ADVISORY NO. 396
###

TOPIC: NEW CHAPTER 133 AND 134 RULES

In the following, we summarize the changes to the Chapter 133 and 134 Rules regarding medical billing and medical disputes. The prior rules referring to these same responsibilities have been repealed. The rules have been reorganized in a more logical manner. Not all of the new rules impose new duties and responsibilities. For the large part, medical billing, payment and dispute practice is very similar to the previous process. However, the rules controlling the duties of carriers and providers have been reorganized, and new language is included to accommodate the changes in HB 7 and other corrections. We recommend a close review of the new rules electronically attached as an appendix to this Advisory.

The following identifies each new rule, and summarizes any important changes within the rule.

Summary

133.1 Applicability of Medical Billing and Processing.
No substantive changes.

133.2 Definitions.
(2) Redefines complete medical bill to be a bill containing all required fields as required in the form specified by DWC.
(7) Specifically acknowledges that pharmacies may present bills through a pharmacy processing agent as mandated by HB 7.

133.3 Communication Between Health Care Providers and Insurance Carriers.
No substantive changes.

133.10 Required Billing Forms/Formats.
(b) Requires pharmacies and their agents to submit bills using the current National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) after January 1, 2007.

133.20. Medical Bill Submission by Health Care Provider.
(b) Incorporates HB 7 changes shortening the timeframe for submitting a medical bill from eleven months to 95 days.
(f) Prohibits providers from resubmitting medical bills after taken response to request for reconsideration.
(i) The health care provider is required to indicate on the medical bill if documentation is submitted related to the medical bill.

(j) Incorporates the previous language from 134.801 permitting providers to direct bill employers. This is not a change. It is simply relocating the language to this new rule number.

133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers.

(a) (2) Enlarges the timeframe for carriers to return incomplete bills from 7 days to 30 days. Documentation requirements for completeness of bills have been abolished. As noted, a complete medical bill has been redefined.

133.210. Medical Documentation.

(c) Changes many documentation requirements. Bill reviewers should familiarize themselves with these changes.

(1) Deletes requirement for physicians to attach documentation for an office visit coded as 99213. However, a carrier is allowed to request the documentation (CMS Guidelines prohibit reimbursement of an office visit and physical therapy on the same day absent documentation that the visit was unrelated to the PT).

(d)(6) When an insurance carrier requests additional information, the carrier must indicate the specific reasons why the carrier is requesting information.

133.230. Insurance Carrier Audit of a Medical Bill.

Applies to "on-site audits" which are rarely performed. Most bills are retrospectively reviewed by "desk" audits.

133.240. Medical Payments and Denials.

(d) Permits and insurance carrier to request additional documentation at any time prior to the 45th day after receipt of the medical bill.

(e) Creates a new documentation requirement for insurance carriers. Carriers must now include on the EOB " any interest amount paid, and the number of days on which interest was calculated."

(l)(m) Bill processing agents for health care providers shall not pay the provider less than the agent collects. An exception is specifically provided for pharmacy processing agents who may reimburse the pharmacy in accordance with its contract with the pharmacy.

133.250. Reconsideration for Payment of Medical Bills.

(b) Includes a new time requirement for requests for reconsiderations. For bills timely submitted within 95 days, and denied by the carrier, the HCP shall submit the request for reconsideration no later than 11 months from the date of the service.

(d) Although carriers are prohibited from changing CPT coding by the provider [133.240(c)(d)] because requests for reconsideration may "reference the original bill and include the same billing codes, dates of service, and dollar amount as the original bill," this implicitly recognizes that insurance carriers may correct modifiers and number of units on medical bills received from the provider.

(e) Insurance carrier may return requests for reconsideration for incompleteness, but must do so within 7 days from the date of receipt.

(g) For requests for reconsideration to which the provider received no response, the provider may submit a second request for reconsideration 26 days after the date of the original request.

§133.260. Refunds.

Changes the timeframe in which carriers must request a refund from a provider for overpayments to the provider. It is now 240 days from the date of service.

(b) Refund requests shall be presented in an EOB.

(c) Health care providers are required to respond to the request for refund by the 45th day after receipt. Providers must either pay the requested amount; or appeal to the carrier explaining the reason the health care provider has failed to remit payment.

(d) Provides for a 45 day deadline for a carrier to respond to a health care provider's appeal.

(e) If the carrier denies the appeal, the health provider "shall" remit the refund with interest within 45 days and may request medical dispute resolution.

