

TITLE 28. INSURANCE

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

CHAPTER 133: GENERAL MEDICAL PROVISIONS

SUPCHAPTER B: HEALTH CARE PROVIDER BILLING PROCEDURES

ADOPT: §133.10

1. INTRODUCTION.

The Texas Department of Insurance, Division of Workers' Compensation (Division) adopts amendments to §133.10, concerning required billing forms and formats.

This section is adopted with changes to the proposed text published in the October 11, 2013, issue of the *Texas Register* (38 TexReg 6999). In the October 18, 2013, issue of the *Texas Register* (38 TexReg 7334), a notice of correction revises the implementation from "April 1, 2013" to "April 1, 2014."

The Division has adopted non-substantive changes throughout the text of §133.10, including conforming to agency style and amending for consistency and clarity. These changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

In accordance with Government Code §2001.033, the Division's reasoned justification for these rules is set out in this order, which includes the preamble. The following paragraphs include a detailed section by section description and reasoned justification of all amendments necessary to implement §133.10.

2. REASONED JUSTIFICATION.

Amended §133.10 is necessary to align the workers' compensation medical billing requirements with the federal Centers for Medicare and Medicaid Services (CMS) June 2013 revision of the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500) to comply with Labor Code §413.011(a). Labor Code §413.011(a) states, "The commissioner shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of Section 413.053." Section 133.10 only affects health care providers who use paper forms for medical billing and does not change electronic medical billing requirements. Amendments to §133.10 eliminate unnecessary requirements, clarify instructions for providers, and diverge from the federal form instructions to meet the requirements of the Texas workers' compensation system.

Not all changes to the CMS-1500 form required amendments to the text of this section. For example, health care providers using the new CMS-1500 form should note that the diagnosis pointers referenced in §133.10(f)(1)(R) changed from numeric diagnosis pointers to reference letter diagnosis pointers. Section 133.10 also updates the requirements for the UB-04, DWC-066, ADA 2006 Dental Claim Form, and CMS-1500 forms to align 28 TAC §§133.200, 134.803 and 134.804.

Section 133.10 addresses **Required Billing Forms and Formats**. The amendment to §133.10(b) changes the form requirement for medical bills filed or resubmitted for professional and noninstitutional services from 1500 Health Insurance Claim form Version 08/05 (CMS-1500) to the updated 02/12 (CMS-1500) and is necessary to comply with Labor Code §413.011(a).

Section 133.10(f)(1)(H) deletes the requirement that the billing provider enter 'UNKNOWN' if the workers' compensation claim number is not known. If the workers' compensation claim number is not known to the billing provider, field 11 "Workers' Compensation Claim Number Assigned by the

Insurance Carrier” must be left blank. The amendment is necessary to align the requirements of §133.10 with 28 TAC §§133.200, 134.803, and 134.804 (relating to Insurance Carrier Receipt of Medical Bills from Health Care Providers, Reporting Standards, and Reporting Requirements, respectively), which require the reporting of medical billing and payment information to the Division. Section 133.10(f)(1)(H) does not include the CMS changes to fields 11 and 11(b) because they are unnecessary in the Texas workers' compensation system and may create an unnecessary burden on health care providers.

Section 133.10(f)(1)(I) adds a date of injury qualifier to field 14 “Date of Current Illness, Injury, or Pregnancy (LMP).” All paper medical bills related to Texas workers' compensation health care must enter the 431 qualifier indicating the “Onset of Current Symptoms or Illness.” The alternative qualifier 484 indicating the “Last Menstrual Period” is not applicable to workers' compensation claims.

Section 133.10(f)(1)(J) clarifies that a qualifier to field 17 “Name of Referring Provider or Other Source” is not required. Paper medical bills related to Texas workers' compensation health care should not indicate any qualifier in this field. Currently, health care providers are not required to report qualifiers on the CMS-1500 form field 17 and the Division has determined that this reporting requirement for healthcare providers is not necessary for the adjudication of a medical bill.

Section 133.10(f)(1)(M) requires that the health care provider enter an “ICD Indicator” in field 21 “Diagnosis or Nature of Injury.” This indicator identifies which version of the ICD code set is being reported (ICD-9-CM or ICD-10-CM).

