Clean Claim and Electronic Medical Billing and Payment Workers' Compensation Companion Guides

Version 1.02
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Texas Department of Insurance
Division of Workers' Compensation

Information Management Services
Electronic Billing and Reimbursement Project

Disclaimer

Purpose of the Electronic Medical Billing and Payment Companion Guides

This guide has been created for use in conjunction with Health Insurance Portability and Accountability Act (HIPAA), American National Standards Institute (ANSI), and the National Council for Prescription Drug Programs (NCPDP) national standard implementation guides. It is not to be a replacement for those national standard implementation guides but rather is to be used as an additional source of information. This companion guide contains data clarifications derived from specific business rules that apply to processing bills and payments electronically within Texas workers' compensation system.

Documentation Change Control

Documentation change control is maintained in this document through the use of the Change Control Table shown below. All changes made to this companion guide after the creation date are noted along with the date and reason for the change.

Change Control Table			
Date	**Page(s)**	**Change**	**Reason**
04/09/2007	All	Baseline Version 1.0	Initial release and publication.
04/13/2007	7, 8, 10, 19, and 31	Version 1.01	Corrections to Chapter 2 regarding the CMS-1500 05-08 form and changes to direction regarding use of the NPI. Corrections to Chapter 4 to remove NCPDP 5.1 references in the HIPAA/WC Gap Analysis.
06/21/207	Multiple	Version 1.02	Corrections identified in Companion Guide Revision Tracking document dated June 21, 2007.

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Chapter 1 Introduction

HIPAA

The Administrative Simplification provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards for electronic health care transactions and national identifiers for Health Care Providers (Provider), health plans, and Employers be established. These standards are adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

The Provider, or their billing agent, uses the HIPAA adopted ANSI ASC X12N 837 (ANSI 837) Professional, Institutional or Dental transaction data to submit medical bill transactions or the NCPDP Telecommunication 5.1 to submit pharmacy bill transactions to the appropriate Insurance Carrier associated with the Employer of the Injured Employee to whom the services are provided. The Insurance Carrier, or their authorized agent, validates the Electronic Data Interchange (EDI) file according to the guidelines provided in the prescribed national standard format implementation guide, this companion guide, and the jurisdiction data requirements. Problems associated with the processing of the EDI file are to be reported using acknowledgment techniques described in this companion guide. The Insurance Carrier will use the HIPAA adopted ANSI ASC X12N 835 Remittance Advice to report an explanation of payments, reductions, and denial to the Provider.

Workers' Compensation Background

The Texas and California workers' compensation systems undertook electronic medical billing initiatives in calendar years 2004 and 2005, respectively. Legislation and regulations adopted in the two states included parallel time frames. Both states created working groups to obtain feedback from, and communicate with, affected stakeholders.

Both states aligned jurisdiction implementation with national standard formats and health care industry practices. The goal of the two initiatives is to leverage existing eBill technology, knowledge, and relationships to facilitate a more efficient transition from paper billing to eBill in workers' compensation.

Recognizing the need for national standards, IAIABC has also initiated efforts to study the feasibility of developing national standard electronic billing formats for workers' compensation. The IAIABC EDI Council gave the EDI Medical Committee permission to pursue the issue of development of electronic standard guides for provider to payer electronic billing. A Health Care Provider-to-Payer (ProPay) Subcommittee was established. The mission of the subcommittee is "to simplify, accelerate, and make efficient all provider bills and related transactions necessary between the health care provider and the workers' compensation payer, through the use of a set of electronic data transmission standards and related business procedures."

California and Texas have developed an implementation plan that meets the time line of both states. The plan also includes collaborating with IAIABC EDI Council, the EDI Medical Committee, and the Health Care Provider-to-Payer Subcommittee to offer draft guides, which might serve as the starting point for developing national standards for electronic billing, reimbursement and ancillary workers' compensation processes.

Texas Background

House Bill (HB) 2511, enacted by the 76th Texas Legislature, Regular Session, added Labor Code §401.024, which was amended by HB 7, 79th Legislature, Regular Session. That section allows or requires electronic transmission of information to be used in lieu of transmitting information via paper format and sets goals for paper reduction in the workers' compensation system. Section 401.024 allows the Division to adopt rules to permit or require electronic transmission in place of established forms, manner, or procedure that require paper processing. HB 7 also enacted Labor Code §408.0251, which requires the commissioner to adopt rules regarding the electronic submission and processing of medical bills by Health Care Providers to Insurance Carriers.

The Division adopted electronic billing and reimbursement rules on July 21, 2006. The rules are included in 28 Tex. Admin. Code, Chapter 133, Subchapter G (Electronic Medical Billing, Reimbursement, and Documentation). Provisions of §§133.500 Electronic Formats for Electronic Medical Bill Processing and 133.501 Electronic Medical Bill Processing are designed to meet the requirements of HB 2511 and HB 7 by establishing procedures for the electronic submission of medical billing and reimbursement data, which will reduce paper in the workers' compensation system.

The rules include provisions for use of non-prescribed electronic formats by mutual agreement between the Insurance Carrier and the Health Care Provider. Non-prescribed formats must contain all of the required, conditionally required, and jurisdiction required elements defined in the national standard implementation guides and Division companion guides.

Audience

Health Care Providers, Insurance Carriers, clearinghouses, or other electronic data submission entities use this guideline in conjunction with HIPAA adopted ANSI ASC X12N national implementation guides, the NCPDP Telecommunication 5.1, and other ANSI national implementation guides. The ANSI ASC X12N implementation guides can be accessed at http://www.wpc-edi.com/Insurance_40.asp. The NCPDP Telecommunication 5.1 is available from NCPDPD at www.ncpdp.org. Other ANSI implementation guides are available from industry publishing sources.

This guide outlines the workers' compensation industry and jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable.

Chapter 2 Clean Claim Instructions – Paper Billing Forms

Paper Billing Forms

Division billing and reimbursement rules, included in Chapter 133 General Medical Provisions, address the paper medical billing and reimbursement process. The purpose of this chapter is to identify the paper medical billing forms prescribed by the Division and to provide instructions for completing these forms.

The paper medical billing forms, and associated forms, referenced in this chapter are identified below.

Form	Purpose	Services
CMS-1500 (08-05 version)	Paper billing form for professional services.	Services such as physician, therapy, or durable medical equipment for example.
UB-04	Paper billing form from institutional services.	Services such as inpatient and outpatient hospital services, and home health care.
NCPDP UCF	Universal Claim Form, paper billing form for pharmaceutical services.	Services such as medication and associated supplies.
ADA J515	Paper billing form for dental services.	Services such as tooth repair.
DWC-62	Explanation of Benefits (EOB).	All

Usage

Usage designators identify when an element is Required (R), Situational (S), Optional (O), or Not Used (N). Current instructions align usage designators with HIPAA electronic format usage designators. Previous usage designator Mandatory (M) is the equivalent of the current usage designator Required (R), which indicates that an element must be submitted on the paper billing form for the bill to be considered complete. Previous usage designator Conditional (C) is the equivalent of the current usage designator Situational (S), which indicates that when defined criteria are met, the element must be submitted on the paper billing form.

CMS-1500

The Centers for Medicare and Medicaid Services (CMS) professional paper billing form, the CMS-1500, was modified recently to support submission of the National Provider Identification Number (NPI). Health Care Providers must use the new version, the CMS-1500 (08-05) when required by CMS, which is currently targeted for June 1, 2007. The Division has adopted CMS coding, billing, and reimbursement policies by reference, and therefore, the use of the NPI and provider taxonomy codes is required as directed by CMS, which is currently targeted for May 23, 2007.

The instructions for completing the CMS-1500 (08-05) are in the table below.

2007 CMS-1500 Box #	Description	Usage	Comments
1a	Injured employee's ID (if SSN not available, use driver's license # & jurisdiction, green card # + "ZY", visa # +"TA", or passport # + "ZZ")	R	
2	Injured employee's name (last name, first name, MI)	R	
3	Injured employee's birth date and gender	R	
4	Insured employer's local name (employer at time of injury)	R	
5	Injured employee's address, city, state, zip code & phone, if known	R	
6	Patient relationship to insured	R	
7	Insured employer's current business address, city, state, zip code & phone, if known	R	
8	Injured employee's marital status	O	
9	Not used	N	
10	Indicate what the employee's condition is related to: (check a, b or c)	R	
10d	Rendering Bill Provider Taxonomy Code	S	Required if Rendering Provider is a health care provider.
11	Workers' Compensation Insurance Carrier claim number, if known	O	
11b	Employer's Name or School Name	S	Employer Department/Division, if available.
11c	Insurance Plan Name or Program Name	R	Insurance Carrier Name.
12	Not used	N	
13	Not used	N	
14	Date of injury or occupational illness	R	
15	Date provider first rendered services for this injury	O	
16	Not used	N	
17	Name of referring or supervising doctor (if different from #31) or ASC surgeon	S	Populate if different than provider in box #31 or ASC surgeon if bill is submitted by ASC.
17a	Professional license type, number, and jurisdiction of health care provider listed in #17	S	Required if box #17 populated. Populate a three character country code as the jurisdiction if provider is a non-US provider.
17b	NPI of health care provider listed in #17	S	Required if box #17 populated.
18	Dates of related hospitalization	O	

19	Additional dates / narrative / information (refer to CMS instructions)	S	If required by CMS instructions. When present, the order should be attachment control number followed by other information; separated by commas.
20	Use when billing for diagnostic tests (refer to CMS instructions)	S	
21	Diagnosis or nature of illness or injury coded to the highest level of specificity (up to 4 codes)	R	
22	Resubmission Code	S	When the bill is a resubmission submit one of the following codes: 07 Duplicate Bill or 30 Provider Reconsideration Request to Insurance Carrier.
23	Preauthorization, concurrent review, and/or voluntary certification number; refer to CMS instructions for CLIA/IDE or ZIP code for ambulance point of pick up	S	
24a	Dates of service: if service begins and ends on the same date enter the date in both the “from” and “to” blocks	R	
24b	24b. Place of service code (see CMS code list / definitions)	R	
24d	HCPCS procedure code, service or supply code(s) (R) and if applicable, modifier(s) that may include both CMS & DWC modifiers (up to four modifiers, refer to CMS instructions)	R	
24e	Diagnosis code item # (relate item numbers 1, 2, 3, and/or 4 from box #21) related to the procedure, service or supply code(s)	R	
24f	Charges for each procedure, service or supply	R	
24g	Number of days or units for each procedure, service or supply	R	
24i	State license qualifier	S	Required when rendering line provider is different than provider listed in box #31.
24j	State license number of the rendering provider for service line	S	Required when rendering line provider is different than provider listed in box #31. Populate a three character country code as the jurisdiction if provider is a non-US provider.
24i	NPI qualifier	N/A	Qualifier is pre-populated on bill.
24j	NPI of the rendering provider for the service line	S	Required when rendering line provider is different than provider listed in box #31.
25	Federal tax I.D., Social Security number or country’s unique ID# of the entity listed in box #33, and check appropriate box	R	
26	Not used	N	
28	Total charge for this bill	R	
31	Signature of Physician or Supplier, including degrees or credentials, and date	R	
32	Name, address, city, state, and ZIP code of the location where the health care was rendered or services were provided	R	

32a	NPI of provider/location where the health care was rendered or services were provided	S	Required if entity populated in box #32 is a licensed health care provider eligible for a NPI.
32b	State license of provider/location where the health care was rendered or services were provided	S	Required if entity populated in box #32 is a licensed health care provider. Populate a three character country code as the jurisdiction if provider is a non-US provider.
33	Billing name of provider/supplier or billing service; address, city, state, ZIP code, and telephone #	R	
33a	NPI of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care, and the date the claim is submitted to the IC. If the service being billed for is an interdisciplinary program as defined in the medical fee guideline, enter the information referenced above for the approved supervisor.	S	Required if billing entity is a health care provider eligible for a NPI.
33b	State license type code, professional license number, and jurisdiction (no spaces or hyphens e.g., MDG1440TX, PT146484OK, ASC255606TX) of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care, and the date the claim is submitted to the IC. If the service being billed for is an interdisciplinary program as defined in the medical fee guideline, enter the information referenced above for the approved supervisor.	S	Required if billing entity is a licensed health care provider.

UB-04

The CMS institutional paper billing form, the UB-92, was also modified to support submission of the NPI and taxonomy codes. Health Care Providers must use the new version of the institutional billing form, the UB-04, when required by CMS, which is currently published as effective on May 23, 2007. The Division has adopted CMS coding, billing, and reimbursement policies by reference, and therefore, the use of the NPI and provider taxonomy codes is required as directed by CMS, which is currently targeted for May 23, 2007.

The instructions for completing the UB-04 are in the table below.

UB-04 Box #	Description	Usage	Comments
1	Name of provider submitting bill, complete mailing address to which the provider wishes payment sent, and provider telephone number.	R	
2	Name of provider receiving payment (pay to provider) if different than billing provider in box 1, pay to provider complete mailing address to which the provider wishes payment sent, and pay to provider telephone number.	S	Required if entity receiving payment is different than the billing provider.
3a	Injured employee account number/Injured employee control number.	R	
3b	Injured employee medical record number/medical record control number.	O	
4	The 3-digit National Uniform Billing Committee (NUBC) code for Type of Bill.	R	
5	United States Federal tax number or other country's unique ID.	R	
6	Beginning and ending service dates of the period included on this bill (from MMDDYY through MMDDYY).	R	
7	Resubmission Code	S	Populate one of the following codes when the bill is a resubmission: 07 Duplicate Bill or 31 Appeal/Reconsideration Request to Insurance Carrier.
8a	Injured employee first name, middle name if applicable.	R	
8b	Injured employee last name.	R	
9a	Injured employee mailing address.	R	
9b	Injured employee city.	R	
9c	Injured employee state.	R	
9d	Injured employee zip code.	R	
9e	Injured employee country code, if located outside of the United States.	S	Required if injured employee lives outside of US.
10	Injured employee's date of birth (MMDDYY).	R	
11	Injured employee gender.	R	
12	Admission date. The date admitted for inpatient care, first date of outpatient service or start of care (MMDDYY).	R	
13	Admission hour. The hour the injured employee was admitted for inpatient or outpatient care (NUBC).	R	Required for admissions, observation stays, and emergency room care.

14	Admission type. The code indicating the priority of the admission (NUBC).	R	Required for admissions.
15	Admission source.	N	
18-28	Condition codes (NUBC).	S	Required if the CMS UB-04 manual contains a condition code appropriate to the patient's condition.
31	NUBC occurrence code 04 (accident-employment related), and date of injury or occupational illness (MMDDYY).	R	
35	Occurrence code and date span (from MMDDYY through MMDDYY).	S	
38	Workers' compensation insurance carrier name and mailing address city, state, and zip code.	R	
42	NUBC revenue code identifying each specific accommodation, ancillary service or billing calculation. And Total Charged-0001 required as last entry of revenue code.	R	
43	Narrative description of the related revenue categories included on this bill.	R	
44	HCPCS/Rate/HIPPS Code	S	Required if services meet the CMS UB-04 manual instructions (e.g., certain outpatient services require HCPCS codes).
45	Service date. Required for outpatient bills, optional for inpatient bills.	S	Required for outpatient bills.
46	Units of service.	R	
47	Total Charges	R	
No #	Page number, enter the page number of the specific page of the bill and total number of pages included in the bill (i.e. 1 of 4).	R	
No #	Creation date, the date the bill was generated.	R	
No #	Totals, total dollar amount for each page of the bill and for the entire bill on the last page.	R	
50	Payer name. Not used.	N	
51	Health Plan ID. Not used.	N	
56	Billing provider NPI.	R	
57	Billing Provider State License Number	S	Required if state license/certification is issued to the billing provider.
58	Insured's Name. Not used.	N	
59	Patient relationship to the insured.	R	
60A	Injured Worker ID (if SSN not available, use driver's license # and jurisdiction, green card # + "ZY" visa # + "TA", or passport # + "ZZ").	R	
61	Not used.	N	
62	Insurance Carrier Claim Number	S	Populate if known.
63	Preauthorization number, if the service provided requires preauthorization per Workers' Compensation Rule 134.600.	S	Required if preauthorization received.
64a	Document Identification Code	S	Required if submitting a resubmission/ reconsideration.

