SUBCHAPTER I. MEDICAL BILL REPORTING
Title 28 TAC §§134.802 – 134.805, 134.807, 134.808

1. INTRODUCTION. The Division of Workers' Compensation (Division) adopts amendments to 28 TAC §134.802, concerning definitions; §134.803, concerning reporting standards; §134.804, concerning reporting requirements; §134.805, concerning records required to be reported; §134.807, concerning state specific requirements; and §134.808, concerning insurance carrier EDI compliance coordinator and trading partners. Section 134.803 and §134.807 are adopted with changes to the proposed text published in the October 31, 2014, issue of the *Texas Register* (39 TexReg 8492). Sections 134.802, 134.804, 134.805, and 134.808 are adopted without changes to the proposed text. The Division considered and incorporated stakeholder feedback throughout the informal draft and proposal process. An informal working draft of amendments to Chapter 134 was posted on the Division's website on July 31, 2014. There was not a request for public hearing submitted to the Division.

As a result of formal comment, the Division made two changes to the proposed text. The Division deleted one column, which contained data element 073 and provided an error message of "must be greater than or equal to the date payor received the bill," from the proposed Texas EDI Medical Data Element Edits Table adopted by reference in §134.803. The Division deleted the column, based upon stakeholder feedback, to clarify that pre-payment and pre-negotiated medical bills are not excluded from reporting requirements. Additionally, commenters requested clarification regarding the limitations on reporting four diagnosis codes and four diagnosis pointers in proposed

§134.807(f)(9) and §134.807(f)(10). As a result of the request for clarification, the Division added the phrase "on a professional medical bill" to adopted §134.807(f)(9) and §134.807(f)(10) to clarify that the limitation of reporting up to four diagnosis codes and four diagnosis code pointers only applies to professional medical bills.

The Division also made one, non-substantive change to correct a typo in the Texas EDI Medical Data Element Edits Table name, adopted by reference in §134.803. An "s" was added to the word "Edit" and now reads "Texas EDI Medical Data Element Edits Table" for consistency with the table name as adopted in §134.803.

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 to §§134.802 – 134.805, 134.807, and 134.808.

2. REASONED JUSTIFICATION. The amendments to 28 TAC §§134.802 – 134.805, 134.807, and 134.808 are necessary to update some of the technical requirements associated with insurance carriers' reporting medical charge and payment data to the Division as required by statutory provisions of Labor Code §413.007 and §413.008. These amendments highlight the requirements associated with the submission of medical charge and payment data where Texas differs from the International Association of Industrial Accident Boards and Commission's EDI Implementation Guide

for Medical Bill Payment Records, Release 1.0, dated July 4, 2002 (IAIABC Guide). The amendments update the existing medical data reporting requirements, with minimal changes to the current technical requirements associated with medical electronic data interchange (EDI) reporting. Lastly, these adopted rules highlight some requirements to improve data quality, such as compound medication reporting and diagnosis-related groups (DRG) reporting.

Labor Code §413.007 and §413.008 require the Division to maintain a statewide database of medical charges, actual payments, and treatment protocols to be used in adopting and administering medical policies and fee guidelines, as well as in detecting patterns and practices in the industry. In addition, these provisions require insurance carriers to provide specific information regarding health care treatment, services, fees, and charges.

These amendments fulfill the purposes of Labor Code §413.007 by requiring insurance carriers to submit to the Division accurate data in a medical EDI record. The accuracy of the data impacts whether or not records can be used for the purposes set forth in Labor Code §413.007. Imposing requirements relating to data accuracy helps ensure the quality and integrity of the data in the database. The availability of quality data will better enable the commissioner to adopt medical policies and fee guidelines and the Division to administer the medical policies, fee guidelines, and rules. Quality data will also better assist the Division in detecting practices and patterns in medical charges, actual payments, and treatment protocols and in using the database in a meaningful way to allow the Division to control medical costs. In addition, quality data

will help ensure that analyses performed by external entities, including the Workers' Compensation Research Institute, will be useful in making recommendations for policy or system enhancements and changes.

Labor Code §413.011, in part, 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 necessary to meet occupational injury requirements. To achieve this standardization, Labor Code §413.011, in part, requires the commissioner to adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting. Under 28 TAC Chapter 134, insurance carriers are required to utilize, in part, information obtained from the medical billing forms adopted by the commissioner when reporting accurate medical EDI records to the Division. The amendments to Chapter 134 further highlight the requirement that insurance carriers must utilize all sources, including but not limited to, the explanation of benefits, claim file, source medical bill, and billing forms adopted by reference in Title 28 TAC Chapter 133 when reporting accurate medical EDI data to the Division.

The Legislature, in Labor Code §§402.00111, 402.00128(b)(12), and 402.061, has given the commissioner rulemaking authority to promulgate rules to regulate the workers' compensation system and enforce the Act. The Division interprets this grant of

rulemaking authority to include the authority to adopt rules to implement the legislative directives in Labor Code §413.007 and §413.008.

The following paragraphs include a description of all of the adopted amendments necessary to implement Labor Code §413.007 and §413.008 and to make the other changes that the Division, with input from stakeholders, determined are necessary for effective reporting and compliance.

Section 134.802 addresses **Definitions**. Section 134.802(a)(1) defines the term "application acknowledgment code" to incorporate the definition of the term from the IAIABC Guide. The Division clarifies that an insurance carrier will receive either an "accepted" or "rejected" application acknowledgment code from the Division once a medical EDI record is submitted. These application acknowledgment codes are necessary to prevent incomplete medical EDI records from populating the database and will put the insurance carrier on notice that either a medical EDI record was accepted or that the medical EDI record was rejected and another medical EDI record must be submitted to the Division.

New §134.802(a)(2) defines the term "claim adjustment reason code (CARC)" to track the definition of the term from the IAIABC Guide. This defined term was recommended by stakeholders during the informal comment period of the draft rules. The Division clarifies that the term "claim adjustment reason code" is synonymous with the term "service adjustment reason code," as used in the IAIABC Guide. Insurance carriers and trading partners may access the complete code set, except for the Texas-specific codes, on the Washington Publishing Company website at www.wpc-edi.com.

The definition of the term "claim adjustment reason code (CARC)" is necessary to define the term as used in the definition of "W3" in §134.802 and as used in §134.804(a).

New §134.802(a)(3) defines the term "claim administrator claim number" to highlight that only one claim administrator claim number may be reported through the life of the workers' compensation claim as indicated in the IAIABC Guide. A claim administrator claim number is a unique identifier that is necessary to appropriately match medical EDI data to the workers' compensation claim. The Division emphasizes that the claim administrator claim number must not change with the acquisition of claims, claim transfer to a different third party administrator, business mergers, or any other reason. The insurance carrier is responsible for ensuring that its agents, including trading partners, have the required data for submission in a medical EDI record.

The existing §134.802(a)(1) definition of the term "Division" is redesignated as §134.802(a)(4). The existing definition of the term "EDI" in §134.802(a)(2) is redesignated as §134.802(a)(5).

New §134.802(a)(6) defines the term "element requirement table" to track the definition in the IAIABC Guide with changes to replace the term "maintenance type code" with the term "bill submission reason code" for consistent use of the term in Title 28 TAC Chapter 134 and the tables adopted by reference. This defined term was recommended by stakeholders during the informal comment period of the draft rules. The Division clarifies that the term "maintenance type code" is not used in the Texas EDI Medical Data Element Requirement Table.

New §134.802(a)(7) defines the term "IAIABC" as the abbreviation for the International Association of Industrial Accident Boards and Commissions. This definition was recommended by stakeholders and is necessary to clarify the term as used in Title 28 TAC Chapter 134.

The existing definition of the term "medical EDI record" in §134.802(a)(3) is redesignated as amended §134.802(a)(8) to keep the alphabetical formatting of the section. The term "accurate" and the phrase "obtained from all sources, including the medical bill, explanation of benefits, and insurance carrier's claim file" were added to reiterate the existing requirement that medical EDI data submitted to the Division must be accurate and obtained by the insurance carrier from source data. Insurance carriers possess the required data for a medical EDI record and should employ sufficient quality control activities to ensure that the data submitted to the Division, including the data sent by a trading partner, accurately reflects the information associated with the medical and payment action.

The existing definitions for "Medical EDI Transmission," "Medical EDI Transaction," "Person," and "Trading Partner" were renumbered from paragraphs (4), (5), (6), and (7) to paragraphs (9), (10), (11), and (12), respectively.

New §134.802(a)(13) defines the term "W3" as a Texas-specific claim adjustment reason code used to designate the medical EDI record as a reconsideration or appeal. The definition of the term is necessary to clarify the use of the term in Title 28 TAC Chapter 134 and the Texas EDI Medical Data Element Requirement Table.

Amended §134.802(b) provides an effective date of September 1, 2015 to provide stakeholders sufficient time to make the system changes outlined in the rules while ensuring that there is no delay in the Division's collection of medical state reporting data.

