Chapter 3 Texas Workers' Compensation Requirements

Compliance

Texas Labor Code §408.0251 requires that insurance carriers accept medical bills submitted electronically by health care providers in accordance with the adopted rules. 28 Texas Administrative Code (TAC) §133.501, Electronic Medical Bill Processing, requires health care providers and insurance carriers to exchange medical bill information electronically on and after January 1, 2008. Medical Billing transactions must be in the prescribed standard formats. Health care providers and insurance carriers may exchange electronic data in non-prescribed formats by mutual agreement. All data elements required in the prescribed formats must be present in a mutually agreed upon format.

Health care providers and insurance carriers may qualify for a waiver from the eBilling requirement in accordance with 28 TAC §133.501(a). Waivers are addressed in a later section of this chapter.

Agents

Electronic billing rules allow for health care providers and insurance carriers to use agents to accomplish the requirement of electronic billing.

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.

Privacy, Confidentiality, and Security

Health care providers, insurance carriers, and their agents must comply with all applicable Federal and state requirements regarding privacy, confidentiality, and security of confidential data.

Complete Electronic Medical Bill

A complete electronic medical bill is defined in 28 TAC §§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 associated Division companion guides; and

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

National Standard Formats

Billing Formats

The national standard formats for billing and remittance are those adopted by the Federal Department of Health and Human Services rules (45 CFR Parts 160 and 162). The formats adopted under 28 TAC §133.500 that are aligned with the current Federal HIPAA implementation include:

- Health Care Claim: Professional ASC X12N 837 (004010X098A1);
- Health Care Claim: Institutional ASC X12N 837 (004010X096A1);
- Health Care Claim: Dental ASC X12N 837 (004010X097A1);
- Health Care Claim Payment/Advice ASC X12N 835 (004010X091A1); and
- NCPDP Telecommunication Standard Implementation Guide 5.1.

The acknowledgment formats and the attachment format have not been adopted in the current HIPAA rules but are also based on ASC X12 standards. The ASC X12N TA1 is used to communicate the syntactical analysis of the interchange header and trailer. The ASC X12N 997 Functional Acknowledgment, version 4010, is used to communicate acceptance or rejection of a transmission (file). The ASC X12N 824 Application Advice or Acknowledgment, version 4010, is used to communicate acceptance or rejection of a bill transaction with an accepted functional group. The ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter, version 4050, is used to transmit electronic documentation associated with an electronic medical bill.

The NCPDP Telecommunication Standard Version 5.1 contains the corresponding acknowledgement and error messages to be used for NCPDP transactions.

Prescribed Formats

Format	Corresponding Paper Form	Function
837P 004010X098A1	CMS-1500	Professional Billing
837I 004010X096A1	UB-04	Institutional/Hospital Billing
837D 004010X97A1	ADA-J515	Dental Billing
NCPDP 5.1	DWC-66	Pharmacy Billing
835 004010X091A1	DWC-62	Explanation of Benefits (EOB)
TA1 004010	None	Interchange Acknowledgement
997 004010	None	Transmission Level Acknowledgment
824 004010	None	Bill Level Acknowledgment
275 004050	Documentation/Attachments	Documentation/Attachments

Ancillary Formats

(Formats not adopted in the current Texas workers' compensation implementation)

Format	Corresponding Process	Function
270 004010X092A1	Claim/Coverage Verification Request	Eligibility Request
271 004010X092A1	Claim/Coverage Verification Response	Eligibility Response
276 004010X093A1	Bill Status Request	Claim Status Request
277 004010X093A1	Bill Status Response	Claim Status Response

Companion Guide Usage

Texas workers' compensation implementation of the national standard formats aligns with HIPAA usage and requirements in most circumstances. These Companion Guides are intended to convey information that is within the framework of the *ASC X12N Implementation Guides* and *NCPDP Telecommunication Standard Version 5.1 Implementation Guide* adopted for use. The Companion Guides are not intended to convey information that in any way exceeds the requirements or usages of data expressed in the *ASC X12N Implementation Guides* or *NCPDP Telecommunication Standard Version 5.1 Implementation Guide.* The Companion Guides, where applicable, provide additional instruction on situational implementation factors that are different in workers' compensation than the HIPAA implementation.

