Chapter 5 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 Division's rules. 28 Tex. Admin. Code §133.501, Electronic Medical Bill Processing, requires providers and insurance carriers to be able to exchange 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 carriers to utilize agents to accomplish the requirement of electronic billing, but these rules 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 eBilling requirement in accordance with 28 Tex. Admin. Code, §133.501 subsection (a). Waivers are addressed in a later section of this chapter.

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.

National Standard Formats

Billing Formats

The national standard formats for billing and remittance are those adopted by Federal HIPAA rules based on ANSI ASC X12 standards. The current Federal HIPAA implementation adopts the 4010A1 version of the Implementation Guides; including the ANSI ASC X12 837 standard for professional billing (837P), institutional billing (837I), and dental billing (837D), and the ANSI ASC X12 835 standard for remittance. The current Federal HIPAA national standard format for electronic retail pharmacy billing is the NCPDP Telecommunication Standard Version 5.1 and the NCPDP Batch Standard Version 1.1.

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 ASC X12 standards. The ANSI ASC X12 997 Functional Acknowledgment, version 4010 is used to communicate acceptance or rejection of a transmission (file). The ANSI ASC X12 824 Application Advice or Acknowledgment, version 4010 is used to communicate acceptance or rejection of a bill transaction with an accepted file. The ANSI ASC X12 275 Additional Information to Support a Health Care Claim or Encounter is used to transmit electronic documentation associated with an electronic medical bill. The NCPDP Telecommunication Standard Version 5.1 and Batch Standard Version 1.1 contain the corresponding acknowledgement and error messages to be used for NCPDP transactions.

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
GS version 4010A1	None	Functional Group Header
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

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 HIPAA standard implementation guides define the conditions that make the element mandatory. Not used elements are omitted.

The HIPAA Implementation Guides are based on the corresponding ASC X12 Standards. Therefore, compliance with the ASC X12 underlying standard is required in all cases. The HIPAA Implementation Guides define additional limits for the usage of Optional data elements, for the repetition and usage of certain segments and loops, and other requirements in addition to those specified in the X12 standards.

Usage is applied in a hierarchal manner based on Loop (primary), Segment (secondary), and Element (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. The first segment of a Loop (Trigger Segment) is required in all cases when the loop is submitted, therefore the Implementation Guides use the requirement designator location of the first segment of each Loop to express the requirement of the entire Loop as either “Required” or “Situational.” If a Loop is situational and the defined condition is not met, the entire Loop is omitted and all the Segments within the Loop are omitted. If a situational Loop is submitted, all required Segments must be present, including the Trigger segment, and all Situational Segments must be present if the defined condition is met. The same logic applies to Segment and Element level requirements for required and situational Segments and Elements.

When the workers’ compensation implementation uses an element in a manner that is different than the HIPAA Implementation Guide, 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 Elements that are required on in the electronic 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 HIPAA standards also include elements that do not relate directly to workers’ compensation processes, for example, coordination of benefits. Only those transaction sets required by §133.500 and the associated data elements outlined in this companion guide are required for this implementation. To the extent possible, this companion guide has been designed to allow HIPAA compliant transactions to be accepted and processed by workers’ compensation insurance carriers.

HIPAA/Workers' Compensation Jurisdictional Usage Analysis

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

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.

The following table outlines the differences between the HIPAA Implementation Guides and the Jurisdictional Usage for the Texas workers' compensation eBill implementation:

HIPAA/Workers' Compensation Jurisdictional Usage Analysis

Format	Loop/Segment/Field	HIPAA/WC Usage	Comments/Reason for Variance
837 Professional, Dental, Institutional	2010BA Subscriber Information N3 Address and N4 City State Zip	HIPAA Situational, WC Jurisdictionally Required. Used to convey employer information.	Required in HIPAA when the patient is not the same person as the subscriber. In workers' compensation, the employer's name, FEIN, and address fields are critical elements for insurance carriers (payers) to confirm coverage and eligibility. This information also ensures that the claims are routed to the appropriate payer entity for processing. Additional employer related information will help the carriers in processing these electronic bills.
837 Professional, Dental, Institutional	2300 Claim Information DTP Date of Accident	HIPAA Situational, WC Jurisdictionally Required	Required in HIPAA when the condition being reported is related to an accident. All workers' compensation claims have a date of injury. This information is critical for insurance carriers (payers) to determine compensability.
837 Professional, Dental, Institutional	REF State License (several loops; including 2010AA, 2010AB, 2310A, and 2310B)	HIPAA Situational, WC Jurisdictionally Situational	Required in HIPAA when a secondary provider identification number is necessary to identify the provider. In workers' compensation, most provider identification loops require the state license number for licensed health care providers on WC transactions and the conditions are noted in the companion guides. Until workers' compensation payers can implement system changes to leverage the NPPES database, this data is needed to validate and process claims. Further, the state license number is a required element on state reporting for research, quality monitoring, and other purposes.
837 Professional, Dental, Institutional	2300 Claim Information CLM Segment CLM11-4	HIPAA Situational, WC Situational	HIPAA implementation guides require this code only when the cause is an automobile accident. In workers' compensation, insurance carriers have indicated a need to determine jurisdiction in certain situations. For this workers' compensation implementation, providers may populate this field