Section 134.803 addresses **Reporting Standards**. Amended §134.803(a) deletes the phrase "International Association of Industrial Accident Boards and Commissions (IAIABC)" because the term is defined in new §134.802(a)(7). Amended §134.803(a) adds the term "IAIABC Guide" to mean the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002.

Amended §134.803(b) adopts by reference amendments to the Texas EDI Medical Data Element Requirement Table, Version 2.0, dated September 2015, the Texas EDI Medical Data Element Edits Table, Version 2.0, dated September 2015, and the Texas EDI Medical Difference Table, Version 3.0, dated September 2015.

Texas EDI Medical Difference Table, Version 3.0 (September 2015):

The Texas EDI Medical Difference Table outlines the technical differences used for medical EDI reporting in Texas from the IAIABC Guide.

The Division requires an insurance carrier to submit the identification code qualifier of a social security number in the NM108 data element in Loop 2010CA. The IAIABC Guide allows for different values; however, the Division only accepts the identification code qualifier "34," identifying the social security number, in the NM108 data element. The Division also emphasizes that for Texas medical EDI reporting, the employee's social security number associated with the workers' compensation claim is

required to be reported. The employee's social security number is necessary to assist with claims matching. If the employee's social security number is unknown, then the insurance carrier must report the social security number in accordance with Title 28 TAC §102.8.

The Division amended the requirement to submit the DN53 in the DMG03 data element. Although the IAIABC Guide provides that the use of the DN53 is situational, it is required to be submitted for Texas medical EDI reporting. The Division changed the requirement of this element from "situational" to "required" to reflect the difference of the data submission requirement in Texas from the IAIABC Guide. Currently, DN53 is only required when reporting professional, institutional, or dental medical EDI records. The Division requires that insurance carriers must report DN53 on all medical EDI records, including those relating to pharmacy medical bills. This amendment is necessary for ease of compliance for system participants to provide the information when reporting all medical EDI records, rather than prescribing a list of exceptions.

The Division amended the provider agreement code DN507 in data element CLM16 to clarify acceptable values and emphasize that the value of "Y" is not accepted in Texas. This amendment is necessary to ensure valid data is submitted to the Division because the IAIABC Guide defines "Y" as "preferred provider organization (PPO) agreement," but that definition is not used in Texas medical EDI reporting. The Division also clarified that "P" excludes services performed within a certified network. Additionally, the Division clarified that "N" means no contractual fee arrangement existed between the insurance carrier and the health care provider for services

performed. A non-substantive amendment deleted the phrase "contract or out of network services" to add the clarifying phrase "contractual fee arrangement for services performed." The phrase "services performed within a" was added to replace "networks" to clarify the exclusion is for services within a certified network, rather than for certified networks.

The Division amended the requirement that segment CN1, contract information, be submitted to the Division from "optional" to "situational." This amendment is necessary because contract information must be reported to the Division when an insurance carrier calculated a reimbursement amount by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (Medicare IPPS) as required under Title 28 TAC §134.404, concerning Hospital Facility Fee Guidelines – Inpatient. An insurance carrier may reimburse an amount subject to calculation using Medicare IPPS on institutional medical bills when medical services were provided in an inpatient acute care hospital. This requirement is necessary for the Division to identify when a DRG was used by the insurance carrier to calculate the reimbursement amount.

The Division added the requirement that the contract type code be reported in the data element CN101, contract type code, with a value of "01." In the IAIABC Guide, a value of "01" identifies the contract type code as a DRG. This additional requirement is necessary for the Division to identify that a DRG was used by the insurance carrier to calculate the reimbursement amount.

The Division added the requirement that the DRG code be reported in DN518 as reference identification in the CN104 data element when the DRG code is used. This requirement will allow the Division to identify the DRG used by the insurance carrier to calculate the reimbursement amount.

The Division added the requirement that the decimal point be reported in data elements HI01-2, HI02-2, HI03-2, HI04-2, and HI05-2 when reporting the principal diagnosis code or the ICD-9-CM or the ICD-10-CM Diagnosis Code. Failure to provide the decimal point when submitting diagnosis or admitting codes will result in the medical EDI record being rejected by the Division. This is necessary because the formatting of the ICD code sets obtained by the Division include decimal points.

The Division amended the bill level adjustment data reporting from "optional" to "not used" in Loop 2320 because the Division requires the submission of medical EDI data adjustment information at the line level of medical bills, rather than at the bill level. This amendment is necessary for ease of compliance for system participants, as the Division does not use this data and therefore it is not necessary to achieve the purposes of Labor Code §413.007.

The Division amended the revenue billed code, DN559, reporting requirement in the SV201 data element, and the revenue paid code, DN576, in the SVD04 data element to clarify that any revenue code valid for Medicare billing will be accepted and is not limited to a three-digit format. The phrase "provided it is submitted in three-digit format" is deleted from the comments section of the SV201 and SVD04 data elements

to allow for the submission of valid codes that are more than 3 digits. This amendment is necessary to allow submission of valid code formats.

The Division amended the requirement to report a claim adjustment reason code in Loop 2430 for data element CAS02, and the situational reporting requirements for the CAS05, CAS08, CAS11, and CAS14 data elements to clarify that a Texas-specific claim adjustment reason code may be used when reporting actions related to a request for reconsideration or appeal. The code "W3" must be used as the claim adjustment reason code when reporting any reconsideration or appeal of a medical bill, as required in §134.804(a), concerning reporting requirements. Additionally, the Division amended the description for Loop 2430 from "claim" adjustment reason code to "service" adjustment reason code for consistency with the Texas EDI Medical Data Element Edits Table and the Texas EDI Medical Data Element Requirement Table. The Division clarifies that under §134.802(a)(2), the term "claim adjustment reason code" is synonymous with "service adjustment reason code."

Texas EDI Medical Data Element Edits Table, Version 2.0 (September 2015):

The Texas EDI Medical Data Element Edits Table sets out the review the Division will perform for each data element to use for validation of data submitted to the Division. This table is necessary because it will notify insurance carriers of the applicable edits and will ensure the data sent to the Division is complete and contains valid data.

The Division added one column to the table to provide for an error message of an "invalid event sequence/relationship" for error code 063. This additional column is

necessary to notify insurance carriers and trading partners that the medical EDI data submitted was rejected by the Division and provides a meaningful error code and message to enable the resubmission of corrected data. This amendment is necessary to assist system participants in complying with the requirement that rejected medical EDI records must be corrected and resubmitted within the time frame required by existing Title 28 TAC §134.804(e).

The Division deleted the "mandatory field not present (001)" for the jurisdiction claim number data element DN05 because it is a conditional data element that becomes required to be submitted only when the insurance carrier has received the jurisdiction claim number from the Division. The Division clarifies that the jurisdiction claim number is a unique identifier that is necessary for the Division to appropriately match medical bill data to the workers' compensation claim. The source of this data element is provided from the payer and not the medical bill. The insurance carrier receives the jurisdiction claim number in the acknowledgment that is sent by the Division to the insurance carrier upon acceptance of a first report of injury claims EDI record. The jurisdictional claim number is useful for matching medical data to the workers' compensation claim because this number does not change.

The Division amended the data elements DN152 and DN153 to remove the requirements that the data must be reported as a mandatory field and that the data must be alphanumeric. The requirement that the employee's social security number be reported negates the need for the Division to collect data elements DN152 and DN153.

The Division amended the data element of DN507, provider agreement code, to clarify that the value of "Y" is not acceptable in Texas and to ensure the data is rejected by the Division if a "Y" value is transmitted in the medical EDI data. This element will be subject to the Code/ID Invalid (058) edit. This amendment is necessary to ensure valid data is submitted to the Division because the IAIABC Guide defines "Y" as "preferred provider organization (PPO) agreement," but that definition is not used in Texas medical EDI reporting.

The Division amended the data element of DN508, bill submission reason code, to add the invalid event sequence/relationship (063) edit. This edit will enable the Division to reject medical EDI records if the medical EDI record is submitted to the Division out of sequence. For example, an insurance carrier will receive an acknowledgement code of "reject" if a cancellation or replacement medical EDI record is submitted to the Division prior to an original medical EDI record being accepted. The Division must receive an original medical EDI record before it can be cancelled or replaced because the Division only retains the most current medical EDI record submitted by the insurance carrier. Therefore, the amendment is necessary to ensure the Division maintains the most current medical EDI record available.

The Division amended the data element of DN515, contract type code. The Division added the Code/ID Invalid (058) because the Division will only accept a value of "01" for this data element and all other values will be rejected. This amendment is necessary to facilitate communication with the insurance carrier that an invalid value for contract type code was submitted to the Division in the medical EDI record.

The Division amended the data element of DN518, DRG code, to add the Code/ID invalid (058) edit because the Division will perform a check of valid DRG codes and will reject the transaction if the value is not valid. This amendment is necessary to identify the DRG code used by the insurance carrier to calculate the reimbursement amount and to help ensure the quality and integrity of the data maintained by the Division.

