Subchapter G. Electronic Medical Billing, Reimbursement, and Documentation
§§133.500 & 133.501

1. INTRODUCTION. The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts new Subchapter G, §§133.500 and 133.501, concerning electronic medical billing, reimbursement, and documentation. The sections are adopted with changes to the proposed text as published in the February 3, 2006 issue of the *Texas Register* (31 TexReg 679).

2. REASONED JUSTIFICATION. House Bill (HB) 2511, enacted by the 76th Legislature, Regular Session, added Labor Code §401.024, which was amended by HB 7, 79th Legislature, Regular Session, allows or requires electronic transmission of information to be used in lieu of transmitting information via paper format and sets goals for paper reduction in the workers' compensation system. HB 7 enacted Labor Code §408.0251, which requires the commissioner to adopt rules regarding the electronic submission and processing of medical bills by health care providers to insurance carriers. Paper medical bills and related medical documentation account for the majority of paper exchanged in the Texas workers' compensation system. Section 401.024 allows the Division to adopt rules to permit or require electronic transmission in place of established forms, manner, or procedures that require paper processing.

The provisions of Subchapter G are designed to meet the requirements of HB 2511 and HB 7 by establishing procedures for the electronic submission of medical billing and reimbursement data, which will reduce paper in the workers' compensation system. Approximately six to eight million paper medical bills are processed annually in the Texas workers' compensation system. The majority of medical bills in the workers' compensation system are submitted by health care providers on paper forms to insurance carriers, third-party administrators, or medical bill review

vendors. Because minimal electronic billing occurs in the system, initial estimates indicate a potential for significant reductions in the administrative costs and handling time for medical bill processing through the use of electronic processing.

Previously, insurance carriers report only professional and hospital bill payment data to the Division in electronic file formats. However, the Division is transitioning from a Texas specific format to a national standard format that will collect pharmacy and dental data as well as professional and hospital data.

The new sections of Subchapter G are part of the Division's Electronic Billing and Reimbursement (eBill) project initiated to identify and implement an electronic billing solution for the Texas workers' compensation system. eBill processing includes the method of transmission; components of the transactions being transmitted; and the structure, organizations, systems, or applications enabling the transmissions. The eBill project is a component of the Division's Business Process Improvement initiative; a coordinated set of projects that use technology to streamline agency processes to meet the requirements of HB 2511 and HB 7.

The new sections were developed in conjunction with a workgroup comprised of insurance carriers and health care providers. Many workgroup member concerns were alleviated during the development of the sections due to the extensive input received from the workgroup.

These adopted sections apply to networks certified under Insurance Code Chapter 1305 and to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

The Division made changes to the proposed sections. However, neither of the changes introduces new subject matter or affect additional persons other than those subject to the rules as originally published.

3. HOW THE SECTIONS WILL FUNCTION. Subchapter G encompasses the processes and methods for transmitting electronic medical bill data and documentation related to electronic medical bills between the Division, health care providers, and insurance carriers. The adopted sections establish the method of transmission and the required elements to be contained within an electronic transaction. Standardized formats for data collection improves the integrity of the data collected by the Division and exchanged between system participants. The collected data is used to administer statutory mandates, such as monitoring for compliance, aiding in fee guideline development, and monitoring the effect of networks in the workers' compensation system. The adopted sections are subject to the specific provisions of Chapters 133 and 134.

Section 133.500 specifies the use of specific national standard formats, national implementation guides, and Division implementation guides for transmitting electronic medical bill data and associated transactions between the Division, health care providers, and insurance carriers. These formats and guides allow the Division to define the elements required in a transaction, the applicable code sets, and data edits by reference to the national and Division implementation guides. The section provides flexibility to exchange data in non-prescribed formats when mutually agreed upon by a health care provider and an insurance carrier. The data elements, code sets, and edits in non-prescribed formats must conform to the requirements of the Division prescribed format which will allow flexibility in responding to participants' needs while ensuring consistency of reporting.

