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

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

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

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §§133.10, 133.20, 133.200, and 133.502, concerning billing and reimbursement for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and maximum medical improvement (MMI) evaluations and impairment rating (IR) examinations by treating and referred doctors. The amendments implement Texas Labor Code Chapters 408 and 413, which govern workers' compensation benefits, including medical examinations required to establish benefit entitlements, and medical review to ensure compliance with DWC rules for health care, including medical policies and fee guidelines. The DWC medical advisor recommended the amendments to the commissioner of workers' compensation under Labor Code §413.0511(b). The amendments to §§133.10, 133.20, and 133.502 are adopted with three changes to the proposed text published in the December 29, 2023, issue of the *Texas Register* (48 TexReg 8153). The changes clarify the effective dates in §§133.10(l), 133.20(o), and 133.502(g). These rules will be republished. Section 133.200 is adopted without changes and will not be republished.

REASONED JUSTIFICATION. Amending §§133.10, 133.20, 133.200, and 133.502 is necessary to attract and retain designated doctors, required medical examination doctors, and doctors that perform MMI evaluations and IR examinations by addressing billing and reimbursement issues, reducing disputes, and decreasing the administrative burden of participating in the program. Labor Code Chapter 408 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Specifically, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. To help determine the health care that meets those standards, the designated doctor program established under Chapter 408 provides for commissioner-ordered medical examinations to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues. Maintaining a viable program that ensures that injured employees can access examinations in a timely way is essential to meeting the statutory mandate of providing health care for injured employees.

Having too few doctors in the program has a negative impact on the doctors that remain in the system, on injured employees, and on insurance carriers. When there are too few doctors able to conduct the examinations needed to determine benefit levels, injured employees must often wait longer and travel farther to attend an examination, which can delay dispute resolution and other essential processes. DWC last adjusted reimbursement rates for workers' compensation-specific services in January 2008 (33

TexReg 364). Over the past 14 years, DWC has experienced a decline in the numbers of doctors providing workers' compensation-specific services. This decline has been particularly pronounced among designated doctors certified under Labor Code §408.1225 and providing designated doctor examinations as Labor Code §408.0041 requires, and especially among licensed medical doctors and doctors of osteopathy. In December 2022, for the entire state of Texas, there were only 63 available medical doctors, 10 doctors of osteopathic medicine, 177 doctors of chiropractic, and no doctors of podiatry, dental science, or optometry. Yet in that month, there were 1,259 designated doctor appointments for those 250 designated doctors to cover.

DWC held stakeholder meetings in March, September, and December 2022 to discuss issues with declining participation in the designated doctor program, including issues with billing logistics and reimbursement rates. DWC invited public comments on three separate informal drafts posted on DWC's website in August 2022, November 2022, and June 2023. In addition, DWC conducted a stakeholder survey to gather information about anticipated implementation costs and benefits in September 2023. DWC considered the comments it received at the meetings and on the informal drafts when drafting the proposal. DWC also considered comments it received in a public hearing on the proposal on January 23, 2024, as well as written comments it received by the January 29, 2024, deadline, when drafting this adoption order.

In April 2023, after gathering data about the program and soliciting input from system participants about how to maintain and increase participation in the designated doctor program and allow better access to specialized examinations, DWC adopted amendments to Chapter 127 of this title, concerning designated doctor procedures and

requirements, and §180.23 of this title, concerning division-required training for doctors. Those rules addressed certification, training, and procedures for designated doctors and were required to address administrative and logistical inefficiencies, and to improve access to examinations, to make participation in the program possible and attractive for more doctors. They were one part of the project to ensure the designated doctor program's viability, in compliance with the Labor Code. After their adoption, DWC saw a near-immediate increase in the numbers of doctors applying to the program, which was very encouraging.