When the workers' compensation application situation needs additional clarification or a specific code value is expected, the Companion Guides include this information in a table format. Shaded rows represent "segments" in the *ASC X12 Implementation Guide*. Non-shaded rows represent "data elements" in the *ASC X12N Implementation Guide*. An example is provided in the following table:

Loop	Segment or Element	Value	Description	Texas Workers' Compensation Instructions
2010AA	**REF**		**Billing Provider Secondary Identifiers**	Required when the billing provider is a licensed health care provider.
	REF01	0B	Reference Identification Qualifier	One occurrence of this REF Segment must have a value '0B' – State License Number.
	REF02		Reference Identification	State License Number

Detailed information explaining the various components of the use of loops, segments, data elements, and conditions can be found in the appropriate *ASC X12N Implementation Guide*.

The *ASC X12N Implementation Guides* also include elements that do not relate directly to workers' compensation processes, for example, coordination of benefits. If necessary, the identification of these loops, segments and data elements can be described in the trading partner agreements to help ensure efficient processing of standard transaction sets.

Description of ASC X12N Transaction Identification Numbers

The ASC X12N Transaction Identification requirements are defined in the *ASC X12N Implementation Guides*. TDI-DWC provides the following additional information regarding specific transaction identification requirements:

Sender/Receiver Trading Partner Identification

Workers' compensation standards require the use of the Federal Employer Identification Number (FEIN) or other mutually agreed upon identification number 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 or other mutually agreed upon identification number. Insurance carrier information is available through direct contact with the insurance carrier.

Health care providers will need to obtain payer identification information from their connectivity trading partner agent (i.e. clearinghouses, practice management system vendors, billing agents, or other third party vendor) when they are not directly connecting to an insurance carrier.

The TDI-DWC also provides insurance carrier information. This information may be obtained by contacting the TDI-DWC directly or by accessing the TXCOMP Claims and Coverage System located at https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp. Health care providers or system participants may search for an insurance carrier by name or search for coverage/policy information by employer.

Health Care Provider Identification

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

Injured Employee/Claim Identification

The injured employee is identified by Social Security Number (SSN), date of birth, and workers' compensation claim number (see below). The 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 workers' compensation claim number assigned by the insurance carrier or claim administrator is required for the electronic submission of ASC X12N 837 transactions. This claim identification number is reported in the REF segment of Loop 2010CA, Property and Casualty Claim Number.

Alternate Injured Employee Identification Numbers

For billing purposes, the TDI-DWC allows health care providers to bill using an injured employees driver's license number, 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

The *ASC X12N Implementation Guides* refer to a bill as a "claim" for electronic billing transactions. This companion guide refers to these transactions as "bill" because in workers' compensation "claim" refers to a unique injured employee and injury.

The health care provider, or his/her agent, assigns a unique identification number to the electronic bill transaction. For ASC X12N 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. The standard allows for a patient account number but strongly recommends that submitters use a completely unique number for this field for each individual bill.

The NCPDP Telecommunication Standard Version 5.1 format structure does not identify a bill in the same manner as the ASC X12 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 prescription/service reference number located in 4Ø2-D2 of the NCPDP 5.1 format.

Document/Attachment Identification

The ASC X12N 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 attachment, is identified in the ASC X12N 837 format in the PWK Claim Supplemental Information (Attachment) Segment in Loop 2300. The PWK Segment is not required for a complete electronic medical bill. Services that require documentation in accordance with the Texas Administrative Code (28 TAC Code §§133 or 134) and do not have a PWK Attachment Segment may not be 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 using the appropriate claim adjustment reason code.

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 standard Report Type Codes. The PWK Segment and the associated documentation also identify the method of submission of the documentation through the use of Report Transmission Codes. Finally, a unique Attachment Control Number is assigned to the documentation. The Attachment Information Control Number populated on the document shall include the Report Type Code, Report Transmission Code, Attachment Control Qualifier (AC) and Attachment Control Number. For example, operative note SX12345 sent by fax is identified as OBFXACSX12345. It is the combination of these data elements that will allow an insurance carrier to appropriately match the incoming attachment to the electronic medical bill.

It is recognized that the code sets currently available for version 4010A1 do not include some of the workers' compensation specific codes to identify the type of medical report. In these situations, the health care provider should use the code value of OZ (Support Data for Claim) as the Report Type Code in the PWK segment (PWK01) and is encouraged to include the additional jurisdiction report type codes as the first two characters of the attachment control number (Loop 2300/PWK/PWK06).