			with the appropriate state code if the electronic medical bill is for a claim covered by a non-Texas jurisdiction. If this field is not populated, payers should assume it is a Texas covered claim.

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 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.

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 the eBill requirements. Billing agents, third party administrators, bill review companies, 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.

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

The eBill rules do 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) 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.

The Division also provides insurance carrier information. This information may be obtained by contacting the Division directly or by accessing the TXCOMP Claims and Coverage System located at 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 the 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. 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 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 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 HIPAA 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 provider, or his/her agent, assigns a unique identification number to the electronic bill transaction. For ANSI ASC X12 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 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 ANSI 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 402-D2 of the NCPDP 5.1 format.

Document Identification

The ANSI ASC X12 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 ASC X12 837 format 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 Chapter 133, Benefits -- Medical Benefits, 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 ANSI ASC X12 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 ASC X12 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, 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 provider should use the code value of OZ (Support Data for Claim) as the Report Type Code in the PWK segment and include the additional jurisdiction report type codes as the first two characters of the document identification number.

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

Specifications and requirements for documentation are addressed in Chapter 12 – 275 Documentation/Medical Attachments.

Insurance Carrier Validation Edits

Insurance Carriers may apply validation edits based on Division rules, HIPAA 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 Division rules in determining appropriate validation edits.

The Division 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. Division 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 ANSI ASC X12 824 Application Advice, referred to in this companion guide as an Acknowledgment, to communicate transaction (individual bill) rejections. ANSI ASC X12 824 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 ANSI ASC X12 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 Division 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 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, 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.

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 ANSI ASC X12 824 Detail Acknowledgment transactions, and the remittance date for ANSI ASC X12 835 Remittance Advice transactions. 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, 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 carrier's "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 ASC X12 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 State Reporting EDI submissions.

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.

Hierarchical Structure

For Texas workers' compensation, it is assumed that these formats are used to communicate information at the transaction (individual bill) 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 X12 standard, national standard HIPAA Implementation Guide, Division rule, and Division 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 Division has developed several jurisdictional claim adjustment reason codes to assist in providing specific directions to health care providers regarding bill reductions or denials. These codes are posted on the Division's website and include the following:

Code	Definition
W2	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
W3	Additional payment made on appeal/reconsideration.
W4	No additional reimbursement allowed after review of appeal/reconsideration.
W5	Request of recoupment for an overpayment made to a health care provider.
W6	Reduction/denial based on subrogation of a third party settlement.
W7	Payment of interest/penalty to provider.
W8	Reimbursement made to employer.
W9	Unnecessary medical treatment based on peer review.
W10	No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
W11	Entitlement to benefits. Not finally adjudicated.
W12	Extent of injury. Not finally adjudicated.
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 - ANSI ASC X12 837 Billing Formats

Health care providers will use the Claim Frequency Type Code of 07 (Resubmission/Replacement) to identify resubmissions of prior claims. The value is populated in Loop 2300 Claim Information CLM Health Claim Segment CLM05-3 Claim Frequency Type Code of ANSI ASC X12 837 billing formats. The 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 ANSI ASC X12 837 billing formats.

The 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 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 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 is billed using the UB-04 paper billing form or in the ANSI ASC X12 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 ASC X12 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 ASC X12 837 institutional electronic billing format, when the individual is different than billing 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 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.

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

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 was replaced by the NPI for managed care and Medicare billing processes in 2007.

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 ASC X12 HIPAA Electronic File Formats

The directions for the elements identified below apply to multiple or all ANSI ASC X12 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 ASC X12 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 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 ANSI 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. 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 an optional format based on ANSI ASC X12 837 Specifications.

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 ASC X12 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 ANSI ASC X12 837 billing formats.

The 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.

Reconsideration bill transactions may be submitted after receipt of an ANSI ASC X12 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 ASC X12 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 ASC X12 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 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 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 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.

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 are 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 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.