However, the common theme throughout the input-gathering process about how to improve the program was billing and reimbursement for certain workers' compensation-specific services, especially designated doctor examinations. Nearly every comment DWC received mentioned some combination of issues about the fees for designated doctor examinations--that they were insufficient, had not been adjusted for inflation or other economic factors in over a decade, did not take into account missed appointments or the time spent reviewing injured employees' medical records, and other similar issues. In adopting the amendments to Chapter 127 and §180.23, DWC stated that billing and reimbursement issues would be addressed in a separate rule project. As a result, the changes in this rule proposal are another part of the project and are necessary to account for past and future inflation, examination complexity, and other economic factors that affect participation in the designated doctor program.

The amendments to §§133.10, 133.20, 133.200, and 133.502 require an assignment number in the prior authorization field of the medical billing forms to identify designated doctor-associated billing. DWC expects the format of the assignment number to be

12345678DD01. The numbers on the left would be the DWC claim number. The "DD" would denote a designated doctor-associated examination. The numbers on the right would indicate whether it is the first, second, third, and so forth, ordered examination for the claim. The DWC-provided assignment number is for identification purposes and does not create a preauthorization or utilization review requirement. The current rules do not provide a billing mechanism to distinguish designated doctor examinations or any additional testing or referral evaluations that result from a designated doctor examination. This produces confusion and delays in payment. For example, under Labor Code §408.1225, insurance carriers must pay for designated doctor examinations, and §127.10(c) of this title requires a designated doctor to perform additional testing and refer an injured employee to other health care providers when necessary to resolve the issue in question. Any required additional testing or referral is not subject to preauthorization requirements and cannot be denied retrospectively based on medical necessity, extent of injury, or compensability. However, if the insurance carrier cannot easily see that an examination is a designated doctor examination or a referral from a designated doctor examination, processing the bill could be unnecessarily delayed, which creates additional work and expense. Requiring an assignment number in the preauthorization field addresses this problem by linking the designated doctor examination and any additional testing or referral evaluations to the DWC-provided assignment number that distinguishes them as designated doctor examinations.

In addition, the amendments clarify that the 95-day period for timely submission of a designated doctor examination bill, where the designated doctor has referred the injured employee for additional testing or evaluation, begins on the date of service for

the additional testing or evaluation. This ensures that any delays in scheduling or performing the additional testing or evaluation do not penalize the designated doctor by making compliance with the billing timeline impossible, which could make the bill unpayable. It gives the designated doctor time to complete the examination report.

The amendments also correct a typographical error in a rule reference and include nonsubstantive editorial and formatting changes throughout that make updates for plain language and agency style to improve the rule's clarity.

Section 133.10. The amendments to §133.10 require an assignment number in the prior authorization field of the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500), Uniform Bill 04 (UB-04), Statement of Pharmacy Services (DWC Form-066), and 2006 American Dental Association Dental Claim Form (ADA 2006) for DWC-ordered designated doctor examinations, and for additional testing or evaluation that a designated doctor refers. They also clarify the dates that apply to the additional testing or evaluation. Amending §133.10 is necessary to better identify that a bill is for a designated doctor examination, and to help associate a bill for additional testing or evaluation that occurs as a result of a designated doctor examination with the original designated doctor examination. These amendments will help insurance carriers and bill review agents identify these types of bills and associate them with the proper examination types, and they will increase the likelihood that the bills will be paid without unnecessary administrative delay.

Section 133.20. The amendments to §133.20 clarify that the 95-day period for timely submission of a bill for additional testing or evaluation under §127.10 of this title begins on the date of service of the additional testing or evaluation. They also require a designated doctor that refers an injured employee for additional testing or evaluation to provide the assignment number to the health care provider performing the testing or evaluation, and they require a designated doctor or a health care provider performing additional testing or evaluation to include the assignment number on the medical bill to conform with amended §133.10. Amending §133.20 is necessary to ensure consistency in billing deadlines, to allow the designated doctor time to complete the designated doctor report after receiving the results from the additional testing or evaluation, and to prevent the designated doctor from being penalized unfairly if scheduling or performing the additional testing or evaluation takes more than a few weeks.

Section 133.200. The amendments to §133.200 correct an incorrect reference to §133.10. Amending §133.200 is necessary to ensure the reference's accuracy.

