TITLE 28. INSURANCE

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

CHAPTER 133 - GENERAL MEDICAL PROVISIONS
SUBCHAPTER A - GENERAL RULES FOR MEDICAL BILLING AND PROCESSING
28 TAC §133.2

SUBCHAPTER C - MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER
28 TAC §§133.240, 133.250, AND 133.270

SUBCHAPTER D - DISPUTE OF MEDICAL BILLS
28 TAC §133.305

ADOPTION

1. INTRODUCTION.

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §§133.2, 133.240, 133.250, 133.270, and 133.305, concerning medical billing and processing and the dispute of medical bills. The sections are adopted with changes to the proposed text as published in the December 30, 2011, issue of the *Texas Register* (36 TexReg 9184) and will be republished. These amendments are necessary to: (1) harmonize these rules with other Division rules and procedures, Chapter 504, Labor Code, and certain provisions of Chapters 1305 and 4201, Insurance Code; (2) clarify the Division's requirements for explanations of benefits submitted in paper format; and (3) make other changes necessary to clarify the implementation and application of these sections. The Division adopts these amendments in conjunction with its amendments to 28 TAC §134.600 (relating to

Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) published elsewhere in this issue of the *Texas Register*.

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

No public hearing was requested or held for this proposal. The public comment period closed on January 30, 2012, and the Division received seven public comments.

2. REASONED JUSTIFICATION.

On December 16, 2011, the Division withdrew its proposed amendments to §§133.2, 133.240, 133.250, 133.270, and 133.305, which were published in the July 29, 2011, issue of the *Texas Register* (36 TexReg 4774). The Division determined this withdrawal was necessary because the primary purpose of those proposed amendments was to harmonize these sections with the amendments to 28 TAC §§19.2001 - 19.2017 and 19.2019 - 19.2021 (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) (Subchapter U) proposed by the Department in the July 8, 2011, issue of the *Texas Register.* On December 2, 2011, however, the Department withdrew these proposed amendments to Subchapter U and announced that it would be issuing new informal draft rules on the same topic at a later date. In light of this withdrawal and announcement, the majority of the Division's

proposed amendments to §§133.2, 133.240, 133.250, 133.270, and 133.305 became premature and were, therefore, withdrawn.

The Division also elected, however, to repropose the July 2011 amendments to §§133.2, 133.240, 133.250, 133.270, and 133.305 that did not relate to the Department's proposed amendments to Subchapter U. Those proposed amendments and other new amendments to these sections were published in the December 30, 2011, issue of the *Texas Register*. The amendments, as stated above, are necessary to: (1) harmonize these rules with other Division rules and procedures, Chapter 504, Labor Code, and certain other provisions of Chapters 1305 and 4201, Insurance Code; (2) clarify the Division's requirements for explanations of benefits submitted in paper format; and (3) make other changes necessary to clarify the implementation and application of these sections. Those proposed amendments also made non-substantive changes to these sections to conform to current nomenclature, reformatting, consistency, clarity, and to correct typographical and/or grammatical errors.

The Division adopts these amended sections with changes from the amendments proposed on December 30, 2011. First, the Division has made a non-substantive typographical change to its definition of "Agent" in §133.2(1). Specifically, the Division has deleted "with" before the word "whom."

Second, in response to public comment, the Division has deleted "who submitted the medical bill" from §133.240(e)(1) and added to paragraph (3) of this subsection "if different from the health care provider identified in paragraph (1) of this subsection." This change is necessary to clarify that the requirements of §133.240(e)(1) have not changed as a result of this proposal and to clarify the application of §133.240(e)(3).

Third, the Division has, in response to public comment, changed new §133.240(p) and §133.250(i) to provide that "all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment." These requirements replace the requirements provided by proposed §133.240 and §133.250, which read: "Additionally, all utilization review agents and registered insurance carriers who perform utilization review under this section must have written policies that evidence compliance with Labor Code §504.055, regarding expedited provision of medical benefits for first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment." These changes are necessary to ensure that this section remains in harmony with any future rules issued by the Department on this topic while still requiring all applicable parties to comply with Labor Code §504.055.

Fourth, the Division, in response to comment, has changed §133.250(f) to provide that an insurance carrier shall provide an explanation of benefits "in accordance with §133.240(e) – (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action" or "in accordance with of §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action." This change is necessary to clarify to which parties the insurance carrier must send an explanation of benefits when the insurance carrier changes its final action and when it does not.

Lastly, the Division has, in response to public comment, added a delayed effective date for these sections of July 1, 2012 and has incorporated the date into new §§133.2(b), 133.240(q), 133.250(j), 133.270(h), and 133.305(f). This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

3. HOW THE SECTIONS WILL FUNCTION.

Amended §133.2. The adopted amendment to §133.2(1) defines "agent" as a "person whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligations under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent." This definition is necessary to correspond with the definition of "agent" in §180.1 of this title (relating to Definitions) and to harmonize the definitions of "health care provider agent" and "insurance carrier agent" that are deleted from this section. This amendment also clarifies that "[t]his definition does not apply to 'agent' as used in the term 'pharmacy processing agent.'" This amendment is necessary because "pharmacy processing agent" is a statutorily defined term under Labor Code §413.0111.

Amended §133.240. The adopted amendment to §133.240(b) clarifies that for pharmaceutical services provided to any injured employee, the insurance carrier shall not deny reimbursement based on medical necessity for pharmaceutical services preauthorized or agreed to under Chapter 134, Subchapter F of this title. The clarification harmonizes §133.240 with the Division's amendments to Chapter 134, Subchapter F of this title (relating to Pharmaceutical Benefits). Specifically, it clarifies that pharmaceutical services provided to injured employees, through either network or non-network workers' compensation coverage, cannot be denied

based on medical necessity if those services were preauthorized or agreed to under §134.510(c) - (d) of this title (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011).