The Division amended the data element of DN535, admitting diagnosis code, to add the requirement that a decimal point be reported. This amendment is necessary to clarify that an insurance carrier must report the decimal point for the Division to process the data collected in a meaningful manner. Failure to provide the decimal point when submitting diagnosis or admitting codes will result in the medical EDI record being rejected by the Division. This is necessary because the formatting of the ICD code sets obtained by the Division include decimal points.

The Division amended the data element of DN559, revenue billed code, and DN576, revenue paid code, to remove the requirement that the data be submitted in a three-digit format, because this edit would reject other valid codes from being submitted. This amendment is necessary to allow submission of valid code formats no matter the number of digits.

The Division amended the data element of DN717, HCPCS modifier billed code, by removing the mandatory field not present (001) edit because there may not be any HCPCS modifiers on a medical bill. The Division added the Code/ID Invalid (058) edit to facilitate communication with the insurance carrier that the HCPCS modifier submitted

to the Division was not valid. HCPCS modifier billed code is needed, if known, to improve the accuracy of identifying the service that was performed or determining the appropriate reimbursement rate. These amendments are necessary because the Division does validate HCPCS modifiers and will reject medical EDI records containing invalid HCPCS modifiers.

The Division amended the data element of DN732, service adjustment reason code, by removing the Code/ID invalid (058) validation to facilitate the resubmission of medical EDI records for historical medical bills. This amendment is necessary because the Division does not conduct a CARC validation of submitted data. The Division does not perform a validation check of current service adjustment reason codes to allow insurance carriers to submit medical EDI records for historical medical bills without receiving a rejection.

Texas EDI Medical Data Element Requirement Table, Version 2.0 (September 2015)

The Texas EDI Medical Data Element Requirement Table outlines the data elements that are required to be submitted to the Division, including the mandatory triggers for conditional data elements. This table is necessary because it identifies the data elements that must be included in the database required by Labor Code §413.007.

The data element DN42, employee social security number, was previously identified on the table as a conditional data element, with a mandatory trigger of reporting only when the injured employee's social security number was available to the insurance carrier. The social security number data element is changed to mandatory because this data should always be reported either with a known social security number

or if no social security number has been assigned, then the insurance carrier must include the information as required under Title 28 TAC §102.8.

The data element DN53 was previously identified on the table as a conditional data element because it was only required when reporting professional, institutional, or dental medical EDI records. The data element DN53 must be reported on all medical EDI records, including those relating to pharmacy medical bills. This amendment is necessary for ease of compliance for system participants to provide the information when reporting all medical EDI records, rather than prescribing a list of exceptions.

The data elements DN152 and DN153 were previously listed on the table as conditional data elements to be reported when the social security number is not reported. Because Title 28 TAC §102.8 provides the reporting format for unknown social security numbers, the DN152 and DN153 data elements are no longer applicable for medical EDI reporting purposes to the Division.

The data element DN154, employee ID assigned by jurisdiction, was previously listed on the table as optional, but is amended to be not applicable. This change is necessary because the Division does not issue an employee ID assigned by jurisdiction, and therefore, the data is unnecessary for medical EDI reporting in Texas.

The data element DN156, employee passport number, was previously listed on the table as optional, but is amended to be not applicable. Because Title 28 TAC §102.8 provides the reporting format for unknown social security numbers, the employee passport number data element is no longer applicable for medical EDI reporting purposes to the Division.

The data element DN515, contract type code, was previously listed on the table as optional, but is amended to be conditional, because it is required to be reported to the Division when an insurance carrier calculated a reimbursement amount by applying the most recently adopted and effective Medicare IPPS. An insurance carrier may reimburse an amount subject to calculation using Medicare IPPS on institutional bills where medical services were provided in an inpatient acute care hospital. This amendment is necessary for the Division to identify the DRG code used by the insurance carrier to calculate the reimbursement amount.

The data element DN518, DRG code, was previously listed on the table as optional, but is amended to be conditional because it is required to be reported to the Division when an insurance carrier calculated a reimbursement amount by applying the most recently adopted and effective Medicare IPPS. An insurance carrier may reimburse an amount subject to calculation using Medicare IPPS on institutional medical bills where medical services were provided in an inpatient acute care hospital. The change will allow the Division to identify the DRG code used by the insurance carrier to calculate the reimbursement amount. This amendment is therefore necessary because it will ensure that the database contains complete records that relate to medical charges, actual payments, and treatment protocols as required by Labor Code §413.007(a). This amendment will also help the Division to ensure that the database contains information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols and can be used in a meaningful way to allow the Division to control medical costs.

The data elements DN543, bill adjustment group code, DN544, bill adjustment reason code, DN545, bill adjustment amount, and DN546, bill adjustment units, were previously listed on the table as optional, and are amended to be not applicable. The Division amended the data element reporting as "not applicable" because the Division does not currently use the data in these elements and therefore they are not necessary to achieve the purposes of Labor Code §413.007.

The data element DN731, service adjustment group code, is conditional but becomes mandatory once a condition in the mandatory trigger is met. The Division amended the mandatory triggers to emphasize the existing requirement that the information is required to be reported when (i) the DN552 total charge per line does not equal the DN574, total paid per line; (ii) when reporting actions related to a request for reconsideration or appeal of a medical bill; (iii) or when both the total charge per line does not equal the total paid per line and it is an action related to a request for reconsideration or appeal.

The data elements DN732, service adjustment reason code, DN733, service adjustment amount, and DN734, service adjustment units, are amended to require they be reported to the Division when the data element of DN731 is reported, because they have the same mandatory triggers as DN731.

Amended §134.803(c) deletes redundant language regarding information on how to obtain the IAIABC Guide and clarifies that the amended tables adopted by reference may be accessed on the Division's website.

Amended §134.803(e) adds an effective date of September 1, 2015 to provide stakeholders sufficient time to make the system changes outlined in the rules while ensuring that there is no delay in the Division's collection of medical state reporting data.

Section 134.804 addresses **Reporting Requirements**. Amended §134.804(a) adds the phrase "or appeal" to clarify that an "00" original medical EDI record must be submitted for an appeal taken on an individual medical bill. A reconsideration or appeal is a subsequent action, and all subsequent actions must be reported to the Division.

The term "payment" is deleted to clarify that original medical EDI records on all subsequent actions, not just payment actions, must be reported to the Division. The phrase "Texas-specific claim" is added and the term "service" is deleted to clarify that the adjustment reason code of "W3" is a Texas-specific claim adjustment reason code. The phrase "to designate the medical EDI record as a reconsideration or appeal" is added to clarify that the "W3" claim adjustment reason code is used by the Division to identify requests for reconsideration and appeals of original medical bills. Additionally, §134.804(a) specifies that "W3", the Texas-specific claim adjustment reason code, must be used in the explanation of benefits as required under existing Title 28 TAC §133.250.

Amended §134.804(b) requires that an '00' original medical EDI record be submitted to the Division by an insurance carrier before an '01' cancel medical EDI record may be submitted. A newly added edit will enable the Division to reject medical EDI records if the medical EDI record is submitted to the Division out of sequence. For example, an insurance carrier will receive an acknowledgement code of "reject" if a

cancellation or replacement medical EDI record is submitted to the Division prior to an original medical EDI record being accepted. This amendment is necessary because the Division must receive an original medical EDI record before it can be replaced or canceled, and the Division will begin to reject a replacement or cancellation of a medical EDI record when the original medical EDI record was not accepted.

Amended §134.804(c) requires that an '00' original medical EDI record be submitted by an insurance carrier to the Division before an '05' replacement medical EDI record may be submitted. The Division must accept an original medical EDI record before it can be replaced.

Amendments to §134.804(b) and (c) are necessary because the Division only retains the most current medical EDI record submitted by the insurance carrier. Therefore, submitting medical EDI records to the Division in the proper sequence is necessary to ensure the Division maintains the most current medical EDI records available.

Amended §134.804(d) deletes the phrase "are responsible for the" and "submission of" and adds the phrases "must submit" and "to the Division" for clarity and to conform to current agency style. The Division notes that this change is not substantive and in no way should be construed to mean that insurance carriers are not responsible for the actions of their agents.

Amended §134.804(d)(2) adds the phrase "medical EDI data may be obtained from all sources, including" and the phrase "an insurance carrier's claim file" to reiterate the existing requirement that insurance carriers must submit accurate medical EDI

records to the Division. Insurance carriers must ensure that the medical EDI data submitted to the Division is accurate and may be obtained from all sources, including but not limited to, the claim file, original medical bill, and explanation of benefits. The phrase "where applicable" and "the same" are deleted because they are redundant and to conform to current agency style. Amended §134.804(d)(2) also deletes the word "as" and the word "and" for clarity and to conform to current agency style.

