Comparison of existing text to informal draft text (not redlined for ease of reading)

The notes column identifies substantive changes in the rule text. Other style and editorial changes are not included in the notes column.

Chapter 133. General Medical Provisions **Subchapter B. Health Care Provider Billing Procedures** **§133.10. Required Billing Forms/Formats**		
Current text	**Informal draft text**	**Notes**
§133.10. Required Billing Forms/Formats	§133.10. Required Billing Forms/Formats	• No change
(a) Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.	(a) Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), must submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.	• Editorial
(b) Except as provided in subsection (a) of this section, health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit paper medical bills for payment on: (1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500); (2) the Uniform Bill 04 (UB-04); or (3) applicable forms prescribed for pharmacists, dentists, and surgical implant providers specified in subsections (c), (d) and (e) of this section.	(b) Except as provided in subsection (a) of this section, health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), must submit paper medical bills for payment on: (1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500); (2) the Uniform Bill 04 (UB-04); or (3) applicable forms prescribed for pharmacists, dentists, and surgical implant providers specified in subsections (c), (d), and (e) of this section.	• Editorial
(c) Pharmacists and pharmacy processing agents shall submit bills using the Division form DWC-066. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:	(c) Pharmacists and pharmacy processing agents must submit bills using the division form DWC-066. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:	• Editorial

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(1) the insurance carrier has approved the alternate billing form prior to submission by the pharmacist or pharmacy processing agent; and (2) the alternate billing form provides all information required on the Division form DWC-066.	(1) the insurance carrier has approved the alternate billing form prior to submission by the pharmacist or pharmacy processing agent; and (2) the alternate billing form provides all information required on the division form DWC-066.	
(d) Dentists shall submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.	(d) Dentists must submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.	• Editorial
(e) Surgical implant providers requesting separate reimbursement for implantable devices shall submit bills using: (1) the form prescribed in subsection (b)(1) of this section when the implantable device reimbursement is sought under §134.402 of this title (relating to Ambulatory Surgical Center Fee Guideline); or (2) the form prescribed in subsection (b)(2) of this section when the implantable device reimbursement is sought under §134.403 or §134.404 of this title (relating to Hospital Facility Fee Guideline--Outpatient and Hospital Facility Fee Guideline--Inpatient).	(e) Surgical implant providers requesting separate reimbursement for implantable devices must submit bills using: (1) the form prescribed in subsection (b)(1) of this section when the implantable device reimbursement is sought under §134.402 of this title (relating to Ambulatory Surgical Center Fee Guideline); or (2) the form prescribed in subsection (b)(2) of this section when the implantable device reimbursement is sought under §134.403 or §134.404 of this title (relating to Hospital Facility Fee Guideline--Outpatient and Hospital Facility Fee Guideline--Inpatient).	• Editorial
(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (A) patient's Social Security Number (CMS-1500/field 1a) is required; (B) patient's name (CMS-1500/field 2) is required; (C) patient's date of birth and gender (CMS-1500/field 3) is required; (D) employer's name (CMS-1500/field 4) is required;	(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (A) patient's Social Security number (CMS-1500/field 1a) is required; (B) patient's name (CMS-1500/field 2) is required; (C) patient's date of birth and gender (CMS-1500/field 3) is required; (D) employer's name (CMS-1500/field 4) is required;	• Added the assignment number for DD exams to (f)(1)(N) in field 23 • Clarified dates of service for DD exams that include referrals for additional testing and evaluation

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(E) patient's address (CMS-1500/field 5) is required; (F) patient's relationship to subscriber (CMS-1500, field 6) is required; (G) employer's address (CMS-1500, field 7) is required; (H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known, the billing provider shall leave the field blank if the workers' compensation claim number is not known by the billing provider; (I) date of injury and "431" qualifier (CMS-1500, field 14) are required; (J) name of referring provider or other source is required when another health care provider referred the patient for the services; No qualifier indicating the role of the provider is required (CMS-1500, field 17); (K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number; (M) diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code and the applicable ICD indicator must be present; (N) prior authorization number (CMS-1500/field 23) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the requesting health care provider; (O) date(s) of service (CMS-1500, field 24A) is required; (P) place of service code(s) (CMS-1500, field 24B) is required; (Q) procedure/modifier code (CMS-1500, field 24D) is required;	(E) patient's address (CMS-1500/field 5) is required; (F) patient's relationship to subscriber (CMS-1500, field 6) is required; (G) employer's address (CMS-1500, field 7) is required; (H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known, the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider; (I) date of injury and "431" qualifier (CMS-1500, field 14) are required; (J) name of referring provider or other source is required when another health care provider referred the patient for the services; no qualifier indicating the role of the provider is required (CMS-1500, field 17); (K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number; (M) diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code and the applicable ICD indicator must be present; (N) prior authorization number (CMS-1500/field 23) is required in the following situations: (i) Preauthorization, concurrent review, or voluntary certification was approved and the insurance carrier provided an approval number to the requesting health care provider. Include the approval number in the prior authorization field (CMS-1500/field 23).	

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(R) diagnosis pointer (CMS-1500, field 24E) is required; (S) charges for each listed service (CMS-1500, field 24F) is required; (T) number of days or units (CMS-1500, field 24G) is required; (U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number; (W) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line; (X) billing provider's federal tax ID number (CMS-1500/field 25) is required; (Y) total charge (CMS-1500/field 28) is required; (Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier; (AA) service facility location information (CMS-1500/field 32) is required; (BB) service facility NPI number (CMS-1500/field 32a) is required when the facility is eligible for an NPI number; (CC) billing provider name, address and telephone number (CMS-1500/field 33) is required;	(ii) The division ordered a designated doctor examination and provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23). (iii) The designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23). (O) date or dates of service (CMS-1500, field 24A) is required; (i) If the designated doctor referred the injured employee for additional testing or evaluation, the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation. (ii) If the designated doctor did not refer the injured employee for additional testing or evaluation, the "From" and "To" dates are the date of the designated doctor examination. (P) place of service code or codes (CMS-1500, field 24B) is required; (Q) procedure/modifier code (CMS-1500, field 24D) is required; (R) diagnosis pointer (CMS-1500, field 24E) is required; (S) charges for each listed service (CMS-1500, field 24F) is required; (T) number of days or units (CMS-1500, field 24G) is required; (U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');	

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(DD) billing provider's NPI number (CMS-1500/Field 33a) is required when the billing provider is eligible for an NPI number; and (EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'). (2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: (A) billing provider's name, address, and telephone number (UB-04/field 01) is required; (B) patient control number (UB-04/field 03a) is required; (C) type of bill (UB-04/field 04) is required; (D) billing provider's federal tax ID number (UB-04/field 05) is required; (E) statement covers period (UB-04/field 06) is required; (F) patient's name (UB-04/field 08) is required; (G) patient's address (UB-04/field 09) is required; (H) patient's date of birth (UB-04/field 10) is required; (I) patient's gender (UB-04/field 11) is required; (J) date of admission (UB-04/field 12) is required when billing for inpatient services; (K) admission hour (UB-04/field 13) is required when billing for inpatient services other than skilled nursing inpatient services; (L) priority (type) of admission or visit (UB-04/field 14) is required; (M) point of origin for admission or visit (UB-04/field 15) is required; (N) discharge hour (UB-04/field 16) is required when billing for inpatient services with a frequency code of "1" or "4" other than skilled nursing inpatient services;	(V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number; (W) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line; (X) billing provider's federal tax ID number (CMS-1500/field 25) is required; (Y) total charge (CMS-1500/field 28) is required; (Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier; (AA) service facility location information (CMS-1500/field 32) is required; (BB) service facility NPI number (CMS-1500/field 32a) is required when the facility is eligible for an NPI number; (CC) billing provider name, address, and telephone number (CMS-1500/field 33) is required; (DD) billing provider's NPI number (CMS-1500/Field 33a) is required when the billing provider is eligible for an NPI number; and (EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'). (2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:	