(f) Health care providers are required to volunteer refunds identified by the provider even though a carrier may not have submitted a refund request.

(g) Requires explanations of refund payments when a provider reimburses a carrier.

133.270. Injured Employee Reimbursement for Health Care Paid.

(a) Exempts employees from a deadline to apply for reimbursement.

(d) Employee may "seek" reimbursement for a payment made by the employee to the provider which is in excess of fee guidelines or contract discount amounts.

(f) Employees are not required to request reconsideration for reimbursement.

133.280. Employer Reimbursement for Health Care Paid.

(c) Employers "may seek" reimbursement for any payment made above the Division fee guidelines or contract amount from the health care provider who received the overpayment.

134.1. Medical Reimbursement.

Exempts networks from DWC requirements, and substitutes the Texas Insurance Code Chapter 1305.

(b) Exempts from Insurance Code, required medical exams and designated doctor exams. Requests for compensable injury exams will be controlled under network contracts, if any.

(e) Requires insurance carriers to consistently apply "fair and reasonable reimbursement amounts" and to maintain documentation about carrier methodologies to be provided DWC upon DWC request.

134.100. Reimbursement of Treating Doctor for Attendance at Required Medical Examination.

No substantive change

134.110. Reimbursement of Injured Employee for Travel Expenses Incurred.

(a) Carriers do not have to reimburse employee travel until the travel exceeds 30 miles one way. The prior rule provided for reimbursement of travel over **20** miles.

134.120. Reimbursement for Medical Documentation.

(a) Carriers are not required to reimburse routine medical documentation provided to the carrier (see (d) (g) below regarding narratives).

(d) If the carrier request requires creation of medical documentation, such as a narrative, the carrier shall reimburse the provider.

(5) Doubles the prior level of reimbursement to $100 for one to two pages and $40 for each page after two pages.

(g) Defines narrative reports to be reimbursed by carriers.

134.130. Interest for Late Payment on Medical Bills and Refunds.

No substantive changes.

134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

(a) (3) Defines a diagnostic study as any test used to help establish or exclude the presence of disease or injury.

(b) For non-network care, DWC treatment guidelines control if inconsistent with carrier adopted guidelines for evaluating reasonable and necessary care. (DWC is in the process of adopting guidelines now.)

(g) (h) Provides for preauthorization of a 60-day treatment plan proposed to treat an injury or diagnosis not accepted by the carrier following an extent of injury exam. The review is based upon medical necessity and relatedness. (This is an exception to the rule requiring URAs to consider only medical necessity when approving or denying preauthorization). **This will probably require a change in carrier processes so that claims shall communicate to URAs the results of extent of injury exams.** This requirement will not go into effect until the Division adopts a rule regarding the treating doctor's extent of injury exam.

(i)(j) Continues the requirement for the URA to respond to a provider approving or denying the request within three working days and to confirm it in writing within one working day.

(m) The denial of preauthorization shall include a statement regarding the clinic basis for the denial. After reconsideration of a denial, the notification denying the reconsideration shall inform the provider of the availability of an independent review. (This will probably require a change in URA form denying preauthorization).

(p) Eliminates the prior specific preauthorization requirements for: bone growth stimulators, chemonucleolysis, myelograms, discograms, surface EMGs, TENS units, outpatient medical rehabilitation, nursing homes, convalescent care, residential care, home health care, chemical dependency and weight loss (except to the extent such items might also fall under the requirement of preauthorization for another classification of service). If listed in the rule, preauthorization is required even if the service is also listed in an approved treatment plan. Preauthorization will be required for the following, once specific rules related to these procedures/guidelines are adopted: for drugs not listed in the closed formulary, services that exceed the Division's treatment guidelines and are not contained in a preauthorized treatment

plan, required treatment plans, and any treatment for an injury or diagnosis not accepted by the carrier following a treating doctor exam to define the compensable injury.

(q) Eliminates the prior requirement of concurrent review of: DME in excess of $500, TENS usage, nursing home, convalescent care, residential care, home health care, chemical dependency and weight loss.

134.802. Insurance Carrier Medical Electronic Data Interchange to the Division.

No substantive change.

DWC deleted the following rules:

133.100
133.104 –133.106
133.300 –133.304
133.401 –133.403
134.1
134.5
134.800
134.801
134.803

Remember that most requirements contained in the repealed rules have been moved to the new sections described above.