Amended §134.804(d) is necessary to fulfill the purposes of Labor Code §413.007, that, in part, requires insurance carriers to submit to the Division accurate data in a medical EDI record. The accuracy of the data impacts whether or not individual records can be used for the purposes set forth in Labor Code §413.007. Insurance carriers possess the source data for a medical EDI record and should employ sufficient quality control activities to ensure that the data submitted to the Division, including the data sent by a trading partner, accurately reflects the information associated with the payment action.

The availability of quality data will better able the commissioner to adopt medical policies and fee guidelines and the Division to administer the medical policies, fee guidelines, and rules. The availability of quality data will also better assist the Division in detecting practices and patterns in medical charges, actual payments, and treatment protocols and using the database in a meaningful way to allow the Division to control medical costs. In addition, quality data will help ensure that analyses performed by external entities, including the Workers' Compensation Research Institute, will be useful in making recommendations for policy or system enhancements and changes.

Additionally, Labor Code §413.008 provides, in part, that on request from the Division for specific information, an insurance carrier shall provide any information in the carrier's possession, custody, or control that reasonably relates to the Division's duties and to health care treatment, services, fees, and charges.

Amended §134.804(f) adds an effective date of September 1, 2015 to provide stakeholders sufficient time to make the system changes outlined in the rules while ensuring that there is no delay in the Division's collection of medical state reporting data.

Section 134.805 addresses **Records Required to be Reported**. Amended §134.805(a)(2) reiterates the existing requirement that insurance carriers must submit medical EDI records relating to duplicate medical bills to the Division if the duplicate medical bill was processed for payment. This amendment is necessary to highlight that insurance carriers are required to submit medical bill payment data on all medical bills that are processed, which may include duplicate medical bills. It should be noted that under existing 28 TAC §133.200(a)(1), insurance carriers must not return medical bills to the health care provider that are complete, unless the medical bill is a duplicate medical bill.

New §134.805(a)(5) and (6) highlight the existing requirement that insurance carriers must submit medical EDI records to the Division when the insurance carrier reimburses an injured employee, or an employer, for health care. New §134.805(a)(5) and (6) reference the existing requirements in Title 28 TAC §133.270 and §133.280, respectively.

Amended §134.805(d) adds an effective date of September 1, 2015 to provide stakeholders sufficient time to make the system changes outlined in the rules while ensuring that there is no delay in the Division's collection of medical state reporting data.

Section 134.807 addresses **State Specific Requirements.** Amended §134.807(f)(2) emphasizes the current requirement that an insurance carrier must report the same prescription number for each reimbursable component of the compound medication, including the compounding fee. This amendment is necessary to ensure that each reimbursable component of the compound medication, including the compounding fee, is linked to the same prescription number. Linking each reimbursable component of a compound medication to the same prescription number is necessary to ensure the Division is receiving quality data. The availability of quality data will better assist the Division in detecting practices and patterns in medical charges, actual payments, and treatment protocols and using the database in a meaningful way to allow the Division to control medical costs.

New §134.807(f)(5) highlights the existing requirement that if the injured employee's social security number is unknown, it must be reported in accordance with Title 28 TAC §102.8(a)(1). This amendment is necessary to ensure that insurance carriers consistently report required medical EDI records in accordance with existing Division rules.

New §134.807(f)(6) adds the requirement that the data element DN53 must be reported on all medical EDI records, including those relating to pharmacy medical bills.

This amendment is necessary for ease of compliance for system participants to provide the information when reporting all medical EDI records, rather than prescribing a list of exceptions.

New §134.807(f)(7) clarifies the requirement that the provider agreement code be reported on all medical EDI records and is consistent with the existing requirement for data element DN507 in the Texas EDI Medical Data Element Requirement Table. The provider agreement code must only contain one of the following values; "H" for services performed within a Certified Workers' Compensation Health Care Network; "P" for services performed under a contractual fee arrangement, excluding services performed within a certified network; or "N" for no contractual fee arrangement for services performed. New §134.807(f)(7) also provides that "Y" is not a valid value in Texas because the IAIABC Guide uses "Y" as a DN507, provider agreement code, for services performed by a preferred provider organization agreement and that definition is not used in Texas medical EDI reporting.

New §134.807(f)(8) provides that when an insurance carrier calculated a reimbursement amount by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) as required in §134.404, the DN515, contract type code, must be reported as "01", and the valid diagnosis related group code for DN518 must be reported. New §134.807(f)(8) is necessary to enable the Division to administer the fee guidelines, in part, through analysis of medical EDI data submitted to the Division.

New §134.807(f)(9) provides that on a professional medical bill, an insurance carrier shall only report up to four diagnosis codes in a medical EDI record. This section is necessary because the Division has adopted the guidance in the IAIABC Guide, and the IAIABC Guide only allows four diagnosis codes to be reported.

New §134.807(f)(10) provides that on a professional medical bill, an insurance carrier shall only report up to four diagnosis code pointers and the corresponding pointers must be reported numerically. This is necessary because the structure of reporting in the IAIABC Guide adopted by the Division only allows four diagnosis code pointers to be reported numerically, and therefore excess diagnosis code pointers must be reported to the default value of "1." This amendment was recommended by stakeholders during the informal comment period of the draft rules.

New §134.807(g) adds an effective date of September 1, 2015 to provide stakeholders sufficient time to make the system changes outlined in the rules while ensuring that there is no delay in the Division's collection of medical state reporting data.

Section 134.808 addresses **Insurance Carrier EDI Compliance Coordinator and Trading Partners.** Amended §134.808(c) and (d) delete the phrase "by fax or email at TxCOMP.Help@tdi.state.tx.us" because the Texas Department of Insurance has changed its internet domain name and email extensions. This amendment is necessary to delete incorrect contact information. Insurance carriers must submit the notice required under amended §134.808(c) and (d) to the Division pursuant to the instructions on the form.

Amended §134.808(e)(1) deletes the word "bills" and adds the phrase "medical EDI records" for consistent use of the term in the section. Additionally, the term "medical EDI records" is defined in new §134.802(a)(8).

Amended §134.808(g) adds an effective date of September 1, 2015 to provide stakeholders sufficient time to make the system changes outlined in the rules while ensuring that there is no delay in the Division's collection of medical state reporting data.

3. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General

Comment: Commenters generally support the proposed amendments; emphasizing that the amendments will improve the current process by providing greater standardization and clarity on how to accurately transmit medical bill data to the Division. The commenters note that the greater clarity should facilitate better and more complete insurance carrier compliance with reporting responsibilities in a standardized fashion, and is a positive first step in establishing a more efficient EDI process. Commenters emphasize that the proposal is a very good first step towards promoting the timely and efficient reporting of accurate data, a goal which is important to all stakeholders.

Division Response: The Division appreciates the supportive comment.

Comment: Commenters appreciate the work of the Division on proposing changes and thank the Division for preparing and publishing EDI State Reporting FAQs

on TDI's website, for committing to updating the FAQs as necessary, and for committing to hold EDI Data Reporting meetings following each Carrier Quarterly Meeting. Commenters note that all of these are important first steps towards the enhancement of communications between the Division, insurance carriers, and EDI vendor companies, and encourage the Division to move forward with developing the EDI minute communication tool.

Division Response: The Division appreciates the supportive comments.

Comment: Commenters request the Division utilize tools being utilized in other jurisdictions to increase communication; such as creating a FAQs webpage for clarification on recurring and emerging issues and scheduling open meetings between the Division and EDI trading partner technical staff to identify problems and reach solutions. Commenters note that the proposal helps increase communication, but emphasize that greater collaboration is needed.

Division Response: The Division is currently using the national standard for EDI. Based upon stakeholder feedback, the Division added a Frequently Asked Questions webpage and, beginning October of 2014, the Division initiated EDI specific meetings following the Carrier Quarterly Meetings.

Comment: A commenter requests that the Division update its EDI Implementation Guide to the latest IAIABC standards Workers' Compensation Medical Bill Data Reporting Implementation Guide (Release 2.0).

Division Response: The Division declines to adopt Release 2.0 of the IAIABC Guide. The Division first adopted Version 1.0 of the IAIABC Guide in 2011, and after

considering the feasibility, timeframes, and costs of implementing Release 2.0 for all system participants, the Division has elected to maintain the system currently in place. These rules are intended to minimize the potential impact on system participants.

Comment: Commenters support the adoption of the proposed amendments to §§134.802, 134.803, and 134.804.

Division Response: The Division appreciates the supportive comment.

Section 134.802

Comment: Commenters state the Division's interpretation of the IAIABC Implementation Guide, that a claim number can never be changed over the life of the claim, is not an explicit statement in the Guide. Commenters state that the Division's interpretation will have a significant and costly impact to third party administrators (TPAs) and to insurance carriers who will be required to store and report different insurance carrier claim numbers than what's present in their respective claim system/medical bill payment systems. The commenters note that a new TPA and/or acquiring insurance carrier cannot 'bring forward' the previous claim number, as it may already exist in the acquiring insurance carrier's system for a different claim or the format/length of the claim number may not be compatible with the new claim system. To do so would require costly changes to not only the claim systems but the medical bill payment systems and possibly even the Division's claims data system.

