

1 **CHAPTER 133. GENERAL MEDICAL PROVISIONS**
2 **SUBCHAPTER B. HEALTH CARE PROVIDER BILLING PROCEDURES**
3 **28 TAC §§133.10 and 133.20**

4
5 **SUBCHAPTER C. MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER**
6 **28 TAC §133.200**

7
8 **SUBCHAPTER G. ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND**
9 **DOCUMENTATION**
10 **28 TAC §133.502**

11
12 **TEXT.**

13 **§133.10. Required Billing Forms/Formats**

14 (a) Health care providers, including those providing services for a certified
15 workers' compensation health care network as defined in Insurance Code Chapter 1305
16 or to political subdivisions with contractual relationships under Labor Code
17 §504.053(b)(2), must [~~shall~~] submit medical bills for payment in an electronic format in
18 accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for
19 Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the
20 health care provider or the billed insurance carrier is exempt from the electronic billing
21 process in accordance with §133.501 of this title.

22 (b) Except as provided in subsection (a) of this section, health care providers,
23 including those providing services for a certified workers' compensation health care
24 network as defined in Insurance Code Chapter 1305 or to political subdivisions with
25 contractual relationships under Labor Code §504.053(b)(2), must [~~shall~~] submit paper
26 medical bills for payment on:

- 27 (1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500);
28 (2) the Uniform Bill 04 (UB-04); or
29 (3) applicable forms prescribed for pharmacists, dentists, and surgical
30 implant providers specified in subsections (c), (d), and (e) of this section.

1 (c) Pharmacists and pharmacy processing agents must [~~shall~~] submit bills using
2 the division [~~Division~~] form DWC-066. A pharmacist or pharmacy processing agent may
3 submit bills using an alternate billing form if:

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

6 (2) the alternate billing form provides all information required on the
7 division [~~Division~~] form DWC-066.

8 (d) Dentists must [~~shall~~] submit bills for dental services using the 2006 American
9 Dental Association (ADA) Dental Claim form.

10 (e) Surgical implant providers requesting separate reimbursement for implantable
11 devices must [~~shall~~] submit bills using:

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

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

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

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

26 (A) patient's Social Security number [~~Number~~] (CMS-1500/field 1a)
27 is required;

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

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

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

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

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

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

9 (H) workers' compensation claim number assigned by the insurance
10 carrier (CMS-1500/field 11) is required when known; ~~[]~~ the billing provider must ~~[shall]~~
11 leave the field blank if the workers' compensation claim number is not known by the
12 billing provider;

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

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

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

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

25 (M) diagnosis or nature of injury (CMS-1500/field 21) is required; ~~[]~~
26 at least one diagnosis code and the applicable ICD indicator must be present;

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

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

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

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

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

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

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

22 (P) place of service code or codes [~~code(s)~~] (CMS-1500, field 24B) is
23 required;

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

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

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

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

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

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

8 (W) supplemental information (shaded portion of CMS-1500/fields
9 24d - 24h) is required when the provider is requesting separate reimbursement for
10 surgically implanted devices or when additional information is necessary to adjudicate
11 payment for the related service line;

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

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

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

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

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

22 (CC) billing provider name, address, and telephone number (CMS-
23 1500/field 33) is required;

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

26 (EE) billing provider's state license number (CMS-1500/field 33b) is
27 required when the billing provider has a state license number; the billing provider must

1 [~~shall~~] enter the 'OB' qualifier and the license type, license number, and jurisdiction code
2 (for example, 'MDF1234TX').

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

5 (A) billing provider's name, address, and telephone number (UB-
6 04/field 01) is required;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (Z) date bill submitted, page numbers, and total charges (UB-
19 04/field 45/line 23) is required;

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

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

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

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

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

1 (FF) patient's Social Security number [~~Number~~] (UB-04/field 60) is
2 required;

