TITLE 28. INSURANCE

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

**CHAPTER134: BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS
SUBCHAPTER E - HEALTH FACILITY FEES
AMEND: §§134.802, NEW: §§134.800, 134.801, and 134.803 - 134.808**

1. INTRODUCTION.

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §134.802 of this title (relating to Definitions) and new §§134.800, 134.801, and 134.803 - 134.808 of this title (relating to Applicability, Purpose, Reporting Standards, Reporting Requirements, Records Required to be Reported, Records Excluded from Reporting, State Specific Requirements, and Insurance Carrier EDI Compliance Coordinator and Trading Partners, respectively). These amendments and new sections are adopted with changes to the proposed text published in the January 28, 2011, issue of the *Texas Register* (36 TexReg 394).

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these sections is set out in this order, which includes the preamble, which in turn includes the sections. The preamble contains a summary of the factual basis of the sections, description of how the sections will function, summary of comments received from interested parties, names of those groups and associations who commented and whether they support or are in opposition to the adoption of these sections, and the reasons why the Division agrees or disagrees with the comments and recommendations.

The Division has changed some of the proposed language in the adopted rules in response to public comments received. The Division has also made some changes to the text of the adopted

rules for clarification and editorial reasons. 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.

A public hearing was held and the public comment period closed on February 28, 2011. The Division received 22 public comments and has incorporated several recommendations by system participants.

2. REASONED JUSTIFICATION.

Vernon's Annotated Civil Statutes Art. 8308-8.01(b), (c), and (h) and Art. 8308-8.04 were codified by H.B. 752, enacted by the 73rd Legislature, Regular Session, and effective September 1, 1993 as Labor Code §413.007 and §413.008. These adopted amendments and new sections are intended to implement legislative requirements in Labor Code §413.007 and §413.008.

Labor Code §413.007 requires the Division to maintain a statewide data base of medical charges, actual payments, and treatment protocols that may be used by the Commissioner in adopting medical policies and fee guidelines and the Division in administering the medical policies, fee guidelines, or sections. In accordance with Labor Code §413.007, the Division shall also ensure that the data base 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 as provided by Labor Code, Title 5, Subtitle A, the Texas Workers' Compensation Act (Act). Labor Code §413.007 further requires the Division to ensure that this data base of medical charges, actual payments, and treatment protocols is available for public access at a reasonable fee. This statute specifically provides that the identities of injured employees and beneficiaries may not be disclosed. Finally, this statute requires the Division to take appropriate

action to be aware of and to maintain the most current information on developments in the treatment and cure of injuries and diseases common in workers' compensation cases.

Labor Code §413.008 provides that on request from the Division for specific information, an insurance carrier shall provide to the Division any information in the insurance carrier's possession, custody, or control that reasonably relates to the Division's duties under the Act and to health care treatment, services, fees, and charges. An insurance carrier commits an administrative violation if the insurance carrier fails or refuses to comply with a request or violates a rule adopted to implement this statute.

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. Due to the breadth of the coverage in the Act and the myriad of complex regulatory issues facing the Division, such rulemaking authority is inherently broad. This delegation of authority to the Commissioner allows for the regulatory flexibility necessary to fulfill the Commissioner's statutorily imposed duties of adopting rules as necessary to fully implement the Act while meeting the changing demands facing the workers' compensation system in Texas.

These adopted rules are intended to fulfill the legislative objectives in Labor Code §413.007 and §413.008. The adopted rules are necessary in order to allow the Division to more effectively gather information required by Labor Code §413.007 to be in the data base and to use that information for the purposes set out in that statute. These rules set out the reporting requirements in a clear manner and will improve insurance carrier understanding of the requirements associated with reporting medical charge and payment data in accordance with the statutory requirements of Labor

Code §413.007 and §413.008. The adopted rules align with existing data reporting requirements with minimal changes to the current technical infrastructure associated with medical electronic data interchange (EDI) reporting.

These adopted rules fulfill the legislative directives in Labor Code §413.007 because these adopted rules require insurance carriers to submit to the Division information in the insurance carrier's possession that relates to medical charges, actual payments, and treatment protocols that occur in the Texas workers' compensation system. Specifically, these adopted rules adopt for use in insurance carrier reporting of medical EDI records to the Division the *IAIABC EDI Implementation Guide for Medical Bill Payment Records,* Release 1.0, dated July 4, 2002 (IAIABC EDI Implementation Guide). This implementation guide was developed by the IAIABC as an EDI standard available for use by the states in their collection of medical charge and payment data in their workers' compensation systems, and this guide establishes data elements that relate to medical charges, payment data, and treatment. This guide is currently used by the Division and insurance carriers in the Texas workers' compensation system for medical charge and payment information reporting.

The tables published by the Division and adopted by these rules set out the data elements in the IAIABC EDI Implementation Guide that are required to be submitted in a record and what edits the Division will apply to a submitted record. As stated, Labor Code §413.007 requires the data base to contain information regarding medical charges, actual payments and treatment protocols that may be used by the Commissioner in adopting the medical policies and fee guidelines, and the Division in administering the medical policies, fee guidelines, or rules. The Division is also required by this statute to ensure that the data base 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 as provided by the Act. In accordance with Labor Code §413.007, these adopted rules therefore require insurance carriers to report to the Division the information that is directly related to the information Labor Code §413.007 requires to be in the data base. For example, these adopted rules require insurance carriers to report to the Division information relating to the employee receiving the health care services, information relating to the health care provider and the amount charged by the health care provider for providing the services, and information relating to the insurance carrier's action on the medical bill, including the amount paid on the bill, if any. This is information Labor Code §413.007 requires to be in the data base and is information that is directly relevant to the Commissioner in adopting medical policies and fee guidelines, and to the Division in administering the medical policies, fee guidelines, or rules.

Further, these adopted rules fulfill the legislative directive in Labor Code §413.007 because these rules require an insurance carrier to submit a medical EDI record to the Division each time the insurance carrier pays a medical bill, reduces or denies payment for a medical bill, receives a refund for a medical bill, or discovers that a submitted record should not have been submitted to the Division and the record had previously been accepted by the Division. These adopted rules also establish the time period in which the insurance carrier is required to submit each record. Requirements establishing the events that trigger the reporting requirement and the deadline for submitting the records helps ensure that the data base required by Labor Code §413.007 contains continuous and up-to-date information regarding medical charges, actual payments, and treatment protocols. A data base with the continuous and up-to-date data required by these rules will assist the Division in ensuring, as required by Labor Code §413.007(b), that the data base will contain the 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.

These adopted rules also fulfill the purposes of Labor Code §413.007 because these rules require 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 in Labor Code §413.007. These rules also define when a medical EDI record will be considered accurately submitted. Further, these adopted rules require insurance carriers to correct data that was inaccurately submitted and establishes the time period in which inaccurate medical EDI records must be corrected. Imposing requirements relating to data accuracy helps ensure the quality and integrity of the data in the data base. The availability of quality data will better able the Commissioner in adopting medical policies and fee guidelines and the Division in administering the medical policies, fee guidelines, or 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 data base 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.