Section 133.501 establishes the exclusive process to exchange medical bill and reimbursement data between the Division, health care providers, and insurance carriers. This section establishes applicability, the effective date for electronic billing, and includes provisions that allow health care providers and insurance carriers to contract with other entities to process electronic medical bill data. The section also includes waiver provisions for health care providers and

insurance carriers. The waiver provisions exempt health care providers or insurance carriers from the requirement of exchanging medical bill data exclusively by electronic means, if implementing electronic medical bill processing would cause an unreasonable financial burden to the health care provider or insurance carrier. The Division changed subsection (a) to permit waivers based on unreasonable financial burden for health care providers, as well as insurance carriers, on a case-by-case basis. In addition, a health care provider whose workers' compensation business constitutes less than 10 percent of their practice and employs 10 or fewer full time employees also qualifies for a waiver. The intent of the provision is to quantify 10 percent of a practice to include patient volume, bill volume, and dollar volume. If a health care provider believes it qualifies for a waiver under this provision, the health care provider may request a waiver from the Division and continue to use the paper billing process. An insurance carrier that questions a health care provider's paper billing practices may forward a request for review to the Division.

Section 133.501 defines an electronic medical bill and the components of a complete electronic medical bill. The section limits the submission of duplicate electronic medical bills by health care providers. This section also establishes an acknowledgment process for the receipt of an electronic medical bill. Subsection (c) is changed to establish that an insurance carrier must acknowledge receipt of an electronic medical bill within one business day rather than 24-hours. The acknowledgment process is not an admission of insurance carrier liability. The acknowledged acceptance of a complete medical bill does not prohibit an insurance carrier from subsequently rejecting an accepted electronic medical bill based on limited or contested liability.

Section 133.501 also includes provisions for electronic remittance notification from insurance carriers to health care providers that comply with Division rules regarding payment or denial of a medical bill, recoupment request, or acknowledgment of receipt of a refund. An

electronic remittance notification must be issued no later than 45 days after receipt of a complete electronic medical bill or within five days of generating a payment. The Division recognizes that in an electronic process, a payment and the electronic remittance notification may not be issued at the same time. The intent is to ensure that there is not an unreasonable delay between the payment and the electronic remittance notification.

Section 133.501 establishes a process for electronically exchanging documentation associated with electronic medical bills by defining the method of transmission and adopting a standard electronic format. This section does not designate documentation as a component of a complete electronic medical bill because the prescribed electronic billing formats do not support electronic documentation in the same billing transaction. Chapters 133 and 134 establish documentation requirements related to health care services provided.

4. **SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.**

§133.500(a): Several commenters recommend offering additional formats to the prescribed formats in §133.500(a).

Agency Response: The Division declines to make the requested change. The Electronic Billing and Reimbursement rules align with HIPAA standards, managed care and Medicare models. In addition, since insurance carriers and health care providers may use non-prescribed formats by mutual agreement as provided in §133.500(d), additional formats will be available without the need to prescribe the formats.

§§133.500(a) and 133.501(b)(2): Several commenters recommend adding a definition of "reconsideration" and the exclusion of reconsiderations from the electronic billing and

reimbursement process. A few commenters state that the rules do not address billing by out-of-network pharmacies and other providers when no pre-arranged method exists for the carrier to receive the bill.

Agency Response: The reconsideration process, as described in §133.250, is not excluded from these rules to avoid unreasonable restrictions on system participants who wish to exchange information in an efficient manner. The Division clarifies that the adopted rules define "electronic billing" as the "exclusive process to exchange medical bill data." Medical bills, including bills for reconsideration, shall be submitted electronically, unless a health care provider meets the waiver criteria, the insurance carrier being billed has obtained a waiver, or a mutual agreement between the two exists. This applies to all system participants, regardless of a provider's network or pharmacy benefit manager status.

§133.500(a)(1)(D): A few commenters state that the ANSI 837 format may be needed by pharmacies when billing for durable medical equipment and other supplies and services.

Agency Response: The Division clarifies that the ANSI 837 format is the appropriate format to use when a pharmacy provides and bills durable medical equipment and supplies. The standard billing formats correspond to the type of service performed and billed rather than the specific provider type.

§133.500(a)(1)(D): A commenter recommends the rules allow for updates to formats, accept input from external stakeholders, and provide sufficient transition time.

Agency Response: The Division notes that updates to adopted formats require the Division to review the formats to ensure system applicability and determine benefits/costs. To the extent that changes to standard formats or versions of adopted formats necessitate a rule revision, such rule

revisions require a formal rulemaking process and a public comment period during which input from external stakeholders is considered and changes are made as appropriate. The rulemaking process for these rules involved substantial input from stakeholders. Additionally, this rule adoption process provides a transition period for system participants.

