CHAPTER 134: BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER I: MEDICAL BILL REPORTING
Title 28 TAC §§134.802 - 134.805, 134.807, 134.808

1. INTRODUCTION.

The Texas Department of Insurance, Division of Workers' Compensation (Division) proposes amendments to Title 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.

These amendments are necessary to clarify 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 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 clarify the existing data reporting requirements, with minimal changes to the current technical infrastructure associated with medical electronic data interchange (EDI) reporting. Lastly, these proposed 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 proposed amendments also 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 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.

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, and may modify documentation requirements as necessary to meet the requirements of Section 413.053. Insurance carriers are required to utilize, in part, the information obtained from those billing forms the commissioner has adopted by reference in compliance with Labor Code §413.011 when reporting accurate medical EDI records to the Division under 28 TAC Chapter 134. The proposed amendments to Chapter 134 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 Division considered and incorporated stakeholder feedback throughout the informal draft and proposal process. As part of the development process for these proposed rules, the Division posted an informal working draft of amendments to Chapter 134 on its website on July 31, 2014. These proposed rule amendments incorporate several recommendations from commenters.

The following paragraphs include a description of all of the proposed 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. For example, a code of "rejected" means that invalid modifiers and qualifiers have been submitted, whereas a code of "accepted" means that valid modifiers and qualifiers have been submitted. These application acknowledgment codes are necessary to prevent incomplete records from populating the database and will put the insurance carrier on notice that either a record was accepted or that another record must be submitted to the Division that is complete.

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.

New §134.802(a)(3) defines the term "claim administrator claim number" to clarify that only one claim administrator claim number may be used 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 clarifies that the claim administrator claim number must not change with the acquisition of claims, claim transfer to a different third party administrator, or business mergers. 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). 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 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, the Texas EDI Medical Data Element Requirement Table, and the Texas EDI Medical Difference 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) proposes to adopt 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 deviations used for medical EDI reporting in Texas from the IAIABC Guide under the current infrastructure implemented by the Division.

The Division clarifies the requirement 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 clarifies that the identification code qualifier "34", identifying the social security number, is the only acceptable value in the NM108 data element. The Division also clarifies that for Texas medical EDI reporting, the employee's social security number associated with the workers' compensation claim is required to be reported. 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 clarifies that insurance carriers must report DN53 on all medical EDI records, including those relating to pharmacy medical bills.

The Division amended the comments for the provider agreement code DN507 in data element CLM16 to clarify that the value of "Y" is not accepted in Texas. This amendment is necessary to ensure valid data is submitted to the Division because under the IAIABC Guide, "Y" is defined as "preferred provider organization (PPO)" and 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 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 the 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 bills when medical services were provided in an inpatient acute care hospital. This additional 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 is required to be reported in data elements H101-2, H102-2, H103-2, H104-2, and H105-2 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 Division's code sets require a decimal point to be reported.

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 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 in the SVD04 data element to clarify that the 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 Elements Table and the Texas EDI Medical Data 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 Elements 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 two columns to the table to provide for an error message of an "invalid event sequence/relationship" and an error message of "must be greater than or equal to the date payer received the bill" for error codes 063 and 073, respectively. These additional columns are 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 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 under the IAIABC Guide, "Y" is defined as "preferred provider organization (PPO)," and 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. This amendment was necessary because the Division will begin to reject a replacement of a medical EDI record when the original medical EDI record was not accepted.

The Division amended the data element of DN512, date insurer paid bill by adding an edit requiring that the insurer paid bill reported date is greater than or equal to the date the payer received

the bill (073). This amendment will ensure that the Division rejects medical EDI records reported by the insurance carrier when the date the claim is paid is prior to the date the insurer received the bill. This amendment is necessary to help ensure the quality and integrity of the data maintained by the Division.

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 a 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. The formatting of the Division's code sets require a decimal point to be reported.

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 limited other 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) validation 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 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 situational rules for conditional data elements. The table also sets out the usage requirements for data elements in the IAIABC Guide, including defining the mandatory trigger for conditional data elements. This table is necessary because it identifies the data 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 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 elements to be reported when the social security number is not reported. Because Title 28 TAC §102.8 provides the reporting format for 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 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 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 use the data in these elements and therefore are not necessary to achieve the purposes of Labor Code §413.007.

The data element DN731, service adjustment group code, is conditional once the requirement 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 trigger as DN731.

Amended §134.803(c) deletes redundant language regarding information on how to obtain the IAIABC Guide and clarifies that the amended tables proposed to be 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.

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

Amended §134.804(c) requires that an '00' original medical EDI record t 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 submitting medical EDI records to the Division in the proper sequence will ensure the Division maintains the most current medical EDI records submitted by insurance carriers.

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 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 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 bills to the Division if the duplicate medical bill was processed for payment. This amendment is necessary to clarify that insurance carriers are required to submit medical bill payment data on all medical bills that are processed, which may include duplicate medical bills. Under existing 28 TAC §133.200(a)(1), insurance carriers must not return bills to the provider that are complete, unless the medical bill is a duplicate 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 accurate prescription number. 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.