In response to public comments on the published proposal and to clarify the sections, the Division has adopted the following changes to the text: (1) Sections 134.800 - 134.808 by providing an effective date of September 1, 2011 for each rule; (2) Section 134.803 by correcting edits for DN524, DN559, DN576, DN726, and DN728 in the *Texas EDI Medical Data Element Edit Table;* modifying the mandatory trigger for DN553, DN554, and DN577 in the *Texas EDI Medical Data Element Requirement Table;* providing for the use of the 'W3' service adjustment reason code in the

Texas EDI Medical Difference Table and making corresponding modifications to the mandatory trigger for DN731, DN732, and DN733 in the *Texas EDI Medical Data Element Requirement Table;* and modifying the publication date of all the tables adopted by reference in this section; (3) Section 134.804 by adding text to this section regarding the use of the 'W3' service adjustment reason code for payment actions in response to requests for reconsideration or appeal; and (4) Section 134.807 by striking subsection (f)(3)(D) from this section and relettering the subsequent subparagraphs in this section.

3. HOW THESE SECTIONS WILL FUNCTION.

Adopted §134.800 provides that this subchapter applies to all insurance carriers as defined in Labor Code §401.011(27), including insurance carriers that have contracted with or established a workers' compensation health care network as defined in Labor Code §401.011(31-a) and insurance carriers that provide medical benefits in a manner authorized by Labor Code §504.053(b)(2) which relates to political subdivisions or a pool. This section requires all insurance carriers to report information prescribed by the Commissioner to the Division for each medical bill on a workers' compensation claim. Labor Code §504.053(d)(7) provides that if the political subdivision or pool provides medical benefits in the manner authorized under subsection (b)(2) of that section, then the political subdivision or pool shall continue to report data to the appropriate agency as required by Labor Code, Title 5 and Insurance Code, Chapter 1305. Insurance Code, §1305.154(c)(8) pertains to workers' compensation health care networks. This section is effective September 1, 2011.

Adopted §134.801 sets forth the purpose of this subchapter which is to prescribe the reporting requirements for medical state reporting and to adopt by reference the implementation guide and specifications necessary for successful EDI transmission of this data. This section is effective September 1, 2011.

Adopted §134.802 provides definitions for specific terms used in this subchapter related to medical EDI reporting. This section is effective September 1, 2011.

Adopted §134.803 adopts by reference the *IAIABC EDI Implementation Guide for Medical Bill Payment Records,* Release 1.0, dated July 4, 2002 (IAIABC EDI Implementation Guide) and clarifies that exceptions are included in this subchapter. Adopted §134.803 also adopts by reference three different tables published by the Division that must be used in conjunction with the IAIABC EDI Implementation Guide in order to successfully transmit medical EDI records to the Division. The *Texas EDI Medical Data Element Requirement Table* sets out whether a data element is mandatory, conditional, optional, or not applicable. This table also defines the mandatory trigger for conditional data elements. The *Texas EDI Medical Data Element Edit Table* sets out the edits the Division will set for each data element. The *Texas EDI Medical Difference Table* sets out the technical differences from the IAIABC EDI Implementation Guide. This section is effective September 1, 2011.

Adopted §134.804 sets forth the Division's reporting requirements for original, cancellation, and replacement medical EDI records. Subsection (d) of this section requires insurance carriers to submit medical EDI records that accurately reflect the information contained on the medical bill and the action the insurance carrier took on the medical bill. Specifically, this subsection sets out three requirements that must be met in order for a record to be considered accurately submitted. A record is accurately submitted when the record (1) received an Application Acknowledgement Code of accepted; (2) where applicable, contained the same data as the source medical bill and explanation of benefits (EOB); and (3) to the extent supported by the format, contained all appropriate modifiers, code qualifiers, and data elements necessary to identify healthcare services, charges and payments. Subsection (e) of this section requires insurance carriers to correct and resubmit rejected medical

EDI records within 30 days of the action that triggered the reporting requirement. This section is effective September 1, 2011.

Adopted §134.805 sets forth the triggering events that require an insurance carrier to submit a medical EDI record. This section also establishes two situations where a medical EDI record will not be considered received by the Division regardless of an Application Acknowledgment Code returned in an acknowledgement. Subsection (b)(1) of this section states that a record will not be considered received if it contains data which does not accurately reflect the code values used or actions taken when the insurance carrier processed the medical bill. For example, a submitted record that contains a service adjustment reason code that does not accurately reflect the action taken by the insurance carrier will not be considered received by the Division. Subsection (b)(2) of this section states that a record will not be considered received if it fails to contain a conditional data element and the mandatory trigger condition existed at the time the insurance carrier processed the medical bill. This section also requires insurance carriers to correct and resubmit rejected records except in situations where the health care provider included an invalid service or procedure code on the medical bill. This section is effective September 1, 2011.

Adopted §134.806 identifies the types of records that are not to be reported under this subchapter. This adopted section also states that insurance carriers shall not report interest and penalty payments paid on health care services, medical cost containment expenses, medical bill review expenses, or data transmission expenses. This section is effective September 1, 2011.

Adopted §134.807 identifies Texas specific technical and formatting requirements related to the submission of medical EDI transmissions, including pharmacy medical EDI records, reported to the Division. This section is effective September 1, 2011.

Adopted §134.808 allows insurance carriers to submit medical EDI records directly to the Division or through the use of identified trading partners. The section also sets forth the requirements for insurance carriers to designate an EDI compliance coordinator to serve as the central compliance control contact for data reporting, establishes notification requirements for insurance carriers and trading partners, and outlines the requirements related to testing before an insurance carrier or trading partner will be approved for production submissions. In addition, this section explicitly states that insurance carriers are responsible for the acts or omissions of their trading partners. An insurance carrier commits an administrative violation if its trading partner fails to timely or accurately submit medical EDI records for the insurance carrier. This section is effective September 1, 2011.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General: A commenter requests that the Division have an EDI work group, appoint a Workers' Compensation Data Collection Advisory Committee, or hold a stakeholder meeting in the near future or after the current legislative session to discuss Texas-specific reporting requirements so that Division staff and insurance carrier representatives can discuss the need for submission of data elements that are specific to the Texas system.

Agency Response: The Division disagrees that additional input is necessary prior to adopting these rules. During the course of this rulemaking initiative the Division sought and received valuable feedback from its stakeholders on required data elements through posting an informal working draft and formal proposal for public comment, and holding a public hearing on the formal posting on February 28, 2011. For the purpose of these adopted rules the Division has received the public input necessary to move forward and adopt these rules. In future rule making efforts affecting EDI

data submissions the Division will continue to seek stakeholder input on such efforts and will consider the requestor's suggestion to form an EDI workgroup.

