Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609
512-804-4000 • 512-804-4001 fax • www.tdi.state.tx.us

MEMORANDUM

DATE: March 26, 2008

TO: All Workers' Compensation System Participants

FROM: Amy Morehouse, Enforcement
Allen McDonald, Information Management Services

RE: Improper Denials Based on Lack of Documentation

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), has received several complaints about insurance carriers and bill review companies that are improperly denying payment for medical services for lack of documentation (denied in a manner which is inconsistent with the provisions of the Texas Labor Code).

The Texas Administrative Code (TAC), including 28 TAC §133.210, defines the types of services that require medical documentation to be submitted along with medical bills and the process to request additional medical documentation when necessary. Workers' compensation health care networks established under Texas Insurance Code Chapter 1305 may decrease any of the documentation requirements.

An insurance carrier may request additional medical documentation after receipt of a medical bill, provided the request complies with the regulatory requirements. Texas Labor Code §408.027(b) allows an insurance carrier to request additional documentation necessary to clarify the provider's charges. Under 28 TAC §133.210(d), any request made by the insurance carrier for additional documentation to process a medical bill shall:

- be in writing;
- be specific to the medical bill or the bill's related episode of care;
- describe with specificity the clinical or other information to be included in the response;
- be relevant and necessary for the resolution of the medical bill;
- be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- indicate the specific reason for which the insurance carrier is requesting the information; and
- include a copy of the medical bill for which the insurance carrier is requesting additional documentation.

In accordance with the Texas Labor Code, insurance carriers shall not deny payment for services based on the failure to provide documentation unless the TAC provisions specifically require documentation to be submitted with the medical bill for the services rendered; or, the health care provider has failed to respond to an insurance carrier's request for documentation submitted in accordance with 28 TAC §133.210(d). The last page of this memorandum contains a list of some of the documentation required to be submitted with a medical bill.

Electronic Medical Billing and Required Documentation
With the implementation of electronic medical billing (eBill), the need to properly associate documentation with the electronic medical bill transaction has become increasingly important. While attaching documentation to a paper bill is relatively simple, the submission of documentation that is not required complicates the eBill process for both health care providers and insurance carriers. In addition, health care providers may submit medical documentation to the insurance carrier using different methods, including facsimile (fax), email or another electronic format.

Insurance carriers must ensure that they have established the technical ability and administrative processes to match any incoming medical documentation with the associated medical bill. An insurance carrier is considered to have received the medical documentation when it is received by the insurance carrier's agent; including an eBill agent, clearinghouse, bill review vendor, utilization review agent, or adjuster. In these situations, the health care provider may charge for subsequent requests for the same documentation consistent with 28 TAC §134.120(b). As stated in 28 TAC §133.210(e):

> It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

Enforcement
TDI-DWC will take appropriate enforcement action if an insurance carrier improperly denies medical bills or requests documentation in violation of agency rules. Insurance carriers should be prepared to demonstrate that their requests for additional documentation were made in compliance with 28 TAC §133.210(d) and to provide the basis for any denials related to the failure of a health care provider to submit documentation with their medical bill.

Texas Labor Code §415.002 provides that an insurance carrier commits an administrative violation if the insurance carrier fails to process claims promptly in a reasonable and prudent manner or violates a rule adopted by the Commissioner of Workers' Compensation.

How to File a Complaint
Health care providers may file complaints regarding inappropriate denials or other potential administrative violations by submitting the complaint by facsimile (fax) to Complaint Resolution at 512-490-1030. Health care providers may also submit complaints using the TDI-DWC on-line complaint form located at http://www.tdi.state.tx.us/consumer/complfrm.html#wc

Questions regarding this memorandum may be directed to Allen McDonald, Director of Information Management Services, at 512-804-4530 or allen.mcdonald@tdi.state.tx.us.

List of Required Medical Documentation

The following table outlines many of the documentation requirements and provides some service identification information to assist insurance carriers in reviewing any bill processing edits complying with the regulatory framework:

Service Description	Required Documentation	Possible Service Identifier
The two highest Evaluation and Management office visit codes for new and established patients (28 TAC §133.210(c)(1))	Office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes	CPT Code 99204, 99205, 99214, or 99215
Surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500 (28 TAC §133.210(c)(2))	A copy of the operative report	CPT Codes 10000 through 60000 series, depending on reimbursement amount
Return to work rehabilitation programs as defined in 28 TAC §134.202 (28 TAC §133.210(c)(3))	A copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates	CPT Code 97545 with modifier "WC"; CPT Code 97546 with modifier "WC"; CPT Code 97545 with modifier "WH"; CPT Code 97546 with modifier "WH"; 97799 with modifier "MR"; or, CPT Code 97799 with modifier "CP" *Note: CARF accredited Programs will add "CA" as a second modifier*
Procedures/services which do not have an established Division maximum allowable reimbursement (28 TAC §133.210(c)(4))	Any supporting documentation for and an exact description of the health care provided	Varied miscellaneous services not valued by Medicare.
Hospital services (28 TAC §133.210(c)(5))	An itemized statement of charges	Hospital bills with the type of bill/type of facility code of "1" (Hospital)
Functional Capacity Evaluations (FCEs) (28 TAC §134.204(g))	All documentation related to the FCE	97750 with modifier "FC."
Certification statement of costs for separately reimbursed surgically implanted devices (28 TAC §§133.402(e)(4), 134.403(g), and 134.404(g))	Certification of the amount which represents actual cost of surgically implanted, inserted, or otherwise applied devices.	ASC bill with claim notes and attachments; or, Hospital bill with bill notes and attachments
Required Medical Examinations (28 TAC §126.6)	Medical report	CPT Code 99456 with modifier "RE"
Designated Doctor Examinations (28 TAC §126.7)	Narrative report and forms, as applicable	Modifiers "W5", "W6", "W7", "W8", and "W9"
Treating Doctor Examination to Define Compensable Injury (28 TAC §126.14)	Narrative report	Modifier "TX"
Work Status Reports (28 TAC §129.5)	Work Status Report	CPT Code 99080 with modifier "73" and with modifier "RR" or "EC," if applicable
MMI/IR Examinations and Determinations (28 TAC §130.1)	Form and narrative report (when applicable)	CPT Code 99455 with Modifiers "MI", "V1", "V2", "V3", "V4", or "V5"

Note: This table may not represent an all-inclusive list of services which require documentation. It is possible that other potential documentation requirements exist, such as those required by CMS payment policies.