The adopted amendment to §133.240(e) requires insurance carriers to send an explanation of benefits in "accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form." This amendment is necessary to harmonize subsection (e) with §133.500 and §133.501, and with new subsection (f) that prescribes the required elements for explanations of benefits submitted in paper form by an insurance carrier.

The adopted amendment to §133.240(e)(2)(B)(iv) clarifies that §133.240(e)(2)(B)(iv) applies when the doctor is performing a designated doctor examination under Labor Code §408.0041 not simply §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings). This amendment is necessary because it updates this provision to reflect the variety of examinations, other than maximum medical improvement and impairment rating examinations, that a designated doctor may perform under Labor Code §408.0041.

The adopted amendment to §133.240(e)(3) provides that insurance carriers must send an explanation of benefits to "the prescribing doctor, if different from the health care provider identified in paragraph (1) of this subsection, when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or

relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services." This amendment is necessary to harmonize proposed §133.240(e) with §134.502(f) of this title (relating to Pharmaceutical Services), which contains the same requirement.

The adopted amendments to §133.240(f) list the required elements of an explanation of benefits sent by an insurance carrier under §133.240(e), §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) and §133.260 of this title (relating to Refunds). These amendments primarily incorporate the elements of the Division's current form DWC-062, and, therefore, provide increased clarity for insurance carriers who must comply with these requirements. Additionally, these amendments also add new requirements to these explanations of benefits. Specifically, amended subsection (f) now requires insurance carriers to include the name of the certified workers' compensation health care network through which the care was provided (if applicable) and the name of any pharmacy informal or voluntary network through which payment was made (if applicable). Amended subsection (f) also requires insurance carriers to include only the last four digits of an injured employee's social security number. Finally, amended subsection (f) permits insurance carriers to use a health care provider's national provider identifier instead of the health care provider federal tax ID number if the health care provider's federal tax ID number is the same as the health care provider's social security number. These new elements are necessary to ensure injured employee and health care provider confidentiality and to provide full disclosure of all network affiliations related to the claim.

The adopted amendment to §133.240(g) provides that when an insurance carrier pays a health care provider for health care for which the Division has not established a maximum

allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.503 of this title (relating to Pharmacy Fee Guideline), if applicable. This amendment is necessary to harmonize this proposed rule with the Division's recently adopted Pharmacy Fee Guideline, which has a separate requirement for determining fair and reasonable reimbursement in the absence of specified fee than the analogous requirement for other health care services under §134.1 of this title (relating to Medical Reimbursement).

The adopted amendment to §133.240(n) provides when an insurance carrier remits payment to a pharmacy processing agent, "the pharmacy processing agent's reimbursement from the insurance carrier shall be made in accordance with §134.503 of this title (relating to Pharmacy Fee Guideline)." This amendment is necessary to clarify that when an insurance carrier remits payment to a pharmacy processing agent, a pharmacy's reimbursement from a pharmacy processing agent shall be made in accordance with the terms of its contract with the pharmacy processing agent. The insurance carrier's reimbursement to the pharmacy processing agent, however, must be made in accordance with the Division's recently adopted Pharmacy Fee Guideline.

Adopted new §133.240(p) provides that "[for] the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title." This amendment is necessary to clarify the application of the Insurance Code and Department rules to utilization review under this section. New §133.240(p) further provides that "all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with

Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment." This provision is necessary to ensure that this section remains in harmony with any future rules issued by the Department on this topic while still requiring all applicable parties to comply with Labor Code §504.055.

Lastly, adopted new §133.240(q) provides a delayed effective date for this section of July 1, 2012. This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

Amended §133.250. The adopted amendment to §133.250(b) provides that health care providers must "submit the request for reconsideration no later than 10 months from the date of service." This amendment reduces the time period for health care providers to file a request for reconsideration from 11 months to 10 months. This amendment is necessary to ensure that health care providers who take the maximum amount of time to submit a denied bill for reconsideration still have opportunity to timely file a request for dispute resolution under §133.307(c) of this title (relating to MDR of Fee Disputes) if an insurance carrier also takes the maximum amount of time to take final action on the request for reconsideration. Previously, when an insurance carrier was limited to 21 days to review a request for reconsideration, the 11 months from the date of service deadline to submit a request for reconsideration was sufficient to ensure that a health care provider whose request is denied could still file a request for dispute resolution within one year of the date of service. Because the Division is also extending the time an insurance carrier has to review a request for reconsideration under this section to 30 days,

however, the 11 month deadline is no longer sufficient for this purpose and is, therefore, reduced to 10 months from the date of service.

The adopted amendments to §133.250(f) state that an insurance carrier shall provide an explanation of benefits in accordance with §133.240(e) – (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the Division when there is a change in the original, final action or in accordance with of §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action. This amendment is necessary to correspond with the amendments made to §133.240(e) - (f). The adopted amendments to §133.250(f) also extend the time an insurance carrier has to take final action on a request for reconsideration from 21 days to 30 days. This requirement is necessary to correspond with Insurance Code §4201.359, which states that a utilization review agent's procedures must provide that it will respond to an appeal of an adverse determination "as soon as practicable but not later than the 30th day after receiving a request for reconsideration." This amendment also harmonizes this requirement with the parallel requirement for network claims under Insurance Code §1305.354, which provides insurance carriers the same amount of time to respond to a request for reconsideration.

The adopted amendment to §133.250(g) extends the time required before a health care provider may resubmit a request for reconsideration. The amendment extends the time period from 26 days after the insurance carrier received the original request or took final action on the request to 35 days after the insurance carrier received the request or took final action on the request. This amendment is necessary to harmonize this requirement with the Division's amendment to §133.250(f), which extended the time an insurance carrier has to take final action on a request for reconsideration from 21 days to 30 days.

Adopted new §133.250(i) provides that "[for] the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title." This amendment is necessary to clarify the application of the Insurance Code and Department rules to utilization review under this section. New §133.250(i) further provides that "all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment." This provision is necessary to ensure that this section remains in harmony with any future rules issued by the Department on this topic while still requiring all applicable parties to comply with Labor Code §504.055.