General: A commenter requests that the Division either adopt other payers' procedures that require documentation only if audited or aberrant billing or certain episode limitations are met or provide a method to attach scanned documentation with the claims submitted.

Agency Response: The Division notes that this comment concerns requirements in §133.210 of this title (relating to Medical Documentation) and the Division's eBilling sections. This comment is outside the scope of this rule initiative. The scope of these sections relate to medical EDI reporting by insurance carriers and do not add or reduce any documentation requirements associated with health care provider submission of medical bills.

General: Commenters recommend that the Division suspend rulemaking activities on medical state reporting until sometime after the current legislative session. Commenters opine that pending legislation may impact various components of the rules.

Agency Response: The Division disagrees. The 82nd Legislature, Regular Session, ended on May 30, 2011. No bill passed by the legislature during this regular session would impact medical EDI reporting by insurance carriers in a way to require the Division to suspend these rulemaking activities. Further, no legislation pending in the current special session will impact medical EDI reporting by insurance carriers.

General: A commenter recommends a central reporting site handling pharmacy reporting for all insurance carriers rather than reporting individually.

Agency Response: The Division disagrees because designating a single entity to handle pharmacy reporting for all insurance carriers would require a significant amount of time and resources to study whether such an entity with the capability of reporting pharmacy data only for all insurance carriers in the Texas workers' compensation system currently exists or could be implemented effectively. Implementing such a system will require significant research and discussion with industry stakeholders. Attempting to implement such a system now in lieu of these adopted rules would delay the Division from achieving the legislative directives in Labor Code §413.007. The Division clarifies that the adopted rules require insurance carriers to submit medical EDI transactions to the Division or the Division's data collection agent which is a central reporting site.

§134.800(b): Commenters request that the Division modify the effective date of the rules to a later date. Commenters suggest a bifurcated approach with notice requirements becoming effective on the proposed date and the technical requirements becoming effective on a later date such as April 1, 2012. Commenters provide various reasons for the extension, primarily due to other regulatory changes, and suggest dates ranging from six months after adoption through September 1, 2012.

Agency Response: The Division agrees that some stakeholders may need additional time to implement the system changes necessary to comply with these adopted rules. The Division has therefore provided in each section an effective date of September 1, 2011, which will provide stakeholders sufficient time to make the system changes outlined in the adopted rules while ensuring that the standards for reporting medical EDI records to the Division are aligned with the changes made to the newly adopted medical billing rules which are effective on August 1, 2011. The new effective date will also ensure that there is no delay in the Division's collection of medical state reporting data.

§134.801: A commenter requests that the Division remove the reference to "medical charges" and "actual payments" from the purpose. Commenter raises concerns that this language may result in the release of information that may conflict with confidentiality requirements contained in certain payment contracts.

Agency Response: The Division disagrees. Labor Code §413.007(a) requires the Division to maintain a statewide data base of "medical charges, actual payments, and treatment protocols" that may be used by the Commissioner in adopting the medical policies and fee guidelines and the Division in administering the medical policies, fee guidelines, or rules. Labor Code §413.007(b) states that the Division shall ensure that this data base 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 as provided by the Act. The adopted section is in compliance with these very specific statutory directives.

§134.802: A commenter requests that the Division add a definition for "federal health care facility" in order to avoid confusion among health care providers. Commenter asks if this is a reference to veteran's hospitals and military base hospitals.

Agency Response: The Division disagrees. The plain language of the phrase "federal health care facility" is sufficient to provide the stakeholders with notice of its meaning. This will include veteran's administration hospitals and military base hospitals.

§134.803(a): A commenter indicates that there is a more recent version of the *IAIABC EDI Implementation Guide for Medical Bill Payment Records* and recommends the Division adopt the recent version.

Agency Response: The Division disagrees. While the Division recognizes that the IAIABC has published a newer version of the implementation guide and is working on a subsequent version, the adopted rules are intended to minimize the potential impact on system participants. As such, the adopted rules adopt the version of the implementation guide that has already been implemented and used by the Division and system participants for the last several years.

§134.803(a): A commenter suggests the Division consider the adoption of the Batch Version 1.1 standard published by the National Council for Prescription Drug Program (NCPDP) for pharmacy reporting based on the assertion that most pharmacies are already familiar with this standard and the data content of those transactions.

Agency Response: The Division disagrees. This NCPDP standard was developed for the submission of pharmacy bills from health care providers to payers, as opposed to reporting data from payers to jurisdictions. Implementing an additional standard for medical EDI reporting would require duplication and replication of systems that have already been implemented by the Division and system participants.

§134.803(b): A commenter opposes the adoption of the three Texas-specific tables based on their deviation from the national standard. Commenter suggests that if the tables are adopted the number of deviations should be kept to a minimum.

Agency Response: The Division disagrees. It is the Division's intent for these adopted rules to reflect current reporting requirements for medical state reporting in Texas with minimal deviations from current practice. This approach will significantly reduce the impact these adopted rules will have on system participants.

Further, these tables are necessary for successful medical state reporting as required by Labor Code §413.007. The IAIABC EDI implementation guide is structured to provide the technical framework regarding the file structure, but does not define what data elements are required to be reported or which edits will be applied by an individual jurisdiction to incoming medical EDI transactions. The *Texas EDI Medical Data Element Requirement Table* sets out the usage requirements for data elements in the IAIABC EDI implementation guide, including defining the mandatory trigger for conditional data elements. The IAIABC EDI implementation guide recognizes that jurisdictions will create this table in order to define the usage requirements to meet a particular jurisdiction's requirements. This table is necessary because it identifies the data that must be included in the data base required by Labor Code §413.007. For example, this table defines as mandatory data regarding the amount billed by the health care provider and total amount paid per bill, as well as other data relating to the bill such as the affected injured employee's name and the billing health care provider. The *Texas EDI Medical Data Element Edit Table* identifies the edits the Division will apply on each data element. 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. This table therefore will improve the quality and usefulness of the data which will enable the Division to achieve the legislative purposes under Labor Code §413.007. The *Texas EDI Medical Difference Table* outlines the technical deviations from the IAIABC implementation guide

and represents the current infrastructure implemented by the Division and system participants. This table is necessary in order to allow programmers to develop the necessary systems.

§134.803(b); *Texas EDI Medical Data Element Requirement Table:* A commenter questions the purpose for requiring the Jurisdiction Claim Number and opines that this data element would not be contained on all medical bills submitted by health care providers. A commenter also asks for clarification as to whether the Jurisdiction Claim Number is a conditional data element or a mandatory data element.

Agency Response: The Division clarifies that the Jurisdiction Claim Number is a unique identifier that is necessary to appropriately match medical bill data to the workers' compensation claim. The source of this data element is 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 notes that other data elements may change with the acquisition of claims, claim transfer to a different third party administrator, payer system upgrades, data inconsistencies, or adjudication outcomes. 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 Jurisdiction Claim Number is a conditional data element that becomes required to be submitted when the insurance carrier has received the Jurisdiction Claim Number from the Division.