Commenters seek guidance for how to handle legacy claims that already have multiple claim numbers reported to the Division, as well as future claims that may be transferred to a different TPA or acquired by a new insurance carrier, by asking the

following questions: (1) Which claim number should be used? (2) Should every past and current claims numbers be reported? (3) If yes to (2), how should all of the various claims numbers for a single claim be reported?

The commenters suggest a consistent definitional interpretation that the claim number can never change over the life of the claim for as long as the TPA or insurance carrier is handling the claim. Then, when the TPA acquires claims from another TPA or an insurance carrier purchases another insurance carrier, the claims transferred will be assigned a new unique claim number within the acquiring TPA or insurance carrier's claim system.

Division Response: The Division declines to make the suggested change. The IAIABC Guide (Release 1.0) clearly states that the claim administrator claim number is "used to identify a specific claim throughout the life of the claim." A claim's life does not begin and end with each new transfer or acquisition of the claim by a new insurance carrier or third party administrator. The claim administrator claim number originally reported should always be the claim number reported to the Division. The originally reported claim number is necessary to appropriately match the medical EDI data to the workers' compensation claim, and must be used for the life of the claim. This ensures that the Division is receiving accurate and complete data throughout the life of the claim.

Insurance carriers and third party administrators may contact edisupport@tdi.texas.gov with any questions regarding compliance with the Division's reporting requirements.

Comment: A commenter asks whether the Division intends to also amend its acceptance criteria for the claim administrator claim number data element via medical EDI reporting. Specifically, the commenter asks whether the Division will begin to reject ("TR") or accept with errors ("TE") non-matching/invalid claim administrator claim numbers?

The commenter cautions against making any additional changes to the claim administrator claim number data element acceptance criteria, stating it is unclear whether the Division's stated position that the claim number not be changed has been properly vetted and is widely accepted or adhered to within the system by insurance carriers and third party administrators. The commenter notes that additional changes could potentially complicate implementation and compliance.

Division Response: The Division emphasizes that adopted §134.802(a)(3) defines claim administrator claim number as "an identifier that distinguishes a specific claim within a claim administrator's claim processing system and is used throughout the life of the claim," as provided in the IAIABC Guide, adopted by reference in existing §134.803. Adopted §134.802(a)(3) does not affect the acceptance criteria of the claim administrator claim number. In adopted §134.802(a)(3), specifically, the Division is highlighting the definition of DN15, claim administrator claim number, as used throughout the tables adopted by reference. Adopted §134.802(a)(3) states that a claim administrator claim number is "an identifier that distinguishes a specific claim within a claim administrator's claim processing system and is used throughout the life of the claim."

Comment: A commenter asks: (1) does the state consider certain industry sites to be a valid source of accurate data for fields such as the NPI (CMS https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do) and zip code (https://tools.usps.com/go/ZipLookupAction_input)? (2) WPC is specifically mentioned for CARC codes in §134.802(a)(2), will the rule include lists of other industry sites for use as a valid source of data, as stated above?

Division Response: The Division clarifies that proposed §134.802(a)(2) does not specifically reference the use of the Washington Publishing Company website for CARC codes, but the preamble states that "insurance carriers and trading partners may access the complete code set, except for the Texas-specific codes, on the Washington Publishing Company website at www.wpc-edi.com." The Division also emphasizes that §134.803 adopts by reference the IAIABC Guide, Version 1.0, and the Texas EDI Medical Data Element Requirement Table, Texas EDI Medical Difference Table, and the Texas EDI Medical Data Element Edits Table.

Section 134.803

Comment: A commenter states that there is nothing to indicate what to utilize when the social security number is unknown. The commenter asks: (1) Will the correct format for reporting be 999MMDDYY? (2) Will this be documented in the Data Elements Requirement Table, Texas EDI Medical Difference Table, and, specifically, the Texas EDI Medical Data Element Edit Table under the Other Format Requirements column?

Division Response: The Division declines to make the suggested change and clarifies that both proposed and adopted §134.807(f)(5) state that when the employee's

social security number is unknown, it "must be reported in accordance with §102.8(a)(1) of this title." Title 28 TAC §102.8(a)(1) requires that "if no social security number has been assigned, insert the numerical digits '999' followed by the claimant's birth date or if unknown, the claimant's date of injury, listed by the month, day, and year (MMDDYY)."

The requirement is already contained in existing §102.8 and adopted §134.807(f)(5). Adding an additional reference to §102.8 in the tables adopted by reference would be repetitive of adopted §134.807(f)(5). Therefore, the Division declines to make the suggested change.

Section 134.804

Comment: A commenter supports the proposal to allow the payor to obtain medical EDI data from all sources, including but not limited to, the claim file, original medical bill, and explanation of benefits. The commenter states that inclusion of this language is helpful.

Division Response: The Division appreciates the supportive comment.

Comment: A commenter questions the proposed addition of language in §134.804(a) pertaining to the explanation of benefit (EOB) contents. The commenter does not disagree with the Division's policy goal of denoting if an EOB is in relation to a request for reconsideration, but the commenter requests modifications to the proposed language so that any new EOB content requirements be incorporated specifically into the relevant EOB rules (§133.240 and/or §133.250) rather than the EDI reporting rules.

The commenter recommends eliminating the following proposed phrase in §134.804(a): "The Texas-specific claim adjustment reason code must be included on

the explanation of benefits issued pursuant to §133.250 of this title (relating to reconsideration for Payment of Medical Bills)." The commenter further recommends separately amending §133.240 by removing "and" from (f)(19), adding "and" at the end of (f)(20), and inserting the following language as new §133.240(f)(21): "if the insurance carrier is issuing the explanation of benefits in relation to a request for reconsideration pursuant to §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), the Texas-specific claim adjustment reason code of 'W3' must be included."

Division Response: The Division declines to make the suggested change. A separate amendment to either §133.240 or §133.250 would require amendments to Title 28 Chapter 133, and is outside the scope of this rulemaking project.

Comment: Commenters note that a "subsequent action" may simply be a duplicate copy and mere duplicates should not trigger EDI requirements. The commenters recommend that §134.804(a) be modified to read: "…Original medical EDI records on subsequent actions other than a duplicate must contain a Texas-specific claim adjustment reason Code of W3 to designate the medical EDI record as a reconsideration or appeal."

Division Response: The Division declines to make the suggested change. All actions taken on a medical bill must be reported, including action on a duplicate copy of a medical bill, even if only to respond that the medical bill has been previously paid or denied and $0.00 is owed. Reporting allows the Division to screen for the CARC and identify patterns and practices that involve duplicate billing. Amended §134.805(a)(2) highlights that reporting duplicate copies is expressly required by inclusion in the rule. If

a subsequent action is a reconsideration or appeal, it must contain a Texas-specific claim adjustment code of "W3." If the subsequent action is not a reconsideration or appeal, the "W3" claim adjustment reason code is not required.

Comment: Commenters support the removal of language in §134.802(a)(8), §134.804(d)(2), and §134.804(f) that the insurance carrier's medical EDI record must be "compiled from sources verified by the insurance carrier to be accurate" and that would have required insurance carriers and vendors to verify the accuracy of information submitted on a medical bill and document differences.

Division Response: The Division appreciates the supportive comment. However, the Division emphasizes that insurance carriers are still required to submit accurate medical bill information under adopted §134.804(d), which states "[i]nsurance carriers must submit timely and accurate medical EDI records to the division" and that "medical data may be obtained from all sources, including the medical bill, explanation of benefits, and insurance carrier's claim file."

Comment: Commenters note that the receipt of a notice of rejection from the Division is an efficient process that allows the insurance carriers and trading partners to then correct the errors and resubmit the data within a reasonable period of time.

Division Response: The Division appreciates the supportive comment.

Comment: Commenters state that the receipt of an acknowledgement of acceptance in Texas, unlike other states, can mislead insurance carriers and trading partners into believing the accepted transmission is timely, complete, and accurate, only to discover some time after the fact that it was not. The commenters emphasize that this

is an unfair and inefficient process that undermines the goal of all stakeholders to have timely and accurate submission of data. The commenters suggest the problem is two-fold in that insurance carriers and trading partners are forced to process incomplete medical bills and that the Division has failed to upgrade its technology to screen the submitted data for completeness.

Commenters recommend addressing these issues by requiring health care providers to submit complete medical bills in order to be entitled to reimbursement and a commitment on behalf of the Division to keeping their technology up to date.

Division Response: The Division declines to make the suggested change. An Application Acknowledgment code is only a first level of screening that indicates whether valid modifiers and qualifiers have been submitted to the Division. It is possible for an insurance carrier or trading partner to submit valid modifiers and qualifiers, and receive a code of accepted, while still submitting inaccurate data. Valid modifiers and qualifiers do not necessarily constitute the appropriate modifiers and qualifiers for that specific medical bill.