Section 133.502. The amendments to §133.502 apply the requirement to include the assignment number in the prior authorization field in §§133.10 and 133.20 to professional, institutional or hospital, dental, and pharmacy electronic medical bills. Amending §133.502 is necessary to ensure consistency in billing between paper and electronic formats, and to allow DWC to better identify designated doctor and designated doctor referral billing in the DWC database of medical charges.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received 30 written comments by the January 29, 2024, deadline, and three oral comments at the January 23, 2024, hearing. Because DWC published the Chapter 133 proposal and the Chapter 134 proposal at the same time and discussed both proposals in the hearing, some commenters submitted comments specifically on both proposals, while others acknowledged both proposals but only commented specifically on one. Twenty-two individuals acknowledged both proposals in their comments but did not specifically state a position on the Chapter 133 proposal. Commenters specifically in support of the Chapter 133 proposal were: the Office of Injured Employee Counsel; the Texas Chiropractic Association; the Insurance Council of Texas; Texas Independent Evaluators, LLC; and three individuals. Commenters specifically in support of the Chapter 133 proposal with changes were: Texas Mutual Insurance Company. No commenters were against the Chapter 133 proposal.

Comments on Chapter 133. Seven commenters stated that they supported the proposal. One commenter expressed support and appreciation for DWC's efforts to provide free training for insurance carriers and health care providers on the new billing requirements and reimbursement rates.

Agency Response to Comments on Chapter 133. DWC appreciates the comments.

Comments on Chapter 133 (assignment number). One commenter stated that the assignment number was for clarity purposes. One commenter stated that they support and appreciate DWC's clarification on the format for designated doctor order numbers,

which will allow insurance carriers to distinguish a designated doctor order number in the preauthorization field of a medical bill from a preauthorization number.

Agency Response to Comments on Chapter 133. DWC appreciates the comments and agrees.

Comment on §133.20 (95-day period). One commenter asked DWC to clarify the start of the 95-day period for timely submission of a designated doctor exam bill.

Agency Response to Comment on §133.20 (95-day period). DWC appreciates the comment. Under §133.10, when a designated doctor refers an 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. Under §133.20, the 95-day period for timely submission of a bill for additional testing or evaluation begins on the date of service of the additional testing or evaluation (the "To" date in the dates of service field in the CMS-1500/field 24A).

Comment on Chapter 133 (effective dates). One commenter recommended that references to effective dates throughout Chapter 133 be changed to say "effective for services provided on or after (insert final effective date)" to correspond with the applicability date references in §134.209(b) of this title.

Agency Response to Comment on Chapter 133 (effective dates). DWC appreciates the comment and has added to the text in §§133.10(l), 133.20(o), and 133.502(g) to clarify the effective dates for medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after the effective date of the rule.

Comment on §133.10 (health care provider type). One commenter recommended that DWC add a health care provider type "AP" for advanced practice registered nurse to the list of provider types in §133.10(i).

Agency Response to Comment on §133.10 (health care provider type). DWC appreciates the suggestion but declines to make the change because it is out of scope for this rule. If DWC later initiates a rule project to review all of the health care provider types in §133.10, DWC will consider recommendations for additions or deletions at that time.

Comment on §§133.10 and 133.502 (pharmacy). One commenter recommended that DWC remove any new billing guidance for additional designated doctor-ordered testing or evaluation services on pharmacy bills. The commenter requested, alternatively, that DWC provide clarification regarding how an insurance carrier would treat such a bill received from a pharmacy.

Agency Response to Comment on §§133.10 and 133.502 (pharmacy). DWC appreciates the suggestion but declines to make the change. It is conceivable that a pharmacy provider could need to complete and bill for designated doctor-ordered testing or evaluation services, and omitting pharmacy providers from the billing guidance could inadvertently create confusion in that situation. An insurance carrier would handle the bill through its normal billing process. DWC will address general questions about the normal billing process through training.

Comment on §133.20 (reference to §126.9). One commenter recommended that DWC revise §133.20(l) to include a reference to §126.9 of this title as an additional condition under which a health care provider may bill an injured employee.