§134.803(b); *Texas EDI Medical Data Element Requirement Table:* Commenters request that the Division define the term "inpatient admission" in the mandatory trigger for the "ICD-9 CM Principal Procedure Code" and the "Admitting Diagnosis Code."

Agency Response: The Division disagrees that a definition for "inpatient admission" is necessary. The plain language of this phrase gives adequate notice as to its meaning and this meaning is consistent with its meaning as it is used in Chapter 134 of this title (relating to Benefits-Guidelines for Medical Services, Charges, and Payments). Further, there should be no confusion as to this term's meaning as this term is currently used in the medical state reporting system.

§134.803(b); *Texas EDI Medical Data Element Requirement Table:* Commenters request that the Division include a reference to the appropriate data element number and name in the mandatory trigger for the "Day(s) Unit(s) Code" and "Day(s) Unit(s) Billed."

Agency Response: The Division agrees. The mandatory trigger for these data elements has been modified to reflect the appropriate data element number and name. This change will provide clarity regarding the mandatory trigger for these data elements.

§134.803(b); *Texas EDI Medical Data Element Requirement Table:* Commenters request that the Division define the term "admission" for the mandatory trigger for the "Admission Type Code." A commenter opines that the term admission applies to all inpatient and outpatient services.

Agency Response: The Division agrees that clarification is needed. The Division notes that the "Priority (Type) of Admission or Visit" is required on all paper institutional medical bills, situational on electronic institutional medical bills submitted before January 1, 2012, and required on all electronic institutional medical bills submitted on and after January 1, 2012. Based on these requirements and

the new effective date of these sections, the secondary condition "and involved an admission" has been removed from the mandatory trigger.

§134.803(b); *Texas EDI Medical Data Element Requirement Table:* A commenter requests that the Division include a reference that the NCPDP number may be provided when reporting the "Rendering Bill Provider National Provider ID."

Agency Response: The Division disagrees. The Division notes that the purpose of the *Texas EDI Medical Data Element Requirement Table* is to specify the requirements associated with reporting data elements and is not intended to define the format or content of the data element. The ability to report the NCPDP number in this data element is already recorded in the *Texas EDI Medical Difference Table* and duplication in the *Texas EDI Medical Data Element Requirement Table* is unnecessary.

§134.803(b); *Texas EDI Medical Data Element Edits Table:* Commenters suggest that the "Mandatory Field Not Present" edit is not appropriate for conditional data elements.

Agency Response: The Division disagrees. When the *Texas EDI Medical Data Element Requirement Table* establishes that a data element is conditionally required and the condition contained in the mandatory trigger has been met, then the data element becomes required. This edit will reject a medical EDI record that fails to include a conditional data element where the mandatory trigger for that data element has been met. When a record is rejected for such a reason, these adopted rules will require the insurance carrier to correct and resubmit the rejected record within 30 days of the action that triggered the reporting requirement. This edit therefore prevents incomplete records from populating the data base and will put the insurance carrier on notice to

submit to the Division a record that is complete. This edit is therefore necessary because it will ensure that the data base contains complete records that relate to medical charges, actual payments, and treatment protocols as required by Labor Code §413.007(a). This edit will also help the Division to ensure that the data base 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.

§134.803(b); *Texas EDI Medical Data Element Edits Table:* Commenters suggest adding additional error codes on multiple data elements.

Agency Response: The Division agrees. The *Texas EDI Medical Data Element Edits Table* was designed to reflect the edits currently contained in the existing automated system. After reviewing the data elements and error codes suggested by the commenters, the Division has modified the edit indicators because the edits are in current use today. These changes include adding "Must be a valid date" and "Must be <=Current date" to the "Procedure Date" data element and adding "Code/ID invalid" to the "Revenue Billed Code," "Revenue Paid Code," "HCPCS Line Procedure Paid Code," and "NDC Paid Code" data elements. Applying these edits will ensure that this data is valid data. If the data is not valid as determined by the edit, the record will be rejected and the insurance carrier will be required to correct and resubmit the data in the time period required by these adopted rules. These edits will therefore prevent a record containing invalid data from populating the data base and will result in insurance carriers correcting and resubmitting the data. These edits therefore ensure that data collected relating to Labor Code §413.007(a) is valid. Enforcing the requirements relating to the validity of data allows the Division to ensure that the data base 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 Division disagrees with adding "Must be >= Date of Injury" to the "Procedure Date" data element. Under Labor Code §408.007, the date of injury for an occupational disease is the "date on which the employee knew or should have known that the disease may be related to the employment." Accordingly, there will be certain situations where an injured employee receives medical services before the date of injury.

The Division also disagrees with adding "Code/ID invalid" to the "ADA Procedure Paid Code," "Billing Provider National Provider ID," "Rendering Bill Provider National Provider ID," and "Referring Provider National Provider ID" data elements. The Division's current technical infrastructure does not use these edits and therefore they are not necessary to achieve the purposes of Labor Code §413.007.

§134.804: A commenter asks that the Division clarify how it intends to reconcile original bills, if Requests for Reconsideration are required to be submitted as original medical bills with their own unique bill identification numbers. The commenter states that proposed language in §134.804(a) creates such a contradiction.

Agency Response: The Division agrees that clarification is necessary on how the Division intends to reconcile original bills where requests for reconsideration are required to be submitted as original bills with their own unique bill identification numbers. The Division also agrees that there is a contradiction in proposed §134.804(a) that will prevent the Division from reconciling original bills where there is a request for reconsideration. In reviewing this comment, the Division discovered that it inadvertently did not provide for the use of the 'W3' service adjustment reason code which is being

used in the current medical EDI framework. Providing for the use of this code will allow the Division to associate requests for reconsideration with original medical bills. Accordingly, the Division has added language to the text of this rule, the *Texas EDI Medical Data Element Requirement Table,* and the *Texas EDI Medical Difference Table* that provides for the use of the 'W3' code.

§134.804: A commenter requests information on whether the Division accepts negative amounts in the amount paid fields or if they should not submit events associated with an insurance carrier's receipt of a refund.

Agency Response: The Division clarifies that §134.805 requires insurance carriers to submit medical EDI records when the insurance carrier "receives a refund for a medical bill..." The IAIABC EDI Implementation Guide, the Accredited Standards Committee X12 004010 standard, and the Texas implementation support the submission of negative amounts in the amount paid fields.

§134.805: A commenter recommends that the Division restructure the rules to require insurance carriers and pharmacy benefit managers to submit medical EDI records on pharmacy bills reflecting the amount paid by the sending entity. The commenter states this recommendation will recognize both the need for the Division to collect actual payments made to pharmacies and the concerns of pharmacy benefit managers about the reporting of what they consider to be proprietary data. Commenter also recommends that these rules provide a corresponding definition for "Pharmacy Benefit Manager." Commenter recognizes that the Division would need to redraft and repropose these rules to implement the commenter's suggestion.