§§133.500(d), 133.501(a)(3) and (4): Several commenters recommend allowing for alternative data exchange methods that would be efficient and cost effective.

Agency Response: The Division points out that §133.500(d) permits insurance carriers and health care providers to exchange data in an alternative method by mutual agreement.

§133.500(a)(1)(D): Several commenters support adoption of the NCPDP Telecommunication Standard Version 5.1 and IAIABC 837 Version 4010 formats. Another commenter supports the Department's efforts on implementing electronic billing and states it will benefit the system in the future. A commenter also supports the provision that allows current electronic relationships to continue.

Agency Response: The Division acknowledges the commenters' support.

§133.500: Some commenters indicate support for the NCPDP Universal Claim form for paper bill processing but are concerned about the timing of the transition from the DWC-66 paper pharmacy billing form.

Agency Response: The Division clarifies that the adoption of the NCPDP Universal Claim Form for pharmacy paper billing was included in the recently adopted billing and reimbursement rules (Chapters 133 and 134) and is outside the scope of these adopted Electronic Billing and

Reimbursement Rules (§§133.500 and 133.501). The Division will take into consideration the deadline for transition to the NCPDP Universal Claim Form in another rule initiative.

§133.500(b): Several commenters recommend implementation guides be finalized 180 days prior to January 1, 2008 and any subsequent changes reflected in a subsequent version of the format with 90 days notice prior to implementation.

Agency Response: The Division clarifies that the implementation guides adopted by HIPAA rules are currently available to the public, with the exception of the NCPDP format. The Division specification documents will be made available as early as possible for review and comment. It is the Division's goal to comply with the commenters' request for at least 180 days prior notice of the initial implementation guides and, to the extent possible, at least 90 days notice of subsequent changes.

§133.501(a)(1): Some commenters recommend changing language in §133.501(a)(1) to "priority" rather than "exclusive" because of potential computer system problems and the cost to implement electronic processes.

Agency Response: The Division declines to make the requested change. The rule includes provisions for health care provider and insurance carrier waivers from the requirement to exchange data electronically and provisions to exchange data in non-prescribed formats by mutual agreement. The Division anticipates that the costs to implement electronic processes are offset by the savings achieved by reducing paper processes. The Division will consider the financial impact when considering waiver requests.

§133.501(a)(2) and (3): A commenter supports a January 1, 2008 implementation date. Several commenters support the health care provider waiver requirements.

Agency Response: The Division acknowledges and appreciates the commenters' support.

§133.501(a)(5): A commenter recommends that the waiver provision for pharmacies apply only when 10 percent or less of the pharmacy's business is workers' compensation. A commenter states that waiver provisions do not provide leverage to providers or a vehicle for provider input.

Agency Response: The Division has changed subsection (a) to allow the Division to consider waivers based on unreasonable financial burden for health care providers on a case-by-case basis. Additionally, the Division will monitor the impact of the waiver criteria on system participants and, if necessary, will change the waiver requirements. The Division has retained the original proposed waiver criteria as well. The specific provider waiver provisions are intended to be non-arbitrary and eliminate burdensome administrative processes to obtain a waiver. The general waiver approach aligns with HIPAA rules, because the number of employees is a criterion for waiver. The Division added the 10 percent of practice criteria to maximize participation and provide cost effective electronic alternatives to paper processing.

§133.501(a)(6): A commenter recommends general guidelines for granting carrier waivers.

Agency Response: The Division believes that it is premature at this point in the project to develop specific criteria prior to identifying potential costs and savings. The preamble indicates that the intent is to allow waivers based on an unreasonable financial burden to the insurance carrier. The Division anticipates that this provision will be monitored and changed, if necessary, based on experience, costs analysis, and voluntary participation.

§133.501(a): A commenter recommends adding subsections to require prompt pay and timely acknowledgment, and to prohibit discrimination against providers filing paper medical bills.

Agency Response: The Division declines to make the requested change and clarifies that §§133.500 and 133.501 apply to the method and content in the electronic exchange of medical bill data. Medical payment requirements and paper medical bill processing are administered in other sections of Chapters 133 and 134.

§133.501(b)(2): Several commenters recommend requiring documentation as a criterion for a complete electronic medical bill. A commenter recommends a medical bill should not be submitted to the insurance carrier until the medical bill is complete.