Additional Jurisdictional Report Type Codes include:

Report Type Code	Definition
J1	Doctor First Report of Injury
J2	Supplemental Medical Report
J3	Medical Impairment Report
J4	Medical Legal Report
J5	Vocational Report
J6	Work Status Report
J7	Medical Consultation Report
J8	Medical Disability Report
J9	Hospital Itemized Statement

Additional information on attachments is addressed in Chapter 9 – 275 Documentation/Medical Attachments.

Insurance Carrier Validation Edits

Insurance Carriers may apply validation edits based on TDI-DWC rules, *ASC X12N Implementation Guide* requirements, or Medicare coding and billing policies when applicable. Insurance carriers should review the requirements contained in Chapter 133 and Chapter 134 of the TDI-DWC rules in determining appropriate validation edits.

The TDI-DWC Medical State Reporting EDI Companion Guide, used in conjunction with the IAIABC 837 Implementation Guide, provides validation edits the Division applies to the insurance carrier reported transactions. TDI-DWC Medical State Reporting EDI validation edits that might also reasonably apply to provider billing transactions may be applied by the insurance carrier to electronic medical billing transactions. However, the insurance carrier must tailor these edits to ensure accurate payment processing, as opposed to the data reporting requirements for which the edits were created. It is not appropriate to apply the data reporting edits without researching or investigating potential impact on processing clean claims.

Insurance Carriers use the ASC X12N 824 Application Advice, referred to in this companion guide as an Acknowledgment, to communicate transaction (individual bill) rejections. Error rejection codes are used to indicate the reason for the transaction rejection.

Decimals

Except where specifically addressed in the implementation guides, decimals are not populated in diagnosis code or unit fields. Unit values in ASC X12N 837 transactions are presented as whole numbers without decimal points or decimal/fractional part. 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 rule.

All percentages should be presented in decimal format. For example, 62.50% is represented as 62.5 without the percent sign.

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. Leading zeros are never used and trailing zeros after the decimal point must be suppressed.

The NCPDP 5.1 format does require decimals in certain data elements and the trading partners should review the details contained in the NCPDP 5.1 technical specification documents to determine appropriate format and edits.

Date Format

All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD. 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, except for date ranges. When the Implementation Guide requires a date range (RD8 qualifier), the two dates are represented with a hyphen to separate the dates (CCYYMMDD-CCYYMMDD).

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 (if contained in the transaction) must be greater (after) than the injured employee's date of birth.

Transmission Dates

Transmission dates must be

- greater than the injured employee's date of birth,
- greater than employee's date of injury (if contained in the transaction), and
- less than or equal to the date the insurance carrier processed the transmission.

Bill Dates

Discharge date must be equal to or greater than the admission date.

Admission/Discharge Dates must be

- greater than the injured employee's date of birth,
- 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,
- 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, and
- greater than the injured employee's date of birth.

Identifier Fields

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

Phone numbers should be presented as a contiguous number string with 10 digits, without spaces, dashes, parenthesis markers, or punctuation. For example, the phone number (999) 555-1212 should be presented as 9995551212. Area codes should always be included.

Description of Transmission/Transaction Dates

The ASC X12N required Transmission/Transaction dates are defined in the *ASC X12N Implementation Guides*. TDI-DWC provides the following additional information regarding specific transaction identification requirements:

Date Sent/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. The date in the Control Header ISA Segment must be the actual date the transmission is sent.

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. The Received Date is used to track timely processing of electronic medical bill transactions, electronic reconsideration/appeal transactions, and acknowledgment transactions.

Date Paid

The Date Paid is considered the "Check Issue or EFT Effective Date" in the ASC X12N 835 (Transaction Set Heater/BPR16). The use of the term "date paid" in this context does not assume a dollar amount is paid. If the insurance carrier is sending an ASC X12N 835 that is information only (no dollars are to be paid), the date of the 835 transaction is reported in this data element.

Code Sets

Code sets utilized in electronic billing and reimbursement and other ancillary processes are prescribed by the applicable *ASC X12N Implementation Guide*, NCPDP Implementation Guide, TDI-DWC rule, and this companion guide. The code sets 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.