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(O) patient discharge status (UB-04/field 17) is required; (P) condition codes (UB-04/fields 18 - 28) are required when there is a condition code that applies to the medical bill; (Q) occurrence codes and dates (UB-04/fields 31 - 34) are required when there is an occurrence code that applies to the medical bill; (R) occurrence span codes and dates (UB-04/fields 35 and 36) are required when there is an occurrence span code that applies to the medical bill; (S) value codes and amounts (UB-04/fields 39 - 41) are required when there is a value code that applies to the medical bill; (T) revenue codes (UB-04/field 42) are required; (U) revenue description (UB-04/field 43) is required; (V) HCPCS/Rates (UB-04/field 44): (i) HCPCS codes are required when billing for outpatient services and an appropriate HCPCS code exists for the service line item; and (ii) accommodation rates are required when a room and board revenue code is reported; (W) service date (UB-04/field 45) is required when billing for outpatient services; (X) service units (UB-04/field 46) is required; (Y) total charge (UB-04/field 47) is required; (Z) date bill submitted, page numbers, and total charges (UB-04/field 45/line 23) is required; (AA) insurance carrier name (UB-04/field 50) is required; (BB) billing provider NPI number (UB-04/field 56) is required when the billing provider is eligible to receive an NPI number;	(A) billing provider's name, address, and telephone number (UB-04/field 01) is required; (B) patient control number (UB-04/field 03a) is required; (C) type of bill (UB-04/field 04) is required; (D) billing provider's federal tax ID number (UB-04/field 05) is required; (E) statement covers period (UB-04/field 06) is required; (F) patient's name (UB-04/field 08) is required; (G) patient's address (UB-04/field 09) is required; (H) patient's date of birth (UB-04/field 10) is required; (I) patient's gender (UB-04/field 11) is required; (J) date of admission (UB-04/field 12) is required when billing for inpatient services; (K) admission hour (UB-04/field 13) is required when billing for inpatient services other than skilled nursing inpatient services; (L) priority (type) of admission or visit (UB-04/field 14) is required; (M) point of origin for admission or visit (UB-04/field 15) is required; (N) discharge hour (UB-04/field 16) is required when billing for inpatient services with a frequency code of "1" or "4" other than skilled nursing inpatient services; (O) patient discharge status (UB-04/field 17) is required; (P) condition codes (UB-04/fields 18 - 28) are required when there is a condition code that applies to the medical bill; (Q) occurrence codes and dates (UB-04/fields 31 - 34) are required when there is an occurrence code that applies to the medical bill; (R) occurrence span codes and dates (UB-04/fields 35 and 36) are required when there is an occurrence span code that applies to the medical bill;	

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(CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider shall enter the license number and jurisdiction code (for example, '123TX'); (DD) employer's name (UB-04/field 58) is required; (EE) patient's relationship to subscriber (UB-04/field 59) is required; (FF) patient's Social Security Number (UB-04/field 60) is required; (GG) workers' compensation claim number assigned by the insurance carrier (UB-04/field 62) is required when known, the billing provider shall leave the field blank if the workers' compensation claim number is not known by the billing provider; (HH) preauthorization number (UB-04/field 63) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider; (II) principal diagnosis code and present on admission indicator (UB-04/field 67) are required; (JJ) other diagnosis codes (UB-04/field 67A - 67Q) are required when there conditions exist or subsequently develop during the patient's treatment; (KK) admitting diagnosis code (UB-04/field 69) is required when the medical bill involves an inpatient admission; (LL) patient's reason for visit (UB-04/field 70) is required when submitting an outpatient medical bill for an unscheduled outpatient visit; (MM) principal procedure code and date (UB-04/field 74) is required when submitting an inpatient medical bill and a procedure was performed; (NN) other procedure codes and dates (UB-04/fields 74A - 74E) are required when submitting an inpatient medical bill and other procedures were performed;	(S) value codes and amounts (UB-04/fields 39 - 41) are required when there is a value code that applies to the medical bill; (T) revenue codes (UB-04/field 42) are required; (U) revenue description (UB-04/field 43) is required; (V) HCPCS/Rates (UB-04/field 44): (i) HCPCS codes are required when billing for outpatient services and an appropriate HCPCS code exists for the service line item; and (ii) accommodation rates are required when a room and board revenue code is reported; (W) service date (UB-04/field 45) is required when billing for outpatient services; (X) service units (UB-04/field 46) is required; (Y) total charge (UB-04/field 47) is required; (Z) date bill submitted, page numbers, and total charges (UB-04/field 45/line 23) is required; (AA) insurance carrier name (UB-04/field 50) is required; (BB) billing provider NPI number (UB-04/field 56) is required when the billing provider is eligible to receive an NPI number; (CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider must enter the license number and jurisdiction code (for example, '123TX'); (DD) employer's name (UB-04/field 58) is required; (EE) patient's relationship to subscriber (UB-04/field 59) is required; (FF) patient's Social Security number (UB-04/field 60) is required; (GG) workers' compensation claim number assigned by the insurance carrier (UB-04/field 62) is required when known, the billing provider must leave	

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(OO) attending provider's name and identifiers (UB-04/field 76) are required for any services other than nonscheduled transportation services, the billing provider shall report the NPI number for an attending provider eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (PP) operating physician's name and identifiers (UB-04/field 77) are required when a surgical procedure code is included on the medical bill, the billing provider shall report the NPI number for an operating physician eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and (QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested. (3) The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care: (A) dispensing pharmacy's name and address (DWC-066/field 1) is required; (B) date of billing (DWC-066/field 2) is required; (C) dispensing pharmacy's National Provider Identification (NPI) number (DWC-066/field 3) is required; (D) billing pharmacy's or pharmacy processing agent's name and address (DWC-066/field 4) is required when different from the dispensing pharmacy (DWC-066/field 1); (E) invoice number (DWC-066/field 5) is required; (F) payee's federal employer identification number (DWC-066/field 6) is required;	the field blank if the workers' compensation claim number is not known by the billing provider; (HH) preauthorization number (UB-04/field 63) is required when: (i) preauthorization, concurrent review, or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider; or (ii) a designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number to the designated doctor. (II) principal diagnosis code and present on admission indicator (UB-04/field 67) are required; (JJ) other diagnosis codes (UB-04/field 67A - 67Q) are required when these conditions exist or subsequently develop during the patient's treatment; (KK) admitting diagnosis code (UB-04/field 69) is required when the medical bill involves an inpatient admission; (LL) patient's reason for visit (UB-04/field 70) is required when submitting an outpatient medical bill for an unscheduled outpatient visit; (MM) principal procedure code and date (UB-04/field 74) is required when submitting an inpatient medical bill and a procedure was performed; (NN) other procedure codes and dates (UB-04/fields 74A - 74E) are required when submitting an inpatient medical bill and other procedures were performed; (OO) attending provider's name and identifiers (UB-04/field 76) are required for any services other than nonscheduled transportation services; the billing provider must report the NPI number for an attending provider eligible for an NPI number and the state license number by entering the '0B' qualifier	