Section 133.10(f)(2)(GG) deletes the requirement that billing providers filing bills for institutional services using the UB-04 must enter ‘UNKNOWN’ if the workers' compensation claim number is not known. If the workers' compensation claim number is not known to the billing provider,

field 62 “Insured’s Group Number” should be left blank. The amendment is necessary to align the requirements of §133.10 with 28 TAC §§133.200, 134.803, and 134.804 which require the reporting of medical billing and payment information to the Division.

Section 133.10(f)(3)(O) deletes the requirement that billing providers filing bills for drugs or other pharmacy services using the Division’s DWC-066 form enter ‘UNKNOWN’ if the workers’ compensation claim number is not known. If the workers’ compensation claim number is not known to the billing provider, field 15 “Insurance Carrier Claim Number” should be left blank. The amendment is necessary to align the requirements of §133.10 with 28 TAC §§133.200, 134.803, and 134.804, which require the reporting of medical billing and payment information to the Division.

Section 133.10(f)(3)(AA) references the requirements for billing compound drugs found in 28 TAC §134.502 (relating to Pharmaceutical Services), which requires compound drugs to be billed by listing each drug included in the compound and calculating the charge for each drug separately. The amendment is necessary to clarify the billing of compound drugs in the Texas workers’ compensation system.

Section 133.10(f)(4)(E) deletes the requirement that billing providers filing bills for dental services using the ADA 2006 Dental Claim Form must enter ‘UNKNOWN’ if the workers’ compensation claim number is not known. If the workers’ compensation claim number is not known to the billing provider, field 15 “Policyholder/Subscriber ID (SSN or ID#)” must be left blank. The amendment is necessary to align the requirements of §133.10 with 28 TAC §§133.200, 134.803 and 134.804, which require the reporting of medical billing and payment information to the Division.

Section 133.10(g) deletes the requirement that the billing provider use a default value of ‘999999999’ if the injured worker does not have a Social Security Number as required in subsection (f). If the Social Security Number is unknown, the field must be left blank. The amendment to existing

§133.10(g) is necessary to align with 28 TAC §§133.200, 134.803 and 134.804, which require the reporting of medical billing and payment information to the Division.

Section 133.10(l) changes the effective date from August 1, 2011 to April 1, 2014. The effective date in §133.10(l) is necessary to comply with the implementation timeline set out by CMS for submission and processing of paper claims submitted on the CMS-1500 (02/12). The Division changed the term “filed” to “submitted” in §133.10(l) for consistency with 28 TAC §133.20 and §408.027.

3. HOW THESE SECTIONS WILL FUNCTION.

Section 133.10 specifies the required billing forms and formats that healthcare providers, pharmacists and pharmacy processing agents, and dentists must use for a complete medical bill related to Texas workers' compensation healthcare.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General

Comment: A commenter agrees that the alignment of the workers' compensation billing requirements with the federal CMS changes is an appropriate objective. The commenter states that Labor Code §413.001 requires the Commissioner of Workers' Compensation to adopt rules aligned with the federal CMS coding and billing policies to promote standardization and efficiency.

A commenter applauds the Division for being one of several state workers' compensation agencies to address the need to update regulations regarding submission of the CMS-1500 claim form. The commenter explains that several states have not yet taken steps to update their workers' compensation billing regulations for the new form version or its accompanying updated National Uniform Claim Committee (NUCC) instructions, which can be concerning for payers, processors and providers who will be required by Medicare to use only the new form version and its specific standard instructions by April 1, 2014.

A commenter supports the amendments to §133.10(b)(1), (f)(1)(I), (f)(1)(J), (f)(1)(M) and (g) and believes each proposed amendment aligns closely with CMS standards while also minimizing burdens on providers.

A commenter strongly agrees with and supports the requirement in §133.10(f)(3)(AA), that clarifies that bills for compound drugs must be submitted in accordance with §134.502 (addressing pharmaceutical services). The commenter notes that §133.10(f)(3)(AA) contains a requirement in existing §134.502(d)(2) that ingredient-level billing is in conformity with the Division's adopted electronic billing standards for pharmacy transactions: NCPDP Telecommunication Standard D.0 and Batch Standard 1.2.