Agency Response: This comment addresses concerns by pharmacy benefit managers with proposed §134.807(f)(3)(D) as that provision relates to the reporting of amounts pharmacy benefit

managers pay pharmacies. Proposed §134.807(f)(3)(D) has not been adopted as provided in the Division's response to the comments concerning that subparagraph. Therefore, a provision requiring pharmacy benefit managers to report to the Division amounts paid to pharmacies and a definition for "pharmacy benefit manager" is not necessary.

§134.805: A commenter recommends that medical bills related to pre-1991 injuries be required to be reported. Commenter indicates that these medical bills are reimbursed under the same fee guidelines and that the Division has never excluded the reporting of these records.

Agency Response: The Division disagrees. Injuries that occurred before January 1, 1991 are governed by a different regulatory framework. Medical bills related to pre-1991 dates of injury are reimbursed under Chapter 42 of the Texas Administrative Code. Although the Division in the current medical EDI framework has not rejected medical EDI records for health care services related to pre-1991 injuries, the Division clarifies that these medical bills have never been required to be reported. These adopted rules provide that medical EDI records related to pre-1991 injuries are not to be reported.

§134.805(b): A commenter requests removing the "not considered received" language and revising the language to predicate any timeliness finding on the results of Division monitoring, audit, investigation, or analysis. Commenter notes that the language contained in this subsection may render a medical EDI record as untimely even if a subsequent correction is filed with the Division.

Agency Response: The Division disagrees. A purpose of this rule is to require insurance carriers to submit accurate data in a timely fashion. As such, a medical EDI record is not timely submitted if any inaccuracies in that record are not corrected within the 30 day period for submitting the record.

This is true regardless of any subsequent correction after the 30 day deadline. The insurance carrier is ultimately responsible for sending the required data to the Division in a timely and accurate fashion. These provisions clearly state the requirements related to data accuracy and any medical EDI record that contains inaccurate data is not considered timely received. Insurance carriers possess the source data for a medical EDI report 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 bill and the payment action.

§134.805(c): Commenters raise concerns about data that is rejected by the Division due to missing code values in the Division's processing systems. Commenters reference situations that have occurred in the past, including the omission of certain National Drug Codes, which resulted in rejected records. A commenter suggested an internal validation process within the Division before records are rejected.

Agency Response: The Division disagrees. The current process used by insurance carriers and trading partners to report and correct these issues is sufficient without additional changes to the proposed language. During the month of January 2011, the Division received 386,884 medical EDI records of which 8,083 were rejected. Of the number rejected, only 15 or .0000387% were identified as resulting from code table issues similar to the situation described by the commenters. Insurance carriers that have records rejected for code table issues should follow the current procedure of notifying the TxCOMP EDI Help Desk and retain documentation regarding the issue. The insurance carrier should provide this documentation in response to an audit or other action by the Division to ensure these types of medical EDI records are excluded from the audit or action.

§134.806: A commenter requests that the denial of duplicate medical bills be listed as a record which is excluded from reporting. Commenter indicates that requiring reporting of these medical bills will add unnecessary and duplicate medical bill data to the Division's data base.

Agency Response: The Division disagrees. The Division notes that payment denials related to duplicate medical bill submission are identified by a singular claim adjustment reason code and can easily be identified when performing analysis related to medical charges and payments. However, the failure to include these payment denials would remove the ability of the Division to identify health care providers that are submitting medical bills in a manner that is contrary to the provisions contained in Chapter 133 of this title (relating to General Medical Provisions).

§134.807: A commenter recommends that the Division limit Texas-specific reporting requirements as much as possible.

Agency Response: The Division generally agrees that it should limit Texas-specific reporting requirements as much as possible. As stated before, the adopted rules limit Texas-specific reporting requirements to those reflected in the current technical implementation of medical EDI reporting in Texas with minimal modifications necessary to meet the requirements of Labor Code §413.007.

§134.807: A commenter requests the Division add two new subsections to the proposed language to allow an insurance carrier to use a contracted agent to report the data, state that the reported data is not releasable under the Public Information Act, and establish penalty provisions for the inappropriate release of data by the agent.

Agency Response: The Division disagrees. Sections governing what data is releasable and not releasable under the Public Information Act and setting penalties are not necessary because state

law, including Chapter 552 of the Government Code, governs these matters. The Division notes that the adopted rules include language in §134.808 which allow an insurance carrier to use one or more external trading partners on its behalf to report medical EDI records to the Division. The Division also notes that these rules do not prohibit an insurance carrier from establishing confidentiality provisions regarding the exchange of data between the insurance carrier and its agents, including trading partners, through contractual provisions.

§**134.807(a)**: A commenter states that the change from 500 medical EDI records contained in a file to 100 medical EDI records is a drastic change and will be difficult to implement.
Agency Response: The Division clarifies that the file size limit for a medical EDI transaction is 1.5 megabytes, not 100 medical EDI records. The limit of 100 medical EDI records applies to a single claimant hierarchical loop, not the size of the file.

§134.807(f): A commenter notes that one of the methods for submitting an electronic medical bill using the NCPDP Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), dated September 1999, includes submitting only the "highest priced ingredient" when a compound medication is dispensed. Commenter notes that the NCPDP Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), dated August 2007, requires the multiple ingredients be reported when a compound medication is dispensed. Commenter recommends that if the Division intends on having multiple ingredients reported, the Division should postpone this requirement until January 1, 2012 when NCPDP Version D.0 will be required.
Agency Response: The Division disagrees. The Division notes that the adopted rules require a separate line for each reimbursable component of the compound medication and the compound fee as a separate service line. In situations where the NCPDP 5.1 method of submitting only the

"highest priced ingredient" is used, the related medical EDI records would include one line for the only reimbursable component and one line for the compounding fee. In situations in NCPDP Version 5.1 or Version D.0 is used and the pharmacy medical bill contains multiple reimbursable components, the related medical EDI records would contain a separate line for each reimbursable component and one line for the compounding fee. For either billing scenario, the adopted rules support the proper reporting of the compound medication and delaying the effective date is therefore unnecessary.

§134.807(f)(3)(A): Commenters recommend amending this provision to provide that the total charge per bill is the total amount charged by the pharmacy, "pharmacy benefit manager or network to the carrier." A commenter recommends striking the language "pharmacy or pharmacy processing agent" and replacing the language with "from the carriers designated agent".