Agency Response to Comment on §133.20 (reference to §126.9). DWC appreciates the suggestion but declines to make the change because it is out of scope for this rule. If DWC later initiates a rule project to review the conditions under which a health care provider may bill an injured employee, DWC will consider recommendations for additions or deletions at that time.

SUBCHAPTER B. HEALTH CARE PROVIDER BILLING PROCEDURES
28 TAC §§133.10 AND 133.20

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §§133.10 and 133.20 under Labor Code §§408.004, 408.0041, 408.021, 408.023, 408.0251, 408.0252, 408.1225, 413.007, 413.011, 413.012, 413.015, 413.0511, 413.053, 402.00111, 402.00116, and 402.061.

Labor Code §408.004 provides that the commissioner may require an employee to submit to medical examinations to resolve any question about the appropriateness of the health care the employee receives, or at the request of the insurance carrier after the insurance carrier has tried and failed to get the employee's permission and concurrence for the examination. It also requires the insurance carrier to pay for those examinations, as well as the reasonable expenses incident to the employee in submitting to them.

Labor Code §408.0041 provides that, at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical

examination to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues.

Labor Code §408.021 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

Labor Code §408.023 requires in part that the commissioner by rule establish reasonable requirements for doctors, and health care providers financially related to those doctors, regarding training, IR testing, and disclosure of financial interests; and for monitoring of those doctors and health care providers. It also requires a doctor, including a doctor who contracts with a workers' compensation health care network, to comply with the IR training and testing requirements in the rule if the doctor intends to provide MMI certifications or assign IRs.

Labor Code §408.0251 requires the commissioner of workers' compensation, in cooperation with the commissioner of insurance, to adopt rules about the electronic submission and processing of medical bills by health care providers to insurance carriers and establish exceptions. It also requires insurance carriers to accept electronically submitted medical bills in accordance with the rules, and it allows the commissioner of workers' compensation to adopt rules about the electronic payment of medical bills by insurance carriers to health care providers.

Labor Code §408.0252 provides that the commissioner of workers' compensation may, by rule, identify areas of this state in which access to health care providers is less available, and adopt appropriate standards, guidelines, and rules about the delivery of health care in those areas.

Labor Code §408.1225 requires the commissioner of workers' compensation to develop a process for certifying designated doctors, which requires DWC to evaluate designated doctors' educational experience, previous training, and demonstrated ability to perform the specific designated doctor duties in §408.0041. It also requires standard training and testing for designated doctors.

Labor Code §413.007 requires DWC to maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the commissioner in adopting the medical policies and fee guidelines, and by DWC in administering the medical policies, fee guidelines, or rules. The database must contain information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols, and must be able to be used in a meaningful way to allow DWC to control medical costs.

Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as needed to meet occupational injury requirements. It requires the commissioner to adopt the most current methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting; and allows

the commissioner to modify documentation requirements as needed to meet the requirements of §413.053. It also requires the commissioner, in determining the appropriate fees, to develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of §413.011(d); and requires the commissioner to provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commissioner rules. The commissioner may not adopt the Medicare fee schedule or conversion factors or other payment adjustment factors based solely on those factors as developed by the federal CMS. Fee guidelines must be fair and reasonable, and designed to ensure the quality of medical care and achieve medical cost control. They may not provide for payment of a fee that exceeds the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. When establishing the fee guidelines, §413.011 requires the commissioner to consider the increased security of payment that Subtitle A, Title 5, Labor Code affords. It allows network contracts under Insurance Code §1305.006. It specifically authorizes the commissioner and the commissioner of insurance to adopt rules as necessary to implement §413.011.

Labor Code §413.012 requires the medical policies and fee guidelines to be reviewed and revised at least every two years to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision is conducted.

Labor Code §413.015 requires insurance carriers to pay appropriate charges for medical services under Subtitle A, Title 5, Labor Code, and requires the commissioner by

rule to review and audit those payments to ensure compliance with the adopted medical policies and fee guidelines. The insurance carrier must pay the expenses of the review and audit.