64b	Report Type Code, Report Submission Code, and Attachment Control Number.	S	Required if submitting documentation associated with the bill
64c	Original Reference Number (ICN/DCN)	S	Required if submitting a resubmission/ reconsideration.
65a	Name of the employer providing workers' compensation insurance coverage.	R	
65b	Employer's business address.	R	
65c	Employer's city, state and zip code.	R	
67	Full ICD-9-CM code describing the principal diagnosis responsible for the admission of the injured employee.	R	Required for bill types 11X, 12X, and 13X
67A-Q	Full ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, or that affect the treatment received and/or the length of stay.	S	Required if there are other diagnoses other than the primary diagnosis.
69	Admitting diagnosis code. Full ICD-9-CM diagnosis code, including the 4th and 5th digits, provided at the time of admission as stated by the physician. Not required for outpatient bills	S	Required for admissions, observation stays, and emergency room care.
70	The Patient Reason for Visit Diagnosis. Required for outpatient bills, not populated for inpatient bills.	S	Required for outpatient bills.
72	E code	O	
74	Principal procedure code/date. ICD-9-CM code that identifies the principal procedure performed during the period covered by this bill and the date that the principal procedure was performed (MMDDYY).	S	Required for inpatient only.
74a-74e	Other procedure codes/dates. Required when significant ICD-9-CM procedures are performed and the dates performed (MMDDYY).	S	Required for inpatient only.
75	Diagnosis Related Grouping Code	S	Required for inpatient only.
76	Attending physician NPI.	R	
76	Attending physician state license qualifier/state license, and jurisdiction.	R	
76	Attending physician last name, first name.	R	
77	Operating physician NPI.	S	Required when surgical services provided.
77	Operating physician state license qualifier/state license and jurisdiction.	S	Required when surgical services provided.
77	Operating physician last name, first name.	S	Required when surgical services provided.
78	Other physician NPI.	S	Required when physician other than attending/operating provides service.
78	Other physician state license qualifier/state license and jurisdiction.	S	Required when physician other than attending/operating provides service.
78	Other physician last name, first name.	S	Required when physician other than attending/operating provides service.

79	Other physician NPI.	S	Required when physician other than attending/operating provides service.
79	Other physician state license qualifier/state license and jurisdiction.	S	Required when physician other than attending/operating provides service.
79	Other physician last name, first name.	S	Mandatory when physician other than attending/operating, or provider in box #78 provides service.
80	Remarks	O	
81a	Attending physician taxonomy code.	R	
81b	Operating physician taxonomy code.	S	Required when box #77 populated.
81c	Other physician taxonomy code.	S	Required when box #78 populated.
81d	Other physician taxonomy code.	S	Required when box #79 populated.

NCPCP UCF

The Division adopted the use of the National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) as the pharmacy paper billing form effective January 1, 2008. In the interim, the current pharmacy paper billing form, the DWC-66 form is used for dates of service through December 31, 2007. The current DWC-66 collects the dispensing pharmacy NCPDP number and the prescribing physician DEA number. These identifiers may transition to the NPI after January 1, 2008 when pharmacies begin using the NCPDP UCF form.

The instructions for completing the NCPDP Universal Claim Form are in the table below.

UCF Field #	Paper UCF Paper Field Label	Description	Usage	Comments
1	I.D.	Injured Worker Social Security Number	R	Injured employee's ID (if SSN not available, use driver's license # & jurisdiction, green card # + "ZY", visa # +"TA", or passport # + "ZZ")
2	Group I.D.	Billing Indicator	R	Enter "Agent Billed" if claim is being processed by a third party billing service. If being billed by the provider enter "Provider Billed". Agent Billed indicates that the pharmacy information is derived from the NCPDP or NPI number.
3	(White Space, upper right hand corner)	Billing Date	R	Enter the date the form was created and sent to the carrier or payer.
4	Name	Provider ID Number	R	Enter the dispensing Pharmacy NCPDP number.
5	Plan Name	Provider ID Number Qualifier	R	Enter "01" if the Provider ID provided in the "Plan Name" field is an NPI number. Enter "07" if the provider ID number provided in the "Plan Name" field is an NCPDP number.
6	Patient Name	Injured Worker Name	R	Enter the injured worker's name - Last Name, First Name, Middle Initial
7	Other Coverage Code	*N/A*	N	*Leave Field Blank*
8	Person Code	*N/A*	N	*Leave Field Blank*
9	Patient Date of Birth	Injured Worker DOB	R	Enter the injured worker's date of birth (Format MM DD CCYY)
10	Patient Gender Code	Injured Worker Gender	R	Enter "1" for male or "2" for female
11	Patient Relationship Code	*N/A*	N	*Leave Field Blank*
12	Pharmacy Name	Payee Name	R	Provider/Entity to whom payment should be made. If the UCF Paper Field #2 indicates "Agent Billed", the dispensing pharmacy information is derived from the ID number in Field #4.)
13	Pharmacy Address	Payee Address	R	Enter the address of the entity receiving payment.
14	Pharmacy City	Payee City	R	Enter the city of the entity receiving payment.
15	Pharmacy State & Zip Code	Payee State & Zip	R	Enter the state and zip code of the entity receiving payment.
16	Service Provider I.D.	Payee Tax ID #	R	Enter the Federal Tax ID number of the entity receiving payment.
17	Qual (5)	Provider Identifier	R	Enter "F" for Federal Tax ID.

18	Pharmacy Phone Number	Payee Phone Number	O	Enter the telephone number of the entity receiving payment.
19	Pharmacy Fax Number	*N/A*	N	*Leave Field Blank*
20	Patient Signature	Overflow for Payer Address	S	Use this line if additional space is needed for payer address.
21	Employer Name	Employer Name	R	Enter the name of the employer of the injured worker.
22	Employer Address	Employer Address	R	Enter the address of the employer of the injured worker.
23	Employer City	Employer City	R	Enter the city of the employer of the injured worker.
24	Employer State	Employer State	R	Enter the state of the employer of the injured worker.
25	Employer Zip Code	Employer Zip Code	R	Enter the zip code of the employer of the injured worker.
26 (and 20)	Carrier I.D.	Payer Name and Address	R	Enter the name (R) and address of the employer's workers' compensation insurance carrier.
27	Employer Phone No.	Employer Phone No.	O	Enter the telephone number of the employer of the injured worker.
28	Date of Injury	Date of Injury	R	Enter the date the injury occurred - MM DD CCYY
29	Claim Reference I.D.	WC Claim Number	R	Enter the claim number assigned by the workers' compensation insurance carrier. Enter "00" if unknown.
30	1 - Prescription/Serv. Ref. #	Prescription Number	R	Enter the pharmacy provided prescription number.
31	1 - Qual (8)	Qualifier Indicator	R	Enter a "1" to indicate RX billing ("XZ" for 837 format prescription number).
32	1 - Date Written	Date script written	R	Enter the date the prescription was written - MM DD CCYY.
33	1 - Date of Service	Date script filled	R	Enter the date the prescription was filled - MM DD CCYY.
34	1 - Fill #	Number of times filled	R	Enter the number of times the prescription has been filled.
35	1 - Qty Dispensed	Quantity Dispensed	R	Enter the quantity of the medication dispensed.
36	1 - Days Supply	Days supply	R	Enter the number of days supply.
37	1 - Product/Service I.D.	NDC number	R	Enter the NDC number for the medication dispensed.
38	1 - Qual (10)	I.D. Qualifier	N	*Leave Field Blank - default is NDC number*

39	1 - DAW Code	DAW Code	R	Enter the appropriate DAW Code: 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed-Patient Requested Product Dispensed 3=Substitution Allowed-Pharmacist Selected Product Dispensed 4=Substitution Allowed-Generic Drug Not in Stock 5=Substitution Allowed-Brand Drug Dispensed as a Generic 6=Override 7=Substitution Not Allowed-Brand Drug Mandated by Law 8=Substitution Allowed-Generic Drug Not Available in Marketplace 9=Other
40	1 - Prior Auth # Submitted	Prior Authorization #	S	Enter the Prior Authorization number when required.
41	1 - PA Type	Prior Auth # Qualifier	S	Enter the Qualifier Code for Prior Authorization number: Ø=Not Specified 1=Prior Authorization 8=Payer Defined Exemption
42	1 - Prescriber I.D.	Doctor's Identification #	R	Enter the prescribing doctor's identification number - DEA # (NPI may replace DEA # in future requirements).
43	1 - Qual (12)	Prescriber ID Qualifier	R	Enter the Prescriber ID# Qualifier Code: Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø7=NCPDP Provider ID Ø8=State License 12=Drug Enforcement Administration (DEA) Number
44	1 - DUR/PPS Codes	*N/A*	N	*Leave Field Blank*
45	1 - Cost Basis	Basis of Cost Determination	R	Enter the Cost Determination Code 00=Not Specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition Cost 06=MAC (Maximum Allowable Cost) 07=Usual & Customary 08=Unit Dose 09=Other (Brand Medically Necessary)
46	1 - Provider I.D.	*N/A*	N	*Leave Field Blank*
47	1 - Qual (15)	*N/A*	N	*Leave Field Blank*
48	1 - Diagnosis Code	*N/A*	N	*Leave Field Blank*
49	1 - Qual (16)	*N/A*	N	*Leave Field Blank*
50	1 - Other Payer Date	*N/A*	N	*Leave Field Blank*
51	1 - Other Payer I.D.	*N/A*	N	*Leave Field Blank*
52	1 - Qual (17)	*N/A*	N	*Leave Field Blank*

53	1 - Other Payer Reject Codes	*N/A*	N	*Leave Field Blank*
54	1 - Usual & Cust. Charge	*N/A*	N	*Leave Field Blank*
55	1 - Ingredient Cost Submitted	*N/A*	N	*Leave Field Blank*
56	1 - Dispensing Fee Submitted	*N/A*	N	*Leave Field Blank*
57	1 - Incentive Amount Submitted	*N/A*	N	*Leave Field Blank*
58	1 - Other Amount Submitted	*N/A*	N	*Leave Field Blank*
59	1 - Sales Tax Submitted	*N/A*	N	*Leave Field Blank*
60	1 - Gross Amt Due Submitted	Gross Amount Due	R	Enter the gross amount due for this prescription.
61	1 - Patient Paid Amount	Patient Paid Amount	S	Enter amount paid by the injured worker - if allowed by jurisdiction.
62	1 - Other Payer Amount Paid	*N/A*	N	*Leave Field Blank*
63	1 - Net Amount Due	*N/A*	N	*Leave Field Blank*
64	2 - Prescription/Serv. Ref. #	Prescription Number	R	Enter the pharmacy provided prescription number.
65	2 - Qual (8)	Qualifier Indicator	R	Enter a "1" to indicate RX billing ("XZ" for 837 format prescription number).
66	2 - Date Written	Date script written	R	Enter the date the prescription was written - MM DD CCYY.
67	2 - Date of Service	Date script filled	R	Enter the date the prescription was filled - MM DD CCYY.
68	2 - Fill #	Number of times filled	R	Enter the number of times the prescription has been filled.
69	2 - Qty Dispensed	Quantity Dispensed	R	Enter the quantity of the medication dispensed.
70	2 - Days Supply	Days supply	R	Enter the number of days supply.
71	2 - Product/Service I.D.	NDC number	R	Enter the NDC number for the medication dispensed.
72	2 - Qual (10)	I.D. Qualifier	N	*Leave Field Blank - default is NDC number*
73	2 - DAW Code	DAW Code	R	Reference Dispensed as Written code set.
74	2 - Prior Auth # Submitted	Prior Authorization #	S	Enter the Prior Authorization number when required.
75	2 - PA Type	Prior Auth # Qualifier	S	
76	2 - Prescriber I.D.	Doctor's Identification #	R	Enter the prescribing doctor's identification number - DEA # (NPI may replace DEA # in future requirements).
77	2 - Qual (12)	Prescriber ID Qualifier	R	Enter the Prescriber ID# Qualifier Code: Blank=Not Specified Ø1=National Provider Identifier (NPI) Ø7=NCPDP Provider ID Ø8=State License 12=Drug Enforcement Administration (DEA) Number

78	2 - DUR/PPS Codes	*N/A*	N	*Leave Field Blank*
79	2 - Cost Basis	Basis of Cost Determination	R	Reference Basis of Cost Determination code set
80	2 - Provider I.D.	*N/A*	N	*Leave Field Blank*
81	2 - Qual (15)	*N/A*	N	*Leave Field Blank*
82	2 - Diagnosis Code	*N/A*	N	*Leave Field Blank*
83	2 - Qual (16)	*N/A*	N	*Leave Field Blank*
84	2 - Other Payer Date	*N/A*	N	*Leave Field Blank*
85	2 - Other Payer I.D.	*N/A*	N	*Leave Field Blank*
86	2 - Qual (17)	*N/A*	N	*Leave Field Blank*
87	2 - Other Payer Reject Codes	*N/A*	N	*Leave Field Blank*
88	2 - Usual & Cust. Charge	*N/A*	N	*Leave Field Blank*
89	2 - Ingredient Cost Submitted	*N/A*	N	*Leave Field Blank*
90	2 - Dispensing Fee Submitted	*N/A*	N	*Leave Field Blank*
91	2 - Incentive Amount Submitted	*N/A*	N	*Leave Field Blank*
92	2 - Other Amount Submitted	*N/A*	N	*Leave Field Blank*
93	2 - Sales Tax Submitted	*N/A*	N	*Leave Field Blank*
94	2 - Gross Amt Due Submitted	Gross Amount Due	R	Enter the gross amount due for this prescription.
95	2 - Patient Paid Amount	Patient Paid Amount	R	Enter amount paid by the injured worker - if allowed by jurisdiction.
96	2 - Other Payer Amount Paid	*N/A*	N	*Leave Field Blank*
97	2 - Net Amount Due	*N/A*	N	*Leave Field Blank*

ADA J515

The American Dental Association (ADA) dental paper billing form J515 is the current paper billing form for dental services. The instructions have been modified to collect the NPI and taxonomy codes for serving providers. These additional elements are required as directed by CMS, which is currently targeted for May 23, 2007.

ADA J515 Box #	Description	Usage	Comments
1	1. Leave blank.	N	
2	Preauthorization or voluntary certification number.	S	
3	Workers' compensation insurance carrier name and address.	R	
4-11	Leave blank.	N	
12	12. Local insured employer's current business address, city, state, zip code, and phone number, if known.	R	
13	Leave blank.	N	
14	Leave blank.	N	
15	15. Workers' Compensation insurance carrier claim number, if known.	S	
16-17	Leave blank.	N	
18	Patient Relationship to Primary Subscriber, populate "Other" for workers' compensation.	O	
19	Leave blank.	N	
20	Injured worker's name address, city, state, zip code, and phone number, if known.	R	
21	Injured worker's date of birth.	R	
22	Injured worker's gender.	R	
23	Injured worker's ID (if SSN not available, use driver's license # & jurisdiction, green card # plus "ZY", visa # plus "TA", or passport # plus "ZZ") NOTE: Do not use dental record or account number.	R	
24	Date of Service	R	
25	Designate the tooth number or letter when a procedure code directly involves a tooth. Use "Area of Oral Cavity" code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity".	S	
26	Enter the applicable ANSI ASC X12 code list qualifier: Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950.	S	
27	Designate the tooth number when the procedure code reported directly involves a tooth. If a range of teeth are being reported, use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.	S	

28	Designate tooth surface(s) when the procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B = Buccal; D = Distal; F = Facial; L = Lingual; M = Mesial; and O = Occlusal.	S	
29	Use the appropriate dental procedure code from the current version of the Code on Dental Procedures and Nomenclature.	R	
30	Description of the service provided.	R	
31	Dentist's full charge for the dental procedure reported.	R	
32	Leave blank.	N	
33	Total of all charges listed on the claim form.	R	
34	Report missing teeth on each claim submission.	S	
35	Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.	S	
36-37	36-37. Leave blank.	N	
38	Indicate the place of service. (ECF is the acronym for Extended Care Facility (e.g., nursing home).	R	
39	Indicate the number of enclosures to the claim form.	S	
40	Check "No" and skip to block 45.	R	
45	Check "Occupational illness/injury."	R	
46	Date of injury or occupational illness.	R	
47	Auto Accident State.	O	
48	Name, address, city, state, and zip code of the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information where the health (dental) care was rendered or services were provided. This information should appear on any payments or correspondence that will be remitted to the billing dentist.	R	
49	Billing Dentist or Dental Entity NPI.	S	Required if billing entity is a health care provider.
50	Billing Dentist or Dental Entity professional license type code, license number, and jurisdiction (no spaces or hyphens e.g. DS12345TX).	S	Required if billing entity is a health care provider.
51	Federal tax I.D., Social Security number or country's unique ID# of the entity listed in box 48.	R	
52	Phone number of the entity listed in box 48.	R	
52A	Additional Provider ID	S	Populate Provider Taxonomy Code if billing entity is a health care provider.
53	The treating, or rendering, dentist's signature and date the claim form was signed.	R	
54	Treating (rendering) dentist National Provider Identification Number.	R	Required as of May 23, 2007.
55	Professional license type code, license number, and jurisdiction (no spaces or hyphens, e.g. DS12345TX) of the individual dentist who rendered the health care.	R	

56	Full address, including city, state, and zip code, where the treatment was performed by the treating (rendering) dentist.	R	
56A	Provider Specialty Code	R	Treating Provider Specialty (taxonomy code)
57	Treating Provider Phone number, if different than the entity listed in box 52.	S	
58	Additional Provider ID	N	Taxonomy Code populated in Box 56A of 2006 ADA J4000 paper billing form.