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(G) insurance carrier's name (DWC-066/field 7) is required; (H) employer's name and address (DWC-066/field 8) is required; (I) injured employee's name and address (DWC-066/field 9) is required; (J) injured employee's Social Security Number (DWC-066/field 10) is required; (K) date of injury (DWC-066/field 11) is required; (L) injured employee's date of birth (DWC-066/field 12) is required; (M) prescribing doctor's name and address (DWC-066/field 13) is required; (N) prescribing doctor's NPI number (DWC-066/field 14) is required; (O) workers' compensation claim number assigned by the insurance carrier (DWC-066/field 15) is required when known, the billing provider shall leave the field blank if the workers' compensation claim number is not known by the billing provider; (P) dispensed as written code (DWC-066/field 19) is required; (Q) date filled (DWC-066/field 20) is required; (R) generic National Drug Code (NDC) code (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19; (S) name brand NDC code (DWC-066/field 22) is required when a name brand drug is dispensed; (T) quantity (DWC-066/field 23) is required; (U) days supply (DWC-066/field 24) is required; (V) amount paid by the injured employee (DWC-066/field 26) is required if applicable; (W) drug name and strength (DWC-066/field 27) is required; (X) prescription number (DWC-066/field 28) is required;	and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (PP) operating physician's name and identifiers (UB-04/field 77) are required when a surgical procedure code is included on the medical bill, the billing provider must report the NPI number for an operating physician eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and (QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested. (3) The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care: (A) dispensing pharmacy's name and address (DWC-066/field 1) is required; (B) date of billing (DWC-066/field 2) is required; (C) dispensing pharmacy's National Provider Identification (NPI) number (DWC-066/field 3) is required; (D) billing pharmacy's or pharmacy processing agent's name and address (DWC-066/field 4) is required when different from the dispensing pharmacy (DWC-066/field 1); (E) invoice number (DWC-066/field 5) is required; (F) payee's federal employer identification number (DWC-066/field 6) is required; (G) insurance carrier's name (DWC-066/field 7) is required; (H) employer's name and address (DWC-066/field 8) is required; (I) injured employee's name and address (DWC-066/field 9) is required;	

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(Y) amount billed (DWC-066/field 29) is required; (Z) preauthorization number (DWC-066/field 30) is required when preauthorization, voluntary certification, or an agreement was approved and the insurance carrier provided an approval number to the requesting health care provider; and (AA) for billing of compound drugs refer to the requirements in §134.502 of this title (relating to Pharmaceutical Services). (4) The following data content or data elements are required for a complete dental medical bill related to Texas workers' compensation health care: (A) type of transaction (ADA 2006 Dental Claim Form/field 1); (B) preauthorization number (ADA 2006 Dental Claim Form/field 2) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider; (C) insurance carrier name and address (ADA 2006 Dental Claim Form/field 3) is required; (D) employer's name and address (ADA 2006 Dental Claim Form/field 12) is required; (E) workers' compensation claim number assigned by the insurance carrier (ADA 2006 Dental Claim Form/field 15) is required when known, the billing provider shall leave the field blank if the workers' compensation claim number is not known by the billing provider; (F) patient's name and address (ADA 2006 Dental Claim Form/field 20) is required; (G) patient's date of birth (ADA 2006 Dental Claim Form/field 21) is required; (H) patient's gender (ADA 2006 Dental Claim Form/field 22) is required;	(J) injured employee's Social Security number (DWC-066/field 10) is required; (K) date of injury (DWC-066/field 11) is required; (L) injured employee's date of birth (DWC-066/field 12) is required; (M) prescribing doctor's name and address (DWC-066/field 13) is required; (N) prescribing doctor's NPI number (DWC-066/field 14) is required; (O) workers' compensation claim number assigned by the insurance carrier (DWC-066/field 15) is required when known, the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider; (P) dispensed as written code (DWC-066/field 19) is required; (Q) date filled (DWC-066/field 20) is required; (R) generic National Drug Code (NDC) (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19; (S) name brand NDC (DWC-066/field 22) is required when a name brand drug is dispensed; (T) quantity (DWC-066/field 23) is required; (U) days supply (DWC-066/field 24) is required; (V) amount paid by the injured employee (DWC-066/field 26) is required if applicable; (W) drug name and strength (DWC-066/field 27) is required; (X) prescription number (DWC-066/field 28) is required; (Y) amount billed (DWC-066/field 29) is required; (Z) preauthorization number (DWC-066/field 30) is required when:	

§133.10. Required Billing Forms/Formats		
Current text	**Informal draft text**	**Notes**
(I) patient's Social Security Number (ADA 2006 Dental Claim Form/field 23) is required; (J) procedure date (ADA 2006 Dental Claim Form/field 24) is required; (K) tooth number(s) or letter(s) (ADA 2006 Dental Claim Form/field 27) is required; (L) procedure code (ADA 2006 Dental Claim Form/field 29) is required; (M) fee (ADA 2006 Dental Claim Form/field 31) is required; (N) total fee (ADA 2006 Dental Claim Form/field 33) is required; (O) place of treatment (ADA 2006 Dental Claim Form/field 38) is required; (P) treatment resulting from (ADA 2006 Dental Claim Form/field 45) is required, the provider shall check the box for occupational illness/injury; (Q) date of injury (ADA 2006 Dental Claim Form/field 46) is required; (R) billing provider's name and address (ADA 2006 Dental Claim Form/field 48) is required; (S) billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) is required if the billing provider is eligible for an NPI number; (T) billing provider's state license number (ADA 2006 Dental Claim Form/field 50) is required when the billing provider is a licensed health care provider; the billing provider shall enter the license type, license number, and jurisdiction code (for example, 'DS1234TX'); (U) billing provider's federal tax ID number (ADA 2006 Dental Claim Form/field 51) is required; (V) rendering dentist's NPI number (ADA 2006 Dental Claim Form/field 54) is required when different than the billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) and the rendering dentist is eligible for an NPI number;	(i) preauthorization, voluntary certification, or an agreement was approved and the insurance carrier provided an approval number to the requesting health care provider; or (ii) a designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number to the designated doctor. (AA) for billing of compound drugs, refer to the requirements in §134.502 of this title (relating to Pharmaceutical Services). (4) The following data content or data elements are required for a complete dental medical bill related to Texas workers' compensation health care: (A) type of transaction (ADA 2006 Dental Claim Form/field 1); (B) preauthorization number (ADA 2006 Dental Claim Form/field 2) is required when: (i) preauthorization, concurrent review, or voluntary certification was approved and the insurance carrier provided an approval number to the health care provider; or (ii) a designated doctor referred the injured employee for additional testing or evaluation and the division provided an assignment number to the designated doctor. (C) insurance carrier name and address (ADA 2006 Dental Claim Form/field 3) is required; (D) employer's name and address (ADA 2006 Dental Claim Form/field 12) is required; (E) workers' compensation claim number assigned by the insurance carrier (ADA 2006 Dental Claim Form/field 15) is required when known, the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;	