Agency Response: The Division declines to make the requested change. The medical billing and reimbursement rules, which are elsewhere in Chapter 133, establish the requirements for documentation. A complete electronic or paper medical bill does not contain documentation as part of the billing transaction. However, insurance carriers and payers may deny services if appropriate, or if required documentation is not timely received rather than rejecting the electronic medical bill. The efficiencies and effectiveness of electronic medical billing are artificially limited if documentation is required every time as part of a complete medical bill. The requirement may put an unreasonable burden to match documentation to an electronic bill on insurance carriers that choose to implement an electronic billing solution independently of a clearinghouse. It may also prevent the participation of health care providers that are able to bill electronically but lack the technology to attach documentation electronically. The rules and implementation guides outline the process to reject an electronic medical bill that does not contain all mandatory fields in the electronic

file format.

§133.501(b)(2): Several commenters recommend adding a "documentation" flag to the definition of a complete medical bill. Other commenters recommend adding specific elements to the definition of a complete medical bill.

Agency Response: The Division declines to make the requested change. The definition of a complete electronic medical bill relates to the bill data in an electronic file format. Documentation requirements are addressed in other sections of Chapter 133. Insurance carriers and payers may deny services if appropriate, or if required documentation is not timely received rather than rejecting the electronic medical bill. The efficiencies and effectiveness of electronic medical billing are artificially limited if documentation is required every time as part of a complete medical bill. Additionally, specific data elements are defined in the national standard implementation guides and Division specification documents.

§133.501(c)(3): Several commenters recommend changing the 24-hour acknowledgement requirement to "one business day" and changing "detail" acknowledgement to "functional" acknowledgement.

Agency Response: The Division has changed subsection (c) to reflect that an insurance carrier must acknowledge receipt of an electronic medical bill within one business day rather than by 24-hours, but declines to change "detail" acknowledgement to "functional" acknowledgement. A functional acknowledgment indicates that the insurance carrier accepts or rejects a file in its entirety. A detail acknowledgement indicates the insurance carrier accepts or rejects each transaction within the file.

§133.501(c)(3)(B): Several commenters agree with duplicate billing submission provisions and recommend enforcement action if health care providers violate this provision.

Agency Response: The Division acknowledges the support for duplicate billing submission provisions. Health care provider compliance is addressed in Chapter 180, Monitoring and Enforcement, Subchapter B, Medical Benefits Regulation.

§133.501(c)(4): A commenter recommends a new proposed section to clarify that all medical bills are still fully subject to the medical bill review and audit process.

Agency Response: The Division declines to make the requested change. Other sections of Chapters 133 and 134 administer the process of medical bill review and reimbursement and need to be read in conjunction with this rule.

§133.501(c)(4): A few commenters state that §133.501(c)(4) does not address returning a bill for reasons other than liability.

Agency Response: The Division clarifies that the rules anticipate that electronic medical bills are rejected in a Detail Acknowledgment as specified in §133.501(c)(2), not returned to the provider through a manual, paper process.

§133.501(e)(1): A few commenters inquired whether documentation received prior to a bill is considered a first notice of injury.

Agency Response: The Division clarifies that notices of an injury or occupational disease are administered under §§120.2, 122.1, and 124.1.

§133.501(e)(3): Some commenters recommend extending the seven-day time frame for health care provider submission of electronic documentation associated with an electronic medical bill to 14 or 21 days.

Agency Response: The Division declines to make the requested change. If there is a known delay before documentation is available, a health care provider may delay submission of the electronic medical bill. Requiring an insurance carrier to hold an electronic medical bill for 14 to 21 days before audit is an unreasonable burden. Insurance carriers may deny an electronic medical bill in a more efficient manner if required documentation is not submitted timely.

§133.501: A commenter states that there is no alternative process if the electronic billing system fails and that paper billing is working and economical and should be maintained as the primary billing process or at least as a back up process.

Agency Response: The Division has accounted for the potential for paper billing if electronic billing poses an unreasonable financial burden to individual participants. The waiver provision allows participants that meet the criteria to be excepted from electronic billing processes, using paper billing as a back up process to electronic billing. The adopted rules provide a more efficient and cost effective method for billing and reimbursement in the Texas workers' compensation system. Electronic billing in general, and electronic billing in the pharmacy system, is a proven process that is documented to deliver traceable, efficient, and cost effective processes.