3 (GG) workers' compensation claim number assigned by the
4 insurance carrier (UB-04/field 62) is required when known, the billing provider must
5 [~~shall~~] leave the field blank if the workers' compensation claim number is not known by
6 the billing provider;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 (I) injured employee's name and address (DWC-066/field 9) is
2 required;
- 3 (J) injured employee's Social Security number [~~Number~~] (DWC-
4 066/field 10) is required;
- 5 (K) date of injury (DWC-066/field 11) is required;
- 6 (L) injured employee's date of birth (DWC-066/field 12) is required;
- 7 (M) prescribing doctor's name and address (DWC-066/field 13) is
8 required;
- 9 (N) prescribing doctor's NPI number (DWC-066/field 14) is required;
- 10 (O) workers' compensation claim number assigned by the insurance
11 carrier (DWC-066/field 15) is required when known; [] the billing provider must [~~shall~~]
12 leave the field blank if the workers' compensation claim number is not known by the
13 billing provider;
- 14 (P) dispensed as written code (DWC-066/field 19) is required;
- 15 (Q) date filled (DWC-066/field 20) is required;
- 16 (R) generic National Drug Code (NDC) code (DWC-066/field 21) is
17 required when a generic drug was dispensed or if dispensed as written code '2' is
18 reported in DWC-066/field 19;
- 19 (S) name brand NDC code (DWC-066/field 22) is required when a
20 name brand drug is dispensed;
- 21 (T) quantity (DWC-066/field 23) is required;
- 22 (U) days supply (DWC-066/field 24) is required;
- 23 (V) amount paid by the injured employee (DWC-066/field 26) is
24 required if applicable;
- 25 (W) drug name and strength (DWC-066/field 27) is required;
- 26 (X) prescription number (DWC-066/field 28) is required;
- 27 (Y) amount billed (DWC-066/field 29) is required;

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

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

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

8 (AA) for billing of compound drugs, refer to the requirements in
9 §134.502 of this title (relating to Pharmaceutical Services).

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

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

13 (B) preauthorization number (ADA 2006 Dental Claim Form/field 2)
14 is required when:

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

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

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

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

25 (E) workers' compensation claim number assigned by the insurance
26 carrier (ADA 2006 Dental Claim Form/field 15) is required when known; [-] the billing

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

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

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

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

9 (I) patient's Social Security number [~~Number~~] (ADA 2006 Dental
10 Claim Form/field 23) is required;

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

13 (K) tooth number or numbers or letter or letters [~~number(s) or~~
14 ~~letter(s)~~] (ADA 2006 Dental Claim Form/field 27) is required;

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

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

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

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

21 (P) treatment resulting from (ADA 2006 Dental Claim Form/field 45)
22 is required; [~~;~~] the provider must [~~shall~~] check the box for occupational illness/injury;

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

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

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

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

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

9 (V) rendering dentist's NPI number (ADA 2006 Dental Claim
10 Form/field 54) is required when different than the billing provider's NPI number (ADA
11 2006 Dental Claim Form/field 49) and the rendering dentist is eligible for an NPI
12 number;

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

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

20 (g) If the injured employee does not have a Social Security number [~~Number~~] as
21 required in subsection (f) of this section, the health care provider must leave the field
22 blank.

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

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

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

- 5 (1) AC for Acupuncturist;
- 6 (2) AM for Ambulance Services;
- 7 (3) AS for Ambulatory Surgery Center;
- 8 (4) AU for Audiologist;
- 9 (5) CN for Clinical Nurse Specialist;
- 10 (6) CP for Clinical Psychologist;
- 11 (7) CR for Certified Registered Nurse Anesthetist;
- 12 (8) CS for Clinical Social Worker;
- 13 (9) DC for Doctor of Chiropractic;
- 14 (10) DM for Durable Medical Equipment Supplier;
- 15 (11) DO for Doctor of Osteopathy;
- 16 (12) DP for Doctor of Podiatric Medicine;
- 17 (13) DS for Dentist;
- 18 (14) IL for Independent Laboratory;
- 19 (15) LP for Licensed Professional Counselor;
- 20 (16) LS for Licensed Surgical Assistant;
- 21 (17) MD for Doctor of Medicine;
- 22 (18) MS for Licensed Master Social Worker;
- 23 (19) MT for Massage Therapist;
- 24 (20) NF for Nurse First Assistant;
- 25 (21) OD for Doctor of Optometry;
- 26 (22) OP for Orthotist/Prosthetist;
- 27 (23) OT for Occupational Therapist;

- 1 (24) PA for Physician Assistant;
- 2 (25) PM for Pain Management Clinic;
- 3 (26) PS for Psychologist;
- 4 (27) PT for Physical Therapist;
- 5 (28) RA for Radiology Facility; or
- 6 (29) RN for Registered Nurse.