Lastly, adopted new §133.250(j) provides a delayed effective date for this section of July 1, 2012. This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

Amended §133.270. The adopted amendment to §133.270(f) provides that an injured employee may request reconsideration of a denied medical bill in accordance with "the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)." This amendment updates this citation to correspond with other changes the Division has made to Subchapter D of Chapter 133.

The adopted amendment to §133.270(g) provides that insurance carriers shall submit injured employee medical billing and payment data to the Division in accordance with Chapter 134, Subchapter I of this title (relating to Medical Bill Reporting). This amendment is necessary to update the reference in this section to match the Division's current applicable sections regarding medical bill reporting.

Lastly, adopted new §133.270(h) provides a delayed effective date for this section of July 1, 2012. This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

Amended §133.305. The adopted amendment to §133.305(a) defines "first responder" and "serious bodily injury" as those terms are defined by Labor Code §504.055(a) and §1.07, Penal Code, respectively. The Division has added these definitions in anticipation of future rulemaking regarding medical dispute resolution.

The adopted amendment to §133.305(c)(3) provides that the Division may assess an administrative fee against an insurance carrier if the Division requests and the insurance carrier fails to provide the Division with the required health care provider notice under Labor Code §408.0281. This amendment is necessary to harmonize §133.305(c) with the requirements of Labor Code §408.0281.

Additionally, the adopted amendment to §133.305(c)(4) provides the Division will not assess an administrative fee against an insurance carrier for a reduced or denied payment based on a contract that indicates the direction or management of health care through a health care provider arrangement authorized under Labor Code §504.053(b)(2). This amendment is necessary to recognize the authority of political subdivisions to contract with health care providers under Labor Code §504.053(b)(2).

Lastly, adopted new §133.305(f) provides a delayed effective date for this section of July 1, 2012. This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES TO COMMENTS.

General: A commenter expresses support for the Division's continued openness and desire to work with system participants to gain perspective on how key rules impact workers' compensation marketplace.

Agency Response: The Division appreciates the supportive comment.

General: A commenter requests the Division consider the changes these amendments will require insurance carriers to implement when determining an effective date for the amendments.

Agency Response: The Division carefully reviewed and considered the additional time for system participants to prepare for implementation of this rule and has determined that July 1, 2012 is the appropriate effective date for these amendments. The Division has incorporated this effective date into new §§133.2(b), 133.240(q), 133.250(j), 133.270(h), and 133.305(f).

§133.2(1): A commenter feels the proposed changes are too vague in relationship to roles and responsibilities for requesting prospective utilization review for the purpose of complying with the Pharmacy Closed Formulary. The commenter seeks clarification as to what role an entity such as a voluntary/informal network or pharmacy benefit manager may play in the utilization review process, such as facilitating utilization review requests to an appropriately licensed entity. The commenter poses the following question to ensure a proper understanding of the role that a

voluntary/informal network or pharmacy benefit manager may play in the utilization review process: can a voluntary/informal network or agent acting on behalf of an insurance carrier or other payor initiate the utilization review process and request utilization review on "N" drugs by forwarding the prescription claim for prospective utilization review to a properly licensed insurance carrier or utilization review entity?

Agency Response: The Division disagrees the proposed definition of "agent" is vague in relationship to roles and responsibilities for requesting prospective utilization review for the purpose of complying with the Pharmacy Closed Formulary. Insurance carriers and health care providers may contract with or utilize persons for fulfilling claim services or medical bill processing obligations under Labor Code, Title 5. If an insurance carrier, therefore, has authorized a person to receive preauthorization requests from pharmacies on its behalf and to forward those preauthorization requests to an appropriately certified utilization review agent for utilization review, that person would properly be acting as the insurance carrier's agent in that process. Whether or not that person was also an informal or voluntary network is irrelevant, however, as acting as an informal or voluntary network neither inhibits nor entitles a particular person to operate as an insurance carrier agent in non-informal non-voluntary network contexts, such as the scenario described by the commenter. The Division also notes, however, that in the scenario described above the timeframe to respond to a preauthorization request would begin when the agent receives the request. Additionally, the Division clarifies that only "requestors" under §134.600(a) of this title and injured employees may request preauthorization of a health care treatment or service.

The Division also reminds all system participants that no person may perform utilization review unless that person has been properly certified or registered under Chapter 4201,

Insurance Code and otherwise complies with that chapter and all associated Division and Department rules. Lastly, the Division clarifies that both the insurance carrier and its agent are responsible for all administrative violations of that agent.

§133.2(1): A commenter believes that there is a grammatical error in the proposed rule text and it appears that the word "with" between "person" and "whom" is not properly included. The commenter recommends the following substitute language: "A person or entity that a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligation under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to 'agent' as used in the term 'pharmacy processing agent'."

Agency Response: The Division disagrees with the commenter's suggestion because the Division's current definition is more appropriate for the purposes of Chapter 133. The Division does, however, acknowledge the grammatical error and has made a change. Specifically, the Division has deleted "with" from the definition.

§133.2(1) and (6): Due to the proposed exclusion of pharmacy processing agent for the definition of agent, a commenter requests the Division's specific clarification of intent regarding pharmacy principal liability for acts or omissions of its agent, consistent with other agency liabilities in the Act and Rules.

Agency Response: The Division clarifies that the modified definition of "agent" only applies to use of the term in Chapter 133. For use of that term in Chapter 180, system participants should apply the definition of "agent" in §180.1 of this title (relating to Definitions).

§133.240(b): A commenter supports this proposed provision to the rule.

Response: The Division appreciates the supportive comment.