§133.501(a): A commenter recommends the electronic billing model be deemed workable and accurate prior to implementation.

Agency Response: The Division clarifies that electronic billing and reimbursement is a proven process with documented efficiencies and cost effectiveness. The adopted rules will provide a significant amount of time to transition to the adopted formats as well as testing electronic billing processes in the Texas workers' compensation system.

§133.501(a): A commenter states that in its practice, a pharmacy that provides workers' compensation services exclusively, must implement an extensive process with potentially significant costs without benefit to the patient or to the pharmacy.

Agency Response: The Division clarifies that the potential costs to implement an electronic billing process is expected to be offset by the savings in administrative costs achieved by eliminating paper processes. Electronic billing is documented to be more efficient and provide benefits to both providers and payers, such as faster billing processing and payment.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: Texas Medical Association.

For, with changes: P2P Link, American Insurance Association, Texas Mutual Insurance Company, Texas Association of School Boards, Texas Pharmacy Association/Texas Association of Drug Stores, The Boeing Company, Insurance Council of Texas, Property and Casualty Insurers of America, Association of Fire and Casualty Insurers of Texas, Working Rx and The Workers' Compensation Pharmacy Alliance.

Against: None.

6. STATUTORY AUTHORITY. The sections are adopted under Labor Code §§401.024,

408.025, 408.0251, 408.027, 413.007, 413.008, 413.053, 402.00111, and 402.061. Section 401.024 provides the commissioner the authority to permit or require by rule the use of facsimile or other electronic means to transmit information in the system. Section 408.025 requires the commissioner to specify by rule the reports a health care provider is required to file. Section 408.0251 gives the commissioner the authority to adopt rules in cooperation with the commissioner of insurance regarding the electronic submission and processing of medical bills by health care providers to insurance carriers. Section 408.027 provides for payment of health care providers by insurance carriers and subsection (g) requires the commissioner to adopt rules as necessary to implement the provisions of §§408.027 and 408.0271. Section 413.007 directs the Division to maintain a statewide database of medical billing information. Section 413.008 authorizes the Division to collect certain medical bill and payment information from the insurance carrier. Section 413.053 gives the commissioner the authority to establish standards of reporting and billing governing both form and content by rule. Section 402.00111 provides that the commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code and other laws of this state. Section 402.061 provides the commissioner the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. <u>TEXT.</u>

§133.500. Electronic Formats for Electronic Medical Bill Processing.

(a) The Division prescribes standard electronic formats by adopting the following implementation guides for the medical billing transactions:

(1) Billing:

(A) Professional Billing – ANSI x12 837(P) Version 4010.

(B) Institutional/Hospital Billing – ANSI x12 837(I) Version 4010.

(C) Dental Billing – ANSI x12 837(D) Version 4010.

(D) Pharmacy Billing – NCPDP Telecommunications Standard Version 5.1.

(2) Acknowledgment:

(A) Functional Acknowledgment – ANSI x12 997 Version 4010.

(B) Detail Acknowledgment – ANSI x12 824 Version 4010.

(3) Remittance – ANSI x12 835 Version 4010.

(4) Reporting – IAIABC 837 Version 4010.

(5) Documentation – ANSI x12 275 Version 4050.

(b) An implementation guide is a:

(1) specification document for national standard electronic formats as defined in subsection (a) of this section and published by a national standard setting organization that defines data requirements, data transaction sets, and data mapping; or

(2) published specification document that defines specific data requirements, data set transactions, data mapping, or data edits and is intended to accompany national standard implementation guides.

(c) Medical billing transactions must:

(1) contain all fields required in the applicable format implementation guide as set forth in subsection (a) of this section and associated Division implementation guides; and

(2) be populated with current and correct values defined in the applicable implementation guide as set forth in subsection (a) of this section and associated Division implementation guides.

(d) Insurance carriers and health care providers may exchange electronic data in a non-

prescribed format by mutual agreement. All data elements required in the Division prescribed formats must be present in a mutually agreed upon format.

§133.501. Electronic Medical Bill Processing.

(a) Applicability.

(1) Electronic medical bill processing is the exclusive process to exchange medical bill data in accordance with §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing) for professional, institutional/hospital, pharmacy, and dental services.

(2) Insurance carriers must be able to exchange electronic data by January 1, 2008 unless the insurance carrier is excepted from the process in accordance with paragraph (6) of this subsection.