DWC-62

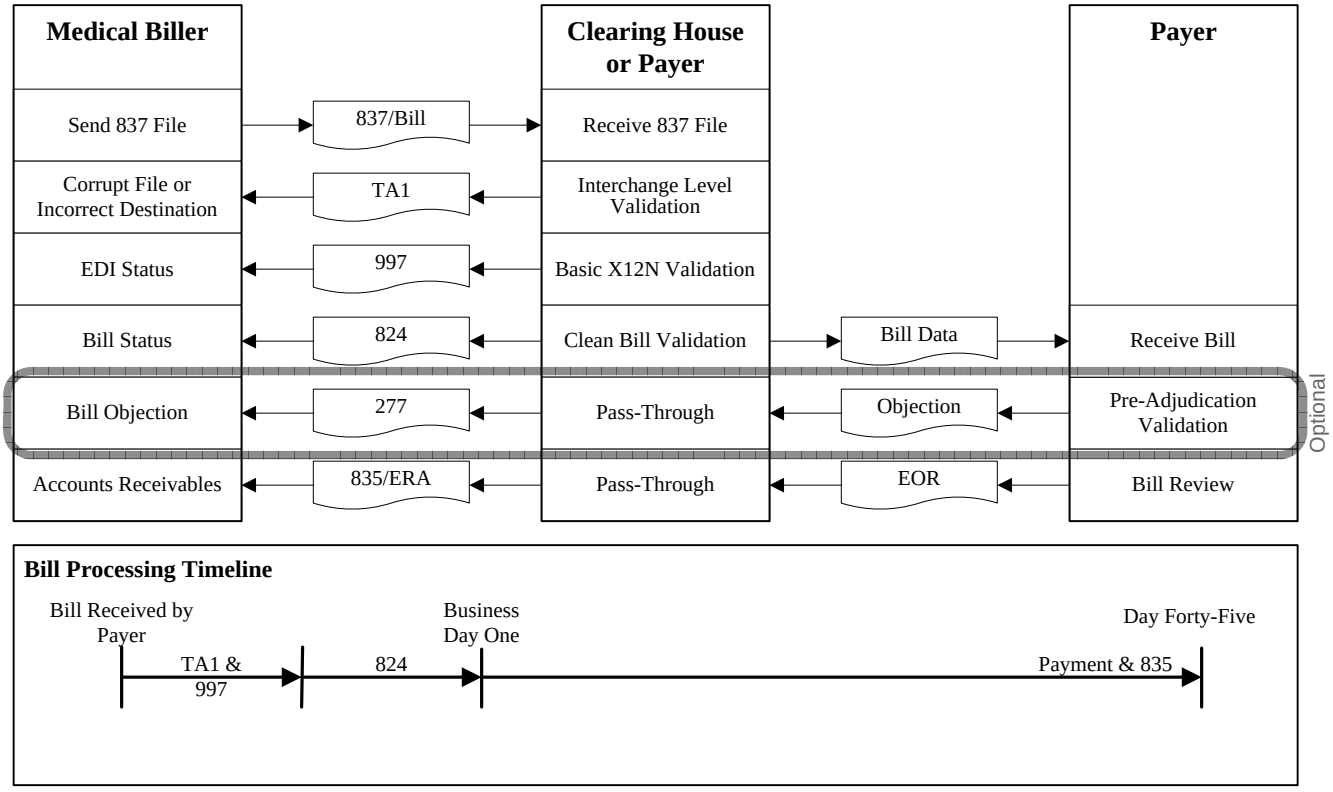
The DWC-62 is the paper Explanation of Benefits (EOB) form used by Insurance Carriers to communicate reimbursement to a Health Care Provider when a payment or denial is made or to acknowledge receipt of a refund from a Health Care Provider.

Box #	Description	Usage	Comments
Top Right	Claim #	S	DWC Claim Number, if known.
Top Right	Carrier Claim #	R	
1	Injured Employee's Name (Last, First, M.I.)	R	
2	Injured Employee's Social Security Number	R	
3	Date of Injury	R	
4	Injured Employee's Mailing Address (Street or P.O. Box)	R	
5	Employer's Name and Address	R	
6	Health Care Provider's Name and Address	R	
7	Insurance Carrier Name and Address	R	
8	Health Care Provider's Federal Tax ID Number	R	
9	Name and Address of the Company Performing the Audit.	R	
10	Date of the Audit	R	
11	Date of Final Action	R	Date the carrier paid, denied, or acknowledged receipt of a refund.
12	Name and telephone number of the person who can be contacted about the bill reduction.	R	
13	Patient Account Number/Bill Identification Number	S	Returned when populated on paper billing form.
14	Payment Identification Number	S	Check number or Electronic Funds Transfer (EFT) transaction identification number required when payment is associated with DWC-62/Explanation of Benefits.
Line Item			
15a	Date of Service	R	
15b	Procedure Code	R	HCPCS Code required on professional bills, Revenue (and HCPCS Code when required on billing) required on hospital bills, Dental Codes required on dental bills, and NDC or jurisdiction compound code required on pharmacy bills.
15c	Type of Service	R	
15d	ICD-9 Diagnosis Code	S	Required for professional and hospital bills.
15e	Units	R	

15f	Charges	R	Total dollar amount charged per line.
15g	Amount Paid	R	Total dollar amount paid per line.
15h	Reason Code	S	Reason code (ANSI or jurisdiction) explaining the payment, denial, request for recoupment, or acknowledgment of a refund is required when the amount paid does not equal the amount charged.
15i	Text to Explain Reason for Reduction/Denial	S	Text explaining the Reason Code value(s) in box 15h.

Chapter 3 Editing and Validation Flow and Timing Diagrams

The process chart below shows how an incoming workers' compensation ANSI 837 Professional, Institutional or Dental transaction might be validated and processed by the receiver. The diagram shows the four error reports that are generated by the receiver and the remittance advice for those bills that are fully processed.



Process steps:

1. **Interchange Level Validation**: Basic file format and the trading partner (Sender/Receiver) information from the Interchange Header are validated. If the file is corrupt or is not the expected type, the file is rejected. If the trading partner information is invalid or unknown, the file is rejected. A TA1 (Interchange Acknowledgment) is returned to indicate the outcome of the validation. A rejected EDI file is not passed on to the next step. *This level of acknowledgment is not mandatory for Texas workers' compensation.*
2. **Basic X12N Validation**: A determination will be made as to whether the transaction set contains a valid X12N 837. A 997 (Functional Acknowledgment) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the locations of the errors are reported. Bills that are part of a rejected transaction set are not passed on to the next step.
3. **Clean Bill Validation**: The standard and jurisdiction specific edits are run against each bill within the transaction set. An ANSI 824 (Application Advice) is returned to acknowledge acceptance or rejection of each bill in the transaction set. Bills that are rejected are not passed on to the next step.
4. **Pre-Adjudication Validation**: This is an optional step to be negotiated between the Insurance Carrier and Provider. Any edits that the Insurance Carrier applies that are not part of the standard or jurisdiction bill edits are applied at this point. An ANSI X12N unsolicited 277 is returned to the Provider to report any bills that are objected to by the Insurance Carrier. An ANSI 277 entry is not returned for bills that pass this validation step. Bills that are objected to are not passed on to the next step. *This level of acknowledgment is not mandatory for Texas workers' compensation.*
5. **Bill Review**: The bill passes through bill review and any post-bill review approval process. An ANSI 835 Remittance Advice will be returned. The ANSI 835 contains the check or electronic Fund Transfer (EFT) payment information plus the adjudication information for each bill paid by the check or EFT.

Chapter 4 Transmission Responses

HIPAA provides the health care community the ability to standardize transactions. It also provides the potential to standardize front-end edits and the acceptance/rejection reports associated with those edits. The acceptance/rejection reports indicate acceptance of transmissions and transactions or, when rejected, the specific errors within EDI transaction format syntax. When a report is generated, the type of report returned is dependent on the edit level that is invalid.

Each EDI file contains three levels where edits (data validation processes) are processed. Rejection of an entire batch or a single bill transaction is designated by the edit level in which the error occurs. The three levels are:

- Interchange Level Validation
- Basic X12N Validation
- Clean Bill Validation

In the description below, the three levels and their affiliated acceptance/rejection reports are discussed.

Interchange Level Validation

This level of validation is used to provide feedback to the sender of any interchange level problems. The edit checks the ISA, GS, GE and IEA level segments, described in a separate section of this companion guide, and the data content within these segments. Edits determine if the data is valid and if a trading partner relationship exists. Errors at this level result in rejection of the entire transmission. File rejection errors are reported in the TA1 or the 997. Only the 997 acknowledgment at the transmission (file) level is mandatory for Texas workers' compensation. If the EDI file passed the initial Interchange Level Validation, it moves on to the Basic X12N Validation.

ANSI ASC X12 TA1 - Interchange Acknowledgment

The ANSI ASC X12N Interchange Acknowledgment, or TA1, is used to provide the sender a positive or negative confirmation of the transmission of the interchange control envelope portion of the EDI file transmission. The TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (i.e. the data is corrupt or the trading partner relationship does not exist) the edit will reject and a TA1, along with the data, will be returned. The entire transmission is rejected at the header level.

The TA1 Interchange Acknowledgment is not mandatory for Texas workers' compensation. Interchange acknowledgment is communicated in the 997 format.

Basic X12N Validation

This edit is used to check for basic syntax problems for all transactions within each functional group. These edits check the ST and SE level segments and the data content within these segments. These segments consist of the entire detailed information within a transaction. Any X12N syntax error that occurs at this level will result in the entire transaction set being rejected. However, if the functional group consists of additional transactions without errors, these may be processed.

ANSI ASC X12N 997 - Functional Acknowledgment

The ANSI ASC X12N 997, or Functional Acknowledgment, is used to provide the sender a positive or negative confirmation of the structure of the 837 EDI file. If the EDI file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred may be reported.

Clean Bill Validation

This level of validation is used to check the bills for standard and jurisdictional specific rules. Any errors that occur at this level will result in a specific bill being rejected. If the batch consists of additional bills without errors, these may be processed.

ANSI ASC X12 824-Application Advice

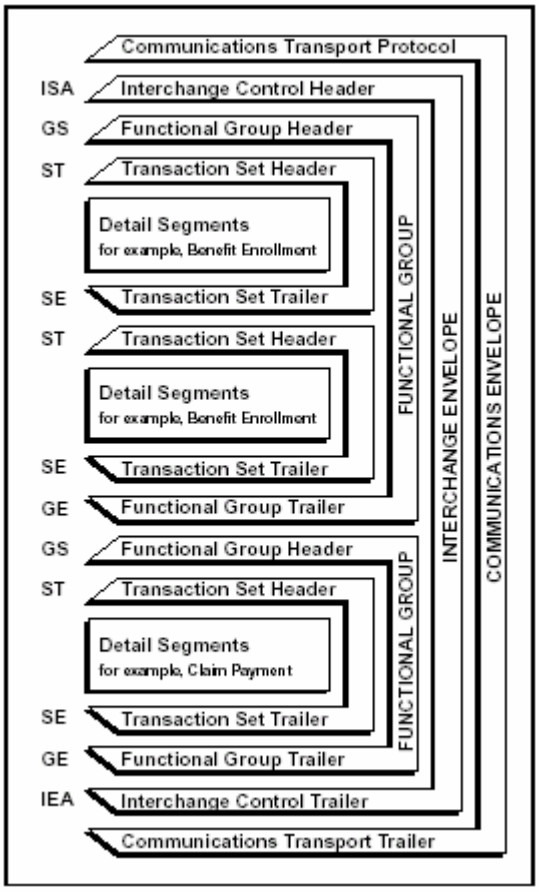
The ANSI ASC X12N 824 Application Advice, or Detail Acknowledgment, is used to provide the sender with a positive or negative confirmation of each bill transaction within the EDI file. The ANSI 824 details acceptance of a bill transaction or, if rejected, information on errors that are present and, if necessary, what action the submitter should take.

ANSI ASC X12N 835-Remittance Advice

An ANSI ASC X12N 835 Remittance Advice is provided as a replacement for, or in addition to, a paper remittance advice or Explanation of Benefits (EOB). After claim adjudication and payment or denial, an ANSI 835 Remittance Advice is delivered to the Provider. The ANSI 835 contains information related to payees, payers, dollar amounts and payments. Please see the ANSI Implementation Guide for details on the ANSI 835 transactions.

X12 Interchange Control Structure

An EDI file is made up of several groups of data organized into a hierarchy of envelopes. The outer-most envelope is generally invisible and is called the Communications Envelope. The next envelope is the Interchange Envelope, which begins with the ISA Interchange Control Header segment and ends with the IEA Interchange Control Trailer segment. Within the ISA Envelope, one or more Functional Groups are submitted. The Functional Group begins with the GS Functional Group Header segment and ends with the GE Functional Group Trailer segment. The Functional Group contains one or more Transaction Sets. The Transaction Set begins with the ST Transaction Set Header segment and ends with ST Transaction Set Trailer.



Interchange Control (ISA/IEA)

The Interchange Control (ISA/IEA) identifies both the sender's and receiver's identifiers, the date and time of the file transfer, and the segment terminators/delimiters used by the sender. If any errors are found in the ISA Interchange Control Header, the entire ISA/IEA Interchange and the Functional Group within it are rejected.

The Texas workers' compensation implementation requires the use of the Federal Employer Identification Number (FEIN) as the unique identifier for the sender and receiver in the Interchange Control envelope.

The Texas workers' compensation direction for the use of the Interchange Control envelope is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***ISA Worksheet***.

Functional Group (GS/GE)

The Functional Group (GS/GE) identifies the type of transaction being sent, identifiers for the sender and receiver of the transactions, as well as the sender's Group Control Number.

The sender and receiver identification numbers in the Functional Group envelope are the FEIN of the sender and receiver.

The Texas workers' compensation direction for the use of the Interchange Control envelope is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***GS Worksheet***.

Chapter 5 Texas Workers' Compensation Requirements

Compliance

28 Tex. Admin. Code, §§133.501 Electronic Medical Bill Processing requires Providers and Insurance Carriers to be able to exchange electronic medical bill information electronically beginning on January 1, 2008. Providers and Insurance Carriers must be able to exchange in the prescribed standard formats and may exchange information in non-prescribed formats by mutual agreement.

Electronic billing rules allow for Providers and Insurance Carrier to utilize agents to accomplish the requirement of electronic billing but do not mandate the method of connectivity, the use of or connectivity to clearinghouses or similar types of vendors.

Providers and Insurance Carriers may qualify for a waiver from the requirement in accordance with 28 Tex. Admin. Code, §133.501 subsection (a), which is addressed in a later section of this chapter.

Privacy, Confidentiality, and Security

Health Care Providers, Insurance Carrier, and their agents must comply with all applicable Federal and state requirements regarding privacy, confidentiality, and security of confidential data.

National Standard Formats

Billing Formats

The national standard formats for billing and remittance are those formats adopted by Federal HIPAA rules based on ANSI standards. The current implementation adopts the 4010A1 version of the ANSI 837 billing formats for Professional billing (837P), Institutional billing (837I), and Dental billing (837D), and the ANSI 835 format for Remittance. The Federal HIPAA national standard format for electronic pharmacy billing is the NCPDP Telecommunication Standard Version 5.1.

The file and bill level acknowledgment formats, and the attachment format, have not been adopted in the current HIPAA rules but are also based on ANSI standards. The ANSI 997 Functional Acknowledgment, version 4010 is used to communicate acceptance or rejection of a transmission (file). The ANSI 824 Application Advice or Detail Acknowledgment, version 4010 is used to communicate acceptance or rejection of a bill transaction with an accepted file. The ANSI 275 Additional Information to Support a Health Care Claim or Encounter is used to transmit electronic documentation associated with an electronic medical bill.

Other formats not adopted by rule are used in ancillary processes related to electronic billing and reimbursement. The use of these formats is voluntary and the companion guide is presented as a tool to facilitate their use in workers' compensation.