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

11 (1) W3 - Level 1 Appeal means a request for reconsideration under
12 §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) or an
13 appeal of an adverse determination under Chapter 19, Subchapter U of this title
14 (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation
15 Insurance Coverage);

16 (2) W4 - Level 2 Appeal means a request for reimbursement as a result of a
17 decision issued by the division, an independent review organization [~~Independent
18 Review Organization~~], or a network [~~Network~~] complaint process; and

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

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

26 (l) This section is effective for medical bills submitted on or after (NEW DATE)
27 [April 1, 2014].

1 **§133.20. Medical Bill Submission by Health Care Provider**

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

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

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

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

14 (3) A health care provider who submits a medical bill to the correct
15 workers' compensation insurance carrier must [~~shall~~] include a copy of the original
16 medical bill submitted, a copy of the explanation of benefits (EOB) if available, and
17 sufficient documentation to support why one or more of the exceptions for untimely
18 submission of a medical bill under §408.0272 should be applied. The medical bill
19 submitted by the health care provider to the correct workers' compensation insurance
20 carrier is subject to the billing, review, and dispute processes established by Chapter
21 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes),
22 which establishes the generally acceptable standards for documentation.

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

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

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

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

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

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

13 (e) A medical bill must be submitted:

14 (1) for an amount that does not exceed the health care provider's usual
15 and customary charge for the health care provided in accordance with Labor Code
16 §§413.011 and 415.005; and

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

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

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

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

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

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

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

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

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

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

13 (B) interest for delayed payment as provided by Labor Code
14 §413.019; and

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

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

20 (3) When a health care provider bills the employer, the health care
21 provider must bill in accordance with the division's [~~Division's~~] fee guidelines and
22 §133.10 of this chapter (relating to Required Billing Forms/Formats).

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

25 (k) A health care provider must [~~shall~~] not submit a medical bill to an injured
26 employee for all or part of the charge for any of the health care provided, except as an

1 informational copy clearly indicated on the bill, or in accordance with subsection (l) of
2 this section. The information copy must [~~shall~~] not request payment.

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

5 (1) Labor Code §413.042;

6 (2) Insurance Code §1305.451; or

7 (3) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by
8 the Injured Employee).

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

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

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

1 **§133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers**

2 (a) ~~On~~ ~~[Upon]~~ receipt of medical bills submitted in accordance with §133.10
3 ~~§133.10(a)(1) and (2)]~~ of this chapter (relating to Required Billing ~~[Medical]~~
4 Forms/Formats), an insurance carrier must ~~[shall]~~ evaluate each medical bill for
5 completeness as defined in §133.2 of this chapter (relating to Definitions).

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

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

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

12 (i) dates of service;

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

14 (iii) number of units; and

15 (iv) charges; or

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

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

23 (b) An insurance carrier must ~~[shall]~~ not return a medical bill except as provided
24 in subsection (a) of this section. When returning a medical bill, the insurance carrier
25 must ~~[shall]~~ include a document identifying the reasons ~~[reason(s)]~~ for returning the bill.
26 The reasons ~~[reason(s)]~~ related to the procedure or modifier codes ~~[code(s)]~~ ~~[shall]~~
27 identify the reasons ~~[reason(s)]~~ by line item.

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

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

1 **§133.502. Electronic Medical Billing Supplemental Data Requirements**

2 (a) In addition to the data requirements and standards adopted under
3 §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill
4 Processing), all professional, institutional or hospital [~~institutional/hospital~~], and dental
5 electronic medical bills submitted before January 1, 2012, must contain:

6 (1) the telephone number of the submitter;

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

10 (3) the injured employee's Social Security number [~~Number~~] as the
11 subscriber member identification number;

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

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

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

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

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

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

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

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

25 (b) In reporting the injured employee Social Security number [~~Number~~] and the
26 state license numbers under subsection (a) of this section, health care providers must

1 follow the data content and format requirements contained in §133.10 of this title
2 (relating to Required Billing Forms/Formats).

3 (c) In addition to the data requirements contained in the standards adopted
4 under §133.500(c) of this title, all professional, institutional or hospital
5 ~~[institutional/hospital]~~, and dental electronic medical bills submitted on or after January
6 1, 2012, must contain:

7 (1) the telephone number of the submitter;

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

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

12 (4) the claim supplemental information, when electronic documentation is
13 submitted with an electronic medical bill; ~~[and]~~

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

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

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

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

22 and

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

24 (e) In reporting the resubmission condition code under this section, the
25 resubmission condition codes must ~~[shall]~~ have the definitions specified in §133.10(j) of
26 this title.

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

3 (g) This section is effective DATE [~~August 1, 2011~~].