§133.10. Required Billing Forms/Formats		
Current text	**Informal draft text**	**Notes**
(W) rendering dentist's state license number (ADA 2006 Dental Claim Form/field 55) is required when different than the billing provider's state license number (ADA 2006 Dental Claim Form/field 50), the billing provider shall enter the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and (X) rendering provider's and treatment location address (ADA 2006 Dental Claim Form/field 56) is required when different from the billing provider's address (ADA Dental Claim Form/field 48).	(F) patient's name and address (ADA 2006 Dental Claim Form/field 20) is required; (G) patient's date of birth (ADA 2006 Dental Claim Form/field 21) is required; (H) patient's gender (ADA 2006 Dental Claim Form/field 22) is required; (I) patient's Social Security number (ADA 2006 Dental Claim Form/field 23) is required; (J) procedure date (ADA 2006 Dental Claim Form/field 24) is required; (K) tooth number or numbers or letter or letters (ADA 2006 Dental Claim Form/field 27) is required; (L) procedure code (ADA 2006 Dental Claim Form/field 29) is required; (M) fee (ADA 2006 Dental Claim Form/field 31) is required; (N) total fee (ADA 2006 Dental Claim Form/field 33) is required; (O) place of treatment (ADA 2006 Dental Claim Form/field 38) is required; (P) treatment resulting from (ADA 2006 Dental Claim Form/field 45) is required, the provider must check the box for occupational illness/injury; (Q) date of injury (ADA 2006 Dental Claim Form/field 46) is required; (R) billing provider's name and address (ADA 2006 Dental Claim Form/field 48) is required; (S) billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) is required if the billing provider is eligible for an NPI number; (T) billing provider's state license number (ADA 2006 Dental Claim Form/field 50) is required when the billing provider is a licensed health care provider; the billing provider must enter the license type, license number, and jurisdiction code (for example, 'DS1234TX');	

§133.10. Required Billing Forms/Formats		
Current text	**Informal draft text**	**Notes**
	(U) billing provider's federal tax ID number (ADA 2006 Dental Claim Form/field 51) is required; (V) rendering dentist's NPI number (ADA 2006 Dental Claim Form/field 54) is required when different than the billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) and the rendering dentist is eligible for an NPI number; (W) rendering dentist's state license number (ADA 2006 Dental Claim Form/field 55) is required when different than the billing provider's state license number (ADA 2006 Dental Claim Form/field 50); the billing provider must enter the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and (X) rendering provider's and treatment location address (ADA 2006 Dental Claim Form/field 56) is required when different from the billing provider's address (ADA Dental Claim Form/field 48).	
(g) If the injured employee does not have a Social Security Number as required in subsection (f) of this section, the health care provider must leave the field blank.	(g) If the injured employee does not have a Social Security number as required in subsection (f) of this section, the health care provider must leave the field blank.	• Editorial
(h) Except for facility state license numbers, state license numbers submitted under subsection (f) of this section must be in the following format: license type, license number, and jurisdiction state code (for example 'MDF1234TX').	(h) Except for facility state license numbers, state license numbers submitted under subsection (f) of this section must be in the following format: license type, license number, and jurisdiction state code (for example 'MDF1234TX').	• No change
(i) In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:	(i) In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:	• No change

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

§133.10. Required Billing Forms/Formats		
Current text	**Informal draft text**	**Notes**
(28) RA for Radiology Facility; or (29) RN for Registered Nurse.	(28) RA for Radiology Facility; or (29) RN for Registered Nurse.	
(j) When resubmitting a medical bill under subsection (f) of this section, a resubmission condition code may be reported. In reporting a resubmission condition code, the following definitions apply to the resubmission condition codes established by the Uniform National Billing Committee: (1) W3 - Level 1 Appeal means a request for reconsideration under §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) or an appeal of an adverse determination under Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage); (2) W4 - Level 2 Appeal means a request for reimbursement as a result of a decision issued by the division, an Independent Review Organization, or a Network complaint process; and (3) W5 - Level 3 Appeal means a request for reimbursement as a result of a decision issued by an administrative law judge or judicial review.	(j) When resubmitting a medical bill under subsection (f) of this section, a resubmission condition code may be reported. In reporting a resubmission condition code, the following definitions apply to the resubmission condition codes established by the Uniform National Billing Committee: (1) W3 - Level 1 Appeal means a request for reconsideration under §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) or an appeal of an adverse determination under Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage); (2) W4 - Level 2 Appeal means a request for reimbursement as a result of a decision issued by the division, an independent review organization, or a network complaint process; and (3) W5 - Level 3 Appeal means a request for reimbursement as a result of a decision issued by an administrative law judge or judicial review.	• No change
(k) The inclusion of the appropriate resubmission condition code and the original reference number is sufficient to identify a resubmitted medical bill as a request for reconsideration under §133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title provided the resubmitted medical bill complies with the other requirements contained in the appropriate section.	(k) The inclusion of the appropriate resubmission condition code and the original reference number is sufficient to identify a resubmitted medical bill as a request for reconsideration under §133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title provided the resubmitted medical bill complies with the other requirements contained in the appropriate section.	• No change
(l) This section is effective for medical bills submitted on or after April 1, 2014.	(l) This section is effective for medical bills submitted on or after (NEW DATE).	• The new date will be determined once we are closer to adoption.

Chapter 133. General Medical Provisions
Subchapter B. Health Care Provider Billing Procedures
§133.20. Medical Bill Submission by Health Care Provider

Current text	Informal draft text	Notes
§133.20. Medical Bill Submission by Health Care Provider	§133.20. Medical Bill Submission by Health Care Provider	• No change
(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.	(a) The health care provider must submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.	• Editorial
(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.	(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider must not submit a medical bill later than the 95th day after the date the services are provided. (1) If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title, the 95-day period for timely submission of the bill begins on the date of service of the additional testing or evaluation. (2) In accordance with subsection (c) of the statute, the health care provider must submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. (3) A health care provider who submits a medical bill to the correct workers' compensation insurance carrier must include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A)-(H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.	• This revision allows DDs that submit referrals to be paid for the examinations that DWC orders them to conduct without having payment depend on a factor outside of the DD's control (the length of time to schedule and conduct the referral test or evaluation). • The DD cannot complete the examination until the DD receives the results of the additional testing or evaluation; and the DD's services are still in progress during the referral. As a result, for a

§133.20. Medical Bill Submission by Health Care Provider		
Current text	**Informal draft text**	**Notes**
		DD exam in which the DD has submitted a referral under §127.10, the 95-day period for timely submission of the bill begins on the date of service of the additional testing or evaluation.
(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.	(c) A health care provider must include correct billing codes from the applicable division fee guidelines in effect on the date or dates of service when submitting medical bills.	• Editorial
(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.	(d) The health care provider that provided the health care must 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 must 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.	• Editorial
(e) A medical bill must be submitted:	(e) A medical bill must be submitted:	• No change

§133.20. Medical Bill Submission by Health Care Provider		
Current text	**Informal draft text**	**Notes**
(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.	(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).	(f) Health care providers must 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).	• Editorial
(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.	(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.	• No change
(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.	(h) Not later than the 15th day after receipt of a request for additional medical documentation, a health care provider must 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.	• Editorial
(i) The health care provider shall indicate on the medical bill if documentation is submitted related to the medical bill.	(i) The health care provider must indicate on the medical bill if documentation is submitted related to the medical bill.	• Editorial
(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:	(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill or bills. 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:	• Editorial

§133.20. Medical Bill Submission by Health Care Provider		
Current text	**Informal draft text**	**Notes**
(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.	(A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031. (2) When a health care provider bills the employer, the health care provider must 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 must 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.	(k) A health care provider must not submit a medical bill to an injured employee for all or part of the charge for any of the health care provided, except as an informational copy clearly indicated on the bill, or in accordance with subsection (l) of this section. The information copy must not request payment.	• Editorial
(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).	(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).	• No change
	(m) A designated doctor must include the assignment number on the medical bill in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).	• New

§133.20. Medical Bill Submission by Health Care Provider		
Current text	**Informal draft text**	**Notes**
	(n) A designated doctor who refers the injured employee for additional testing or evaluation under §127.10 must provide the assignment number to the health care provider performing the testing. The health care provider performing the testing must include the assignment number on the medical bill in accordance with §133.10.	• New
	(o) This section is effective for medical bills submitted on or after (NEW DATE).	• The new date will be the same as the new date for §133.10.