A commenter states that the requirements in §133.10(f)(3)(AA) are common practice in pharmacy billing across many healthcare markets because they provides needed transparency as to what specific underlying medications are being provided to patients and aids in more accurate and reasonable reimbursement. A commenter states that ingredient national drug codes (NDCs) are also needed to properly apply the Division's Pharmacy Fee Guideline. The commenter states this requirement aids in determining applicability of the Division's Pharmacy Closed Formulary rules to ingredients within the compound, which may be listed.

A commenter agrees that the new NUCC requirement to submit the employer's workers' compensation policy number in field 11 is less relevant to the adjudication of a medical bill in workers' compensation and potentially burdensome on providers. The commenter supports not adding this data element as a new requirement for Texas workers' compensation.

Division Response: The Division appreciates the supportive comments.

§133.10(f)(1)(H).

Comment: A commenter recommends §133.10(f)(1)(H) align with the standard instructions for use of the CMS-1500 (02/12) and to better comply with Labor Code provisions requiring adoption of standardized structures for billing.

A commenter states that field 11 on the new form version should be used for workers' compensation purposes only to submit the employer's workers' compensation policy number. The commenter states that only field 11b should be used to submit the workers' compensation claim number assigned by the insurance carrier. The commenter states the Division's proposed rules suggest field 11 should still be used to submit the claim number and population of 11b is not addressed.

A commenter strongly encourages use of field 11b only for submission of the claim number on the new form to avoid a requirement unique to Texas, to maintain standardization, and ease the transition for providers. The commenter states that other states may require claim number submission in field 11b rather than field 11. The commenter states that maintaining different submission standards in Texas compared to other states may create an additional burden on providers and the payers reviewing their bills.

The commenter also states this will be more in line with the statutory requirement in Labor Code §413.011(a).

Division Response: The Division agrees that the NUCC has changed its standard instructions for fields 11 and 11b. However, the Division disagrees that these changes are necessary for the Texas workers' compensation system. The Division has determined that the field changes are not relevant to the adjudication of a medical bill in the Texas workers' compensation system and are potentially burdensome to healthcare providers. The changes would offer no new information necessary for a complete medical bill and may require programming changes from system

participants. The Division disagrees with the recommendation because such changes are not necessary, could cause confusion, and medical bills that would be complete under the adopted rule would potentially be rejected based on a failure to correctly fill in an unnecessary field. Labor Code §413.011(a) requires the Division to adopt standardized structures based on the most current CMS policies with respect to billing. However, under Labor Code §413.011(a) and §413.053, the commissioner has discretion to establish standards for the Division that may diverge from federal standards to meet the requirements of the Texas workers' compensation system.

§133.10(I)

Comment: Commenters suggest amendments to the timelines for rule implementation. A commenter noted that the revised CMS 1500 paper claim form was changed by the NUCC to accommodate and implement ICD-10-CM diagnosis codes. The commenter states that revised form includes indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes, expands the number of possible diagnosis codes to 12, and contains qualifiers to identify provider roles of ordering, referring, and supervising that will require substantive and administrative adjustments. The commenter states the Division should allow for a dual use period, as well as align with the CMS tentative schedule for implementing the revised form for an effective transition.

A commenter states that the effective date does not align with the proposed CMS dual use period, between January 6, 2014 and April 1, 2014. The commenter strongly recommends that the Division follow the CMS timeline to assist physicians in compliance with claim filing requirements and decrease administrative burden on physicians.

A commenter is concerned implementing the changes to the form. The commenter states some health care providers may start submitting medical bills using the updated CMS-1500 before the 04/01/2014 effective date. The commenter states there is also a concern over the possible use of ICD-10 codes by the health care provider prior to the effective date of 10/01/2014. Based on these

concerns, the commenter would like guidance from the Division over whether or not medical bills should be rejected for submitting the wrong version of the CMS-1500 form or for using the wrong version of the ICD codes. The commenter noted that the Maryland Workers Compensation Commission recently adopted the CMS-1500 (version 02/12) effective 04/01/2014 and ICD-10 effective 10/01/2014 and provided guidance to stakeholders. The commenter suggests that the Maryland timeline provides for an orderly transition for both health care providers and carriers for the mandatory use of CMS-1500 (version 02/12) and ICD-10 codes based on current CMS directives.