§133.240(e): A commenter is concerned these proposed changes (and existing language) do not adequately address market-based practices of insurance carriers and other payors utilizing agents in a variety of contractual, proven cost-effective ways. Without further clarity, participants in the pharmacy marketplace could be confused as to what role(s) various entities can lawfully play since implementation of House Bill (HB) 528 in 2011. The commenter requests this concept be explicitly included by adding: "or their agent" after the words "The insurance carrier" to make clear that either an insurance carrier or an insurance carrier's agent – pursuant to contract – can send the state-mandated explanations of benefits. If not included in the final rule, the commenter requests the Division clarify either in the adoption order or responses to comments of an insurance carrier's agent ability to disseminate an EOB on behalf of the insurance carrier, pursuant to contract, without removing the insurance carrier responsibility.

Agency Response: The Division declines to make the change as adding the phrase "or their agent" after "insurance carrier" in subsection (e) of this section is not necessary. As stated above and in the definition of "agent," an agent of the insurance carrier is the insurance carrier for the purpose of medical bill processing and claims service obligations under the Labor Code, Title 5. If an insurance carrier has authorized a person to issue EOBs on its behalf, then that

person may do so. Furthermore, the Division notes that the insurance carrier may not contract away its responsibility for management of a claim and is ultimately responsible for the actions of its agents.

Lastly, the Division clarifies that HB 528 authorized insurance carriers or their authorized agents and health care providers to contract with informal or voluntary networks for reduced fee schedules for pharmaceutical benefits. HB 528 did not modify or in any other way affect the ability of an agent of an insurance carrier to issue EOBs on its behalf. Thus, while an informal or voluntary network may issue EOBs on behalf of an insurance carrier, it may not do so simply because it is an informal or voluntary network. It must otherwise be the agent of the insurance carrier and authorized to perform that action on the insurance carrier's behalf.

§133.240(e)(1): A commenter requests additional language to cover market situations where the health care provider does not directly submit a medical bill to an insurance carrier, which is a frequent occurrence in the pharmacy marketplace. Given that both a pharmacy processing agent's role has been acknowledged in existing law and a voluntary and informal network's role is acknowledged by provisions of HB 528, the commenter feels it important for the Division to clarify which entity is actually responsible for the claim and thus should receive an EOB in the unique process flow and contractual arrangements of the workers' compensation pharmacy marketplace – as frequently the health care provider (pharmacy) is not the ultimate party contractually responsible for submitting the prescription claim for payment.
Additionally, the commenter states that since implementation of HB 528 the pharmacy is already paid at a contractual rate by the processing agent, network, voluntary/informal network, or third party biller and is not subject to a reduction or denial. Thus, sending an EOB to a pharmacy that

has been paid regarding a short pay or reduction made in reference to the actual submitter's bill would only cause confusion and increase costs for carriers and their agents. The commenter believes the proper entity to receive the EOB is the entity actually submitting the bill and at risk for payment reduction or denial by the insurance carrier. Thus, depending on the route a particular transaction takes, either the health care provider (pharmacy) or another entity contractually authorized to submit a final bill (and thus at risk for no payment or short payment) for payment to the insurance carrier will receive an EOB.

Agency Response: The Division disagrees with the commenter's requested change. Submission of a medical bill is not synonymous with the right to reimbursement for that medical bill because health care provider agents can contract to submit bills on behalf of a health care provider without acquiring the right to reimbursement for that bill. Insurance carriers, therefore, have no means to verify when a billing entity is simply billing on behalf of a health care provider or when the entity has acquired the rights to the claim, and therefore, insurance carriers would have no means of verifying to which entity it should properly send the EOB. The health care provider and health care provider agent are aware of which entity should receive the EOB, however, and can determine the appropriate means to receive information or transfer information between themselves through their contract.

Furthermore, the Division clarifies that HB 528 authorized insurance carriers or their authorized agents and health care providers to contract with informal or voluntary networks for reduced fee schedules for pharmaceutical benefits. It did not modify or in any other way affect the rights and abilities of a pharmacy processing agent under Labor Code §413.0111 or the ability of a health care provider agent to receive EOBs on behalf of the health care provider.

Lastly, the Division notes it has made a change to this subsection to clarify that these adopted amendments do not change the current requirement of §133.240(e)(1).

§133.240(e)(1): A commenter recommends adding the following text to the subparagraph (e)(1): "….when the insurance carrier makes payment, denies, or reduces payment on a medical bill."

Agency Response: The Division declines to make the change. When an insurance carrier makes a payment as currently provided within the pertinent text, a payment includes one which may have been reduced, and the EOB should provide sufficient explanation of the insurance carrier's reasons for payment action.

§133.240(e)(2): A commenter recommends a new, added element that is (e)(2)(B)(v) as follows: "A treating doctor or referral doctor performing an alternate certification in accordance with Texas Labor Code §408.0041(f-2)." The commenter opines that proposed (e)(2)(B)(i) through (iv) is not a complete list without including the health care providers authorized to give alternate certifications of maximum medical improvement and impairment rating in §408.0041(f-2).

Agency Response: The Division declines the recommended new rule text. Treating doctors and referral doctors are already addressed in subsection (e)(2)(B)(i) and (ii).

§133.240(e)(3): Commenters seek clarification to the following questions: (1) does this proposed requirement apply to payment denials in which only one pharmaceutical service is disputed as well as denials in which all pharmaceutical services are disputed? and (2) does this proposed requirement apply to EOBs issued for the original bill, the request for reconsideration, or both?

Agency Response: In regards to the first question, the Division clarifies the requirement applies to any situation in which there is a denial from the insurance carrier. Regarding the second question, the Division recognizes the requirements as proposed are unclear and has made a change. Specifically, the Division adopts language in §133.250(f) of this title that clarifies when reconsideration EOBs must be sent to all parties identified in §133.240(e).

§133.240(e)(3): A commenter supports the proposed new provision, which expands the mailing requirements for an explanation of benefits to include the prescribing doctor when payment for pharmaceutical services is denied.

Agency Response: The Division appreciates the supportive comments that recognize the inclusion of the prescribing doctor.