Chapter 133. General Medical Provisions
Subchapter C. Medical Bill Processing/Audit by Insurance Carrier
§133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers

Current text	Informal draft text	Notes
§133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers	§133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers	• No change
(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.	(a) On receipt of medical bills submitted in accordance with §133.10 of this chapter (relating to Required Billing Forms/Formats), an insurance carrier must evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions). (1) Insurance carriers must not return medical bills that are complete, unless the bill is a duplicate bill. (2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier must: (A) complete the bill by adding missing information already known to the insurance carrier, except for the following: (i) dates of service; (ii) procedure or modifier codes; (iii) number of units; and (iv) charges; or (B) return the bill to the sender, in accordance with subsection (c) of this section. (3) The insurance carrier may contact the sender to get 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 gets the missing information and completes the bill, the insurance carrier must document the name and telephone number of the person who supplied the information.	• Correct references • Editorial
(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	(b) An insurance carrier must not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier	• Editorial

§133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers		
Current text	**Informal draft text**	**Notes**
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.	must include a document identifying the reasons for returning the bill. The reasons related to the procedure or modifier codes must identify the reasons 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.	(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.	• No change
(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.	(d) An insurance carrier must not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.	• Editorial

Chapter 133. General Medical Provisions
Subchapter G. Electronic Medical Billing, Reimbursement, and Documentation
§133.502. Electronic Medical Billing Supplemental Data Requirements

Current text	Informal draft text	Notes
§133.502. Electronic Medical Billing Supplemental Data Requirements	§133.502. Electronic Medical Billing Supplemental Data Requirements	• No change
(a) In addition to the data requirements and standards adopted under §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional/hospital, and dental electronic medical bills submitted before January 1, 2012 must contain: (1) the telephone number of the submitter; (2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN"; (3) the injured employee's Social Security Number as the subscriber member identification number; (4) the injured employee's date of injury; (5) the rendering health care provider's state provider license number; (6) the referring health care provider's state provider license number; (7) the billing provider's state provider license number, if the billing provider has a state provider license number; (8) the attending physician's state medical license number, when applicable; (9) the operating physician's state medical license number, when applicable; (10) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and (11) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.	(a) In addition to the data requirements and standards adopted under §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional or hospital, and dental electronic medical bills submitted before January 1, 2012, must contain: (1) the telephone number of the submitter; (2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN"; (3) the injured employee's Social Security number as the subscriber member identification number; (4) the injured employee's date of injury; (5) the rendering health care provider's state provider license number; (6) the referring health care provider's state provider license number; (7) the billing provider's state provider license number, if the billing provider has a state provider license number; (8) the attending physician's state medical license number, when applicable; (9) the operating physician's state medical license number, when applicable; (10) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and (11) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.	• Editorial
(b) In reporting the injured employee Social Security Number and the state license numbers under subsection (a) of this section, health care providers must	(b) In reporting the injured employee Social Security number and the state license numbers under subsection (a) of this section, health care providers must	• Editorial

§133.502. Electronic Medical Billing Supplemental Data Requirements		
Current text	**Informal draft text**	**Notes**
follow the data content and format requirements contained in §133.10 of this title (relating to Required Billing Forms/Formats).	follow the data content and format requirements contained in §133.10 of this title (relating to Required Billing Forms/Formats).	
(c) In addition to the data requirements contained in the standards adopted under §133.500(c) of this title, all professional, institutional/hospital, and dental electronic medical bills submitted on or after January 1, 2012 must contain: (1) the telephone number of the submitter; (2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN"; (3) the injured employee's date of injury; (4) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and (5) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.	(c) In addition to the data requirements contained in the standards adopted under §133.500(c) of this title, all professional, institutional or hospital, and dental electronic medical bills submitted on or after January 1, 2012, must contain: (1) the telephone number of the submitter; (2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN"; (3) the injured employee's date of injury; (4) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; (5) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission; and (6) for a designated doctor and a health care provider performing a designated doctor referral examination, include the assignment number in the prior authorization field (CMS-1500/field 23).	• Added assignment number • Editorial
(d) In addition to the data requirements contained in the standards adopted under §133.500 of this title, all pharmacy electronic medical bills must contain: (1) the dispensing pharmacy's National Provider Identification number; and (2) the prescribing doctor's National Provider Identification number.	(d) In addition to the data requirements contained in the standards adopted under §133.500 of this title, all pharmacy electronic medical bills must contain: (1) the dispensing pharmacy's National Provider Identification number; and (2) the prescribing doctor's National Provider Identification number.	• No change
(e) In reporting the resubmission condition code under this section, the resubmission condition codes shall have the definitions specified in §133.10(j) of this title.	(e) In reporting the resubmission condition code under this section, the resubmission condition codes have the definitions specified in §133.10(j) of this title.	• Editorial

§133.502. Electronic Medical Billing Supplemental Data Requirements		
Current text	**Informal draft text**	**Notes**
(f) This section does not apply to paper medical bills submitted for payment under §133.10(b) of this title.	(f) This section does not apply to paper medical bills submitted for payment under §133.10(b) of this title.	• No change
(g) This section is effective August 1, 2011.	(g) This section is effective DATE.	• Same effective date as §133.10.

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments
Subchapter C. Medical Fee Guidelines
§134.209. Applicability

Current text	**Informal draft text**	**Notes**
§134.209. Applicability	§134.209. Applicability	• No change
(a) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply to workers' compensation specific codes, services, and programs provided in the Texas workers' compensation system, other than: (1) professional medical services described in §134.203 of this title; (2) prescription drugs or medicine; (3) dental services; (4) the facility services of a hospital or other health care facility; and (5) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.	(a) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title apply to workers' compensation specific codes, services, and programs provided in the Texas workers' compensation system, other than: (1) professional medical services described in §134.203 of this title; (2) prescription drugs or medicine; (3) dental services; (4) the facility services of a hospital or other health care facility; and (5) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.	• Added a new section
(b) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply to workers' compensation specific codes, services, and programs provided on or after September 1, 2016.	(b) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply to workers' compensation specific codes, services, and programs provided on or after September 1, 2016.	
(c) If a court of competent jurisdiction holds that any provision of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications that can be given effect without the invalid provision or application and the provisions of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title are severable.	(c) Sections 134.210, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title apply to workers' compensation specific codes, services, and programs provided on or after DATE.	• New