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 carrier's 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 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.

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 an insurance carrier shall only report up to four diagnosis codes on a medical EDI record because the guidance in the IAIABC Guide adopted by the Division only allows four codes to be reported.

New §134.807(f)(10) provides that an insurance carrier shall only report up to four diagnosis code pointers and that the pointers must be reported numerically. If the diagnosis code pointer reported on a medical bill is not an "A, B, C or D", the extra pointers must be reported with a value of "1". 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 ensure that the insurance carrier or trading partner has access to the Division's current email and website 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)(7).

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.

2. FISCAL NOTE.

Matthew Zurek, Executive Deputy Commissioner of Health Care Management and System Monitoring, has determined that for each year of the first five years the proposed sections will be in effect, there will be no foreseeable implications relating to cost or revenues of the state or local governments, except to the extent set forth below in the Public Benefit/Cost Note portion of this proposal. There will be no measurable effect on local employment or the local economy as a result of the proposed amendments.

3. PUBLIC BENEFIT/COST NOTE.

Mr. Zurek has also determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of the proposed sections will be (i) clarification of existing rules to facilitate ease of compliance and submission of accurate data; (ii) increased accuracy of medical EDI records submitted to the Division; and (iii) availability of quality data that will better able the commissioner to adopt medical policies and fee guidelines and the Division to administer 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 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.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL

Mr. Zurek anticipates that there will be probable costs to persons required to comply with several of the proposed amended sections during each year of the first five years that the rules will be in effect. As stated in this proposal, much of this rule merely reiterates existing requirements. Those changes would not have any associated costs. Insurance carriers and trading partners will

experience some cost in the modification of automated systems to report the DRG code modifiers under amended §134.807, to adjust their systems to ensure proper sequencing of medical EDI records submitted to the Division under amended §134.804, and minimal modifications to automated systems to comply with the proposed amendments to §§134.802 - 134.805, 134.807, and 134.808. While many insurance carriers and trading partners already report the DRG code, several insurance carriers may need to update their databases and automated systems with the new data elements and updates may be necessary to comply with the proposed amended sections and amended tables proposed to be adopted by reference.

Division records show that there are approximately 40 insurance carriers and trading partners currently submitting medical EDI records to the Division. Each of these entities will need to initiate an automation project to design the minimal changes, modify their existing database, modify the extract, transform and load processes, and test the changes prior to implementation. It is estimated that this type of automation project will require approximately 30 hours of work by a computer programmer.

The Division determined that the total estimated cost for an insurance carrier or trading partner to make minimal modifications to their automated systems to comply with §§134.802 - 134.805, 134.807, and 134.808 could vary based on the cost of a computer programmer wages. According to the Wage Information Network available from the Labor Market and Career Information of the Texas Workforce Commission, computer programmers receive a median wage of $64.97 per hour. The combined cost to implement these minimal automation changes would be approximately $1,950 for persons required to comply with the proposed amended sections. Additional costs are not anticipated after implementation and any costs in subsequent fiscal years would be restricted to standard system maintenance.

Insurance carriers and trading partners that have not implemented systems that comply with the current IAIABC Guide and existing requirements under Title 28 TAC Chapter 134, Subchapter I,

will experience additional programming and development costs, but those changes are not related to the requirements contained in the proposed amendments and new sections.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Government Code §2006.002(c) provides that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. Government Code §2006.001(1) defines a "micro-business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated; and has not more than 20 employees.

In accordance with Government Code §2006.002(c), the Division has determined that the proposal may have an adverse economic effect on small and micro-businesses in order to comply with the requirement to submit DRG code modifiers under amended §134.807, to adjust their systems to ensure proper sequencing of medical EDI records submitted to the Division under amended §134.804, and to make other changes to their systems in compliance with the amendments to 28 TAC Chapter 134 contained in this proposal.

According to Division records, there are approximately 40 insurance carriers and trading partners currently submitting medical EDI records to the Division. The Division does not know the total number of persons affected by the proposal or the number that will be small or micro-businesses under Government Code §2006.002(c), however, the Division estimates that the majority of persons required to comply with amendments to Title 28 TAC Chapter 134 do not qualify as small or micro-businesses for the purposes of Government Code §2006.001. The cost of compliance with the proposal will not vary between large businesses and small or micro-businesses, and the Division's

cost analysis and resulting estimated costs in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or micro-businesses. Because the Division has determined that the proposed amendments may have an adverse economic effect on small or micro-businesses, this proposal contains the required economic impact statement and a regulatory flexibility analysis, as detailed under Government Code §2006.002.

The adverse impact is partially driven by the low number of client companies for which trading partners provide medical EDI transaction processing and submission. Given the lower customer base, it will likely be more difficult for these businesses to spread any development and deployment costs in a manner which would mitigate potential financial impact. However, it is noted that these businesses choose to offer these services to insurance carriers and none are mandated to comply with these requirements if they choose to no longer participate in medical EDI transaction processing.