Claim Adjustment Reason Codes

In addition to the codes available from various national standard organizations to meet specific jurisdictional requirements, the TDI-DWC has developed several jurisdictional claim adjustment reason codes to assist in providing specific directions to health care providers regarding bill reductions or denials.

The Claim Adjustment Reason Code Committee has adopted new codes or revised existing codes to meet workers' compensation needs. As such, insurance carriers may immediately begin using the new replacement codes and should work toward replacing the use of the Texas-specific codes by January 1, 2009.

The Texas-specific codes and the national standard codes, where applicable, are contained in the following table:

Texas Code	Replaced By	Definition
W2	214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)
W3		Additional payment made on appeal/reconsideration.
W4	193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
W6	215	Based on subrogation of a third party settlement
W7		Payment of interest/penalty to provider.
W8	100	Payment made to patient/insured/responsible party/employer.
W9	216	Based on the findings of a review organization
W10	217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)
W11	218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)
W12	219	Based on extent of injury (Note: To be used for Workers' Compensation only)
T13		Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 11 months from the date of

		service.
T14		Appeal/reconsideration denied based on medical necessity. You may submit a request for an IRO review no later than 45 days from receipt of this notice. Contact us for the IRO form.

Claim Resubmission Code - ASC X12N 837 Billing Formats

Health care providers will use the Claim Frequency Type Code of 07 (Resubmission/Replacement) to identify resubmissions of prior claims (not including duplicate original submissions). The value is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code of ASC X12 837 billing formats. The health care provider must also populate the Original Document Control Number/Internal Control Number assigned to the bill by the insurance carrier when the payer has provided this number on the previous bill submission. This information is populated in Loop 2300 Claim Information REF Original Reference Number (ICN/DCN) of ASC X12N 837 billing formats.

Beginning on January 1, 2009, the health care provider must also populate the appropriate condition code to identify the type of resubmission on electronically submitted medical bills. Condition codes may be used in the resubmission of paper medical bills, but are not required. Condition codes provide additional information to the payer when the resubmitted bill is a request for reconsideration or a new submission after receipt of a decision from the TDI-DWC or other administrative proceeding (such as the State Office of Administrative Hearings or judicial review). These condition codes are not required if the resubmission is simply a corrected bill.

Resubmission of original claim prior to payment:

- CLM05-3 = same value as original;
- Condition codes in HI/K3/NTE are populated with a condition code qualifier ‘BG’ and code value: W2; and,
- Original Reference Number does not apply.

Corrected bill:

- CLM05-3 = 7;
- Condition codes in HI/K3/NTE are not used; and,
- REF*F8 includes the Original Reference Number.

Reconsideration bill:

- CLM05-3 = 7;
- Condition codes in HI/K3/NTE are populated with a condition code qualifier ‘BG’ and one of the following codes values: W3, W4 or W5; and,
- REF*F8 includes the Original Reference Number.

The health care provider may also use the appropriate value in Loop 2300 Claim Information CLM Health Claim Segment CLM20 Delay Reason Code, when applicable. For example, a bill that is submitted as a result of a court decision that found the claim compensable may include code value “2” (Litigation) as the Delay Reason Code.

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 health care provider, or their agent, is the sender in the 837 electronic billing process. The insurance carrier, or their agent, is the sender in the 997 or 824 electronic acknowledgment or 835 remittance processes.

Receiver

A Receiver is the entity that receives a transmission submitted by a sender. The health care provider, or their agent, is the receiver in the 997 or 824 electronic acknowledgment or 835 remittance processes. The insurance carrier, or their agent, is the receiver in the 837 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 parent or spouse, or the patient's employer. In the workers' compensation 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. The use of pay to provider is discouraged.

Rendering Provider

The Rendering Provider is the individual or entity that provided the services included in the electronic medical bill transaction. 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. Generally, the attending provider is not the billing, rendering, or referring provider on an institutional bill.

Referring Provider

The Referring Provider is the provider who referred the injured employee to the provider of the services included in the electronic medical bill transaction. Generally, referring provider is not the provider rendering the services for the bill which includes data on a referring provider.

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 another licensed health care provider, for example an anesthesiologist supervising a Certified Registered Nurse Anesthetist (CRNA).