Division's Response: The Division declines to make the suggested change. The Division recognizes that changes to the form will require administrative adjustments for both healthcare providers and insurance carriers. While providers who participate in the Medicare system may be ready to implement these form changes starting in January, most workers' compensation insurance carriers will not be ready to accept the new form at the time. The division has determined the April 1, 2014 deadline will afford the hundreds of insurance carriers participating in the system ample time to update their bill processing systems as necessary in order to ensure that medical bills submitted are processed correctly and timely. It will also provide the Division ample time to conduct outreach activities to educate those healthcare providers who treat workers' compensation patients, but do not participate in the Medicare system. The Division acknowledges that Medicare's tentative timeline has a dual use period, but has determined that a dual use period is not appropriate for the Texas workers' compensation system because the significant volume of varying billing formats and submissions might cause confusion, which may result in unnecessary medical bill denials and fee disputes. The single deadline of April 1, 2014 offers system participants certainty as to the implementation date. The Division anticipates offering guidance on the ICD-9 to ICD-10 diagnoses codes through educational and informational outreach.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For:

None

For, with changes:

Texas Medical Association, Property Casualty Insurers Association of America, and PMSI

Against:

None

Neither for nor against, with changes:

None

6. STATUTORY AUTHORITY.

This amended section is adopted under the Labor Code §§402.00111, 402.061, 413.053 and 413.011. Labor Code §413.011 generally requires the Commissioner of Workers' Compensation to adopt rules aligned with the federal Centers for Medicare and Medicaid Services coding and billing policies and permit modification when necessary. Labor Code §413.053 requires the Commissioner to establish standards of reporting and billing governing both form and content. Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code. Labor Code §402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

7. TEXT.

§133.10 *Required Billing Forms/Formats*

(a) Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title

(relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.

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

(1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500);

(2) the Uniform Bill 04 (UB-04); or

(3) applicable forms prescribed for pharmacists, dentists, and surgical implant providers specified in subsections (c), (d) and (e) of this section.

(c) Pharmacists and pharmacy processing agents shall submit bills using the Division form DWC-066. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:

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

(2) the alternate billing form provides all information required on the Division form DWC-066.

(d) Dentists shall submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.

(e) Surgical implant providers requesting separate reimbursement for implantable devices shall submit bills using:

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

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

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

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

(A) patient's Social Security Number (CMS-1500/field 1a) is required;

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

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

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

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

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

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

(H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known, the billing provider 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;

(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;

(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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider 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;

(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 'OB' 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 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

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

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

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

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

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

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

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

- (F) payee's federal employer identification number (DWC-066/field 6) is required;
- (G) insurance carrier's name (DWC-066/field 7) is required;
- (H) employer's name and address (DWC-066/field 8) is required;
- (I) injured employee's name and address (DWC-066/field 9) is required;
- (J) injured employee's Social Security Number (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;

(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;
- (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;

(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).

(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.

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

(i) In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:

(1) AC for Acupuncturist;

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

(25) PM for Pain Management Clinic;

(26) PS for Psychologist;

(27) PT for Physical Therapist;

(28) RA for Radiology Facility; or

(29) RN for Registered Nurse.

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

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

(2) W4 - Level 2 Appeal means a request for reimbursement as a result of a decision issued by the division, an Independent Review Organization, 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.

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

(l) This section is effective for medical bills submitted on or after April 1, 2014.

8. CERTIFICATION.

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

Issued at Austin, Texas, on December 16, 2013.

X

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

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to 28 TAC §133.10 specified herein, concerning required billing forms and formats are adopted.

AND IT IS SO ORDERED.

X

ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

TITLE 28. INSURANCE
Part 2. Texas Department of Insurance,
Division of Workers' Compensation
Chapter 133 – General Medical Provisions

ATTEST:

X

Dirk Johnson
General Counsel

COMMISSIONER ORDER NO