The Division, in accord with Government Code §2006.002(c)(1), has considered two alternative methods of achieving the purpose of the proposed rule that would not adversely affect small or micro-businesses. The two alternative methods are (i) not adopting the proposed amendments; and (ii) exempting the requirements of the proposed amendments.

Not adopting the proposed amendments. The Division rejected this approach because the current regulatory framework already requires the reporting of this data consistent with the requirements of Labor Code §413.007, which requires the Division to maintain a statewide database of medical charges, actual payments, and treatment protocols. The proposed changes highlight the data reporting requirements in order to improve the quality of the data.

Exempting small and micro-businesses from the requirements of the proposed amendments and new sections. The Division rejected this option because trading partners choose to participate in electronic data interchange as a mechanism to secure new business and sustain existing business. The reporting requirement is primarily on the insurance carriers, not the trading partners, which are

generally not small or micro-businesses. Exempting small and micro-businesses from the proposed amendments would result in inaccurate and incomplete data, which eliminates the ability of the Division to meet the statutory obligation to maintain a statewide database.

Section 2006.002(c-1) of the Government Code requires that the regulatory analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro-businesses, would not be protective of the health, safety, and environmental and economic welfare of the state. These proposed amendments 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 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 able the commissioner to adopt medical policies and fee guidelines and the Division to administer the medical policies, fee guidelines, or rules. 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.

The purpose of the clarifications in amendments to Title 28 TAC Chapter 134 is to consistently and uniformly impose requirements relating to data accuracy. This helps ensure the quality and integrity of the data in the database, and to 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, thereby protecting the economic welfare of the state. To waive or modify the requirements of the proposed clarification for small and micro-

businesses would result in a disparate effect on system participants by the proposed rule amendments and would not be equally protective of the economic welfare of the state. Therefore, the Division has further determined that there are no regulatory alternatives, including the waiving or modifying of the requirements of proposed amendments to Title 28 TAC Chapter 134, which will sufficiently protect the economic interests of consumers and the economic welfare of the state.

5. TAKINGS IMPACT ASSESSMENT.

The Division has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT.

To be considered, submit written comments on the proposal no later than 5:00 p.m., Central Time, on December 1, 2014. All comments should be submitted by email at rulecomments@tdi.texas.gov or by mail to Maria Jimenez, Texas Department of Insurance, Division of Workers' Compensation, Office of Workers' Compensation Counsel, MS-4D, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645. Comments received after the close of comment will not be considered.

If you want to request a public hearing on the proposal, you must submit the request separately to the Office of Workers' Compensation Counsel before the close of the public comment period. If a hearing is held, written comments and public testimony presented at the hearing will be considered.

7. STATUTORY AUTHORITY.

The amendments are proposed 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.

8. CROSS REFERENCE TO STATUTE.

The proposed rules affect the following statutes: Labor Code §§402.00111 (Relationship between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking), 402.061 (Adoption of Rules), 413.007 (Information maintained by the Division) and 413.008 (Information from Insurance Carriers; Administrative Violation).

9. 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)[~~(1)~~] Division--The Texas Department of Insurance, Division of Workers' Compensation or its data collection agent.

(5)[~~(2)~~] 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)[~~(3)~~] 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)[~~(4)~~] Medical EDI Transmission--The data that is contained within the interchange envelope.

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

(11)[~~(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.

(12)[~~(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.

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

(b) The commissioner adopts by reference the *Texas EDI Medical Data Element Requirement Table*, Version 2.0 [~~1.0~~], dated September 2015 [~~June 2011~~], the *Texas EDI Medical Data Element Edits Table*, Version 2.0 [~~1.0~~], dated September 2015 [~~June 2011~~], and the *Texas EDI Medical Difference Table*, Version 3.0 [~~2.0~~], dated September 2015 [~~January 2013~~]. All tables are published by the division.

(c) The [~~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.texas.gov/wc/edi/index.html [~~http://www.tdi.texas.gov/wc/indexwc.html~~].

(d) In the event of a conflict between the IAIABC Guide [~~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, 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 [~~payment~~] actions must contain a Texas-specific claim [~~service~~] 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). [~~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. 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 [~~are responsible for the~~] timely and accurate [~~submission of~~] 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) [~~where applicable,~~] contained accurate medical EDI [~~the same~~]data; medical EDI data may be obtained from all sources, including [~~as~~] the [~~source~~] medical bill, [~~and~~] 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 [~~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, including duplicate bills;

(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; [~~.~~]

(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 [~~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 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) An insurance carrier shall only report up to four (4) diagnosis codes on each medical EDI record.

(10) An insurance carrier shall only report to the Division up to four diagnosis code pointers and those pointers must be reported numerically. If a 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 [~~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 medical EDI records [~~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, 2015 [~~September 1, 2011~~].

10. CERTIFICATION.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Issued at Austin, Texas, on October 17, 2014.

×

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