Agency Response: The Division disagrees. Labor Code §413.007 requires the data base to contain information concerning medical charges. "Medical charges" in Labor Code §413.007 references the amount the health care provider, which includes a pharmacy, charges the insurance carrier for the health care services. The definition of health care provider, as defined by Labor Code §401.011(22), does not include insurance carriers or their agents, including pharmacy benefit managers and networks. Further, the commenter's suggested language would allow insurance carriers to report one of three charged amounts: the pharmacy's charge, the pharmacy benefit manager's charge, or the network's charge. This would cause the data base to contain inconsistent data regarding medical charges for pharmacy services in the Texas workers' compensation system. The suggested language requiring only what the insurance carrier's agent charged the insurance carrier would cause the data base to not contain any information regarding charges by a pharmacy.

Both suggestions would prevent the Division from ensuring that the data base contains information necessary to detect practices and patterns in medical charges for pharmacy services. These suggestions would also prevent the data base from being used in a meaningful way to control pharmacy costs and to assist in the development of a pharmacy fee guideline.

§134.807(f)(3)(B): Commenters recommend that the received date of a pharmacy bill be the date the insurance carrier or "the insurance carrier's agent" received the bill.

Agency Response: The Division disagrees that the recommended language is necessary. If an insurance carrier contracts with an agent to process pharmacy bills then the received date would be when the agent received the pharmacy bill because the agent would be acting on behalf of the insurance carrier. If the bill is sent directly to the carrier then the received date would be the date the carrier actually received the bill.

§134.807(f)(3)(C): Commenters recommend including the term "or insurance carrier's agent" to this subparagraph so that the date the bill is paid by the insurer may be the date the insurance carrier or the insurance carrier's agent paid the pharmacy or the pharmacy processing agent. Commenters also recommend striking "pharmacy processing agent" from this provision. A commenter recommends changing the language to reflect that the date the bill is paid by the insurance carrier to the agent is the date that the insurance carrier paid the bill.

Agency Response: The Division disagrees. The data the Division seeks is the date the insurance carrier paid the medical bill to the pharmacy or pharmacy processing agent because a pharmacy processing agent acts on behalf of the pharmacy. This data is necessary to ensure that the insurance carrier is in compliance with applicable provisions in the Act and Division rules such as

statutes and rules setting out medical bill payment timeframes. If the rule is amended to allow insurance carriers to report the date the insurance carrier paid their agent, then the data base would not contain the information necessary to allow the Division to determine whether the insurance carrier is complying with the Act and Division rules. The collection of inconsistent data is contrary to the statutory directives in Labor Code §413.007. Additionally, the Division disagrees to include the term "or insurance carrier's agent" to this subparagraph as it is not necessary. An insurance carrier's agent acts on behalf of an insurance carrier. Therefore, if an insurance carrier contracts with an agent to process pharmacy bills then the payment date would be the date the agent paid the pharmacy or the pharmacy processing agent. This situation would be true for the length of the contract between the insurance carrier and the insurance carrier's agent.

§134.807(f)(3)(D): Commenters oppose this provision because this provision will require insurance carriers to report data regarding the amount a pharmacy or pharmacy processing agent is actually paid for a prescription, compared to the amount that an insurance carrier paid a bill review agent or pharmacy benefit manager for the prescription. Commenters list the following reasons for their opposition to this provision: (1) the amount a pharmacy benefit manager pays a pharmacy is proprietary information and made confidential by their contracts with the pharmacies; (2) insurance carriers do not have possession, custody, or control of this information; (3) disclosing this information will adversely affect competition in the marketplace and destroy pharmacy benefit managers operating in Texas; (4) this data will not provide the Division with the true costs of pharmacy services; (5) requiring this data will deviate from national standards and make Texas an anomaly in the country; (6) there is no sound policy objective obtained by requiring this data; (7) requiring this data will lead to higher costs in the system and harm access to health care; and (8) other system

changes are currently occurring. A commenter recommends deleting this provision. Other commenters recommend various types of edits to this provision that would authorize insurance carriers to report the actual amount paid to the pharmacy benefit manager or network. Several commenters recommend adding the term "pharmacy benefit manager" and "network" to this provision. One commenter recommended that the Division should require both payment amounts to be reported; the amount paid to a pharmacy or pharmacy processing agent and the amount paid by the insurance carrier to a bill review agent or pharmacy benefit manager.

Agency Response: The Division disagrees but does not adopt §134.807(f)(3)(D) at this time and has relettered the subsequent subparagraphs accordingly. Although the Division has the statutory authority to adopt rules requiring insurance carriers to report to the Division data related to medical charges and actual payments, the Division has determined that it will be beneficial to continue discussions with its stakeholders on this issue. There are other recently adopted Division rules, such as Chapter 133 Subchapter G rules regarding electronic medical billing and Chapter 134 Subchapter F regarding pharmaceutical benefits that will become effective at or around the same time as these adopted rules. Not adopting §134.807(f)(3)(D) will allow system participants to implement these adopted rules in a more timely manner, minimizing the need for extensions to the effective date. The implementation guide adopted by reference in adopted §134.803 will provide the definition for DN516 Total Amount Paid Per Bill, which is the definition applied in the current medical EDI reporting system.

Commenters raise various reasons for not adopting this provision; however, the Division clarifies that there exists statutory authority and a sound policy basis for requiring insurance carriers to report data regarding the amount a pharmacy benefit manager pays a pharmacy or pharmacy processing agent. Labor Code §413.007 requires the Division to maintain a statewide data base of

medical charges, actual payments, and treatment protocols that may be used by the Commissioner in adopting medical policies and fee guidelines and the Division in administering the medical policies, fee guidelines, or rules. This statute imposes a duty upon the Division to ensure that this data base contains accurate 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 as provided by the Act.

As already stated, the legislature has given the Commissioner broad rulemaking authority to promulgate rules to regulate the workers' compensation system and enforce the Act. This rulemaking authority includes the authority to adopt rules to implement the legislative directives in Labor Code §413.007. Finally, Labor Code §413.008 provides that on request from the Division for specific information, an insurance carrier shall provide to the Division any information in the insurance carriers' possession, custody, or control that reasonably relates to the Division's duties and to health care treatment, services, fees, and charges.

Collecting data regarding the actual payments made to pharmacies and pharmacy processing agents is consistent with Labor Code §413.007 because that statute requires the data base required by that section to contain information concerning actual payments. Further, this data would greatly assist the Division in carrying out the purposes of that statute. For example, data regarding actual payments to pharmacies provides the Division with data regarding what amount pharmacies are willing to accept for payment for providing pharmaceutical services in the Texas workers' compensation system. This data would be valuable to the Division in setting reimbursement rates in a pharmacy fee guideline.

Commenters argue that data regarding the amount a pharmacy benefit manager paid a pharmacy or pharmacy processing agent is not in the insurance carrier's possession, custody, or

control. The Division notes that Labor Code §408.027(b) requires, in part, the insurance carrier to pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the insurance carrier of the health care provider's claim. When a pharmacy submits a medical bill for reimbursement, Labor Code §408.027(b) requires the insurance carrier to process the medical bill. In light of statutory requirements placed upon insurance carriers for processing medical bills, the insurance carrier does have possession, custody, and control of information related to medical billing and reimbursement including actual amounts paid to pharmacies. Commenters cite *In re Kuntz,* 124 S.W.3d 179 (Tex. 2003) as authority for the argument that insurance carrier's do not have possession, custody, or control of this data and therefore are unable to provide this data to the Division. This case is distinguishable in light of the statutory requirements the Act places upon insurance carriers.