(3) Health care providers must be able to exchange electronic data by January 1, 2008 unless the health care provider is excepted from the process in accordance with paragraph (5) of this subsection.

(4) Health care providers and insurance carriers may contract with other entities for electronic medical bill processing. 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.

(A) Health care provider agent is a person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for electronic medical bill processing under the Texas Labor Code or Division rules.

(B) Insurance carrier agent is a person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims service or fulfilling the insurance

carrier's obligations for electronic medical bill processing under the Texas Labor Code or Division rules.

(5) A health care provider is waived from the requirement to submit medical bills electronically to an insurance carrier if:

(A) the health care provider employs 10 or fewer full time employees~~,~~ and workers' compensation constitutes less than 10% of their practice; or

(B) the health care provider requests and the Division approves a waiver. The Division will approve a request on a case-by-case basis and will base the decision on whether or not electronic billing causes an unreasonable financial burden on the health care provider.

(6) An insurance carrier is waived from the requirement to receive medical bills electronically from health care providers on approval from the Division. The Division may grant an exception on a case-by-case basis if an insurance carrier establishes that electronic billing will result in an unreasonable financial burden.

(b) Electronic medical bill.

(1) An electronic medical bill is a medical bill submitted electronically by a health care provider or an agent of the health care provider.

(2) A complete electronic medical bill is an electronic medical bill that:

(A) is submitted in accordance with this chapter, and

(B) identifies the:

(i) injured employee;

(ii) employer;

(iii) insurance carrier;

(iv) health care provider; and

(v) service, supply, or medication.

(3) The received date of an electronic medical bill is the date the bill is electronically transmitted in accordance with §102.4(p) of this title (relating to General Rules for Non-Division Communication). An electronic medical bill is considered received if it meets the criteria of a complete electronic medical bill.

(c) Acknowledgment.

(1) A Functional Acknowledgment is an electronic notification to the sender of an electronic file that the file has been received and:

(A) accepted as a complete, correct file, or

(B) rejected with a valid rejection code.

(2) A Detail Acknowledgment is an electronic notification to the sender of an electronic transaction within an electronic file that the transaction has been received and:

(A) accepted as a complete, correct submission, or

(B) rejected with a valid rejection code.

(3) An insurance carrier must acknowledge receipt of an electronic medical bill by returning a Detail Acknowledgment within <u>one business day</u> ~~24 hours~~ of receipt of the electronic submission.

(A) Notification of a rejection is transmitted in a Detail Acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.

(B) A health care provider may not submit a duplicate electronic medical bill earlier than 45 days from the date submitted if an insurance carrier has acknowledged acceptance of the original complete electronic medical bill. A health care provider may submit a corrected medical

bill electronically to the insurance carrier after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

(4) Acceptance of a complete medical bill is not an admission of liability by the insurance carrier. An insurance carrier may subsequently reject an accepted electronic medical bill if it is determined that the employer listed on the medical bill is not a policyholder of the insurance carrier.

(A) The subsequent rejection must occur no later than 7 days from the date of receipt of the complete electronic medical bill.

(B) The rejection transaction must clearly indicate the reason for the rejection is due to denial of liability.

(d) Electronic remittance notification.

(1) An electronic remittance notification is an explanation of benefits (EOB), submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

(2) An insurance carrier must provide an electronic remittance notification no later than 45 days after receipt of a complete electronic medical bill or within 5 days of generating a payment.

(e) Electronic documentation.

(1) Electronic documentation consists of medical reports and/or records submitted electronically that are related to an electronic medical bill.

(2) Complete electronic documentation related to an electronic medical bill:

(A) is submitted by fax, electronic mail, or in an electronic format and

(B) identifies the:

(i) injured employee,

(ii) insurance carrier,

(iii) health care provider;

(iv) related medical bill(s), and

(v) date(s) of service.

(3) When a health care provider submits electronic documentation related to an electronic medical bill, the documentation must be submitted within 7 days of submission of the electronic medical bill.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2006.

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Norma Garcia
General Counsel
Division of Workers' Compensation
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that Subchapter G, §§133.500 and 133.501, concerning electronic medical billing, reimbursement, and documentation, is adopted.

AND IT IS SO ORDERED.

_____
ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

_____
Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO. DWC-06-0035