§133.240(e)(3): A commenter recognizes the need for the prescribing doctor to receive a copy of the EOB when a pharmacy bill has been denied; however, a prescribing physician's address is not a required field for medical electronic data interchange (EDI) and is not captured from the DWC-066 form even though the health care provider is required to list this information on the DWC-066. It will be cumbersome and require implementation of system changes, as well as workflow changes, in order to locate the correct address to mail the EOB so the prescribing physician will receive a copy of it. A physician can practice at many different locations and there can be multiple physicians with the same name. There would be significant added system wide costs to implement this. The commenter requests a minimum timeframe of six months if this portion of the rule is adopted as proposed.

Agency Response: The Division disagrees that these changes will be cumbersome. The Division notes that insurance carriers are currently required to send an EOB to the prescribing doctor in accordance with §134.502 of this title (relating to Pharmaceutical Services) when payment for a prescription is denied. Therefore, system participants should not incur new costs to comply with the adopted provision of this rule since it has been a long-standing requirement of §134.502 of this title. The Division also notes, however, that for other reasons the Division has determined an effective date of July 1, 2012, is most appropriate for these amendments.

§133.240(e)(3): Commenters believe that this new requirement is unnecessary, cumbersome, and promotes ongoing ineffective medical utilization review processes for pharmaceutical services, and recommends deletion. The proposed rule provision is unnecessary since the prescribing doctor is made aware of those claims issues with the processing of the medical bills for the services rendered by the prescribing doctor. When the reason for denial relates to the reasonableness or necessity of the pharmaceutical services, requiring the pharmaceutical services EOB to be sent to the treating doctor does is ineffective as it is too late to avoid harm to the injured employee that results from the injured employee taking inappropriate and potentially dangerous medication or to a pharmacy that has already filled the prescription. This new requirement will add unnecessary expense to the system. There is no justification for the anticipated system cost increase that would result from the proposed provision of the rule.

Another commenter also requests deletion of proposed language "because of any reason relating to the compensability of, liability of, or relatedness to the compensable injury, or…." because it is too burdensome, broad and will inject unnecessary work and cost into the system. Requiring the insurance carrier or their agent to send an EOB to a physician for reasons other

than fostering prescribing compliance with the pharmacy closed formulary is clearly unwarranted. Often an insurance carrier will deny payment on a properly prescribed medication for compensability, liability, extent of injury or relatedness to the compensable injury and a myriad of other reasons which have no bearing on the physician's choice of pharmacy treatment. The commenter believes the treating physician has no desire to receive this EOB and it will have no bearing on future pharmacy prescribing patterns as the medical necessity of the prescribed treatment is not in question. This proposed requirement will only lead to confusion and unnecessary costs on behalf of the insurance carrier and/or their agent, and language should be amended to focus on and drive compliance with the Closed Formulary and avoid unnecessary documentation and costs.

Agency Response: The Division declines to delete the new requirement. This provision originates in existing §134.502 of this title, effective since January 1, 2003, and as such, should not require any new or additional effort on the part of the insurance carrier. Additionally, this information is important so the prescribing doctor may consider these factors in future treatment and prescription decisions.

§133.240(f): A commenter supports the proposed amendment which revises the required data elements for an EOB.

Agency Response: The Division appreciates the supportive comments concerning the revised required data elements for an EOB.

§133.240(f): A commenter states it appears data elements and information required on an electronic EOB, versus newly proposed paper EOB requirements are distinctly different,

questions why this type of difference would be proposed, and feels this proposed policy will create confusing and costly bifurcated billing, EOB and EDI system processes. If electronic and paper requirements are different and all system stakeholders are required to implement and maintain two different processes and systems for the creation, dissemination, handling and possible subsequent EDI reporting of paper and electronic EOBs, this will be overly burdensome on all system stakeholders. Most pharmacies, payors, pharmacy processing agents, voluntary/informal networks and health care provider billing/EDI systems are established to operate within a single set of parameters for capture and dissemination of billing and EOB data elements (and subsequent EDI reporting); any mandate which requires separate processes and procedures to ensure compliant billing and EDI state reporting actions will be costly and extremely time consuming to implement. For these reasons, the commenter requests further clarification on the following: (1) does the proposed rule language negate or limit the ability to utilize "mutually agreed upon formats," so long as the required state reporting information is contained? and (2) why has the Division created a bifurcated EOB data element requirement, and what is the expected impact on all system stakeholders and subsequently EDI reporting entities?

Agency Response: The Division disagrees that its new paper EOB requirements will create a confusing, bifurcated billing process. The Division's requirements for the paper EOB addresses the situations when the electronic remittance advice (ERA) cannot be sent. These situations include when a health care provider submits a paper medical bill or when the insurance carrier must send a copy to the injured employee or prescribing doctor. Moreover, the Division notes that the majority of these requirements already exist on the current DWC-062 and that these amendments only add a small number of additional elements. The additional data elements

contained on the paper EOB are necessary, in part, to correspond with the paper billing requirements of §133.10 of this title (relating to Required Billing Forms/Formats) and, in part, to help the recipient understand the action taken by the insurance carrier, ensure injured employee and health care provider confidentiality, and to provide full disclosure of all network affiliations related to the claim.

Furthermore, the Division notes that this adopted rule provision does not amend or modify the provisions of §133.501(f) of this title, which allows for the use of non-prescribed electronic formats by mutual agreement. However, the Division clarifies that the non-prescribed electronic formats must contain the data elements and content prescribed by the adopted standards in §133.501 of this title, not those related to insurance carrier medical electronic data interchange reporting to the Division.

§133.240(f): Commenters seek clarification to the following question: do the required elements of proposed §133.240(f) apply to EOBs issued for the original bill, the request for reconsideration, or both?

Agency Response: The Division clarifies that required elements of an EOB apply equally in all cases.

§133.240(f)(7): A commenter asks if the insurance carrier can use the last four numbers of the health care provider's social security number instead of the national provider identifier?

Agency Response: The Division declines to adopt the commenter's recommended substitution. The National Provider Identifier (NPI), adopted by 45 Code of Federal Regulations (CFR) §162.406, is the standard unique health identifier for health care providers. The NPI is

required to be contained on the medical bill and the use of the NPI is a more efficient and effective means to ensure the appropriate review of services.