§134.807(f)(3)(D): Commenters recommend modifying this provision to provide that the amount paid per bill is the net amount the insurance carrier or insurance carrier's agent actually paid to the pharmacy or pharmacy processing agent. Commenters also recommend modifying this provision to provide that the amount paid to a pharmacy benefit manager or network may be reported by the insurance carrier as the amount paid per bill.

Agency Response: The Division disagrees with these recommendations because §134.807(f)(3)(D) as proposed is not adopted. Although the Division has the statutory authority to enact rules requiring insurance carriers to report data related to medical charges and actual payments to the Division, the Division has determined that it will be beneficial to continue discussions with its stakeholders on this issue as set forth previously. The Division has therefore deleted §134.807(f)(3)(D) as proposed.

§134.808: A commenter recommends that the term "Pharmacy Benefit Manager" be added to this section in the event that the Division requires a pharmacy benefit manager to report data in addition to the insurance carrier.

Agency Response: The Division disagrees as such a requirement is not included in these adopted rules.

§134.808(b): A commenter requests clarification with regard to the "centrally-located employee" and asks whether this means a person in Texas or can the person be located in any state.

Agency Response: The Division clarifies that this requirement related to the EDI Compliance Coordinator is not intended to be a geographical limitation. The Division's intent is to ensure that the person designated as the EDI Compliance Coordinator has ready access to information relating to medical EDI reporting.

§134.808(d): A commenter requests that the Division "grandfather" all existing DWC EDI-01 forms instead of requiring existing trading partners to resubmit new or revised forms. Commenter raises questions regarding which forms will be required to be submitted on or before the effective date of these rules.

Agency Response: The Division clarifies that the text of this subsection requires the information set out in this subsection be provided at least five working days before the first transaction. The Division notes that the "Trading Partner Profile" component of the DWC EDI-01 form contains the same information that will be required on the new DWC EDI-02 form. As such, existing trading partners with an up-to-date DWC EDI-01 on file with the Division will not be required to complete and submit the new DWC EDI-02 form unless there is a change to the information required to be reported.

§134.808(e): A commenter requests clarification on the requirement for trading partners to complete testing and receive Division approval for the submission of production data. Commenter asks if the testing and approval process for a trading partner is singular or must the trading partner receive Division approval for each insurance carrier it has contracted with.

Agency Response: The Division clarifies that the trading partner testing and approval process is singular.

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

For:

None.

For, with changes:

American Insurance Association, CompPharma, Corvel, Coventry Workers' Comp Services, Cypress Care, Healthesystems, Injured Workers' Pharmacy, Insurance Council of Texas, Medco Health Solutions, Modern Medical, myMatrixx, Pharmacy Management Services, Inc. (PMSI), Progressive Medical, Inc., Property Casualty Insurers Association of America, StrataCare, Texas Mutual Insurance Company, StoneRiver Pharmacy Solutions, United Surgical Partners..

Against:

None.

Neither for nor against, with changes:

Texas Physical Therapy Association.

6. STATUTORY AUTHORITY.

These amendments and new sections are adopted under Labor Code §§401.011(31-a), 401.011(27), 402.00111(a), 402.00128(b)(12), 402.061, 402.075(c), 405.0025(a)(5) and (b), 408.007, 408.027(b) and (e), 408.028(f), 413.007(a)-(c), 413.008(a), 413.011(a) and (d), 413.012, 413.0511, 413.0512, 413.052, 414.002, 414.004, 504.053(b)(2), 504.053(d)(7), and Insurance Code §§1305.154(c)(8), 1305.501, and 1305.502.

Labor Code §401.011(27) provides that "insurance carrier" means an insurance company; a certified self-insurer for workers' compensation insurance; a certified self-insurance group under Labor Code Chapter 407A; or a governmental entity that self-insures, either individually or collectively.

Labor Code §401.011(31-a) provides that the definition for "network" or "workers' compensation health care network" means an organization that is formed as a health care provider network to provide health care services to injured employees; certified in accordance with Insurance Code, Chapter 1305, and rules of the commissioner of insurance; and established by, or operates under contract with, an insurance carrier.

Labor Code §402.00111(a) provides that the division is administered by the commissioner of workers' compensation as provided by Labor Code, Title 5, Subchapter A. Except as otherwise provided by Labor Code, Title 5 the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Labor Code, Title 5.

Labor Code §402.00128(b)(12) provides that the commissioner or the commissioner's designee may exercise other powers and perform other duties as necessary to implement and enforce Labor Code, Title 5.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary for the implementation and enforcement of Labor Code, Title 5, Subchapter A.

Labor Code §402.075(c) requires that at least biennially, the division shall assess the performance of insurance carriers and health care providers in meeting the key regulatory goals. Further, the division shall examine overall compliance records and dispute resolution and complaint resolution practices to identify insurance carriers and health care providers who adversely impact the workers' compensation system and who may require enhanced regulatory oversight. Additionally,

the division shall conduct the assessment through analysis of data maintained by the division and through self-reporting by insurance carriers and health care providers.

Labor Code §405.0025(a)(5) requires the workers' compensation research and evaluation group to conduct professional studies and research related to the quality and cost of medical benefits. Labor Code §405.0025(b) requires the workers' compensation research and evaluation group to objectively evaluate the impact of the workers' compensation health care networks certified under Chapter 1305, Insurance Code, on the cost and the quality of medical care provided to injured employees and report the group's findings to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature not later than December 1 of each even-numbered year.

Labor Code §408.007 provides that, for purposes of Labor Code, Title 5, Subtitle A, the date of injury for an occupational disease is the date on which the employee knew or should have known that the disease may be related to the employment.

Labor Code §408.027(b) provides, in part, that the insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the insurance carrier of the health care provider's claim.

Labor Code §408.027(e) provides that if the insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the division, the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. The insurance carrier is entitled to a hearing as provided by Labor Code §413.031(d).

Labor Code §408.028(f) requires the commissioner to adopt a fee schedule for pharmacy and pharmaceutical services.

Labor Code §413.007(a) provides that the division shall maintain a statewide data base of medical charges, actual payments, and treatment protocols that may be used by the commissioner in adopting the medical policies and fee guidelines; and the division in administering the medical policies, fee guidelines, or rules. Labor Code §413.007(b) states that the division shall ensure that the data base 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 as provided by the Workers' Compensation Act. Labor Code §413.007(c) states the division shall ensure that the data base is available for public access for a reasonable fee established by the commissioner. Further, the identities of injured workers and beneficiaries may not be disclosed.