The Division is committed to providing the highest level of service and communication possible through updated technology; however, it is the insurance carrier's duty to submit accurate medical EDI data to the Division. The Division declines to make the suggested changes to require health care providers to submit complete medical bills for reimbursement because an amendment to the health care provider rules, under Title 28 TAC §133.240 and §133.250, is outside the scope of this

rulemaking project. Additionally, if an insurance carrier receives a not complete bill, the carrier must follow the requirements in existing §133.200.

Comment: Commenters emphasize that the initial affirmative duty should be placed on the health care provider to provide the insurer with a complete and accurate medical bill. The commenters recommend §134.804(d) be modified to read: "After receiving a complete and accurate medical bill from the health care provider, insurance carriers must submit timely and accurate medical EDI records to the division."

Division Response: The Division declines to make the suggested change because it is inconsistent with existing rules and limits the insurance carrier's responsibility to submit timely and accurate medical EDI records to the Division. Under existing §133.200, in certain circumstances, when an insurance carrier receives a bill that is not complete, they shall either return the bill to the health care provider, or complete the bill by adding information already known to the insurance carrier. Thus, the insurance carrier's responsibility to submit timely and accurate medical EDI records is not limited to when they receive a complete medical bill from the health care provider, because, in certain circumstances, the insurance carrier has the option to fill in the missing information already known to them.

Section 134.805

Comment: A commenter questions whether duplicate bills received after September 1, 2011 need to be reported, regardless of the date of service. The commenter notes that the reporting of duplicate bills processed on or after September 1, 2011 is based on a clarification provided in August of 2011 by the state and that the

new proposed rule does not provide any specific effective date for the reporting of duplicate bills.

Division Response: Since September 2011, the Division has required insurance carriers to submit duplicate medical bills processed by the insurance carrier. Specifically, existing §134.805(a)(2) states that an insurance carrier "shall submit medical EDI records when the insurance carrier reduces or denies payment for a medical bill." Adopted §134.805(a)(2) further highlights this existing requirement that insurance carriers must submit a medical EDI record for duplicate medical bills processed for payment after September 1, 2011.

Comment: Commenters request clarification regarding the Division's expectations for compiling and reporting reimbursements made to employees and employers who have paid for health care services. The commenters note it is not uncommon for the insurance carrier to be presented with documentation (invoice, receipt, health care provider's super bill) that may meet requirements for requesting payment, but fail to meet the needs for medical EDI state reporting. Examples of data elements required for reporting that are frequently missing include DN561 and DN562. Commenters emphasize that these situations will require insurance carriers and/or their bill review vendors to spend time and resources compiling the data for submission to the Division. Commenters ask whether the Division intends to relax certain data elements for employee or employer reimbursement so that these bills can be accepted for reporting?

Commenters question the inclusion of §134.805(a)(5) and (a)(6) because these paragraphs require submission of a full EDI medical record whenever an insurance carrier reimburses either an injured employee or an employer for health care paid. The commenters emphasize that an insurer cannot submit a complete medical EDI record until the health care provider first submits a complete and accurate medical bill. The commenters recommend these sections be deleted from the rule.

Division Response: The Division declines to make the suggested changes. The Division emphasizes that adopted §134.805 references the requirements set forth in existing §133.270 and §133.280, regarding insurance carrier reimbursements to injured employees and employers for health care paid, adopted to be effective May 2, 2006.

Section 134.807

Comment: A commenter supports the clarifying language regarding multi-ingredient compound drug reporting, noting it encourages more consistent and transparent reporting of compound drug transactions to the Division. Commenters emphasize that this improved reporting holds the promise of greatly assisting the Division in capturing more accurate data and in researching the extent of utilization and costs associated with custom drug products within the workers' compensation system.

Division Response: The Division appreciates the supportive comment.

Comment: Commenters recommend the Division explain the billing requirement for compounded drugs in the appropriate billing rules, and educate pharmacists about the billing requirements regarding compound drugs because paper medical bills do not have a breakdown of compounds (while the e-Bill does). Commenters state that

clarification of the billing process regarding compounded drugs should result in an improvement in the quality of billing data associated with those drugs.

Division Response: The Division declines to make the suggested changes. An amendment to the medical billing rules is outside the scope of the current rulemaking project.

Comment: Commenters ask these questions regarding the reporting of compound prescriptions: (1) If an insurance carrier receives a compound bill that happens to have different prescription numbers for each reimbursable component, how would the insurance carrier comply with §134.807(f)(2) for reporting purposes? (2) Would insurance carriers be required to only transmit the first prescription number for all reimbursable components, if the others were different? (3) Would that be considered changing the contents of the bill based on what was submitted by the health care provider?

Division Response: The Division emphasizes that the same prescription number must be reported for each reimbursable component of the compound medication, including the compounding fee. Insurance carriers must report accurate data to the Division. If an insurance carrier receives a not complete bill, the insurance carrier must follow the requirements in existing §133.200.

Comment: A commenter suggests the Division require health care providers to bill compounding fees as a separate line item, noting that this would improve the identification and reporting of compound prescriptions.

Division Response: The Division declines to make the suggested change because it is outside the scope of the rulemaking project. The Division reiterates that the same prescription number should be provided for each ingredient within the compound drug for ease of compliance with reporting requirements and to ensure the availability of quality data.

Comment: Commenters state that the language of §134.807(f)(7) differs from the language included in the Texas EDI Medical Difference Table. The commenters note that the Division's comment included for Segment CLM16/DN507 in the Texas EDI Medical Difference Table is very clear as to what codes may be reported to the Division. Therefore, the commenters recommend the language in the rule be changed to mirror the language in the Texas EDI Medical Difference Table, suggesting it read:

(7) The provider agreement code must be reported on all medical EDI records. For Texas EDI Reporting purposes, the following definitions apply:

(A) "H" for services performed within a Certified Workers' Compensation Health Care Network;

(B) "P" for services performed under a contractual fee agreement, excluding services performed within a certified network; or

(C) "N" for no contractual fee arrangement for services performed.

Division Response: The Division declines to make the suggested change. The language of both the adopted Texas EDI Medical Difference Table and §134.807(f)(7) accurately reflect the reporting requirements for the provider agreement code in Texas. Adopted §134.807(f)(7) establishes requirements for reporting the provider agreement

code, including that it "must not be reported with the value of 'Y'." The Texas EDI Medical Difference Table Segment CLM16 comment provides definitions of acceptable values for this data element, including that "Y is not an acceptable value." Therefore, in both §134.807(f)(7) and the Texas EDI Medical Difference Table, it is clearly stated that "Y" is not an acceptable value for reporting the provider agreement code in Texas.

Comment: Commenters request the Division clarify that the limitations on reporting four diagnosis codes and four diagnosis pointers in §134.807(f)(9) and (f)(10) only applies to services submitted on the CMS 1500, as addressed in the February 2014, Memorandum.

Division Response: The Division made the suggested change to clarify that up to four diagnosis codes may be reported on a professional medical bill. The February 21, 2014, Division Memorandum addressed the recent adopted changes to the CMS 1500 form and how they are applied in Texas. Under adopted §134.807(f)(9) and (f)(10), insurance carriers are required to report diagnosis code information for each professional medical bill on a workers' compensation claim.

Comment: A commenter generally supports the inclusion of DRG as a mandatory reporting data element.

Division Response: The Division appreciates the supportive comment. However, it should be noted that this is a conditional reporting data element, not a mandatory one.

Comment: A commenter requests that the Division modify the associated billing rules to require that health care providers include the DRG along with their billing

statements, and expressly permit a payer to deny a bill that fails to include the required DRG.

Division Response: The Division declines to make the suggested change because it is outside the scope of the rulemaking project. The suggested change would require amendments to the applicable health care provider and DRG rules, under Title 28 TAC §§133.240, 133.250, and 134.404.

Comment: A commenter requests changes be made to the state-specific pharmacy billing form to include gender, and that the Division require this data element be populated by health care providers as well.

Division Response: The Division declines to make the suggested change because it is outside the scope of the rulemaking project. The suggested change would require an amendment to the pharmacy medical billing form.

Texas EDI Medical Difference Table

Comment: Commenters note that the Texas EDI Medical Difference Table does not include the mandatory use of "W3" as a difference. The commenters request the Division include "W3" in the Texas EDI Medical Difference Table, with a comment that "W3" is used by Texas for reporting a medical EDI record as a reconsideration or appeal, because it is the only valid Texas-specific code allowed in the CAS segments.

Division Response: The Division declines to make the suggested change. The Texas-specific code, "W3", is not considered a difference from the IAIABC Guide. Instead, the Texas-specific code is used in addition to the IAIABC Guide, and thus, included in §134.804 and not the tables.