Prescribed Formats

Format	Corresponding Paper Form	Function
837P version 4010A1	CMS-1500	Professional Billing
837I version 4010A1	UB-04	Institutional/Hospital Billing
837D version 4010A1	ADA-J515	Dental Billing
NCPDP 5.1	DWC-66/NCPDP UCF	Pharmacy Billing
835 version 4010A1	DWC-62	Explanation of Benefits (EOB)
997 version	None	File Level Acknowledgment
824 version 4010	None	Bill Level Acknowledgment
275 version 4050	Documentation/Attachments	Documentation/Attachments

Ancillary Formats

Format	Corresponding Process	Function
ISA version 4010A1	None	Interchange Header/Footer
GS version 4010A1	None	Functional Group Header/Footer
TA1 version 4010A1	None	Interchange Acknowledgment
837Rx version 4010A1	DWC-66/NCPDP UCF	Alternate Pharmacy Billing Format
270 version 4010A1	Claim/Coverage Verification Request	Eligibility Request
271 version 4010A1	Claim/Coverage Verification Response	Eligibility Response
276 version 4010A1	Bill Status Request	Claim Status Request
277 version 4010A1	Bill Status Response	Claim Status Response

Usage

Texas workers' compensation implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. When the usage designation (Required/Situational) is different from the HIPAA implementation but the function of the Loop, Segment, or Field is the same, the workers' compensation usage column in the spreadsheet tool in this companion guide will reflect the usage for Texas workers' compensation.

Loop	Segment / Element	ANSI HIPAA Version	Workers' Comp	State Reporting Req.	Occurrence	Length	Data Type	Value	EOR Data Reference #	Description	Comments Loop, Segment, and Field usage is Required (R), Situational (S) Jurisdictional Situational (J) and Not Applicable (N)

When the usage is different, and the defined workers' compensation conditions are different than the defined HIPAA conditions, the workers' compensation usage is defined as Jurisdiction Situational (J). Each jurisdiction using the standard implementation and companion guides defines the specific jurisdiction conditions for the Loop, Segment, or Field. The specific conditions for Texas workers' compensation are defined in this chapter.

The Loop, Segment, and Field requirements are defined by usage designators. Elements are Required (R), Situational (S), or Not Used (N) in the HIPAA implementation guides. Required elements are mandatory without exception. Situational elements are conditional and the national standard implementation guides define the conditions that make the element mandatory. Not used elements are omitted.

Usage is applied in a hierarchal manner based on Loop (primary), Segment (secondary), and Field (tertiary). When a Loop is required, all required Segments must be present and all Situational Segments must be present if the defined condition is met. If a Loop is situational and the defined condition is not met, the Segments within the Loop are omitted. If a situational Loop is submitted, all required Segments must be present and all Situational Segments must be present if the defined condition is met. The same logic applies to Field level requirements for required and situational Segments.

When the workers' compensation implementation uses an element in a manner that is different than the standard implementation, the usage designator is Jurisdictional (J). The jurisdiction defines the use of the element for the implementation of eBill in that specific jurisdiction. When an element is Jurisdictional, the Division defines the conditions for the use of the element in this companion guide.

Standard Elements

The workers' compensation companion guide includes, and addresses, Loops, Segments, and Fields that are required on paper forms in the medical billing process. Some elements in the electronic formats do not map directly to paper form fields. To the extent possible, electronic requirements align with paper billing requirements.

The national standard formats also include elements that do not relate directly to workers' compensation processes, for example, coordination of benefits. When workers' compensation industry use, or future Texas workers' compensation requirements, are identified related Loops, Segments, and Fields usage are addressed in the companion guide. Only those elements in the workers' compensation companion guide are required for this implementation. Usage designation of elements not identified in this companion guide is assumed to be Not Used (N). Trading partners may choose to accept this element by mutual agreement, or without agreements. Trading partners that choose to reject transmissions or transactions that include elements not identified in this companion guide are compliant with the implementation of this companion guide.

HIPAA Not Used

Elements identified as Not Used (N) in HIPAA implementation guides are not used in this implementation unless designated as Jurisdictional (J) element. Trading partners may reject transmissions or transactions that include Not Used (N) elements.

Workers' Compensation Not Used

Specific elements are identified as Not Used (N) for the workers' compensation implementation. Trading partners may choose to accept these elements by mutual agreement, or without agreements. Trading partners that reject transmissions or transactions that include elements with usage designations of Not Used (N) for workers' compensation are compliant with the implementation of this companion guide.

HIPAA/Workers' Compensation Gap Analysis

The HIPAA/Workers' Compensation Gap Analysis identifies occurrences at the Loop, Segment, Field, and Code(s) level where the workers' compensation usage is different in than the HIPAA implementation. Specific direction is provided in this companion guide for the usage and conditions for the Texas workers' compensation implementation.

The HIPAA/Workers' Compensation Gap Analysis addresses two categories of formats, the 837 billing formats and the 835 remittance format.

Texas eBill HIPAA Workers' Compensation Gap Analysis.xls

When coordination of a solution is required, the Division is working with the California Department of Industrial Relations, Division of Workers' Compensation and the IAIABC EDI Medical Committee and Provider to Payer Subcommittee to work with national standard setting organizations and committees to address workers' compensation needs.

Three specific elements in the ANSI 837 billing formats and two elements in the ANSI 835 remittance format require coordination of a solution through the IAIABC.

HIPAA/Workers' Compensation Gap Analysis Issue Resolution

Format	Loop/Segment/Field	HIPAA/WC Usage	Resolution
827 Professional, Dental, Institutional	2300 Claim Information CLM Claim Information CLM19 Claim Submission Reason Code	HIPAA Not Used, WC Jurisdictional	Claim Submission Reason Code is required when CLM05-3 Bill Resubmission Reason Code indicates the transaction is a resubmission. Valid values for CLM19 are part of an existing ANSI Code Set. Request IAIABC coordinate with ANSI to allow use of the field for workers' compensation.
837 Dental	2010AA Billing Provider PER Contact Information	HIPAA Not Used, WC Jurisdictional	Billing Provider Contact Information required when it is different than the Sender Contact Information. Request IAIABC coordinate with ANSI to allow use of Segment for workers' compensation.
837 Dental	2010AA Pay to Provider PER Contact Information	HIPAA Not Used, WC Jurisdictional	Pay to Provider Contact Information required when it is different than the Sender Contact Information. Request IAIABC coordinate with ANSI to allow use of Segment for workers' compensation.
835	2100 Bill Payment Information DTM Date Time Segment Date of Accident (Injury)	HIPAA Not Used, WC Jurisdictional	Date of Accident (Date of Injury) is required for workers' compensation. Request IAIABC to coordinate with ANSI to allow the use of Segment for 835 processing.
835	2110 Service Payment Information REF Reference Information - Prescription Information	HIPAA Not Used, WC Jurisdictional	Prescription Information is required for pharmacy remittance information. Request IAIABC to coordinate with ANSI to allow the use of Segment for 835 processing.

Complete Electronic Medical Bill

A complete electronic medical bill is defined in 28 Texas. Admin. Code §133.500(c) and §133.501(b) (2). A complete electronic medical bill transaction must meet the following criteria.

(1) The electronic medical bill transaction must identify the

(i) injured employee;

(ii) employer;

(iii) insurance carrier;

(iv) health care provider; and

(v) service, supply, or medication.

(2) It must contain all fields required in the applicable national standard format implementation guide and the Division companion guide

(3) It must contain current and correct values as defined in the applicable national standard format implementation guide and the Division companion guides.

Health Care Provider Agent/Insurance Carrier Agent

Electronic billing and reimbursement rules include provisions that allow for Providers and Insurance Carriers to utilize agents to comply with eBill requirements. Billing agents, software vendors, data collection agents, and clearinghouses are examples of companies that may have a role in eBill. Insurance Carriers and Health Care Providers are responsible for the acts or omissions of its agents executed in the performance of services for the Insurance carrier or health care provider.

eBill rules require that Providers and Insurance Carriers have the ability to exchange medical billing and reimbursement information electronically. The rules do not mandate the use of, or regulate the costs of, agents performing eBill functions. Provider and Insurance Carriers are not required by rule to establish connectivity with a clearinghouse or utilize a specific media/method of connectivity (i.e. Secured File Transfer Protocol or SFTP).

The rules include provisions that allow for the use of non-standard formats by mutual agreement between the Provider and the Insurance Carrier. eBill rules to not regulate the formats utilized between Providers and their agents, or Insurance Carriers and their agents, or the method of connectivity between those parties.

Identification Numbers

Sender/Receiver Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) to identify the Sender or Receiver in electronic billing and reimbursement transmissions.

Insurance Carrier Identification

Insurance Carriers, and their agents, are also identified through the use of the FEIN. Insurance carrier information is available through direct contact with the Insurance Carrier.

The Division also provides Insurance Carrier information by contacting the Division directly or through the TXCOMP Claims and Coverage System, https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp. Providers or system participants may search for an Insurance Carrier by Name or search for coverage/policy information by Employer.

Provider Identification

Provider roles and identification numbers are addressed in Health Care Provider section below.

Injured Employee/Claim Identification

The Injured Employee is identified by Social Security Number (SSN), date of birth, and date of injury. SSN fields are required in electronic billing and reimbursement formats. If an Injured Employee does not have a SSN, alternate identifications numbers are accepted. The Division has also established a default format for the SSN value when a SSN or alternate identification number are not available to submit to the Division in Claims EDI and Medical EDI reporting. When a SSN or other identification number is not available, the Provider may report 999MMDDYY in the SSN field. 999 and the Injured Employees date of birth are populated in the SSN field. If the date of birth is not known, 999 and the Injured Employees date of injury are populated.

The Division Claim Number and the Insurance Carrier Claim Number are not required elements on an electronic billing transaction. The Provider may submit these identification numbers if they are known.

Alternate Injured Employee Identification Numbers

For billing purposes, the Division allows Providers to bill using an Injured Employees driver's license, green card number, visa number, or passport number when the Injured Employee does not have a SSN. When using these identification numbers in the SSN field on electronic billing and reimbursement formats, the following suffixes are populated to indicate the type of identification number.

- Drivers License Number + Jurisdiction + ZY
- Green Card Number + ZY
- Visa Number + TA
- Passport Number + ZZ

Bill Identification

HIPAA implementation guides refer to a bill as a "claim" for electronic billing transactions. Workers' compensation refers to these transactions as "bill" transactions to minimize confusion with the workers' compensation use of the word "claim" in referring to a unique Injured Employee and injury.

The Provider, or their agent, assigns a unique identification number to the electronic bill transaction. For ANSI 837 transactions, the bill transaction identification number is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM01 Claim (Bill) Submitter's Identifier field. This standard HIPAA implementation allows for a patient account number but "strongly recommends that submitters use completely unique number for this field for each individual claim."

The NCPDP Telecommunication Standard Version 5.1 format structure does not identify a bill in the same manner as the ANSI 837 formats, i.e. a bill as a set of lines. The unique electronic bill transaction identification number for pharmacy billing is based on the individual prescription and is located in 402-D2 of the NCPDP 5.1 format.

Document Identification

The ANSI 275 Additional Information to Support a Health Care Claim or Encounter is the prescribed standard electronic format for submitting electronic documentation and is addressed in a later chapter of this companion guide.

Documentation, or attachments, is identified in the ANSI 837 format in PWK Claim Supplemental Information (Attachment) Segment. The PWK Segment is not required for a complete electronic medical bill. Services that require documentation in accordance with 28 Tex. Admin. Code §133 General Medical Provisions and do not have a PWK Attachment Segment are not rejected by Insurance Carriers. Bill transactions that include services that require documentation and are submitted without the associated documentation may be denied after bill review based on the lack of documentation.

Documentation related to electronic medical bills may be submitted by facsimile (fax), electronic mail (email) or by electronic transmission using the prescribed format or a mutually agreed upon format. Documentation related to electronic medical bills must be submitted within seven (7) days of submission of the electronic medical bill and must identify the following elements;

- Injured Employee,
- Insurance Carrier
- Health Care Provider
- Related Medical Bill(s), and
- Date(s) of Service.

The PWK Segment and the associated documentation identify the type of documentation through use of ANSI standard Report Type Codes. The PWK Segment and the associated documentation also identify the method of submission of the documentation through the use of ANSI Report Transmission Codes. Finally a unique Attachment Control Number is assigned to the documentation. The Attachment Control Number populated on the document shall include the Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number. For example, operative note SX12345 sent by fax is identified as OBFXACSX12345. ANSI code sets are provided as a reference from the following link, PWK Code Definitions. Jurisdictions codes, when present, are also included in this document.

Specifications and requirements for documentation are addressed in Chapter 11 – 275 Documentation/Medical Attachments.

Insurance Carrier Validation Edits

Insurance Carriers may apply validation edits based on Division Rule, or Medicare coding and billing policies when applicable and in accordance with 28 Tex. Admin. Code §§ 134.201Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act and 134.202 Medical Fee Guideline.

The Division Medical EDI Companion Guide, used in conjunction with the IAIABC 837 Implementation Guide, provides validation edits the Division applies to the Insurance Carrier reported transactions. Division Medical EDI validation edits that might also reasonably apply to Provider billing transactions may be applied by the Insurance Carrier to electronic medical billing transactions.

Insurance Carriers use the ANSI 824 Application Advice format, referred to in this companion guide as a Detail Acknowledgment format, to communicate transaction (bill) rejections. ANSI 824 error rejection codes are used to indicate the reason for the transaction rejection.

Decimals

Decimals are not populated in diagnosis code or unit fields. Unit values are presented as whole numbers without decimal points. The value is determined on the definition of the service, procedure, supply, or medication. Partial units are billed as defined by the applicable source, statute, or Division rule.

All percentages should be presented in decimal format.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Date Format

All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD and the default SSN value where the date format is MMDDYY. The only values acceptable for the "CC" (century) value are 18, 19, or 20.

Date fields that include hours should use the following format: CCYYMMDDHHMM. Use military format: 00 to 23 to indicate hours and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15 p.m.

No spaces or character delimiters should be used in presenting dates or times.

Dates that are logically invalid (e.g. 20011301) may be rejected. Dates must be valid within the context of the transaction. Validation edits against the dates identified below apply to transmissions (files) and transactions (bills).

Date of Birth

The Injured Employee's date of birth must be less than (before) the date the Insurance Carrier processes the transmission or the transaction.

Date of Injury

The Injured Employee's date of injury must be greater (after) than the Injured Employees date of birth.

Transmission Dates

Transmission dates must be

- greater than the Injured Employees date of birth,
- greater than Employee's date of injury, and
- less than or equal to the date the Insurance Carrier processed the transmission.

Bill Dates

Admission/Discharge Dates must be

- greater than the Injured Employee's date of birth,
- greater than or equal to the Injured Employee's date of injury,
- less than or equal to the date the Insurance Carrier processed the transmission, and
- less than or equal to the transmission date.

ICD-9 Principal Procedure and subsequent ICD-9 Procedure Dates must be

- greater than the Injured Employee's date of birth,
- greater than the Injured Employee's date of injury,
- less than or equal to the date the Insurance Carrier processed the transmission, and
- less than or equal to the transmission date.

Date of Service

Date(s) of Service must be

- less than or equal to the date the Insurance Carrier processed the transmission,
- greater than the Injured Employee's date of birth, and
- greater than or equal to the Injured Employee's date of injury.

Transmission/Transaction Dates

Unless specified otherwise in electronic billing and reimbursement or medical billing reimbursement rules, the dates in this section are administered in accordance with §102.3 Computation of Time.

Date Sent

The date an electronic transaction is sent is the date reflected in the Interchange Control Header ISA Segment Interchange Date. This date is used to identify the Health Care Provider Date Sent for electronic medical bill transactions, the Acknowledgment Date for Insurance Carrier 824 Detail Acknowledgment transactions, and the remittance date for Insurance Carrier 835 Remittance Advice transactions.

Date Received

The Date Sent, the Interchange Control Header ISA Segment Interchange Date, is considered the Date Received for the purposes of electronic billing and reimbursement transactions, unless the receiver can show that the transmission was not received, was rejected, or the date the transmission was submitted is different than the Interchange Control Header ISA Segment Interchange Date. The Received Date is used to track timely processing of electronic medical bill transactions, electronic reconsideration/appeal transactions, and acknowledgment transactions.

Invoice Date

In the manual paper medical bill processing model, the paper bill included a date the bill was generated for timely filing purposes. The Invoice Date is the Date Sent for electronic billing and is reflected in the Interchange Control Header ISA Segment Interchange Date.

Date Paid

The standard electronic formats and industry practices use the term Date Paid to represent the date the Insurance Carrier paid or denied a medical bill, or acknowledged receipt of a refund. It is also referred to as the Insurance Carriers "final action". Use of the term Date Paid in this context does not assume a dollar amount is paid.

The current implementation assumes the Date Paid is the Date Sent for ANSI 835 Remittance Advice. The coordination of the electronic Remittance transactions and paper checks or Electronic Funds transfer may affect the reported Date Paid in the IAIABC 837 format for Insurance Carrier Medical EDI submissions.