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 services provided by a Home Health Care Agency are billed using the UB-04 paper billing form or in the ASC X12N 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 ASC X12N 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 ASC X12N 837 institutional electronic billing format, when the individual is different than billing provider.

Bill v. Line Health Care Providers

The health care 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 health care providers are identified on specific service lines 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. The NPI number is required for all Texas workers' compensation medical bills when the health care provider is eligible for an NPI number.

State License Number

State License Numbers are administered by each state licensing 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.

If a provider does not find an exact match of their license type in the Texas License Type Code table, the provider should select the license type code that is most appropriate for their discipline and type of service rendered. 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.

The following table contains the Provider Type Prefix Code List:

Texas License Type Codes	
The following codes should be used in either the submission of paper claims, electronic medical billing, or state reporting,	
Code	**Definition**
AC	Acupuncturist
AMB	Ambulance Services
ASC	Ambulatory Surgical Center
AU	Audiologist

CNS	Clinical Nurse Specialist
CPS	Clinical Psychologist
CR	Cert. Reg. Nurse Anesthetist
CSW	Clinical Social Worker
DC	Doctor of Chiropractic
DME	Durable Medical Equipment Supplier
DO	Doctor of Osteopathy
DP	Doctor of Podiatric Medicine
DS	Dentist
IL	Independent Lab
LPC	Licensed Professional Counselor
LSA	Licensed Surgical Assistant
MD	Doctor of Medicine
MT	Massage Therapist
NFA	Nurse First Assistant
NP	Nurse Practitioner
OD	Doctor of Optometry
OT	Occupational Therapist
PA	Physician Assistant
PSY	Psychologist
PT	Physical Therapist
RAD	Radiology Facility

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.

Texas and Workers' Compensation Specific Requirements

The requirements in this section identify Texas 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.

ASC X12N Electronic File Formats

The directions for the elements identified below apply to multiple or all ASC X12N 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 ASC X12N 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 ASC X12 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 ASC X12 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.

State License Numbers

Current medical bill and payment data reported to the TDI-DWC contains state license information. In order to continue analysis of medical bill and payment data, the TDI-DWC 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 6 Companion Guide Pharmacy.

All Electronic Formats

Referring Provider

The Referring Provider information is a Situational (S) requirement in the ASC X12N Implementation Guides 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 ASC X12N 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 Original Internal Control Number/Document Control Number assigned to the bill by the insurance carrier when the payer has provided this number on the previous bill submission. This information is populated in Loop 2300 Claim Information REF Original Reference Number (ICN/DCN) of ASC X12N 837 billing formats.

Beginning on January 1, 2009, the health care provider must also populate the appropriate condition code to identify the type of resubmission on electronically submitted medical bills. Condition codes may be used in the resubmission of paper medical bills, but are not required. Condition codes which apply to reconsiderations and appeals include:

- W2 – Duplicate of Original
- W3 – 1st Level Appeal (request for reconsideration or appeal with the insurance carrier)
- W4 – 2nd Level Appeal (resubmitted after receipt of a TDI decision, typically from Medical Fee Dispute resolution)
- W5 – 3rd Level Appeal (resubmitted after receipt of a hearing or other judicial decision and order).

These codes are included in the 2300/K3 segment on professional claims, 2300/HI segment on institutional claims, and 2300/NTE segment on dental claims.

Reconsideration bill transactions may be submitted after receipt of an ASC X12N 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 ASC X12N 835 Remittance transaction has been received. Reconsideration bill transactions shall be submitted by the provider, and processed by the insurance carrier, in accordance with 28 TAC §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 ASC X12N 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 original request for reconsideration was sent or after the insurance carrier has taken final action on the reconsideration request.

The recommendation of the *ASC X12 Implementation Guides* and the TDI-DWC 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 links the original bill (parent) to the subsequent 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 *ASC X12 Implementation Guides* 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. This number needs to be included on resubmitted bills to ensure that the payer can match the resubmission request with their original processing action.

Waivers

The TDI-DWC may waive the requirement to exchange medical billing and reimbursement information electronically in accordance with 28 TAC §133.501, Electronic Medical Bill Processing.

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

Health care providers and insurance carriers may qualify for a waiver if the 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. All requests for waivers are closely reviewed by the TDI-DWC and requestors must encouraged to provide detailed information and documentation, including cost estimates by system vendors and/or clearinghouses.

The TDI-DWC 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.