Comment: Commenters request the Division substitute the following for the proposed language in the Segment NM108: "For Texas EDI reporting purposes, the injured employee's social security number shall be reported. If no social security number has been assigned, insert the numerical digits "999"; use of "999" shall not be used in place of a valid social security number in order to meet timeliness of reporting requirements." Commenters emphasize that the NM108 Texas EDI Medical Difference Table comment, for clarity and consistency purposes, should reflect the language set out in §102.8(a)(9).

Division Response: The Division declines to make the suggested change. The Texas EDI Medical Difference Table data element NM108 comment accurately reflects that the employee's social security number must be reported in Texas. Existing 28 TAC §102.8(a)(1) provides the formatting for this data element only when the employee's social security number is unknown.

Texas EDI Medical Data Element Edits Table

Comment: A commenter notes that Edit 073, on DN 512, limits insurance carriers from reporting pre-payment or pre-negotiated bills. The commenter states it is not apparent that the Division has specifically excluded pre-payments/pre-negotiations from the reporting requirements, or that the proposed changes to §134.806 exclude medical bills from EDI reporting. The commenter asks whether the Division intends to exclude these bills from the reporting requirements?

Division Response: The Division agrees with the suggested change. The Division deleted the column containing data error code 073, providing an error message

of "must be greater than or equal to the date payor received the bill," from the proposed Texas EDI Medical Data Element Edits Table, adopted by reference in §134.803. The Division deleted the column to clarify that pre-payment and pre-negotiated medical bills are not excluded from reporting requirements.

Comment: A commenter notes that the state is amending certain data elements which will be subject to the Code/ID Invalid (058) edit, but currently the state applies edits to FEINs that are not documented anywhere in the rule. The commenter asks whether the Division will provide further clarification on edit 058 – Code/ID Invalid Validation, specifically for FEIN fields?

Division Response: The Division declines to make the suggested change. Providing further clarification of the 058 edit would be cumbersome, as it would require listing all of the possible logic tests done for the Code/ID Invalid 058 edit on every data element. Generally, for the Code/ID Invalid (058) edit, the Division validates for logical data. For example, on an FEIN validation the Division rejects data for sequential numbers (123456789) and less than 9 digits. However, for DN53, the Division rejects if the value is not the specific value of M, F, or U.

4. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For:

None.

For, with changes:

Helios; EDI Task Force; Insurance Council of Texas; American Insurance Association; Property Casualty Insurers; Mitchell International (Workers' Compensation Solutions); Coventry Workers' Compensation Services; and, Texas Mutual Insurance.

Against:

None.

Neither for nor against:

None.

5. STATUTORY AUTHORITY. The amendments are adopted under the authority of Labor Code §§402.00111, 402.061, 402.00128, 413.007, 413.008, 413.052, 413.053, 414.002, and 414.004.

Labor Code §402.00111 (relationship between commissioner of insurance and commissioner of workers' compensation; separation of authority; rulemaking) 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 (adoption of rules) provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §402.00128 (general powers and duties of commissioner) provides, in part, that the Commissioner of Workers' Compensation may prescribe the form, manner, and procedure for the transmission of information to the Division, and furthermore, may exercise other powers and perform other duties as necessary for the implementation and enforcement of the Labor Code.

Labor Code §413.007 (information maintained by the Division) provides that the Division shall maintain a statewide database of medical charges, actual payments and treatment protocols. Labor Code §413.007 further provides that the Division shall ensure the database contains information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols that can be used in a meaningful way to allow the Division to control medical costs as provided by the Texas Workers' Compensation Act.

Labor Code §413.008 (information from insurance carriers; administrative violation) provides that, on request from the Division for specific information, an insurance carrier shall provide to the Division any information in the carrier's possession, custody, or control that reasonably relates to the Division's duties and to health care treatment, services, fees, and charges.

Labor Code §413.052 (production of documents) and §413.053 (standards of reporting and billing) require the commissioner to establish procedures to compel the production of documents, and to establish standards of reporting and billing governing both form and content.

Labor Code §414.002 (monitoring duties) provides, in part, that the Division shall monitor persons, including insurance carriers, for compliance with Division rules, Labor Code, Title 5, Subtitle A, and other laws relating to workers' compensation.

Labor Code §414.004 (performance review of insurance carriers) further provides, in part, that the Division shall regularly review the workers' compensation records of insurance carriers to ensure compliance with Labor Code, Title 5, Subtitle A.

Each insurance carrier, insurance carrier's agent, and those with whom the insurance carrier has contracted to provide, review, or monitor services under Labor Code, Title 5, Subtitle A, are required to cooperate with the Division, making available to the Division any records or other necessary information, and allowing the Division to access information at reasonable times.

6. TEXT.

§134.802 Definitions

(a) The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(1) Application Acknowledgment Code--A code used to identify the accepted or rejected status of the transaction being acknowledged.

(2) Claim Adjustment Reason Code (CARC)--A code that is used on a medical EDI record and an explanation of benefits to communicate why the amount paid for a medical bill or service line does not equal the amount charged. The term is synonymous with service adjustment reason code in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002.

(3) Claim Administrator Claim Number--An identifier that distinguishes a specific claim within a claim administrator's claim processing system and is used throughout the life of the claim.

(4) Division--The Texas Department of Insurance, Division of Workers' Compensation or its data collection agent.

(5) EDI--Electronic data interchange.

(6) Element Requirement Table--A receiver specific list of requirement codes for each data element depending on the bill submission reason code.

(7) IAIABC--The International Association of Industrial Accident Boards and Commissions.

(8) Medical EDI Record--The accurate data associated with a single medical bill which is being reported in a Medical EDI Transaction obtained from all sources, including the medical bill, explanation of benefits, and insurance carrier's claim file.

(9) Medical EDI Transmission--The data that is contained within the interchange envelope.

(10) Medical EDI Transaction--The data that is contained within the functional group.

(11) Person--An individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity. This term does not include an injured employee.

(12) Trading Partner--A person that has entered into an agreement with the insurance carrier to format electronic data for transmission to the division, transmits electronic data to the division, and responds to any technical issues related to the contents or structure of an EDI file.

(13) W3--A Texas-specific claim adjustment reason code to designate the medical EDI record as a reconsideration or appeal.

(b) This section is effective September 1, 2015.

§134.803 Reporting Standards

(a) Except as provided in this subchapter, the commissioner adopts by reference the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002 (IAIABC Guide) published by the IAIABC.

(b) The commissioner adopts by reference the *Texas EDI Medical Data Element Requirement Table*, Version 2.0, dated September 2015, the *Texas EDI Medical Data Element Edits Table*, Version 2.0, dated September 2015, and the *Texas EDI Medical Difference Table*, Version 3.0, dated September 2015. All tables are published by the division.

(c) The adopted division tables may be found on the division's website: http://www.tdi.texas.gov/wc/edi/index.html.

(d) In the event of a conflict between the IAIABC Guide and the Labor Code or division rules, the Labor Code or division rules shall prevail.

(e) This section is effective September 1, 2015.

§134.804 Reporting Requirements

(a) Insurance carriers shall submit an '00' original medical EDI record for each action (initial processing, request for reconsideration or appeal, or subsequent orders) taken on an individual medical bill. Original medical EDI records shall be reported within 30 days after the date of the action. Each iteration of an '00' original medical EDI record

must contain a different unique medical bill identification number. The amount paid on each action related to a medical bill must contain only the amount issued for that event and must not contain a cumulative amount reflecting all events related to an individual medical bill. Original medical EDI records on subsequent actions must contain a Texas-specific claim adjustment reason code of 'W3' to designate the medical EDI record as a reconsideration or appeal. The Texas-specific claim adjustment reason code must be included on the explanation of benefits issued pursuant to §133.250 of this title (relating to Reconsideration for Payment of Medical Bills).

(b) Insurance carriers shall submit an '01' cancel medical EDI record if the '00' original medical EDI record should not have been sent or contained the incorrect insurance carrier identification number. Cancel medical EDI records shall be reported within 30 days after the earliest date the insurance carrier discovered the reporting error. The '01' cancel medical EDI record must contain the same unique bill identification number as the '00' original medical EDI record that was previously submitted and accepted. An '00' original medical EDI record must be accepted by the division before an '01' cancel medical EDI record may be submitted.

(c) Insurance carriers shall submit an '05' replacement medical EDI record when correcting data on a previously submitted medical EDI record. Replacement medical EDI records shall be submitted within 30 days after the earliest date the insurance carrier discovered the reporting error. The '05' replacement medical EDI record must contain the same unique bill identification number as the associated '00' original medical

EDI record. An '00' original medical EDI record must be accepted by the division before an '05' replacement medical EDI record may be submitted.

(d) Insurance carriers must submit timely and accurate medical EDI records to the division. For the purpose of this section, a medical EDI record is considered to have been accurately submitted when the record:

(1) received an Application Acknowledgment Code of accepted;

(2) contained accurate medical EDI data; medical EDI data may be obtained from all sources, including the medical bill, explanation of benefits, and insurance carrier's claim file; and

(3) to the extent supported by the format, contained all appropriate modifiers, code qualifiers, and data elements necessary to identify health care services, charges and payments.