§133.240(f)(8): A commenter requests clarification for, or a rule definition of, "patient control number" because it appears unnecessary and cumbersome for pharmacy processing agents, voluntary/informal networks, and subsequently state reporting agents to capture and disseminate.

Agency Response: The Division clarifies that this data element is defined in the electronic transaction sets adopted by reference under §133.501 of this title and the medical state reporting EDI implementation guide adopted by reference under §134.803 of this title (relating to Reporting Standards). Accordingly, further definition of this data element does not appear necessary.

§133.240(f)(9), (13) and (14): A commenter asks if an insurance carrier is providing claims administration services for a self-insured entity, would the self-insured entity be listed as the "insurance carrier" under paragraph (9) of this subsection, and the insurance carrier listed under paragraphs (13) and (14) as the company performing bill review and bill review contact? Also, if an insurance carrier is providing claims administration services for another insurance carrier, would the insurance carrier issuing the insurance policy be listed under paragraph (9) and the carrier performing claims administration services be listed under paragraphs (13) and (14)?

Agency Response: The Division clarifies that the term "insurance carrier" is specifically defined in Labor Code §401.011(27). The Division also clarifies and notes that the commenter's

suggested population of the paper EOB appears consistent with this statutory definition, and the intent of the adopted rules.

§133.240(f)(10): A commenter requests clarification for or a rule definition of "insurance carrier control number" because it appears unnecessary and cumbersome for pharmacy processing agents, voluntary/informal networks, and subsequently state reporting agents to capture and disseminate.

Agency Response: The Division clarifies that this data element is defined in the electronic transaction sets adopted by reference under §133.501 of this title and the medical state reporting EDI implementation guide adopted by reference under §134.803 of this title. Accordingly, further definition of this data element does not appear necessary.

§133.240(f)(12): A commenter requests clarification for, or a rule definition of, this data element as the commenter is uncertain if this data element is the ICD-9 code or soon-to-be implemented ICD-10 codes. The commenter further inquires if it is the intent that requirements for provision of "Diagnosis Codes" should synergize with CMS requirements for usage of ICD-9 codes and eventually ICD-10 codes? Is a paper EOB submitted with older/previous ICD code(s) considered to be incomplete, and will it subject the submitter to possible administrative action? Are EOB-submitting entities required to use ICD-9 codes until implementation of ICD-10 codes, and when implementation transition takes effect should ICD-9 codes be used on EOBs sent for claims which were submitted prior to transition to ICD-10 codes?

Agency Response: The Division clarifies that use of the term "diagnosis code(s)" is general in order to accommodate the use of either ICD-9-CM or ICD-10-CM codes. The Division also

notes that Labor Code §413.011, in pertinent part, requires the Division to adopt the most current reimbursement methodologies used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable coding policies. In addition, §§134.203, 134.402, 134.403, and 134.404 adopt Medicare payment policies relating to coding, except where otherwise provided by rule. Therefore, when the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) (including The Official ICD–10–CM Guidelines for Coding and Reporting), as maintained and distributed by HHS becomes effective for CMS coding, those ICD-10-CM codes will be required for use on Texas workers' compensation medical bills and EOB for dates of service on and after that effective date not the date an ERA transaction or paper EOB is generated.

§133.240(f)(20): The proposed rule specifies use of an unspecified product or service code when paying interest; however, §134.806(b) of this title (relating to Records Excluded from Reporting) states, "Insurance carriers shall not report interest and penalty payments paid on health care service..." It is confusing that the Division does not want the interest reported via medical bill state reporting, which contains the information from the DWC-062 (EOB), but provides instruction on what code to use on the DWC-062 (EOB) when paying interest.

Agency Response: The Division clarifies that §133.240 and §134.806 of this title serve different purposes, and the different requirements of these two rules noted by the commenter reflect those different purposes. Specifically, the Division notes that while the Division does not have a need to know interest paid to a health care provider for the purpose of its medical state reporting rules, a health care provider will need to know what portion of the payment is being provided to pay interest when the provider receives payment from an insurance carrier.

§133.240(f) and §134.250(f): A commenter objects to the proposed changes by stating that it adds additional parties and change elements of the EOB. The implementation of these changes will increase costs to the state.

Agency Response: The Division acknowledges that these adopted sections will impose new costs on insurance carriers based on new elements in the paper EOB under §133.240(f), but the Division has addressed both the necessity of these changes and the costs of the changes in the reasoned justification section of this adoption order and in the cost analysis of the formal proposal of these adopted amendments. Furthermore, the Division notes that no additional parties are required to receive the EOB. Insurance carriers are currently required to send an EOB to the prescribing doctor in accordance with §134.502 of this title when payment for a prescription is denied for certain reasons. Therefore, system participants should not incur new costs to comply with the adopted provision of this rule, because it is a long-standing requirement of §134.502 of this title.

§133.240(p) and §133.250(i): A commenter is unsure what proposed language, "expedited provision of medical benefits" means in regards to timeframes for paying or denying medical bills. This verbiage is vague and subjective.

Agency Response: The Division notes that the concept of "expedited provision of medical benefits" is included in Labor Code §504.055. Section 504.055(c) specifically directs the political subdivision, Division, and insurance carrier to accelerate and give priority to an injured first responder's claim for medical benefits.

§133.240(p): A commenter notes that the provisions of Labor Code §504.011(c), as added by HB 2605, applies to specific insurance carriers that handle political subdivision first responder serious bodily injury claims, as opposed to all insurance carriers in the State of Texas. Requiring all utilization review agents and insurance carriers in the state to have written policies to comply with provisions of Chapter 504 appears to exceed the statutory scope.

Agency Response: The Division disagrees that these provisions exceed the statutory scope. The Division has, nonetheless, made a change to this subsection in order to ensure that the Division's rules harmonize with any future amendments to the Department's rules regarding this issue.