Identifier Fields

Identifiers, such as the NDC numbers, Federal Employer Identification Number or Social Security Number should be transmitted without dashes or hyphens.

Phone numbers should be presented as a contiguous number string, without dashes or parenthesis markers. For example, the phone number (999) 555-1212 should be presented as 9995551212. Area codes should always be included.

Hierarchical Structure

For Texas workers' compensation, it is assumed that these formats are used to communicate information at the transaction level, with the exception of the 997 acknowledgment file. To that end, the parent/child hierarchical structure requires each file to contain the necessary hierarchical levels, parent/child qualifiers, and parent-child relationships. Each transmission must contain at least one Billing Provider (parent) with at least one Employer (child). Each Employer (parent) must contain at least one Injured Employee (child).

Beneath the hierarchical levels, the same logic applies to Injured Employees, bills, and lines. Each Injured Employee record must contain at least one bill transaction; each bill transaction must contain at least one detail line. The maximum number of bills and lines is determined by format standard.

Sample Hierarchical Structure

Hierarch. ID #	Parent Hierarch. ID #	Hierarchical Level Code	Description	Child Code
1	None	20 Billing/Pay to Provider	1st Billing Provider	1
2	1	22 Subscriber	1st Employer of 1st Billing Provider	1
3	2	23 Patient	1st Injured Employee of 1st Employer of 1st Billing Provider	0
4	2	23	2nd Injured Employee of 1st Employer of 1st Billing Provider	0
5	2	23	3rd Injured Employee of 1st Employer of 1st Billing Provider	0
6	1	22	2nd Employer of 1st Billing Provider	1
7	6	23	1st Injured Employee of 2nd Employer of 1st Billing Provider	0
8	6	23	2nd Injured Employee of 2nd Employer of 1st Billing Provider	0
9	1	22	3rd Employer of 1st Billing Provider	1
10	9	23	1st Injured Employee of 3rd Employer of 1st Billing Provider	0
11	None	20	2nd Billing Provider	1
12	11	22	1st Employer of 2nd Billing Provider	1
13	12	23	1st Injured Employee of 1st Employer of 2nd Billing Provider	0
14	12	23	2nd Injured Employee of 1st Employer of 2nd Billing Provider	0

Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable national standard implementation guide, Division rule, and Division companion guide. The code sets are dynamic and are maintained by multiple standard setting organizations. Participants are required to utilize current, valid codes based on the date the service or process occurred (i.e. medical service, payment/denial processing, etc.).

The current implementation of electronic billing and reimbursement processes for workers' compensation may utilize jurisdiction or workers' compensation specific values that may not be present in national standard code sets. The IAIABC is coordinating efforts to update national standard implementation guides and code sets to address workers' compensation industry needs. Until such time as these jurisdiction or workers' compensation codes are added to national standard code sets, the definition and use of these codes shall be in accordance with this companion guide. Reference Appendix I Code Set Matrix for a comprehensive list of code sets used in the workers' compensation implementation of electronic billing and reimbursement processes.

Claim Resubmission Code - ANSI 837 Billing Formats

The Division prescribes the use of codes 07 Duplicate Bill, 15 Revised Bill, and codes 30, 31, or 32 Appeal/Reconsideration in the Claim Frequency Type Code to indicate the bill is a resubmission transaction. The value is populated in Loop 2300 Claim Information CLM Health Claim Segment of ANSI 837 billing formats. The prescribed values below are required in field CLM19 Bill Submission Reason Code and indicate the category of resubmission when CLM05-3 Claim Frequency Type is populated with code 7 to indicate the bill transaction is a resubmission.

Duplicate Bill Transactions

Duplicate bill, 07, transactions shall be submitted no earlier than forty five (45) days after the Insurance Carrier has acknowledged receipt of a complete electronic bill transaction and prior to receipt of an ANSI 835 Remittance transaction. The 07 bill must use the same bill identification numbers as the original transaction.

The Insurance Carrier may reject a bill transaction with a 07 indicator if (1) the 07 bill is received within 45 days after acknowledgment, (2) the bill has been processed and an 835 transaction has been generated, or (3) the Insurance Carrier does not have a corresponding accepted original transaction with the same bill identification numbers. If the Insurance Carrier does not reject the 07 bill transaction within one business day, the 07 bill transaction may be denied for the reasons listed above through the use of an 835 Remittance transaction.

Revised Bill Transactions

The Revised Bill transaction is not mandated in this implementation of eBill for Texas workers' compensation. The transaction may used by mutual agreement. When used, a Revised Bill, 15, transactions shall be submitted no later than sixty (60) days after the Insurance Carrier has acknowledged receipt of a complete electronic medical bill and prior to receipt of an ANSI 835 Remittance transaction. The 15 bill must use the same bill identification numbers as the original transaction.

The Insurance Carrier may reject a bill transaction with a 15 indicator if (1) the 15 bill is received later than 60 days after acknowledgment, (2) the bill has been processed and an ANSI 835 transaction has been generated, or (3) the Insurance Carrier does not have a corresponding accepted original transaction with the same bill identification numbers. If the Insurance Carrier does not reject the 15 bill transaction within one business day, the 15 bill transaction may be denied for the reasons listed above through the use of an 835 Remittance transaction.

Appeal/Reconsideration Bill Transactions

Appeal/Reconsideration bill transactions may be submitted after receipt of an ANSI 835 Remittance transaction for the corresponding accepted original bill or fifty (50) days after the Insurance Carrier acknowledged receipt of a complete electronic medical bill when no ANSI 835 Remittance transaction has been received. Appeal/Reconsideration Bill transaction shall be submitted by the Provider, and processed by the Insurance Carrier, in accordance with 28 Tex. Admin. Code §133.250 Reconsideration for Payment of Medical Bills. The same bill identification number is used on both the original and Reconsideration bill to associate the transactions. All elements, fields, and values in the Reconsideration bill transaction, except the Reconsideration qualifier and PWK Attachment Segment, must be the same as the original bill transaction. Subsequent Reconsideration bills transactions related to the same original bill transaction shall not be submitted prior to twenty six days (26) from the date the Insurance Carrier acknowledged the complete electronic 30 Appeal/Reconsideration bill transaction. The appropriate ANSI code values for Reconsideration transactions are 30 – Payer Reconsideration, 31 – Jurisdictional Reconsideration, or 32 – Judicial Reconsideration. The value 30 is used to indicate when reconsideration is generated and submitted by a Provider in accordance with 28 Tex. Admin. Code §133.250. The values 31 or 32 may be used if reconsideration is submitted by a Provider as a result of administrative dispute resolution action. However, these processes generally do not require a Provider to submit an appeal after a decision is rendered. These values, 31 and 32, are not mandated in this implementation.

The Insurance Carrier may reject a bill transaction with an Reconsideration indicator if (1) the bill information does not match the corresponding original bill transaction, (2) the Insurance Carrier does not have a corresponding accepted original transaction, (3) the original bill transaction has not been completed (no corresponding ANSI 835 Remittance transaction), or (4) the Reconsideration bill transaction is submitted outside of the specified time frames. Corresponding documentation related to appeals/reconsideration is required in accordance with 28 Tex. Admin. Code §133.250. The Insurance Carriers may deny Reconsideration bill transactions for missing documentation but shall not reject the Reconsideration bill transaction if the PWK Attachment Segment is omitted. If the Insurance Carrier does not reject the Reconsideration bill transaction within one business day, the Reconsideration bill transaction may be denied for the reasons listed above through the use of an ANSI 835 Remittance transaction. The Insurance Carrier may also deny the Reconsideration bill transaction through the use of an ANSI 835 Remittance transaction if the documentation is not submitted within the required time frame.

Participant Roles

Roles in the HIPAA implementation of the national standard implementation guides are generally the same in workers' compensation. The Employer, Insured, Injured Employee and Patient are the roles that are used differently in workers' compensation and are addressed later in this section.

Trading Partner

Trading Partners are entities that have established EDI relationships and exchange information electronically in standard or mutually agreed upon formats. Trading Partners are both Senders and Receivers depending on the electronic process (i.e. Billing v. Acknowledgment).

Sender

A Sender is the entity submitting a transmission to the receiver, or the Trading Partner. The Provider, or their agent, is the Sender in the electronic billing process. The Insurance Carrier, or their agent, is the Sender in the electronic acknowledgment or remittance processes.

Receiver

A Receiver is the entity that accepts a transmission submitted by a Sender. The Provider, or their agent, is the Receiver in the electronic acknowledgment or remittance processes. The Insurance Carrier, or their agent, is the Receiver in the electronic billing process.

Employer

The Employer, as the policyholder of the workers' compensation coverage, is the Subscriber in the workers' compensation implementation of the HIPAA electronic billing and reimbursement formats.

Subscriber

The Subscriber is the individual or entity that purchases or is covered by a policy. In this implementation, the workers' compensation policy is obtained by the Employer, who is considered the Subscriber.

Insured

The Insured is the group or individual to whom the insurance policy covers. In managed care, the Insured may be the patient, the patient's employer, or a group health plan. In this implementation, the Employer is considered the Insured entity.

Injured Employee

The Injured Employee is considered the Patient. In managed care, there are many relationships a Patient may have to the insured. For example, the Patient may be the child, spouse, or employee of the Insured.

Patient

The Patient is considered the Injured Employee in the workers' compensation implementation of electronic billing and reimbursement processes.

Health Care Provider Role/Identification Numbers

Billing Provider

The Billing Provider is the Health Care Provider submitting the electronic medical bill transaction and to whom payment should be made, or the entity billing on behalf of the Billing Provider. When the Billing Provider is the same individual or entity as the Rendering Provider, the Rendering Provider information may be omitted.

Pay to Provider

The Pay to Provider is the individual or entity that receives payment for the services included in the electronic medical bill transaction. The Pay to Provider information is only populated when the individual or entity receiving payment is different than the individual or entity identified in the Billing Provider information.

Rendering Provider

The Rendering Provider is the individual or entity that provided the services included in the electronic medical bill transaction. Texas workers' compensation requirements mandate that the Rendering Provider is the licensed health care provider who provided the services or the licensed health care provider supervising the non-licensed health care provider who provided the service. When the Billing Provider is the same individual or entity as the Rendering Provider, the Provider information may be populated in the Billing Provider Loop and the Rendering Provider Loop may be omitted.

Attending Provider

The Attending Provider is a term used for hospital billing and represents the provider that admitted or is responsible for the care of a patient in a hospital setting. The Attending Provider may be the Billing, Rendering, or Referring Provider based on the billing transaction and role.

Referring Provider

The Referring Provider is the Provider directing care (i.e. the treating doctor), or another Provider providing treatment to the Injured Employee, who referred the Injured Employee to the Provider of the services included in the electronic medical bill transaction.

Supervising Provider

The Supervising Provider is the Provider who supervised the rendering of a service included in the electronic medical bill. In the workers' compensation implementation, the Supervising Provider is used when a licensed health care provider is supervised by a licensed health care provider, for example an anesthesiologist supervising a Certified Registered Nurse Anesthetist (CRNA). When a licensed health care provider is supervising a non-licensed health care provider, the supervising provider is considered the Rendering Provider.

Facility

The Facility is the laboratory, facility, or location where the services were rendered or took place.

Dispensing Pharmacy

The Dispensing Pharmacy is the pharmacy or mail order pharmacy that provided the medications or supplies included in the electronic pharmacy bill transaction.

Prescribing Physician

The Prescribing Physician is the Provider responsible for determining the medical necessity and prescribing the medications or supplies provided by the Dispensing Pharmacy. The Prescribing Physician is considered the Referring Provider for electronic pharmacy bill transactions.

Home Health Care

A Home Health Care Provider is an organization and is considered the Billing Provider for electronic billing purposes. Home health care is billed using the UB-04 paper billing form or in the ANSI 837 Institutional electronic billing format. The licensed primary physician responsible on a Home Health Agency Plan of Treatment is reported as the Attending Physician in the ANSI 837 Institutional electronic billing format. The individual or organization that rendered the care to the Injured Employer is reported as the Other Provider for Home Health Care services in the ANSI 837 Institutional electronic billing format, when the individual is different than Billing Provider. The licensed Provider rendering the home health service, or the licensed individual supervising an unlicensed Provider rendering the home health service, is considered the Other Provider

Bill v. Line Providers

The providers listed above are identified as providers responsible for all services included in the electronic bill transaction. National standard formats, paper billing forms, and CMS policies allow for health care providers to be identified at the line level as well. Bill level Health Care Providers are assumed to have provided all services identified at the line level unless Line Level Providers are identified in the electronic bill transaction.

National Provider Identification Number

The Centers for Medicare and Medicaid Services (CMS) administers the National Provider Identification Number (NPI). The NPI is used as the unique provider identifier in standard electronic health transactions. The NPI replaces national (i.e. Medicare number, Universal Provider Identification Number-UPIN) and proprietary health plan identification numbers. It is a HIPAA requirement and is required for Texas workers' compensation medical billing beginning in calendar year 2007, as prescribed by the Division.

State License Number

State License Numbers are administered by each state licensing or certifying board. Texas workers' compensation requires state license numbers for all electronic billing transactions for most Providers. Some Providers, such as Durable Medical Equipment (DME) Providers and some types of hospitals, may not have a State License but are required to populate a value in the State License field. State License Number requirements will remain for electronic medical billing for a period of time through the transition to use of the NPI. Currently the State License Number is submitted as three separate components in one field, Provider Type Prefix Code + State License Number + Jurisdiction Issuing State License. When a Provider does not have a State License Number, the field is submitted with the Provider Type Prefix Code and the Jurisdiction where the services were rendered.

NCPDP Number

The National Council for Prescription Drug Programs (NCPDP) administers the unique identification number for mail order and free-standing pharmacies. Formerly administered by the National Association of Pharmacy Boards (NABP), the identifier previously referred to as the NABP number is the NCPDP number.

DEA Number

The Drug Enforcement Administration (DEA) assigns a registration number to physicians related to prescribing controlled substances. The DEA number is currently used as an identification number to identify the Prescribing Physician on pharmacy bills. The DEA number will continue to be submitted in electronic pharmacy billing transactions through the transition to the use of the NPI for Provider identification.

Medicare Number

The Medicare Number is an identification number administered by CMS to identify hospitals and similar entities for statistical research and reimbursement purposes. The Medicare Number is replaced by the NPI for managed care and Medicare billing processes in 2007 and for Texas workers' compensation as prescribed by the Division.

Taxonomy Code

The Healthcare Provider Taxonomy Codes (HPTC) set is a data code set designed for use in classifying Providers according to Provider type or practitioner specialty. Taxonomy codes apply to both individuals and organizations or facilities. Taxonomy codes are expected to replace Provider Type Prefixes when workers' compensation transitions to the use of the NPI for Provider identification.

Texas and Workers' Compensation Specific Requirements

The requirements in this section identify Texas or workers' compensation specific requirements that apply to more than one electronic format. Requirements that are related to a specific format are identified in the chapter related to that format.

ANSI HIPAA Electronic File Formats

The directions for the elements identified below apply to multiple or all ANSI HIPAA electronic file formats.

Claim Filing Indicator

The Claim Filing Indicator in Loop 2000B Subscriber Information SBR Subscriber Information Segment field SBR09 Claim Filing Indicator Code is populated as WC, Workers' Compensation Health Claim, for Texas workers' compensation electronic billing transactions using the ANSI 837 formats.

Transaction Set Purpose Code

The Transaction Set Purpose Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT02 in ANSI 837 formats is designated as 00 Original. Insurance Carriers are required to acknowledge acceptance or rejection of transmissions (files) and transactions (bills). Transmissions that are rejected by the Insurance Carrier are corrected by the Provider and are submitted, after correction, as 00 Original transmissions.

Transaction Type Code

The Transaction Type Code in the Transaction Set Header BHT Beginning of Hierarchical Transaction Segment field BHT06 in ANSI 837 formats is designated as CH Chargeable. Currently, there is not a requirement for health care providers to report electronic medical billing data to the Division. Therefore, code RP Reporting is not appropriate for this implementation.

FEIN/NPI

The FEIN is populated in the NM1 Individual or Organizational Name Segment; field NM109, with the appropriate qualifier in field NM108 when required. When the entity is a Health Care Provider, the NPI is populated in the NM1 Segment and the FEIN is populated in the associate REF Reference Identification Segment with the appropriate qualifier. This logic follows the HIPAA implementation guide usage of the FEIN and NPI fields.

State License Numbers

Current medical bill data reported to the Division contains state license information. In order to continue analysis of medical bill data, the Division will continue to collect the state license in the current defined format. The state license and NPI are required for electronic billing transactions. When no license is available, for example for a Durable Medical Equipment provider, the state license field is submitted with the appropriate Provider Type Prefix followed by the Jurisdiction. The license value is omitted. In this example, the state license would appear as DMTX.