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

Labor Code §413.011(a) states that the commissioner shall 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 occupation injury requirements. Additionally, to achieve standardization, the commissioner shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirement as necessary to meet the requirement of Labor Code §413.053.

Labor Code §413.053 requires the commissioner by rule to establish standards of reporting and billing governing both form and content.

Labor Code §413.011(d) states that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by Labor Code, Title 5, Subchapter A.

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

Labor Code §413.0511 and §413.0512 require the division's medical advisor and medical quality review panel to monitor the quality of health care and recommend appropriate actions regarding doctors, other health care providers, insurance carriers, utilization review agents, and independent review organizations.

Labor Code §413.052 provides that the commissioner by rule shall establish procedures to enable the division to compel the production of documents.

Labor Code §414.002(a) provides that the division shall monitor for compliance with commissioner rules, the Labor Code, Title 5, Subtitle A, and other laws relating to workers' compensation the conduct of persons subject the Labor Code, Title 5, Subtitle A and persons to be monitored include insurance carriers and health providers. Labor Code §414.004(a) and (b) provide that the division shall review regularly the workers' compensation records of insurance carriers as

required to ensure compliance with Labor Code, Title 5, Subtitle A. Further, 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 shall cooperate with the division, make available to the division any records or other necessary information, and allow the division access to the information at reasonable times at the person's offices.

Labor Code §504.053(b)(2) provides that a political subdivision or a pool that determines that a workers' compensation health care network certified under Insurance Code, Chapter 1305 is not available or practical for use by the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool by directly contracting with health care providers or by contracting through a health benefits pool established under Chapter 172, Local Government.

Labor Code §504.053(d)(7) provides that if the political subdivision or pool provides medical benefits in the manner authorized under subsection (b)(2) of this section, then the political subdivision or pool shall continue to report data to the appropriate agency as required by Labor Code, Title 5 and Insurance Code, Chapter 1305.

Insurance Code §1305.154(c)(8) provides that a network's contract with an insurance carrier must include a requirement that the insurance carrier, the network, any management contractor, and any third party to which the network delegates a function comply with the data reporting requirements of the Texas Workers' Compensation Act and rules of the commissioner of workers' compensation.

Insurance Code §1305.501 pertains to the evaluation of networks and provides that in accordance with the research duties assigned to the group under Chapter 405, Labor Code, the group shall, in accordance with the requirements adopted under §405.0025, Labor Code objectively

evaluate the impact of the workers' compensation health care networks certified under this chapter on the costs and quality of medical care provided to injured employees and report the group's findings to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature not later than December 1 of each even-numbered year.

Insurance Code §1305.502 pertains to consumer report cards and requires the group to develop and issue an annual informational report card that meets the requirements of this section.

7. TEXT.

§134.800*. Applicability.*

(a) This subchapter applies to all insurance carriers as defined in Labor Code §401.011(27), including insurance carriers that have contracted with or established a workers' compensation health care network as defined in Labor Code §401.011(31-a) and insurance carriers that provide medical benefits in a manner authorized by Labor Code §504.053(b)(2). All insurance carriers are required to report information prescribed by the commissioner under Labor Code §413.007 and §413.008 for each medical bill on a workers' compensation claim.

(b) This section is effective September 1, 2011. Insurance carriers and trading partners may submit medical EDI records in accordance with this subchapter prior to this effective date.

§134.801. *Purpose*.

(a) The purpose of this subchapter is to prescribe the reporting requirements for information and data submitted to the division and to adopt by reference the implementation guide and specifications necessary for successful electronic data interchange transaction processing. The reporting of information and data is necessary to maintain a statewide data base of medical charges, actual payments, and treatment protocols pursuant to Labor Code §413.007 and §413.008.

(b) This section is effective September 1, 2011.

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

(2) EDI--Electronic data interchange.

(3) Medical EDI Record--The data associated with a single medical bill which is being reported in a Medical EDI Transaction.

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

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

(6) 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.

(7) 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.

(b) This section is effective September 1, 2011.

§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 EDI Implementation Guide) published by the International Association of Industrial Accident Boards and Commissions (IAIABC).

(b) The commissioner adopts by reference the Texas EDI Medical Data Element Requirement Table, Version 1.0, dated June 2011, the Texas EDI Medical Data Element Edits Table, Version 1.0, dated June 2011, and the Texas EDI Medical Difference Table, Version 1.0, dated June 2011. All tables are published by the division.

(c) Information on how to obtain or inspect copies of the IAIABC EDI Implementation Guide and the adopted division tables may be found on the division's website: http://www.tdi.state.tx.us/wc/indexwc.html.

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

(e) This section is effective September 1, 2011.

§134.804. *Reporting Requirements*.

(a) Insurance carriers shall submit an '00' original medical EDI record for each action (initial processing, request for reconsideration, 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 payment actions must

contain a service adjustment reason code of 'W3' when a payment is made following a request for reconsideration or appeal and the service adjustment amount associated with this code value may be populated with zero.

(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.

(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.

(d) Insurance carriers are responsible for the timely and accurate submission of medical EDI records. 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) where applicable, contained the same data as the source medical bill and explanation of benefits; 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, 2011.

§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;

(3) receives a refund for a medical bill; or

(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.

(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, 2011.

§134.806. *Records Excluded from Reporting*.

(a) Insurance carriers shall not report medical EDI records for health care services:

(1) rendered outside the United States;

(2) related to dates of injury before January 1, 1991;

(3) rendered at a Federal health care facility and the health care facility does not provide the insurance carrier with the data required to be reported;

(4) related to an injured employee's travel reimbursement as provided in §134.110 of this title (relating to Reimbursement of Injured Employee for Travel Expenses Incurred); or

(5) related to a request for reimbursement by a health care insurer in accordance with the provisions of Labor Code §409.0091.

(b) Insurance carriers shall not report interest and penalty payments paid on health care services, medical cost containment expenses, medical bill review expenses or data transmission expenses in medical EDI records.

(c) This section is effective September 1, 2011.

§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 shall 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 shall include a separate line for each reimbursable component of the compound medication. 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.

(g) This section is effective September 1, 2011.

§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 by fax or email at TxCOMP.Help@tdi.state.tx.us. 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 by fax or email at TxCOMP.Help@tdi.state.tx.us. 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 bills 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, 2011.

8. CERTIFICATION.

This agency certifies that the adopted amendments and new sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on June 20, 2011.

X

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

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to §134.802 and new §§134.800, 134.801, 134.803, 134.804, 134.805, 134.806, 134.807, and 134.808 specified herein, concerning applicability, purpose, definitions, reporting standards, reporting requirements, records required to be reported, records excluded from reporting, state specific requirements, and insurance carrier EDI compliance coordinator and trading partners are adopted.

AND IT IS SO ORDERED.

X

ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

_X_____

Dirk Johnson
General Counsel

COMMISSIONER ORDER NO.