§133.250(f): A commenter supports the extended time to 30 days from 21 for final action on a request for reconsideration.

Agency Response: The Division appreciates the supportive comment.

§133.305(a)(3): Commenters opine the term "life-threatening" appears to be appropriately defined but should not be placed in the workers' compensation rules. Interjecting that term into the workers' compensation rules could mislead stakeholders into believing that the expedited utilization review and appeal provisions for life-threatening conditions covered by health insurance and health benefit plans also applies to workers' compensation.

Agency Response: The Division notes that this is an existing definition, and other than number reformatting, is not amended. The definition of life-threatening was originally adopted in this rule to be effective December 31, 2006 without any noted disruption or confusion reported to the Division by system participants.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.
For: none.

For, with changes: Insurance Council of Texas, PMSI, State Office of Risk Management, and Texas Mutual Insurance Company

Against: none.

Neither for or against, with changes: Office of Injured Employee Counsel, Property and Casualty Insurers Association of America, and Texas Association of School Boards.

SUBCHAPTER A - GENERAL RULES FOR MEDICAL BILLING AND PROCESSING 28 TAC §133.2

6. STATUTORY AUTHORITY.

This section is adopted under the Labor Code §408.027 and Government Code §2001.036 and under the general authority of §402.00128 and §402.061. Labor Code §408.027, concerning payment of health care provider, provides that the Commissioner shall adopt rules as necessary to implement §408.027. Government Code §2001.036 provides, in relevant part, a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State, except that if a later date is specified in the rule, the late date is the effective date.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT.

§133.2. *Definitions*.

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

(1) Agent--A person whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligations under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to "agent" as used in the term "pharmacy processing agent."

(2) Bill review--Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, Division or Department rules, and the appropriate fee and treatment guidelines.

(3) Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(4) Emergency--Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(5) Final action on a medical bill--

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(6) Pharmacy processing agent--A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(7) Retrospective review--The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(8) In this chapter, the following terms have the meanings assigned by Labor Code §413.0115:

(A) Voluntary networks; and

(B) Informal networks.

(b) This section is effective July 1, 2012.

SUBCHAPTER C - MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER
28 TAC §§133.240, 133.250, 133.270

6. STATUTORY AUTHORITY.

These sections are adopted under the Labor Code §§408.027, 413.031, 504.055, Insurance Code §§1305.354, 4201.054 and 4201.359, and Government Code §2001.036 and under the general authority of §402.00128 and §402.061. In relevant part, Labor Code §408.027, concerning payment of health care provider, provides that the Commissioner shall adopt rules as necessary to implement §408.027. Labor Code §413.031 provides that the commissioner by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement. Labor Code §504.055 provides, in relevant part, that insurance carriers and political subdivisions shall accelerate and give priority to an injured first responder's claim for medical benefits. Insurance Code §1305.354 provides that a utilization review agent's procedures for review of reconsideration of an adverse determination must include written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the utilization review agent received the request. Insurance Code §4201.054 provides that the requirements of Chapter 4201 apply to utilization review of a health care services provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code. Insurance Code §4201.359 provides that a utilization review agent's procedures for review of reconsideration of an adverse determination must include written notification of determination of the appeal to the requesting party as soon as practicable, but not later than the 30th day after the utilization review agent received the request. Government Code §2001.036 provides, in relevant part, a rule takes effect 20 days after the date on which it is filed

in the Office of the Secretary of State, except that if a later date is specified in the rule, the late date is the effective date.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT.

§133.240. *Medical Payment and Denials*.

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments). For pharmaceutical services provided to any injured employee, the insurance carrier shall not deny reimbursement based on medical necessity for pharmaceutical services preauthorized or agreed to under Chapter 134, Subchapter F of this title (relating to Pharmaceutical Benefits).

(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

(d) The insurance carrier may request additional documentation, in accordance with §133.210 of this chapter (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

(e) The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and

(2) the injured employee when payment is denied because the health care was:

(A) determined to be unreasonable and/or unnecessary;

(B) provided by a health care provider other than:

(i) the treating doctor selected in accordance with Labor Code §408.022;

(ii) a health care provider that the treating doctor has chosen as a consulting or referral health care provider;

(iii) a doctor performing a required medical examination in accordance with §126.5 of this title (relating to Entitlement and Procedure for Requesting

Required Medical Examinations) and §126.6 of this title (relating to Required Medical Examination);

(iv) a doctor performing a designated doctor examination in accordance with Labor Code §408.0041; or

(C) unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(3) the prescribing doctor, if different from the health care provider identified in paragraph (1) of this subsection, when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services.

(f) The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

(1) division claim number, if known;

(2) insurance carrier claim number;

(3) injured employee's name;

(4) last four digits of injured employee's social security number;

(5) date of injury;

(6) health care provider's name and address;

(7) health care provider's federal tax ID or national provider identifier if the health care provider's federal tax ID is the same as the health care provider's social security number;

(8) patient control number if included on the submitted medical bill;

(9) insurance carrier's name and address;

(10) insurance carrier control number;

(11) date of bill review/refund request;

(12) diagnosis code(s);

(13) name and address of company performing bill review;

(14) name and telephone number of bill review contact;

(15) workers' compensation health care network name (if applicable);

(16) pharmacy informal or voluntary network name (if applicable);

(17) health care service information for each billed health care service, to include:

(A) date of service;

(B) the CPT, HCPCS, NDC, or other applicable product or service code;

(C) CPT, HCPCS, NDC, or other applicable product or service code description;

(D) amount charged;

(E) unit(s) of service;

(F) amount paid;

(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

(18) a statement that contains the following text: "Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally

adjudicated not to be compensable, or the insurance carrier is relieved of the liability under Labor Code §408.024. However, pursuant to §133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination";

(19) if the insurance carrier is requesting a refund, the refund amount being requested and an explanation of why the refund is being requested; and

(20) if the insurance carrier is paying interest in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds), the interest amount paid through use of an unspecified product or service code and the number of days on which interest was calculated by using a unit per day.