NCPDP Telecommunication Standard 5.1 Pharmacy Formats

Issues related to electronic pharmacy billing transactions are addressed in Chapter 8 Companion Guide Pharmacy. This chapter addresses both the NCPDP 5.1 and the ANSI 837 Pharmacy format.

All Electronic Formats

Referring Provider

The Referring Provider information is a Situational (S) requirement in the HIPAA and workers' compensation implementations of electronic billing. Texas workers' compensation requirements define the conditions for populating the Referring Provider as (1) mandatory when the service involved a referral and (2) when the services were performed and billed at an Ambulatory Surgery Center (ASC). The Referring Provider for ASC services is the operating physician. The Referring Provider for pharmacy services is the prescribing physician.

Reconsiderations/Appeals

Electronic submission of Reconsideration transactions is accomplished in the ANSI 837 billing format through the use of Claim Frequency Type Code 7 in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code. The value 7 Replacement of a Prior Claim represents Resubmission transactions.

The Reconsideration Claim Frequency Type Code 7 is used in conjunction with the value 30 Appeal/Reconsideration in the Claim Submission Reason Code field. The value 30 is populated in Loop 2300 Claim Information CLM Health Claim Segment. The use of the 30 value is described in the Code Set section in this chapter of the companion guide.

Reconsideration bill transactions may be submitted after receipt of an ANSI 835 Remittance transaction for the corresponding accepted original bill or fifty (50) days after the Insurance Carrier acknowledged receipt of a complete electronic medical bill when no ANSI 835 Remittance transaction has been received. Reconsideration bill transaction shall be submitted by the Provider, and processed by the Insurance Carrier, in accordance with 28 Tex. Admin. Code §133.250 Reconsideration for Payment of Medical Bills. The same bill identification number is used on both the original and the Reconsideration bill transaction to associate the transactions. All elements, fields, and values in the Reconsideration bill transaction, except the Reconsideration specific qualifiers and PWK Attachment Segment, must be the same as the original bill transaction. Subsequent Reconsideration bills transactions related to the same original bill transaction may be submitted after receipt of an ANSI 835 transaction corresponding to the initial Reconsideration bill transaction. Subsequent Reconsideration bill transactions shall not be submitted prior to twenty six days (26) from the date the Insurance Carrier acknowledged the initial complete electronic Reconsideration bill transaction.

The Insurance Carrier may reject a Reconsideration bill transaction if (1) the bill information does not match the corresponding original bill transaction, (2) the Insurance Carrier does not have a corresponding accepted original transaction, (3) the original bill transaction has not been completed (no corresponding ANSI 835 Remittance transaction), or (4) the Reconsideration bill transaction is submitted outside of the specified time frames. Corresponding documentation related to Reconsideration bill transactions is required in accordance with 28 Tex. Admin. Code §133.250. The Insurance Carriers may deny Reconsiderations bill transactions for missing documentation but shall not reject the Reconsideration bill transaction if the PWK Attachment Segment is omitted. If the Insurance Carrier does not reject the 30 bill transaction within one business day, the 30 bill transaction may be denied for the reasons listed above through the use of an ANSI 835 Remittance transaction. The Insurance Carrier may also deny the 30 bill transaction through the use of an ANSI 835 Remittance transaction if the documentation is not submitted within the required time frame.

The recommendation of the HIPAA Implementation Guides and the Division is that the value passed in CLM01 represents a unique identification number specific to the bill transaction, the Provider Unique Bill Identification Number. The Texas workers' compensation implementation of the Appeal 30 bill transaction links the original bill (parent) to the subsequent Appeal 30 bill transaction through the use of the Provider Unique Bill Identification Number (CLM01). The intent is to link an appeal, or multiple subsequent appeals, to a single original parent bill transaction.

The HIPAA implementation includes a REF Reference Identification Number Segment in Loop 2300 Claim Information that represents an Original Reference Number (ICN/DCN), which represents an Insurance Carrier generated unique transaction identification number. Health Care Providers and Insurance Carriers may use this REF Segment and value, by mutual agreement, to link appeal 30 bill transactions to original parent bill transactions.

Waivers

The Division may waive the requirement to exchange medical billing and reimbursement information electronically in accordance with 28 Tex. Admin. Code §133.501 Electronic Medical Bill Processing.

Providers might qualify for a waiver under one of two conditions; small practices or unreasonable financial burden. Small providers that have ten or fewer employees and less than ten percent of the practice is workers' compensation may be waived from eBill requirements.

Providers and Insurance Carriers may qualify for a waiver if a participant demonstrates that the cost to implement electronic billing and reimbursement or the ongoing transaction costs to exchange medical billing information electronically presents an unreasonable financial burden. The eBill Cost Analysis identifies costs for paper medical bill processing and expected implementation and ongoing costs for electronic medical billing and reimbursement processing. This analysis is used to measure average industry costs and anticipated savings to compare to Provider and Insurance Carrier reported costs. The average cost is used to determine if a Provider or Insurance Carrier might be excepted from the electronic billing and reimbursement requirements based on unreasonable financial burden.

The Division anticipates that some level of paper medical bill processing will be required as a result of waiver provisions. Paper billing and reimbursement requirements and processes are aligned, to the extent possible, with electronic billing and reimbursement requirements and processes.

Chapter 6 Companion Guide 837 Professional

This companion guide for the ANSI 837 Professional Healthcare Claim transaction has been created for use in conjunction with the *ANSI ASC X12N 837 004010A1 Professional Healthcare Claim Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 004010A1 Professional Healthcare Claim Implementation Guide*, but rather used as an additional source of information.

Directions on Texas specific requirements are provided in Chapter 4 Texas Specific Requirements. When Texas and workers' compensation specific usage is different than the HIPAA implementation, it is identified in the HIPAA/Workers' Compensation Gap Analysis and in Chapter 4 in this companion guide.

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 837 *004010A1* Professional Healthcare Claim transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI 837 Professional Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***Prof 837 Worksheet***.

Chapter 7 Companion Guide 837 Institutional

This companion guide for the ANSI 837 Institutional Healthcare Claim transaction has been created for use in conjunction with the *ANSI ASC X12N 004010A1 Institutional Healthcare Claim Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 004010A1 Institutional Healthcare Claim Implementation Guide*, but rather used as an additional source of information.

Directions on Texas specific requirements are provided in Chapter 4 Texas Specific Requirements. The difference between the HIPAA implementation and Texas or workers' compensation implementation specific usage is identified in the HIPAA/Workers' Compensation Gap Analysis and in Chapter 4 in this companion guide.

Texas requirements that are specific to 837 Institutional billing are identified in this chapter.

Diagnosis Related Grouping (DRG) Information

DRG information is used in the CMS reimbursement methodology for inpatient hospital services. The field, DRG HI01-2, is required for inpatient hospital services.

Principal/Other Procedure Code

The ICD-9 Procedure Codes identify Home IV Therapy and inpatient surgical services. The ICD-9 Procedure Code is used to identify DRG information. The ICD-9 Principal Procedure and subsequent ICD-9 Procedure Codes are required for Home IV Therapy services or when surgical procedures are provided as part of inpatient hospital services.

HCPCS Codes for Outpatient Services

Healthcare Common Procedure Coding System (HCPCS) includes Level I codes, also referred to as CPT or Common Procedural Terminology Code, and Level II codes, also referred to as HCPCS or DMEPOS Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies. HCPCS (Level I and Level II) are used in the CMS Ambulatory Payment Classification (APC) reimbursement methodology. HCPCS codes are required on outpatient services for revenue codes that require or conditionally require HCPCS codes in Medicare policies, the Hospital Outpatient Prospective Payment System (OPPS), and APC requirements.

The SV2 Institutional Service Line Segment allows for more than one code set to be populated in the Composite Medical Procedure Product/Service qualifier and identification number in fields SV202-1 and SV202-2. For the Texas workers' compensation implementation of eBill, only the HCPCS code qualifier and HCPCS codes may be used in these fields.

Admitting Diagnosis Code

The Admitting ICD-9 Diagnosis code is required for inpatient services. When the services are outpatient hospital services, the Patient Reason for Visit qualifier is used to indicate the diagnosis related to the outpatient service.

Attachment Control Number

Attachment Control Number is part of a series of values that allows a Provider to related documentation to an electronic bill transaction. Documentation is required for specific services but the indicator in the billing format is not required to be populated for a complete electronic bill transaction. The usage indicator for Texas workers' compensation is Situational. If documentation is associated with bill transaction, the PWK Attachment Segment is populated with Report Type Code, the Report Transmission Code, the Attachment Control Qualifier Code, and the Attachment Control Number.

Document Control Number

The Document Control Number is an internal control number assigned by an Insurance Carrier, or their agent, to a bill transaction to facilitate retrieval or association of a bill transaction.

Original Reference Number

The Original Reference Number, also referred to as the Internal Control Number (ICN) or Document Control Number (DCN), is the control number assigned to the original bill transaction by the Insurance Carrier to identify a unique bill transaction.

Medical Record Number

The Medical Record Number is a unique number assigned to the patient (Injured Employee) by the Provider to assist in retrieval of medical records. The Segment, REF Reference Identification - Medical Record Number is not required for Texas 837 Institutional billing.

Line Level Date of service

The Line Level Date of Service is defined as Jurisdictional requirement. The Texas workers' compensation implementation requires the Segment on outpatient hospital services.

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 837 004010A1 Institutional Healthcare Claim transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI 837 Institutional Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***Inst 837 Worksheet***.

Chapter 8 Companion Guide Pharmacy

This companion guide for the ANSI ASC X12N 837 Pharmacy Healthcare Claim transaction and the NCPDP Telecommunication Standard Version 5.1 has been created for use in conjunction with the *ANSI ASC X12N 837 004010A1 Implementation Guide and the NCPDP Telecommunication Standard Version 5.1 Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 004010A1 Implementation Guide or the NCPDP Telecommunication Standard Version 5.1 Implementation Guide*, but rather used as an additional source of information.

The Division has adopted the NCPDP Telecommunications Standard Version 5.1 as the prescribed format for electronic pharmacy billing. §133.500 does not mandate a method of connectivity or processing method. Providers and Insurance Carriers may utilize non-prescribed electronic formats by mutual agreement.

Pharmacy Invoice Number

Paper pharmacy billing processes using the DWC-66 Pharmacy Billing Form required a bill level identification number, Invoice Number, which uniquely identified the paper pharmacy bill. A paper pharmacy bill may include one or more lines (prescriptions). Real time and batch electronic pharmacy bill processing use the specific prescription number to identify an individual, unique pharmacy transaction.

Billing Date

The prescription date is generally used to identify the date the bill was generated, Billing Date, by the dispensing pharmacy. The NCPDP 5.1 does not contain a specific element that represents the date the bill was generated. For the Texas workers' compensation implementation, the prescription date is considered the Billing Date. The prescription date is communicated in the Claim Segment of the NCPDP 5.1 Date of Service value 401-D1.

The direction and mapping for the ANSI 837 Pharmacy Healthcare Claim format is included in the link identified below.

Provider Roles

Provider roles pertaining to ANSI 837 billing formats are described in the Health Care Provider Roles/Identification Numbers section of Chapter 4 Texas Workers' Compensation Requirements of this companion guide.

Pharmacy Billing Agents

The current versions of the NCPDP UCF and 5.1 do not support the use of pharmacy billing agents, such as third party billing agents or pharmacy benefit managers (PBM). The form and format do not currently support a designated field, an identifier, or a qualifier to flag an entity as a pharmacy billing agent. When the dispensing pharmacy is the billing entity, the FEIN and NCPDP Number are that of the dispensing pharmacy. Until such time as the form and format are modified, the billing entity is identified through the use of the FEIN when the dispensing pharmacy is not the billing entity. The dispensing pharmacy is identified though the use of the NCPDP Number. Reference section NCPDP Telecommunications Standard Version 5.1 498-PP Field for specific direction on identifying the billing entity in the current format and UCF.

DWC-66 and NCPDP Universal Claim Form

The use of the DWC-66 Statement of Pharmacy Services paper pharmacy billing form is discontinued as of January 1, 2008. The Division adopted the NCPDP Universal Claim Form (UCF) as the prescribed paper billing form for pharmacy services beginning January 1, 2008. To the extent possible, the Division aligned the paper billing requirements with the electronic billing requirements.

Fill Number v. Number of Fills Remaining

The DWC-66 form required the number of refills remaining to be populated in box 25 of the form. The NCPDP UCF and the NCPDP 5.1 collect the Fill Number, rather than the number of refills remaining.

Compound Medications

Division rules, paper billing forms, and the NCPDP 5.1 require components of a compound medications be identified. Compound medications in the NCPDP 5.1 are identified through the use of the Compound Code identifier "2" in Field 406-D6.

NDC Codes

The Division prescribes the use of National Drug Codes (NDC) as the code set for pharmacy billing. Other code sets, such as HCPCS codes for supplies or Universal Product Codes (UPC) are not appropriate for billing in the Texas workers' compensation system. The Division does not currently prescribe the use of a specific NDC format. Currently the ten-digit or eleven-digit NDC code may be used in the Texas workers' compensation pharmacy billing.

Default NDC Code

The Division prescribes the use of the Texas workers' compensation default NDC code when billing compounding fees for compound medications. The default NDC code is a series of the numeric value nine (9). The ten or eleven-digit default NDC (nine x 10 or nine x 11) are valid values for the default NDC code. The default NDC code is not appropriate for billing medications or supplies.

Amount Fields

Providers are required to provide information regarding the gross charged amount and the Patient (Injured Employee) paid amounts in relation to brand medication dispensed at the request of the Injured Employee. The dispensing pharmacy, or their agent, bills the total amount charged for each line item in the Gross Amount Due field.

Brand v. Generic

The DWC-66 form contained a series of fields (box 17-19) that indicated if the medication was brand or generic, if a generic equivalent was available, and the dispensed as written status (i.e. Provider DAW or Injured DAW). The NCPDP UCF and 5.1 contain a code set to indicate dispensed as written status. Some dispensed as written codes do indicate the generic availability status. However, the name of the medication, and the brand/generic status of the NDC code, is not communicated for each medication in the same manner as on the DWC-66 form. Insurance Carriers may obtain this information from purchased NDC code sets or from their agents/vendor partners.

Injured Employee Paid Amount

Provisions of §133.504 Pharmaceutical Expenses Incurred by the Injured Employee allow the Injured Employee to choose to receive a brand name drug rather than a generic drug or over-the-counter alternative to a prescription medication. When the Injured Employee elects to obtain brand name medication when a generic or over-the-counter equivalent is available and the prescribing doctor has not indicated the prescription should be dispensed as written, the dispensing pharmacy populates the brand name medication National Drug Code (NDC) in the transaction. The Gross Amount Due field reflects the total dollar amount billed to the Insurance Carrier and the amount the Injured Worker paid (difference between brand and generic charges) is populated in the Patient Paid Amount Field. A NDC code of the generic medication equivalent is populated in 498-PP Jurisdictional Defined Field 5.

NCPDP Telecommunications Standard Version 5.1 498-PP Field

The data populated in field 498-PP will be populated using a comma delimited format in the following order:

Pay To ID # (see Field 498-PF), Pay To ID Qualifier (See Code List), Jurisdictional Defined Field 1 Prescribing Physician Secondary Identification Number (State License Number for California, omit for Texas), Jurisdictional Defined Field 2 Prescribing Physician Identification Qualifier, Jurisdictional Defined Field 3 Generic NDC code (as defined above), END

The jurisdictional defined fields can be used for information that is required but does not have an NCPDP 5.1 field. The 498-PP field is 500 characters long.

Reference Information

This companion guide for the NCPDP Telecommunication 5.1 pharmacy transaction has been created for use in conjunction with the *NCPDP Telecommunication Standard Version 5.1 Implementation Guide.* It should not be considered a replacement for the *NCPDP Telecommunication Standard Version 5.1 Implementation Guide*, but rather used as an additional source of information.

The HIPAA implementation guide for the NCPDP Telecommunications 5.1 electronic pharmacy billing transaction is available through the National Council for Prescription Drug Programs (NCPDP), www.ncpdp.org.

The Texas workers' compensation direction for the use of the ANSI 837 Pharmacy Health Care Claim Implementation Guide and the NCPDP Telecommunication Standard Version 5.1 is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***Rx837-5.1 Worksheet***.

Chapter 9 Companion Guide 837 Dental

This companion guide for the ANSI ASC X12N 837 Dental Healthcare Claim transaction has been created for use in conjunction with the *ANSI ASC X12N 837 004010A1 Dental Claim Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 837 004010A1 Dental Claim Implementation Guide*, but rather used as an additional source of information.

Dentist License Number

The dentist license number is populated in the applicable REF Reference Identification – State License Segment. The REF Reference Identification - Dentist License Number Segment is not required for the Texas workers' compensation implementation. The dentist may be populated in the REF Dentist License Number Segment if the provider chooses.