(e) Insurance carriers are responsible for correcting and resubmitting rejected medical EDI records within 30 days of the action that triggered the reporting requirement. The insurance carrier's receipt of a rejection does not modify, extend or otherwise change the date the transaction is required to be reported to the division. The resubmitted medical EDI record must contain the same unique bill identification number as the previously rejected medical EDI record.

(f) This section is effective September 1, 2015.

§134.805 Records Required to be Reported

(a) Insurance carriers shall submit medical EDI records when the insurance carrier:

(1) pays a medical bill;

(2) reduces or denies payment for a medical bill, including duplicate bills;

(3) receives a refund for a medical bill;

(4) discovers that a medical EDI record should not have been submitted to the division and the medical EDI record had previously been accepted by the division;

(5) reimburses an injured employee for health care paid in accordance with §133.270; or

(6) reimburses an employer for health care paid in accordance with §133.280.

(b) Regardless of the Application Acknowledgment Code returned in an acknowledgment, medical EDI records are not considered received by the division if the medical EDI record:

(1) contains data which does not accurately reflect the code values used or actions taken when the insurance carrier processed the medical bill; or

(2) fails to contain a conditional data element and the mandatory trigger condition existed at the time the insurance carrier processed the medical bill.

(c) Except in situations where the health care provider included an invalid service or procedure code on the medical bill, rejected medical EDI records are not considered received and shall be corrected and resubmitted to the division as provided in §134.804(e) of this title (relating to Reporting Requirements). Medical EDI records submitted in the test environment are not considered received and do not comply with the reporting requirements of this section.

(d) This section is effective September 1, 2015.

§134.807 State Specific Requirements

(a) A medical EDI transmission shall not exceed a file size of 1.5 megabytes. A transaction set shall not contain more than 100 medical EDI records in a claimant hierarchical loop.

(b) Insurance carriers shall submit medical EDI transactions using Secure File Transfer Protocol (SFTP). All alphabetic characters used in the SFTP file name must be lower case and the file must be compressed/zipped. Files that do not comply with these requirements or the naming convention may be rejected and placed in appropriate failure folders. Insurance carriers must monitor these folders for file failures and make corrections in accordance with §134.804(e) of this title (relating to Reporting Requirements).

(c) SFTP files must comply with the following naming convention:

(1) Two digit alphanumeric state indicator of 'tx';

(2) Nine digit trading partner Federal Employer Identification Number (FEIN);

(3) Nine digit trading partner postal code;

(4) Nine digit insurance carrier FEIN or 'xxxxxxxxx' if the file contains medical EDI transactions from different insurance carriers;

(5) Three digit record type '837';

(6) One character Test/Production indicator ('t' or 'p');

(7) Eight digit date file sent 'CCYYMMDD';

(8) Six digit time file sent 'HHMMSS';

(9) One character standard extension delimiter of '.'; and

(10) Three digit alphanumeric standard file extension of 'zip' or 'txt'.

(d) The transaction types accepted by the division include '00' original, '01' cancel, and '05' replacement.

(e) Insurance carriers are required to use the following delimiters:

(1) Date Element Separator--'*' asterisk;

(2) Sub-element Separator--':' colon; and

(3) Segment Terminator--'~' tilde.

(f) In addition to the requirements adopted under §134.803 of this title (relating to Reporting Standards), state reporting of medical EDI transactions shall comply with the following formatting requirements:

(1) Loop 2400 Service Line Information must not contain more than one type of service. Only one of the following data segments may be contained in an iteration of this loop: SV1 Professional Service, SV2 Institutional Service, SV3 Dental Service or SV4 Pharmacy Service.

(2) When reporting compound medications, Loop 2400 Service Line Information SV4 Pharmacy Drug Service must include a separate line for each reimbursable component of the compound medication. The same prescription number for each reimbursable component of the compound medication, including the compounding fee, must be reported. The compounding fee must be reported using a default NDC number equal to '99999999999' as a separate service line.

(3) When reporting pharmacy medical EDI records, the following data element definition clarifications apply:

(A) DN501 Total Charge Per Bill is the total amount charged by the pharmacy or pharmacy processing agent;

(B) DN511 Date Insurer Received Bill is the date the insurance carrier received the bill;

(C) DN512 Date Insurer Paid Bill is the date the insurance carrier paid the pharmacy or pharmacy processing agent;

(D) DN638 Rendering Bill Provider Last/Group Name is the name of the dispensing pharmacy;

(E) DN690 Referring Provider Last/Group Name is the last name of the prescribing doctor; and

(F) DN691 Referring Provider First Name is the first name of the prescribing doctor.

(4) When ICD-10-CM and ICD-10-PCS codes are contained on the medical bill, the insurance carrier must report these codes in the associated ICD-9-CM data elements using the ICD-9-CM code qualifiers.

(5) If the injured employee's social security number is unknown, it must be reported in accordance with §102.8(a)(1) of this title (relating to Information Requested on Written Communications to the Division).

(6) The DN53 data element must be reported on all medical EDI records.

(7) The provider agreement code must be reported on all medical EDI records, must not be reported with the value of "Y", and must only contain one of the following values:

(A) "H" for services performed within a Certified Workers' Compensation Health Care Network;

(B) "P" for services performed under a contractual fee arrangement, excluding services performed within a certified network; or

(C) "N" to indicate no contractual fee arrangement for services performed.

(8) When an insurance carrier calculated a reimbursement amount by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) as required in §134.404 of this title (relating to Hospital Facility Fee Guideline--Inpatient), the DN515 (Contract Type Code) must be reported as "01" and the valid Diagnosis Related Group Code for DN518 must be reported.

(9) On a professional medical bill, an insurance carrier shall only report up to four (4) diagnosis codes on each medical EDI record.

(10) On a professional medical bill, an insurance carrier shall only report to the Division up to four diagnosis code pointers and those pointers must be reported numerically. If a professional medical bill containing more than four diagnosis pointers is reported to the insurance carrier, each diagnosis pointer after the first four shall be reported to the Division with the value of "1."

(g) This section is effective September 1, 2015.

§134.808 Insurance Carrier EDI Compliance Coordinator and Trading Partners

(a) Insurance carriers may submit medical EDI records directly to the division or may contract with an external trading partner to submit the records on the insurance carrier's behalf.

(b) Each insurance carrier, including those using external trading partners, must designate one individual to the division as the EDI Compliance Coordinator and provide the individual's name, working title, mailing address, email address, and telephone number in the form and manner prescribed by the division. The EDI Compliance Coordinator must:

(1) be a centrally-located employee of the insurance carrier who has the responsibility for EDI reporting;

(2) receive and appropriately disperse data reporting information received from the division; and

(3) serve as the central compliance control for data reporting under this subchapter.

(c) At least five working days prior to sending its first transaction to the division under this subchapter, the insurance carrier shall send a notice to the division. The notice shall be in the form and manner established by the division. The notice shall include the name of the insurance carrier, the insurance carrier's FEIN, the insurance carrier's TxCOMP customer number, the name of the trading partner(s) authorized to conduct medical EDI transactions on behalf of the insurance carrier, the FEIN of the trading partner(s), and the EDI Compliance Coordinator's signature. The insurance

carrier shall report changes within five working days of any amendment to data sharing agreements, including the addition or removal of any trading partners. The failure to timely submit updated information may result in the rejection of medical EDI records.

(d) At least five working days prior to sending its first test transaction to the division under this subchapter, the insurance carrier or trading partner sending the medical EDI transmission shall send a notice to the division. The notice shall be in the form and manner established by the division. The notice shall include the entity's name, FEIN, nine-digit postal code, address, and the technical contact's name, address, phone number, and email address. The insurance carrier or trading partner shall report changes within five working days of any amendment to the information required to be reported.

(e) Insurance carriers and trading partners must successfully complete testing prior to transmitting any production data. Trading partners must receive approval to submit data for at least one insurance carrier prior to initiating the testing process. Insurance carriers and trading partners must submit each transaction type during the testing process which can be successfully processed by the division. The division will not approve an insurance carrier or trading partner for production submissions until the insurance carrier or trading partner has:

(1) successfully submitted ten percent of its anticipated monthly volume per service type, not to exceed 100 medical EDI records per service type;

(2) received and reviewed the acknowledgments generated by the division; and

(3) correctly resubmitted rejected records identified in the acknowledgments.

(f) Insurance carriers are responsible for the acts or omissions of their trading partners. The insurance carrier commits an administrative violation if the insurance carrier or its trading partner fails to timely or accurately submit medical EDI records.

(g) This section is effective September 1, 2015.

10. CERTIFICATION. This 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 _____, 2014.

_____
Dirk Johnson
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to §§134.802 – 134.805, 134.807, and 134.808.

_____
Ryan Brannan
Commissioner of Insurance

ATTEST:

X _____

Dirk Johnson

General Counsel

COMMISSIONER'S ORDER NO._____