The insurance carrier shall take final action on a reconsideration request within 21 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits for all items included in a reconsideration request in the form and format prescribed by the Division.

(g) A health care provider shall not resubmit a request for reconsideration earlier than 26 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request.

(h) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

§133.260. Refunds.

(a) An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided.

(b) The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division.

(c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by:

(1) paying the requested amount; or

(2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment.

(d) The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal.

(e) If the insurance carrier denies the appeal, the health provider:

(1) shall remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal; and

(2) may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(f) The health care provider shall submit a refund to the insurance carrier when the health care provider identifies an overpayment even though the insurance carrier has not submitted a refund request.

(g) When making a refund payment, the health care provider shall include: a copy of the insurance carrier's original request for refund, if any; a copy of the original explanation of benefits containing the overpayment, if available; and a detailed explanation itemizing the refund. The explanation shall:

(1) identify the billing and rendering health care provider;

(2) identify the injured employee;

(3) identify the insurance carrier;

(4) specify the total dollar amount being refunded;

(5) itemize the refund by dollar amount, line item and date of service; and

(6) specify the amount of interest paid, if any, and the number of days on which interest was calculated.

(h) All refunds requested by the insurance carrier and paid by a health care provider on or after the 60th day after the date the health care provider

received the request for the refund shall include interest calculated in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds).

§133.270. Injured Employee Reimbursement for Health Care Paid.

(a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in:

(1) Insurance Code §1305.451, or

(2) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

(b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider.

(c) The insurance carrier shall pay or deny the request for reimbursement within 45 days of the request. Reimbursement shall be made in accordance with §134.1 (relating to Medical Reimbursement).

(d) The injured employee may seek reimbursement for any payment made above the Division fee guideline or contract amount from the health care provider who received the overpayment.

(e) Within 45 days of a request, the health care provider shall reimburse the injured employee the amount paid above the applicable Division fee guideline or contract amount.

(f) The injured employee may request, but is not required to request, reconsideration prior to requesting medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(g) The insurance carrier shall submit injured employee medical billing and payment data to the Division in accordance with §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Division).

§133.280. Employer Reimbursement for Health Care Paid.

(a) An employer may request reimbursement from the insurance carrier when the employer has paid for health care provided for a compensable injury, and provided notice of injury in compliance with Labor Code §409.005.

(b) The employer shall be reimbursed in accordance with §134.1.

(c) The employer may seek reimbursement for any payment made above the Division fee guideline or contract amount from the health care provider who received the overpayment.

(d) The employer's request for reimbursement shall be legible and shall include:

(1) a copy of the health care provider's required billing form;

(2) any supporting documentation submitted by the health care provider as required in §133.210 of this chapter (relating to Medical Documentation); and

(3) documentation of the payment to the health care provider.

(e) The insurance carrier shall submit employer medical bill and payment data to the Division in accordance with §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Division).