Dental Procedure Codes

Services provided by a dentist are billed using the ANSI 837 Dental format. HCPCS Codes are not supported in this format. American Dental Association Current Dental Terminology (CDT) Codes, also referred to as Codes on Dental Procedures and Nomenclature, are used in ANSI HIPAA 837 Dental transactions. Health Care Providers may contact the Division if dental services are provided by a dentist, such as some oral surgery procedures, and ADA CDT codes describing the procedure are not available.

Provider Contact information

The ANSI 837 Dental transaction specifications indicate that the Billing Provider and Pay to Provider PRV Provider Contact Information Segments are "not used". The workers' compensation implementation used these fields to capture Billing Provider and Pay to Provider contact name and phone number information. These segments are Required for Texas workers' compensation.

Patient Paid Amount

The AMT Patient Paid Amount Segment is not used in the Texas workers' compensation implementation of ANSI 837 Dental transactions.

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 837 *004010A1* Dental Healthcare Claim transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI HIPAA 837 Dental Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***Dental 837 Worksheet.***

Chapter 10 Companion Guide 835 Payment & Remittance Advice

This companion guide for the ANSI ASC X12N 835 Healthcare Claim Payment/Advice transaction has been created for use in conjunction with the *ANSI ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 835 004010A1 Healthcare Claim Payment and Remittance Advice Implementation Guide*, but rather used as an additional source of information.

Claim Adjustment Group Code

The Division prescribes the use of ANSI Claim Adjustment Group Codes in the ANSI 835 format. The most current, valid codes should be used as appropriate for workers' compensation. The ANSI Group Code represents the general category of payment, reduction, or denial. For example, the ANSI Group Code CO Contractual Obligation might be used in conjunction with an ANSI Reason Code for a network contract reduction.

The ANSI Group Code transmitted in the ANSI 835 is the same code that is transmitted in the IAIABC 837 Medical EDI reporting format. The Division accepts ANSI Group Codes that we valid on the date the Insurance Carrier paid, denied, or acknowledged receipt of a refund. The Division does not validate for ANSI Group Code/ANSI Reason Code agreement in Medical EDI reporting.

Claim Adjustment Reason Code

28 Tex. Admin. Code §133.240 subsection (e) requires Insurance Carriers to provide the explanation of benefits (EOB) in the "form and manner prescribed by the Division." The ANSI s835 requires the use of ANSI code as the electronic means of providing specific payment, reduction, or denial information. The Division prescribes the use of ANSI Claim Adjustment Reason Codes in conjunction with ANSI Group Codes in the ANSI 835 format. As a result, use of the ANSI 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Benefits (EOB)/DWC-62 forms. Accordingly, Insurance Carriers that provide the required ANSI 835 information in the transmission, including the use of the standard and jurisdictional claim adjustment reason codes, are complaint with 28 Tex. Admin. Code §133.240 (e).

Remittance Remark Codes

The ANSI 835 format supports the use of ANSI Remittance Advice Remark Code to provide supplemental explanation for a payment, reduction or denial already described by an ANSI Reason Code. The use of ANSI Remark Codes is not mandated. However, use of the ANSI 835 eliminates the use of proprietary reduction codes and free form text used on paper Explanation of Benefits (EOB)/DWC-62 forms. ANSI Remark Codes are not associated with an ANSI Group or Reason Code in the same manner that an ANSI Reason Code is associated with an ANSI Group Code.

Product/Service ID Qualifier

The Product/Service Identification Number transmitted in the inbound electronic billing format is returned in the ANSI 835 SVC Service Payment Information Segment with the appropriate qualifier. For example, a Revenue Code billed with a HCPCS on a UB-04 is transmitted to the Insurance Carrier. The Revenue Code qualifier and Revenue Code are returned in the ANSI 835, not the HCPCS Code.

Reference Information

The HIPAA Implementation Guide for the ANSI ASC X12 835 *004010A1* Healthcare Claim Payment and Remittance Advice transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI HIPAA 835 Healthcare Payment and Remittance Advice Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***835 Worksheet***.

Chapter 11 Companion Guide Acknowledgment Transaction Sets

This companion guide for the acknowledge transaction sets has been created for use in conjunction with the *ANSI ASC X12N Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N Implementation Guide*, but rather used as an additional source of information.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment format is not mandated for Texas workers' compensation process. The information regarding the format is offered as a tool to facilitate effective communication between Health Care Providers and Insurance Carriers.

The Texas workers' compensation direction for the use of the ANSI TA1 Interchange Acknowledgment is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***TA1 Worksheet***.

997 Functional Acknowledgment

Reference Information

The Texas workers' compensation direction for the use of the ANSI 997 Functional (Transmission Level) Acknowledgment Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***997 Worksheet***.

824 Application Acknowledgment

The ANSI 824 Application Advice, referred to in this companion guide as a Detail Acknowledgment supports three levels of acknowledgment: Transaction Set, Batch, and Item (transaction). Texas workers' compensation requirements to not mandate acknowledgment at the Transaction Set or Batch level. Health Care Providers and Insurance Carriers, or their agents, may choose to exchange Transaction Set or Batch level acknowledgments.

Insurance Carriers are required to acknowledge electronic billing transactions at the Item or transaction level (bill level) within one business day of receipt. The ANSI 824 Detail Acknowledgment format supports multiple types of acknowledgment; for example Accept, Accept with Errors, or Partial Accept. The Texas workers' compensation implementation allows only two types of acknowledgment actions, Accept or Reject.

Reference Information

The Texas workers' compensation direction for the use of the ANSI 824 Application Advice/Detail (Transaction/Bill Level) Acknowledgment Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***824 Worksheet***.

Chapter 12 Companion Guide 275 Additional Information to Support a Health Care Claim or Encounter (Documentation/Medical Attachment)

This companion guide for the ANSI ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter transaction has been created for use in conjunction with the *ANSI ASC X12N 275 004050 Additional Information to Support a Health Care Claim or Encounter Implementation Guide*. It should not be considered a replacement for the *ANSI ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter Implementation Guide*, but rather used as an additional source of information.

Method of Transmission

The ANSI 275 Additional Information to Support a Health Care Claim or Encounter is the prescribed standard electronic format for submitting electronic documentation. Providers and Insurance Carriers may agree to exchange documentation in a non-prescribed format by mutual agreement. The components required to identify information associated with documentation must be present in non-prescribed formats.

Providers may elect to submit documentation associated with electronic bill transactions through facsimile (fax) or electronic mail (email) in accordance with 28 Tex. Admin. Code §133.501 Electronic Medical Bill Processing.

Documentation Requirements

Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results. Documentation requirements for Texas workers' compensation billing are defined in 28 Tex. Admin. Code §133.210 Medical Documentation.

Documentation related to electronic medical bill transactions is also referred to as attachments. Documentation is identified in the ANSI 837 formats in the PWK Claim Supplemental Information (Attachment) Segment. The PWK Segment is not required for a complete electronic medical bill. Services that require documentation in accordance with 28 Tex. Admin. Code §133 General Medical Provisions and do not have a PWK Attachment Segment are not rejected by Insurance Carriers. Bill transactions that include services that require documentation and are submitted without the associated documentation may be denied after bill review based on the lack of documentation.

Documentation related to electronic medical bills must be submitted within seven (7) days of submission of the electronic medical bill. The documentation may be exchanged through facsimile, electronic mail, or electronic transmission (ANSI 275).

Security and Privacy

Documentation submitted in these methods must comply with applicable Federal and state requirements related to confidentiality and privacy.

Documentation Identification

Documentation related to electronic medical bills is submitted by using the ANSI 275 or a mutually agreed upon format. Provider may also submit documentation by facsimile (fax) or electronic mail (email).

Providers must identify the elements listed below in the prescribed manner in the top section of the documentation. This allows the Insurance Carrier to identify the related Injured Employee, claim, and bill transaction in order to associate the documentation to the bill transaction.

- Injured Employee
- Insurance Carrier
- Health Care Provider
- Date(s) of Service
- Related Medical Bill Transaction(s)
- Document Identification Number

The elements identified below are identified as required (R) or situational (S).

Category of Information	Element	Usage (R/S)
Injured Employee	Last Name	S
	First Name	S
	Date of Birth	S
	Identification Number	S
	DWC Claim Number	S
	Insurance Carrier Claim Number	S
	Date of Injury	S
Insurance Carrier	Insurance Carrier Name	R
	Insurance Carrier FEIN	S
Provider	Last Name	R
	First Name	R
	Group/Organization Name	R
	NPI	R
	State License	S
	City/State	R
Dates	Date(s) of Service	R
Bills	Electronic Medical Bill Identification Number(s)	R
Document	ANSI Report Type Code	R
	ANSI Report Transmission Code	R
	ANSI Attachment Control Qualifier (AC)	R
	Document Identification Number	R
	Page Number/Number of Pages	R

The elements are populated in the upper part of each page of the document, left justified, in the order identified above when required or when situational and the defined conditions are met. The information is populated on the first page of the document. Subsequent pages identify the unique bill transaction identification number, the provider NPI, the date or dates of service, and the page number/number of pages in the header of the page.

Additional directions for specific elements identified above are provided in the following section.

Injured Employee Name

The Injured Employee Last and First Name are required on all documentation submitted through ANSI 275 transactions. Name fields are populated in documentation that is faxed or emailed in compliance with applicable Federal and state privacy and confidentiality regulations. If the Injured Employee's Name is not included in the documentation, the Insurance Carrier Claim Number and the Date of Injury is required on the documentation.

Injured Employee Identification Number

The Injured Employee Identification Number is the SSN or other identification number as defined in Chapter 4 Texas Workers' Compensation Requirements of this companion guide. The Injured Employee Identification Number is required on all documents submitted through ANSI 275 transactions. Injured Employee Identification Numbers are populated in documentation that is faxed or emailed in compliance with applicable Federal and state privacy and confidentiality regulations.

Date of Birth

The Injured Employee Date of Birth is required on all documents submitted through ANSI 275 transactions. Injured Employee Date of Birth is populated in documentation that is faxed or emailed in compliance with applicable Federal and state privacy and confidentiality regulations.

DWC Claim Number

The DWC Claim Number for the Injured Employee's workers' compensation claim is populated on documentation if it is known to the Provider. If the DWC Claim Number is not known, the value is omitted in the documentation.

Insurance Carrier Claim Number

The Insurance Carrier Claim Number for the Injured Employee's workers' compensation claim is required on documentation when it is known to the Provider. The Insurance Carrier Claim Number may not be known during the initial period of treatment post injury. The Provider must populate the Insurance Carrier Claim Number on all documentation once the information is available and known to the Provider.

The Insurance Carrier Claim Number may be used to identify the Injured Employee and Claim when the Injured Employee's private health care information is omitted. If the Injured Employee's Name is not included in the documentation, the Insurance Carrier Claim Number and the Date of Injury is required on the documentation.

Date of Injury

The Date of Injury for the Injured Employee's workers' compensation claim is submitted on all documentation related to electronic bill transactions in accordance with applicable Federal and state privacy and security regulations.

Insurance Carrier Name/FEIN

The Insurance Carrier Name is required on all documentation related to electronic bill transactions. The Insurance Carrier FEIN may be submitted in addition to the Insurance Carrier Name to ensure proper routing.

Provider/Organization Name

The Provider's First and Last Name are required for individuals. The Provider's Organization Name is required when the Provider is an organization or when an individual Provider is associated with an organization (i.e. group practice or hospital).

Provider Identification Numbers

The Provider's NPI is required on all documentation associated with electronic bill transactions. The Provider's State License Number is required, in addition to the NPI, if the Provider has a state license.

Date of Service

The Date, or Dates, of Service related to the electronic medical bill transactions and the documentation is required on documentation. The first page of a multiple page attachment must contain the Date or Dates of Service related to all pages of the document. The date or dates of service on subsequent pages may relate to specific dates of service included in that particular page of the documentation.

Bill Transaction Identification Number

The Bill Transaction Identification Number is the unique Provider Bill Identification Number, populated in the CLM01 Claim Submitter Identifier Field in the CLM Claim Information Segment of Loop 2300 Claim Information. The HIPAA implementation of the ANSI 837 formats allows for a patient account number in this field but "strongly recommends that submitters use completely unique number for this field for each individual claim."

The NCPDP Telecommunication Standard Version 5.1 format structure does not identify a bill in the same manner as the ANSI 837 formats, i.e. a bill as a set of lines. The unique electronic bill transaction identification number for pharmacy billing is based on the individual prescription and is located in 402-D2 of the NCPDP 5.1 format.

When the electronic bill transaction is a resubmission, the Bill Identification Number in the bill transaction and in the documentation relates to the original bill submission Bill Transaction Identification Number.

The documentation must contain the Bill Transaction Identification Number or numbers of bill transactions associated with the submitted documentation.

ANSI Identifiers

Report Type Codes

ANSI Report Type Codes identify the title, type, category, or content of documentation associated with an electronic bill transaction. For example, OB is the Report Type Code representing operative notes.

Report Transmission Code

ANSI Report Transmission Codes define the timing, transmission method or format by which documentation is to be sent. For example, FX is the Report Transmission Code representing submission by fax.

The PWK Segment in ANSI 837 formats requires an identification code qualifier to designate the identification number in the corresponding field. The ANSI identification code qualifier for document identification numbers, the Attachment Control Number, is AC Attachment Control Qualifier.

These three elements are required on all documentation immediately preceding the Document Identification Number (Attachment Control Number) in a continuous data string. For example, operative note SX12345 sent by fax is identified as OBFXACSX12345.

Document Identification Number

The Document Identification Number is referred to as the Attachment Control Number in the context of ANSI standard formats. The Attachment Control Number represents a unique identification number for the document associated with an electronic bill transaction. The Attachment Control Number applies to all pages associated with a multiple page document.

Multiple documents may be associated with an electronic medical bill transaction. The ANSI 837 formats support a maximum of ten (10) occurrences of a PWK Attachment Segment related to a single electronic bill transaction.

The Document Identification Number or numbers, the Attachment Control Number, is required on all documentation.

Page Number

The page number of each individual page and the total number of pages included in the document is required on each page of the document (i.e. page 3 of 4). This page number/number of pages may be included in additional areas of the page but it is always required in the document header in the order described in this section of the companion guide.

Associating Documentation to Electronic Bill Transactions

Documentation associated with electronic medical bill transactions identifies the specific transactions or transactions as defined in the preceding section. The documentation is associated to the electronic bill transactions or transactions in this manner.

ANSI 837 electronic bill transactions are associated to the documentation through the use of the PWK Claim Supplementation Information (Paperwork) Segment. The PWK Segment identifies the type of documentation through use of ANSI standard Report Type Codes and the method of submission through the use of ANSI Report Transmission Codes. A unique Attachment Control Number is assigned to the documentation. The Attachment Control Number populated on the document shall include the Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the Attachment Control Number.

Health Industry Level 7 Documentation Formats (HL7)

The ANSI 275 format supports the exchange of HL7 claim attachment information as well as other attachment formats. The intent of adopting the ANSI 275 is to provide a standard format to exchange documentation and attachments related to electronic medical bills rather than prescribe specific attachment formats (i.e. HL7). For the purposes of this implementation, the HL7 Interface Standard Format code, HL, in the CAT Category of Patient Information Service Segment is included as an optional attachment format standard. Health Care Providers and Insurance Carriers, or their agents, may exchange documentation using HL7 formatted documentation by mutual agreement.

Reference Information

The Texas workers' compensation direction for the use of the ANSI 275 Additional Information to Support a Health Care Claim or Encounter (Documentation) Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***275 Worksheet***.