§134.209. Applicability		
Current text	**Informal draft text**	**Notes**
(d) When billing for a treating doctor examination to define the compensable injury, refer to §126.14 of this title.	(d) If a court of competent jurisdiction holds that any provision of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications that can be given effect without the invalid provision or application and the provisions of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title are severable.	• Added a new section
	(e) When billing for a treating doctor examination to define the compensable injury, refer to §126.14 of this title.	• No change except relettering
	(f) For coding, billing, reporting, and reimbursement of medical services, Texas workers' compensation system participants must apply Medicare payment policies, as defined in §134.203 of this chapter and in Chapter 133 of this title, that are in effect on the date a service is provided with any additions or exceptions in the rules.	• Inserted language from §134.203 to establish correct coding and application of Medicare policies for payment

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments
Subchapter C. Medical Fee Guidelines
§134.210. Medical Fee Guideline for Workers' Compensation Specific Services

Current text	Informal draft text	Notes
§134.210. Medical Fee Guideline for Workers' Compensation Specific Services	§134.210. Medical Fee Guideline for Workers' Compensation Specific Services	• No change
(a) Specific provisions contained in the Labor Code or division rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent review organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, take precedence, in that case only, over any division rules and Medicare payment policies.	(a) Specific provisions contained in the Labor Code or division rules, including this chapter, take precedence over any conflicting provision adopted or used by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent review organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, take precedence, in that case only, over any division rules and Medicare payment policies.	• Editorial
(b) Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows: (1) Health care providers shall bill their usual and customary charges using the most current Level I Current Procedural Terminology (CPT) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. Health care providers shall submit medical bills in accordance with the Labor Code and division rules. (2) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill. (3) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in §§134.220, 134.225,	(b) Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows: (1) Health care providers must bill their usual and customary charges using the most current Level I Current Procedural Terminology (CPT) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. Health care providers must submit medical bills in accordance with the Labor Code and division rules. (2) Modifying circumstance must be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers must treat them in accordance with Medicare and Texas Medicaid rules. In addition, division-specific modifiers are identified in subsection (f) of this section and in §§134.235, 134.240, 134.250, and 134.260. When two or more modifiers apply to a single HCPCS code, indicate each modifier on the bill.	• Adds annual adjustment to fees under: o §134.235 (Required Medical Examination Doctor); o §134.240 (Designated Doctor); o §134.250 (Treating Doctor); and o §134.260 (Referral Doctor).

§134.210. Medical Fee Guideline for Workers' Compensation Specific Services		
Current text	**Informal draft text**	**Notes**
134.235, 134.240, and 134.250 of this title and subsection (d) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title.	(3) A 10% incentive payment must be added to the maximum allowable reimbursement (MAR) for services outlined in §§134.220, 134.225, 134.235, 134.240, 134.250, and 134.260 of this title and subsection (d) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title. However, reimbursement for a missed appointment under §134.240 does not qualify for the 10% incentive payment. (4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be adjusted annually by applying the adjustment factor identified in §134.203(c)(2). The adjusted fees will be effective on January 1 of each new calendar year.	• No 10% incentive payment for DD missed appointment fee
(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.	(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement must be the negotiated or contracted amount that applies to the billed services.	• Editorial
(d) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.	(d) When billing for services in §§134.215, 134.220, 134.225, or 134.230, and there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement must be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.	• Clarifies applicability of subsection • Editorial
	(e) For services provided under §§134.235, 134.240, 134.250, or 134.260, health care providers must bill and be reimbursed the MAR.	• New
(e) The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.	(f) The following division modifiers must be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.	• Relettered • Adds modifier 25 for DD exams

§134.210. Medical Fee Guideline for Workers' Compensation Specific Services		
Current text	**Informal draft text**	**Notes**
(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs--This modifier shall be used when a health care provider bills for a return to work rehabilitation program that is CARF accredited. (2) CP, chronic pain management program--This modifier shall be added to CPT code 97799 to indicate chronic pain management program services were performed. (3) FC, functional capacity--This modifier shall be added to CPT code 97750 when a functional capacity evaluation is performed. (4) MR, outpatient medical rehabilitation program--This modifier shall be added to CPT code 97799 to indicate outpatient medical rehabilitation program services were performed. (5) MI, multiple impairment ratings--This modifier shall be added to CPT code 99455 when the designated doctor is required to complete multiple impairment ratings calculations. (6) NM, not at maximum medical improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI. (7) RE, return to work (RTW) and/or evaluation of medical care (EMC)--This modifier shall be added to CPT code 99456 when a RTW or EMC examination is performed. (8) SP, specialty area--This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report. (9) TC, technical component--This modifier shall be added to the CPT code when the technical component of a procedure is billed separately. (10) VR, review report--This modifier shall be added to CPT code 99455 to indicate that the service was the treating doctor's review of report(s) only.	(1) 25--This modifier must be added to CPT code 99456 when the division ordered the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B)-(I) of this title. (2) 52--This modifier must be added to CPT code 99456 when the division ordered the designated doctor to perform an examination of an injured employee and the injured employee missed the examination. (3) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs--This modifier must be used when a health care provider bills for a return-to-work rehabilitation program that is CARF accredited. (4) CP, chronic pain management program--This modifier must be added to CPT code 97799 to indicate chronic pain management program services were performed. (5) FC, functional capacity--This modifier must be added to CPT code 97750 when a functional capacity evaluation is performed. (6) MR, outpatient medical rehabilitation program--This modifier must be added to CPT code 97799 to indicate outpatient medical rehabilitation program services were performed. (7) MI, multiple impairment ratings--This modifier must be added to CPT code 99456 when the designated doctor is required to complete multiple impairment ratings calculations. (8) NM, not at maximum medical improvement (MMI)--This modifier must be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI. (9) VR, review report--This modifier must be added to CPT code 99455 to indicate that the service was the treating doctor's review of reports only.	• Corrects the CPT code reference for the MI modifier • Removes modifiers RE, SP, TC, V1, V2, WP • For modifiers V3, V4, and V5, ties the description to the appropriate CPT code for the level of service instead of a severity level range and time period

§134.210. Medical Fee Guideline for Workers' Compensation Specific Services		
Current text	**Informal draft text**	**Notes**
(11) V1, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to a "minimal" level. (12) V2, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "self limited or minor" level. (13) V3, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "low to moderate" level. (14) V4, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "moderate to high severity" level and at least 25 minutes duration. (15) V5, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "moderate to high severity" level and at least 45 minutes duration. (16) WC, work conditioning--This modifier shall be added to CPT code 97545 to indicate work conditioning was performed. (17) WH, work hardening--This modifier shall be added to CPT code 97545 to indicate work hardening was performed. (18) WP, whole procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single health care provider. (19) W1, case management for treating doctor--This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor. (20) W5, designated doctor examination for impairment or attainment of MMI--This modifier shall be added to the appropriate examination code	(10) V3, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99213. (11) V4, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99214. (12) V5, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99215. (13) WC, work conditioning--This modifier must be added to CPT codes 97545 and 97546 to indicate work conditioning was performed. (14) WH, work hardening--This modifier must be added to CPT codes 97545 and 97546 to indicate work hardening was performed. (15) W1, case management for treating doctor--This modifier must be added to the appropriate case management billing code activities when performed by the treating doctor. (16) W5, designated doctor examination for impairment or attainment of MMI--This modifier must be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI. (17) W6, designated doctor examination for extent--This modifier must be added to the appropriate examination code performed by a designated doctor when determining extent of the injured employee's compensable injury. (18) W7, designated doctor examination for disability--This modifier must be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury. (19) W8, designated doctor examination for return to work--This modifier must be added to the appropriate examination code performed by a designated doctor when determining the ability of the injured employee to return to work.	