(g) When the insurance carrier pays a health care provider for health care for which the division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline).

(h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

(1) the injury is not compensable;

(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the health care was provided was not related to the compensable injury.

(i) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title.

(j) If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(k) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D of this title.

(l) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.130 of this title without any action taken by the division. The interest payment shall be paid at the same time as the medical bill payment.

(m) When an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the full amount that the insurance carrier reimburses.

(n) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy processing agent's reimbursement from the insurance carrier shall be made in accordance with §134.503 of this title. The pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(o) An insurance carrier commits an administrative violation if the insurance carrier fails to pay, reduce, deny, or notify the health care provider of the intent to audit a medical bill in accordance with Labor Code §408.027 and division rules.

(p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(q) This section is effective July 1, 2012.

§133.250. *Reconsideration for Payment of Medical Bills*.

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

(c) A health care provider shall not submit a request for reconsideration until:

(1) the insurance carrier has taken final action on a medical bill; or

(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

(d) The request for reconsideration shall:

(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;

(2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;

(3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and

(4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

(e) An insurance carrier shall review all reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its request to the insurance carrier.

(f) The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:

(1) in accordance with §133.240(e) – (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or

(2) in accordance with of §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

(g) A health care provider shall not resubmit a request for reconsideration earlier than 35 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request.

(h) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(i) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(j) This section is effective July 1, 2012.

§133.270. ***Injured Employee Reimbursement for Health Care Paid*****.**

(a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in:

(1) Insurance Code §1305.451, or

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

(b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider.

(c) The insurance carrier shall pay or deny the request for reimbursement within 45 days of the request. Reimbursement shall be made in accordance with §134.1 of this title (relating to Medical Reimbursement).

(d) The injured employee may seek reimbursement for any payment made above the division fee guideline or contract amount from the health care provider who received the overpayment.

(e) Within 45 days of a request, the health care provider shall reimburse the injured employee the amount paid above the applicable division fee guideline or contract amount.

(f) The injured employee may request, but is not required to request, reconsideration prior to requesting medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(g) The insurance carrier shall submit injured employee medical billing and payment data to the division in accordance with Chapter 134, Subchapter I of this title (relating to Medical Bill Reporting).

(h) This section is effective July 1, 2012.

SUBCHAPTER D - DISPUTE OF MEDICAL BILLS
28 TAC §133.305

6. STATUTORY AUTHORITY.

These sections are adopted under Labor Code §504.055 and Government Code §2001.036 and under the general authority of §402.00128 and §402.061. Section 504.055 defines "first responder" and "serious bodily injury." Government Code §2001.036 provides, in relevant part, a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State, except that if a later date is specified in the rule, the late date is the effective date.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT.

§133.305. *MDR--General*.

(a) Definitions. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Adverse determination--A determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary, as defined in Insurance Code §4201.002.

(2) First responder--As defined in Labor Code §504.055(a).

(3) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code §4201.002.

(4) Medical dispute resolution (MDR)--A process for resolution of one or more of the following disputes:

(A) a medical fee dispute; or

(B) a medical necessity dispute, which may be:

(i) a preauthorization or concurrent medical necessity dispute; or

(ii) a retrospective medical necessity dispute.

(5) Medical fee dispute--A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes). The following types of disputes can be a medical fee dispute:

(A) a health care provider, or a qualified pharmacy processing agent as described in Labor Code §413.0111, dispute of an insurance carrier reduction or denial of a medical bill;

(B) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and

(C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

(6) Network health care--Health care delivered or arranged by a certified workers' compensation health care network, including authorized out-of-network care, as defined in Insurance Code Chapter 1305 and related rules.

(7) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. "Non-network health care" includes health care delivered pursuant to Labor Code §413.011(d-1) and §413.0115.

(8) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this title (relating to MDR by Independent Review Organizations).

(9) Requestor--The party that timely files a request for medical dispute resolution with the division; the party seeking relief in medical dispute resolution.

(10) Respondent--The party against whom relief is sought.

(11) Retrospective medical necessity dispute--A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this title.

(12) Serious bodily injury--As defined by §1.07, Penal Code.

(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be

resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

(c) Division Administrative Fee. The division may assess a fee, as published on the division's website, in accordance with Labor Code §413.020 when resolving disputes pursuant to §133.307 and §133.308 of this title if the decision indicates the following:

(1) the health care provider billed an amount in conflict with division rules, including billing rules, fee guidelines or treatment guidelines;

(2) the insurance carrier denied or reduced payment in conflict with division rules, including reimbursement or audit rules, fee guidelines or treatment guidelines;

(3) the insurance carrier has reduced the payment based on a contracted discount rate with the health care provider but has not made the contract or the health care provider notice required under Labor Code §408.0281 available upon the division's request;

(4) the insurance carrier has reduced or denied payment based on a contract that indicates the direction or management of health care through a health care provider arrangement that has not been certified as a workers' compensation network, in accordance with Insurance Code Chapter 1305 or through a health care provider arrangement authorized under Labor Code §504.053(b)(2); or

(5) the insurance carrier or healthcare provider did not comply with a provision of the Insurance Code, Labor Code or related rules.

(d) Confidentiality. Any documentation exchanged by the parties during MDR that contains information regarding a patient other than the injured employee for that claim must be redacted by the party submitting the documentation to remove any information that identifies that patient.

(e) Severability. If a court of competent jurisdiction holds that any provision of §§133.305, 133.307, or 133.308 of this title is inconsistent with any statutes of this state, unconstitutional, or invalid for any reason, the remaining provisions of these sections remain in full effect.

(f) This section is effective July 1, 2012.

8. CERTIFICATION.

This agency hereby certifies that this order has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on the 26th day of March 2012.

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 §§133.2, 133.240, 133.250, 133.270, and 133.305, specified herein, concerning medical billing and processing and the dispute of medical bills, is adopted.

_____

Rod Bordelon
Commissioner of Workers' Compensation

ATTEST:

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