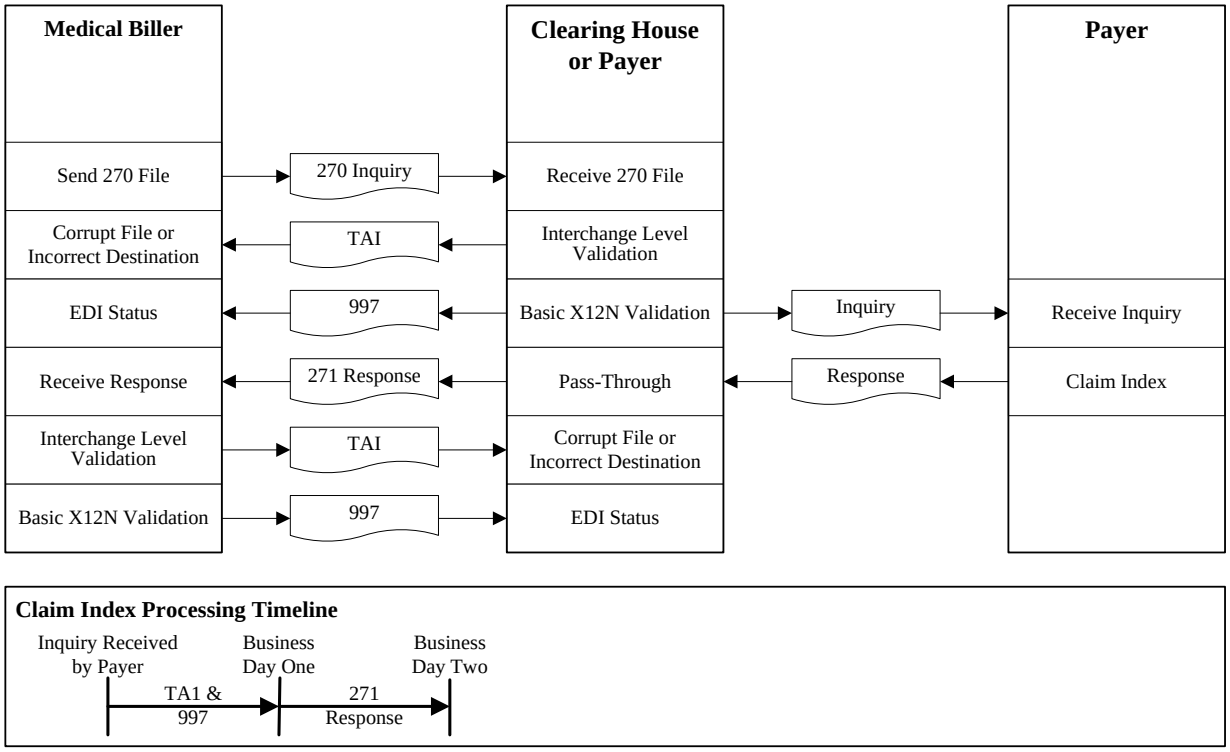
Chapter 13 Electronic Funds Transfer

House Bill (HB) 7, adopted by the 79th Texas Legislature, Regular Session, enacted Labor Code §408.0251, which allows the commissioner to adopt rules regarding the electronic payment of medical bills by Insurance Carriers to Health Care Providers on or after January 1, 2008. This chapter is reserved for future use for the purposes of providing additional direction to Insurance Carriers and Providers on the use of national standard formats related to EFT transmissions and transactions in the Texas workers' compensation system.

Appendix A - Other EDI Data Exchanges

270-271 Health Care Eligibility Benefit Inquiry and Response

The 270 and 271 transaction set is used in the group health industry to inquire about eligibility benefit status of a subscriber. The 270 transaction is the inquiry and the 271 transaction is the reply. The 270/271 transaction set described in this companion guide has been adapted for use in workers' compensation as a mechanism to perform claim indexing. The 270/271 Health Eligibility Inquiry and Response formats are not mandated for Texas workers' compensation process. They are offered as a tool to facilitate effective communication between Health Care Providers and Insurance Carriers.



ANSI 270 Request

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 270 *004010A1* Healthcare Eligibility Inquiry transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI HIPAA 270 Healthcare Eligibility Inquiry Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***270 Worksheet***.

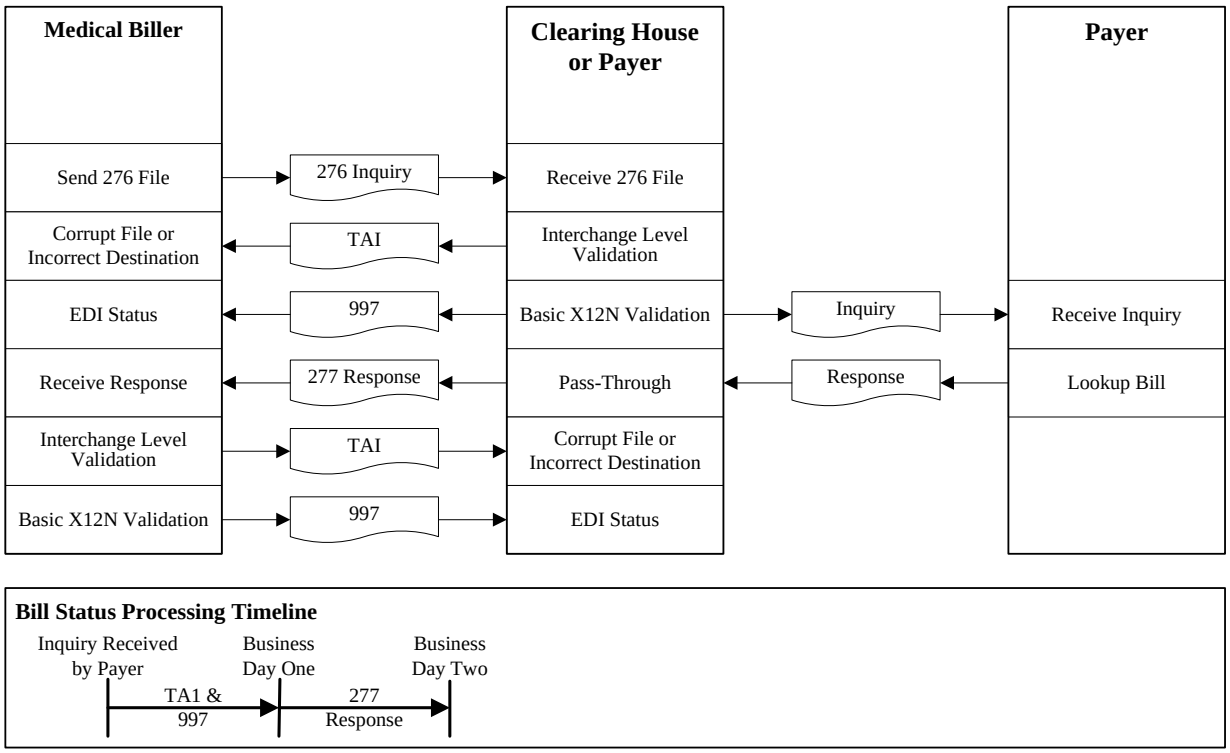
ANSI 271 Response

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 271 *004010A1 Healthcare* Eligibility Response transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI HIPAA 271 Healthcare Eligibility Response Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***271 Worksheet***.

276/277 Claim Status Request and Response

The 276 and 277 transaction set is used in the group health industry to inquire about the current status of a specified healthcare bill or bills. The 276 transaction is the inquiry and the 277 transaction is the reply. It is possible use these transaction set unchanged in workers' compensation bill processing. The 276/277 Claim (Bill) Status formats are not mandated for Texas workers' compensation process. They are offered as a tool to facilitate effective communication between Health Care Providers and Insurance Carriers.



ANSI 276 Inquiry

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 276 *004010A1 Claim* (Bill) Status Request/Inquiry transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI HIPAA 276 *004010A1 Claim* Status Request/Inquiry Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***276 Worksheet***.

ANSI 277 Response

Reference Information

The HIPAA implementation guide for the ANSI ASC X12 277 *004010A1 Claim* (Bill) Status Response transaction is available through the Washington Publishing Company, www.wpc-edi.com. The Texas workers' compensation direction for the use of the ANSI HIPAA 277 *004010A1 Claim* (Bill) Status Response Implementation Guide is accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***277 Worksheet***.

ANSI 277 STC Code Set

Reference Information

The HIPAA Code Set for the ANSI ASC X12 277 *004010A1 Claim* (Bill) Status Response transactions is available through the Washington Publishing Company, www.wpc-edi.com. The code set may also be accessed through the following link, Texas eBill Workers' Compensation Companion Guide ***277 STC Codes Worksheet***.

Appendix B – ANSI Claim Adjustment Reason Codes

Claim Adjustment Group Codes:

The ASC X12 Claim Adjustment Status Code Committee maintains ANSI Claim Adjustment Group Codes and ANSI Claim Adjustment Reason Codes sets adopted by HIPAA. The current code sets are available from the Washington Publishing Company, http://www.wpc-edi.com/codes/claimadjustment. Claim Adjustment Group Codes reflect the general category of payment, reduction, or denial.

Claim Adjustment Reason Codes:

The ASC X12 Claim Adjustment Status Code Committee maintains ANSI Claim Adjustment Group Codes and ANSI Claim Adjustment Reason Codes sets adopted by HIPAA. The current code sets are available from the Washington Publishing Company, http://www.wpc-edi.com/codes/claimadjustment. Claim Adjustment Reason Codes provide specific explanation for payment, reduction, or denial.

Jurisdiction reason codes are administered by the Texas Department of Insurance, Division of Workers' Compensation. Direction on the use of ANSI Claim Adjustment Reason Codes and jurisdiction reason codes is available at http://www.tdi.state.tx.us/wc/carrier/documents/ansicodedir.xls.

Remittance Remark Code

The ANSI Claim Adjustment Remittance Remark Codes set adopted by HIPAA is maintained by the Center for Medicare and Medicaid Services (CMS). The current code set is available from the Washington Publishing Company, http://www.wpc-edi.com/codes/remittanceadvice.

Appendix C - CMS-1500 2007/837 Mapping

The referenced document maps the paper CMS-1500 Professional paper billing form to the ANSI 837 Professional billing format, eBill Texas Paper to ANSI Mapping.xls, ***CMS 2007 Map Worksheet***.

Appendix D – UB04/837 Mapping

The referenced document maps the paper CMS UB-04 paper hospital billing form to the ANSI 837 Institutional billing format, eBill Texas Paper to ANSI Mapping.xls, ***UB04 Map Worksheet***.

Appendix E – Pharmacy UCF/837 and NCPDP 5.1 Mapping

The referenced document maps the paper NCPDP Universal Claim Form paper pharmacy billing form to the NCPDP Telecommunication Standard Version 5.1 and ANSI 837 Pharmacy billing format, eBill Texas Paper to ANSI Mapping.xls, ***Rx Map Worksheet***.

Appendix F - Dental/837 Mapping

The referenced document maps the paper ADA Dental billing form to the ANSI 837 Dental billing format, eBill Texas Paper to ANSI Mapping.xls, ***ADA Map Worksheet***.

Appendix G – Scenarios

Reserved for Future Use

Appendix H – Glossary of Terms

Acknowledgment	Electronic notification to original sender of an electronic file that the file or the transactions within the file were received and accepted or rejected.
ADA	American Dental Association.
ADA-J515	American Dental Association (ADA) standard paper billing form.
ANSI	American National Standards Institute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system.
ANSI X12 275	National standard format for attachments/documentation. The 275 format is being reviewed for possible adoption as a HIPAA standard format.
ANSI X12 824	HIPAA compliant national standard detail acknowledgment format.
ANSI X12 835	HIPAA compliant national standard remittance/reimbursement format.
ANSI X12 837	HIPAA compliant national standard billing format for professional services (837P), hospital/facility services (837I), and dental services (837D).
ANSI X12 997	HIPAA compliant national standard functional acknowledgment format.
BPI	Business Process Improvement initiative is a group of coordinated projects designed to improve and streamline agency processes and applications through the use of advanced technology and tools, as appropriate.
CDT	Current Dental Terminology coding system used to bill dental services.
Clearinghouse	An entity that processes information received in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction and processes that information into a nonstandard transaction
CMS	Centers for Medicare and Medicaid Services, the federal agency and administers these programs.
CMS-1450	The paper hospital, institutional or facility billing form also referred to as a UB or UB-92, formerly referred to as a HCFA-1450.
CMS-1500	The paper professional billing form formerly referred to as a HCFA or HCFA-1500.
Code Sets	Tables or lists of codes used for specific purposes. National standard formats may use code sets developed by the standard setting organization (i.e. ANSI Provider Type qualifiers) or by other organizations (i.e. HCPCS codes).
COMPASS	Texas Compensation Automated Support System is the agency legacy mainframe computer system.

CPT	Current Procedural Terminology is the coding system used to bill professional services.
Data Collection Agent	An entity that collects data from insurance carriers or third party administrators for regulatory reporting purposes and submits that data electronically to the Division on behalf of the insurance carrier or third party administrator.
DEA	Drug Enforcement Agency
DEA Number	Prescriber DEA identifier used for pharmacy billing.
Detail Acknowledgment	Electronic notification to original sender of an electronic file that the transactions within a file were received and accepted or rejected.
DWC	Division of Workers' Compensation.
DWC-62	Texas proprietary Explanation of Benefits form.
DWC-66	DWC proprietary pharmacy billing form and instructions.
DWC-67	DWC proprietary professional billing instructions relating to the CMS-1500 billing form.
DWC-68	DWC proprietary hospital billing instructions relating to the CMS-1450/UB-92 billing form.
eBill	The BPI Electronic Billing and Reimbursement Project. eBill is also used to identify an electronic medical bill.
ECS	Electronic Claim Submission was the Texas workers' compensation proprietary electronic format used for insurance carrier to jurisdiction reporting of medical bill payment data.
EFT	Electronic Funds Transfer.
Electronic File	A collection of data stored in a defined electronic format. An electronic file may be a single electronic transaction or a set of transactions.
Electronic Format	The specifications defining the layout of data in an electronic file.
Electronic Record	A group of related data elements. A record may represent a line item, a provider, or an employer. One or more records may form a transaction.
Electronic Transaction	A set of information or data stored electronically in a defined format that has a distinct and different meaning as a set. An electronic transaction is made up of one or more electronic records.
Electronic Transmission	Transmission of information by facsimile, electronic mail, electronic data interchange, or any other similar method and does not include telephonic communication. For the purposes of the eBill project, electronic transmission generally does not include facsimile or electronic mail.
EOB	Explanation of Benefits/DWC-62 paper form sent by the insurance carrier to the health care provider to explain payment or denial of a medical bill. The EOB might also be used to request a recoupment of an overpayment or acknowledge receipt of a refund.

Fiscal Intermediary	A private company contracted to process and pay medical bills in the Medicare system.
Functional Acknowledgment	Electronic notification to original sender of an electronic file that the file was received and accepted or rejected.
HCP	Health care provider.
HCPCS	Health Care Common Procedure Coding System is the HIPAA code set used to bill durable medical equipment, prosthetics, orthotics, supplies, and biologics (Level II) as well as professional services (Level I). Level I HCPCS codes are CPT codes.
HIPAA	Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.
HMO	Health Maintenance Organization.
IAIABC	International Association of Industrial Accident Boards and Commissions.
IAIABC 837	A version of the ANSI 837 electronic file format adopted by IAIABC for insurance carrier to jurisdiction reporting of medical bill payment data.
ICD-9	International Classification of Diseases, the code set administered by the World Health Organization used to identify diagnoses.
NABP	National Association of Boards of Pharmacy, the organization previously charged with administering pharmacy unique identification numbers.
NABP Number	Identification number assigned to individual pharmacy, now administered by NCPDP.
NCPDP	National Council on Prescription Drug Programs, organization currently administering pharmacy unique identification numbers.
NCPDP Number	Identification number assigned to individual pharmacy, previously referred to as NABP number.
NCPDP Telecommunication 5.1	HIPAA compliant national standard billing format for pharmacy services.
NDC	National Drug Code, code set used to identify medication dispensed by pharmacies.
Network	Provider network. Used in reference to workers' compensation certified networks on or after March 2006.
PBM	Pharmacy Benefit Manager.
POC	Proof of Coverage.
POS	Point of Sale System
PPO	Preferred Provider Organization
Receiver	The entity receiving/accepting an electronic transmission.
Remittance	Remittance is used in the electronic environment to refer to reimbursement or denial of medical bills.
Sender	The entity submitting an electronic transmission.

Switches	Clearinghouses transmitting information between entities that do not convert data. Switches may be a "connection" between entities that do not have a direct interface.
TDI	Texas Department of Insurance.
TPA	Third Party Administrator.
Trading Partner	eBill – An entity exchanging data electronically by mutual agreement with another entity. Medical EDI - An entity submitting electronic transmissions to the Division in a test or production environment.
TXCOMP	Texas workers' compensation proprietary computer system.
UB-04	Universal billing form used for hospital billing. Replaces the UB-92 as the CMS-1450 billing form effective May 23, 2007.
UB-92	Universal billing form used for hospital billing, also referred as a CMS-1450 billing form. Discontinued use as of May 23, 2007
UCF	Universal Claim Form, NCPDP proprietary pharmacy billing form.
Version	Electronic formats may be modified in subsequent releases. Version naming conventions indicate the release or version for a format. Naming conventions are administered by the standard setting organization. Some ANSI formats, for example, are 3050, 4010, and 4050.
Waiver	Exception to electronic billing and reimbursement requirements for health care providers and insurance carriers.
WCN	Workers' Compensation Network, network certified by TDI to operation in workers' compensation in Texas.

Appendix I Code Set Matrix

Electronic billing and reimbursement and state reporting code matrix (Excel).