§134.210. Medical Fee Guideline for Workers' Compensation Specific Services		
Current text	**Informal draft text**	**Notes**
performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI. (21) W6, designated doctor examination for extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the injured employee's compensable injury. (22) W7, designated doctor examination for disability--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury. (23) W8, designated doctor examination for return to work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of injured employee to return to work. (24) W9, designated doctor examination for other similar issues--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.	(20) W9, designated doctor examination for other similar issues--This modifier must be added to the appropriate examination code performed by a designated doctor when determining other similar issues.	

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments **Subchapter C. Medical Fee Guidelines** **§134.235. Return to Work/Evaluation of Medical Care**		
Current text	**Informal draft text**	**Notes**
§134.235. Return to Work/Evaluation of Medical Care	§134.235. Required Medical Examinations	• New
The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.	(a) Required medical examination doctors (RME doctors) must perform examinations in accordance with Labor Code §§408.004, 408.0041, 408.0043, and 408.0045; and division rules.	• New
	(b) Each examination and its individual billable components will be billed and reimbursed separately.	• New
	(c) When conducting an insurance carrier-requested examination to determine impairment or attainment of maximum medical improvement, the RME doctor must bill, and the insurance carrier must reimburse, using CPT code 99456, with the modifiers and at the rates specified in paragraphs (c)(2)-(3). (1) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films;	• New

§134.235. Return to Work/Evaluation of Medical Care		
Current text	**Informal draft text**	**Notes**
	(D) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title. (2) RME doctors must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code, and Chapter 130 and §180.23 of this title. (A) If the RME doctor determines that MMI has not been reached, the RME doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(3) of this section. The RME doctor must add modifier "NM." (B) If the RME doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, and an IR evaluation was not warranted, the RME doctor must only bill, and the insurance carrier must only reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(3) of this section. (C) If the RME doctor determines MMI has been reached and an IR evaluation is performed, the RME doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR evaluation portions of the examination in accordance with this subsection. (3) MMI. MMI examinations will be reimbursed at $437.50. (4) IR. For IR evaluations, the RME doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.	

§134.235. Return to Work/Evaluation of Medical Care		
Current text	**Informal draft text**	**Notes**
	(A) For musculoskeletal body areas, the RME doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet). (ii) For musculoskeletal body areas: (I) the reimbursement for the first musculoskeletal body area is $360; and (II) the reimbursement for each additional musculoskeletal body area is $180. (B) For non-musculoskeletal body areas, the RME doctor may bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined. (i) Non-musculoskeletal body areas are: (I) body systems; (II) body structures (including skin); and (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides. (iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $180. (C) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the RME doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the RME doctor outlined in subsection (c) of this section.	

§134.235. Return to Work/Evaluation of Medical Care		
Current text	**Informal draft text**	**Notes**
	(d) When conducting an insurance carrier-requested examination to determine the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the compensable injury, the ability of the injured employee to return to work, other similar issues, or appropriateness of medical care, the RME doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and at the rates specified in paragraphs (d)(1)-(5). (1) Extent of injury. The reimbursement rate for determining the extent of the injured employee's compensable injury is $660. (2) Disability. the reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $565. (3) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $565. (4) Other similar issues. The reimbursement rate for determining other similar issues is $565. (5) Appropriateness of health care. The reimbursement rate for appropriateness of health care as defined in §126.6 (concerning Required Medical Examination) and Labor Code §408.004 is $565.	• New
	(e) When the RME doctor refers testing to a specialist, the referral specialist must bill, and the insurance carrier must reimburse, the appropriate CPT code or codes for the tests required for the assignment of IR, according to the applicable division fee guideline. Documentation is required.	• New

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments **Subchapter C. Medical Fee Guidelines** **§134.239. Billing for Work Status Reports**		
Current text	**Informal draft text**	**Notes**
§134.239. Billing for Work Status Reports	§134.239. Billing for Work Status Reports	• No change
When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title.	Work status reports described by §129.5 of this title may not be billed or reimbursed separately when completed as a component of an ordered examination.	• Clarification

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments
Subchapter C. Medical Fee Guidelines
§134.240. Designated Doctor Examinations

Current text	Informal draft text	Notes
§134.240. Designated Doctor Examinations	§134.240. Designated Doctor Examinations	• No change
The following shall apply to designated doctor examinations. (1) Designated doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W6"; (D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W7"; (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W8"; and	(a) Designated doctors must perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules.	
	(b) The designated doctor must bill, and the insurance carrier must reimburse, for a missed appointment when the injured employee does not attend a properly scheduled or rescheduled examination under 28 TAC §127.5(h)-(j). (1) The designated doctor may bill for the missed appointment fee when: (A) the injured employee does not attend a scheduled appointment, and (B) the designated doctor waits at the examination location for at least 30 minutes after the scheduled appointment time. (2) When billing for the missed appointment, the designated doctor must bill CPT code 99456 with modifier 52. (3) Reimbursement for a missed appointment is $150. (4) Reimbursement for a missed appointment under this section does not qualify for the 10% incentive payment under §134.2 of this chapter.	• Missed appointment fee
	(c) Each examination and its individual billable components will be billed and reimbursed separately.	
	(d) When conducting a designated doctor examination, the designated doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and with the modifiers and rates specified in subsections (d)(1)-(7). (1) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or	

§134.240. Designated Doctor Examinations		
Current text	**Informal draft text**	**Notes**
(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W9." (2) When multiple examinations under the same specific division order are performed concurrently under paragraph (1)(C) - (F) of this section: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in §134.235 of this title; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in §134.235 of this title; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in §134.235 of this title.	areas evaluated for the assignment of an IR. The MMI or IR examination must include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title. (2) A designated doctor must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code, and Chapter 130 and §180.23 of this title. (A) If the designated doctor determines that MMI has not been reached, the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. The designated doctor must add modifier "NM." (B) If the designated doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. (C) If the designated doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination must be billed and reimbursed in accordance with subsection (d) of this section.	

§134.240. Designated Doctor Examinations		
Current text	**Informal draft text**	**Notes**
	(3) MMI. MMI examinations will be reimbursed at $437.50, and the designated doctor must apply the additional modifier "W5." (4) IR. For IR evaluations, the designated doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. The designated doctor must apply the additional modifier "W5." Indicate the number of body areas rated in the units column of the billing form. (A) For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet). (ii) For musculoskeletal body areas: (I) the reimbursement for the first musculoskeletal body area is $360; and (II) the reimbursement for each additional musculoskeletal body area is $180. (B) For non-musculoskeletal body areas, the designated doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined. (i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.	