Labor Code §413.0511 requires DWC to employ or contract with a medical advisor. The medical advisor must be a doctor, as defined in §401.011. The medical advisor's duties include making recommendations about the adoption of rules and policies to: develop, maintain, and review guidelines as provided by §413.011, including rules about IRs; reviewing compliance with those guidelines; regulating or performing other acts related to medical benefits as required by the commissioner; and determining minimal modifications to the reimbursement methodology and model used by the Medicare system as needed to meet occupational injury requirements.

Labor Code §413.053 requires the commissioner by rule 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 §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

TEXT.

§133.10. Required Billing Forms/Formats.

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

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

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

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

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

(c) Pharmacists and pharmacy processing agents must 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 must submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.

(e) Surgical implant providers requesting separate reimbursement for implantable devices must 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 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).

(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');

(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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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) code (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19;

(S) name brand NDC code (DWC-066/field 22) is required when a name brand drug is dispensed;

(T) quantity (DWC-066/field 23) is required;

(U) days supply (DWC-066/field 24) is required;

(V) amount paid by the injured employee (DWC-066/field 26) is required if applicable;

(W) drug name and strength (DWC-066/field 27) is required;

(X) prescription number (DWC-066/field 28) is required;

(Y) amount billed (DWC-066/field 29) is required;

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

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

(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;

(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');

(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.

(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) Effective Date.

(1) This section is effective for medical bills submitted on or after June 1, 2024.

(2) For medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024, the provisions of subsection (f) of this section are effective on and after June 1, 2024.

§133.20. Medical Bill Submission by Health Care Provider.

(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.

(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 no 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.

(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.

(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.

(e) A medical bill must be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) When a health care provider bills the employer, the health care provider must 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 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.

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

(1) Labor Code §413.042;

(2) Insurance Code §1305.451; or

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

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

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

(o) This section is effective for medical bills submitted on or after June 1, 2024, including medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024.

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

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §133.200 under Labor Code §§413.053, 402.00111, 402.00116, and 402.061.

Labor Code §413.053 requires the commissioner by rule 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 §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

TEXT.

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

(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.

(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 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.

(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.

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

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §133.502 under Labor Code §§408.0251, 413.053, 402.00111, 402.00116, and 402.061.

Labor Code §408.0251 requires the commissioner of workers' compensation, in cooperation with the commissioner of insurance, to adopt rules about the electronic submission and processing of medical bills by health care providers to insurance carriers and establish exceptions. It also requires insurance carriers to accept electronically submitted medical bills in accordance with the rules, and it allows the commissioner of workers' compensation to adopt rules about the electronic payment of medical bills by insurance carriers to health care providers.

Labor Code §413.053 requires the commissioner by rule 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 §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

TEXT.

§133.502. Electronic Medical Billing Supplemental Data Requirements.

(a) In addition to the data requirements and standards adopted under §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional or hospital, 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.

(b) In reporting the injured employee Social Security number and the state license numbers under subsection (a) of this section, health care providers must follow the data content and format requirements contained in §133.10 of this title (relating to Required Billing Forms/Formats).

(c) In addition to the data requirements contained in the standards adopted under §133.500(c) of this title, all professional, institutional or hospital, 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 test or evaluation as a result of a designated doctor's referral, the assignment number in the prior authorization field.

(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;

(2) the prescribing doctor's National Provider Identification number; and

(3) for a health care provider performing a test or evaluation as a result of a designated doctor's referral, the assignment number in the prior authorization field.

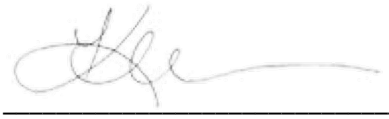
(e) In reporting the resubmission condition code under this section, the resubmission condition codes must have the definitions specified in §133.10(j) of this title.

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

(g) This section is effective for medical bills submitted on or after June 1, 2024, including medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024.

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on February 23, 2024.



Kara Mace
General Counsel
TDI, Division of Workers' Compensation

The commissioner adopts amendments to 28 TAC §§133.10, 133.20, 133.200, and 133.502.

Jeff Nelson
Commissioner
TDI, Division of Workers' Compensation

Commissioner's Order No. 2024-8540