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	(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $180. (iv) The test or tests required by Chapter 127 of this title for the assignment of IR, as outlined in the AMA Guides, must be billed using the appropriate CPT code or codes and reimbursed under the applicable division fee guideline in addition to the fees outlined in subsection (b) and (d)(1)-(3) of this section. (C) If the examination for the determination of MMI or the assignment of IR requires testing authorized by Chapter 127 of this title that is not outlined in the AMA Guides, the appropriate CPT code or codes must be billed, and the insurance carrier must reimburse, according to the applicable division fee guideline, in addition to the fees outlined in subsections (b) and (d)(1)-(3) of this section; (D) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor must bill for the number of body areas rated, and the insurance carrier must reimburse, $60 for each additional IR calculation. (E) When the division requires the designated doctor to complete multiple IR calculations, the designated doctor must apply the additional modifier "MI." (5) Extent of injury. The reimbursement rate for determining the extent of the employee's compensable injury is $660, and the designated doctor must apply the additional modifier "W6." (6) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $565, and the designated doctor must apply the additional modifier "W7."	

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	(7) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $565, and the designated doctor must apply the additional modifier "W8." (8) Other similar issues. The reimbursement rate for determining other similar issues is $565, and the designated doctor must apply the additional modifier"W9" when examining issues similar to those described in subsection (d)(1)-(6).	
	(e) Required testing or evaluation under §127.10 of this title must be billed using the appropriate CPT codes. Reimbursement will be according to §134.203 or other applicable division fee guideline in addition to the examination fee. If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title: (1) The 95-day period for timely submission of the bill begins on the date of service of the additional testing or evaluation. (2) The dates of service (CMS-1500/field 24A) are as follows: the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation. (3) The designated doctor and any referral providers must include the DWC-provided assignment number in the prior authorization field (CMS-1500/field 23) in accordance with §133.10(f)(1)(N).	
	(f) When the designated doctor refers an injured employee to a specialist for additional testing or evaluation under §127.10 of this title, the referral specialist must bill: (1) using the appropriate CPT codes, and the insurance carrier must reimburse, according to §134.203 or other applicable division fee guideline in addition to the examination fee;	

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	(2) using the assignment number provided by the designated doctor; and (3) attaching the required documentation.	
	(g) When the division orders the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B)-(I) of this title: (1) The designated doctor must add modifier "25" to the appropriate examination code when: (A) determining IR or attainment of MMI; (B) determining the extent of the employee's compensable injury; (C) determining whether the injured employee's disability is a direct result of the compensable injury; (D) determining the ability of the injured employee to return to work; or (E) determining other similar issues. (2) The designated doctor must add modifier "25" only one time for each examination conducted, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine. (3) The designated doctor must bill, and the insurance carrier must reimburse, $300 in addition to the examination fee.	

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments
Subchapter C. Medical Fee Guidelines
§134.250. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Treating Doctors

Current text	Informal draft text	Notes
§134.250. Maximum Medical Improvement Evaluations and Impairment Rating Examinations	§134.250. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Treating Doctors	• Specific to treating doctors
Maximum medical improvement (MMI) and/or impairment rating (IR) examinations shall be billed and reimbursed as follows: (1) The total maximum allowable reimbursement (MAR) for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.	(a) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include: (1) the examination; (2) consultation with the injured employee; (3) review of the records and films; (4) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and (5) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.	
(2) A health care provider shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Labor Code and Chapter 130 of this title. (A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall	(b) Treating doctors must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code, and Chapter 130 and §180.23 of this title. (1) If the treating doctor determines that MMI has not been reached, the treating doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section. (2) If the treating doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR	

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Current text	**Informal draft text**	**Notes**
be billed and reimbursed in accordance with paragraph (3) of this section. Modifier "NM" shall be added. (B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this section. (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this section. (3) The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1," "V2," "V3," "V4," or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit. (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and the referral examining doctor has: (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this section; or	evaluation is not warranted and the treating doctor must bill, and the insurance carrier must reimburse, only the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section. (3) If the treating doctor determines MMI has been reached and an IR evaluation is performed, the treating doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR evaluation portions of the examination in accordance with subsection (c) of this section. (c) The following applies for billing and reimbursement of an MMI or IR evaluation by a treating doctor. (1) CPT code. The treating doctor must bill using CPT code 99455 with the appropriate modifier. Modifiers "V3," "V4," or "V5" must be added to CPT code 99455 to correspond with the last digit of the applicable office visit. (2) MMI. MMI examinations must be reimbursed based on the applicable established patient office visit level associated with the examination. (3) IR. For IR evaluations, the treating doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form. (A) For musculoskeletal body areas, the treating doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet). (ii) For musculoskeletal body areas: (I) the reimbursement for the first musculoskeletal body area is $360; and	

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Current text	**Informal draft text**	**Notes**
(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this section. (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (B) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows: (I) $150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area. (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill	(II) the reimbursement for each additional musculoskeletal body area is $180. (B) For non-musculoskeletal body areas, the treating doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined. (i) Non-musculoskeletal body areas are: (I) body systems; (II) body structures (including skin); and (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides. (iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $180.	
	(d) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the treating doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the treating doctor outlined in subsection (c) of this section.	
	(e) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Labor Code and Chapter 130 of this title. The treating doctor must bill using CPT code 99455 with modifier "VR" to indicate a review of the report only, and the insurance carrier must reimburse, $60.	

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Current text	**Informal draft text**	**Notes**
using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR. (iv) If, in accordance with §130.1 of this title, the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR. (v) If a health care provider, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the health care provider shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the health care provider must be certified. Reimbursement shall be 20 percent of the total MAR. (D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR. (i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides. (iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply: (I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating		

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Current text	**Informal draft text**	**Notes**
one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination. (II) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required. (iv) When there is no test to determine an IR for a non-musculoskeletal condition: (I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category. (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings. (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph. (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150. (5) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this section. (6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Labor Code and Chapter 130 of this title. The treating doctor shall bill using CPT code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.		

Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments **Subchapter C. Medical Fee Guidelines** **§134.260. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referral Doctors**		
Current text	**Informal draft text**	**Notes**
	§134.260. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referral Doctors	• New section specific to referral doctors
	(a) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include: (1) the examination; (2) consultation with the injured employee; (3) review of the records and films; (4) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and (5) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.	
	(b) Referral doctors must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code, and Chapter 130 and §180.23 of this title. (1) If the referral doctor determines that MMI has not been reached, the referral doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section. The referral doctor must add modifier "NM." (2) If the referral doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor and IR	

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Current text	**Informal draft text**	**Notes**
	evaluation is not warranted, the referral doctor must bill, and the insurance carrier must reimburse, only the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section. (3) If the referral doctor determines MMI has been reached and an IR evaluation is performed, the referral doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR evaluation portions of the examination in accordance with subsection (c) of this section.	
	(c) The following applies for billing and reimbursement of an MMI or IR evaluation by a referral doctor. (1) CPT code. The referral doctor must bill using CPT code 99456 with the appropriate modifier. (2) MMI. MMI examinations will be reimbursed at $437.50. (3) IR. For IR evaluations, the referral doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form. (A) For musculoskeletal body areas, the referral doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet). (ii) For musculoskeletal body areas: (I) the reimbursement for the first musculoskeletal body area is $360; and (II) the reimbursement for each additional musculoskeletal body area is $180.	

§134.260. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referral Doctors		
Current text	**Informal draft text**	**Notes**
	(B) For non-musculoskeletal body areas, the referral doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined. (i) Non-musculoskeletal body areas are: (I) body systems; (II) body structures (including skin); and (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides. (iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $180.	
	(d) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the referral doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the referral doctor outlined in subsection (c) of this section.	