ADVISORY NO. 480

TOPIC: AMENDMENTS TO MEDICAL BILLING, PROCESSING AND DISPUTE RESOLUTION

This is a companion to Advisory No. 477 which addressed amendments to Rule 134.600 concerning preauthorization, concurrent review, and voluntary certification of healthcare.

The Division adopted amendments to Rules 133.2 (Definitions for Medical Billing and Processing), 133.240 (Medical Payment and Denials), 133.250 (Reconsideration of Payment of Medical Bills), 133.270 (Injured Employee Reimbursement for HealthCare Paid), 133.305 (Medical Dispute Resolution-General) which will become effective on **July 1, 2012.**

In the preamble, the Division explained that these changes are necessary to (1) harmonize these rules with other Division rules and procedures, Chapter 504 of the Texas Labor Code, and certain provisions of Chapters 1305 and 4201 of the Texas Insurance Code; (2) clarify the Division's requirements for explanations of benefits submitted in the paper format; and (3) clarify the implementation and application of these rules.

Rule 133.2 (Definitions for Medical Billing and Processing)
Rule 133.2 provides that system participants who utilize or contract with agents may also be responsible for the administrative violations of that agent.

Rule 133.240 (Medical Payment and Denials)
Rule 133.240 clarifies that pharmaceutical services provided to injured employees, through either network or non-network workers' compensation coverage, cannot be denied based on medical necessity if those services were preauthorized or agreed to under §134.510(c) - (d) (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011).

If the carrier submits its explanation of benefits (EOB) in the form of an electronic remittance, then it shall do so in compliance with Rules 133.500 and 133.501. If the carrier submits its EOBs in a paper format, then it shall do so in compliance with Rule 133.240(f). Rule 133.240(f) now requires the name of the certified workers' compensation health care network through which the care was provided and the name of any pharmacy informal or voluntary network

through which payment was made (if applicable). Amended subsection (f) also requires only the last four digits of an injured employee's social security number. Finally, amended subsection (f) permits the use of the health care provider's national provider identifier instead of the health care provider federal tax ID number if the health care provider's federal tax ID number is the same as the health care provider's social security number.

The amendment to Rule 133.240(e)(3) provides that carriers must send an EOB to the prescribing doctor, if the prescribing doctor is different from the health care provider (HCP) identified in Rule 133.240(e)(1) (the HCP who submitted the medical bill), when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services.

The amendment to Rule 133.240(g) provides that when an insurance carrier pays a health care provider for health care for which the Division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with Rule 134.1 (relating to Medical Reimbursement) or Rule 134.503 (relating to Pharmacy Fee Guideline).

The amendment to Rule 133.240(n) addresses those circumstances when a pharmacy processing agent and pharmacy are involved in the transaction. Subsection (n) clarifies that a carrier must remit payment to a pharmacy processing agent in accordance with Rule 134.503 (Pharmacy Fee Guideline). The pharmacy processing agent will then reimburse the pharmacy according to the terms of the contract between those two entities.

Adopted new Rule 133.240(p) provides that all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Chapter 4201 of the Texas Insurance Code and Chapter 19 of Title 28 of the Texas Administrative Code. Moreover, when the injured employee is a "first responder," all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with section 504.055 of the Texas Labor Code (Expedited Provision of Medical Benefits for Certain Injuries Sustained By First Responder in Course and Scope of Employment) and any other provisions of subchapter U of Chapter 19 of Title 28 of the Texas Administrative Code.

<u>Rule 133.250 (Reconsideration of Payment of Medical Bills)</u>
Amended Rule133.250(b) reduces the time period for health care providers to file a request for reconsideration from 11 months to 10 months from the date of service. The Division indicated that this amendment allows health care providers to take the maximum amount of time to submit a denied bill for reconsideration and still have an opportunity to timely file a request for medical

dispute resolution under Rule 133.307(c).

The amendments to Rule 133.250(f) provide that the carrier now has 30 days (formerly 21days) after receiving a request for reconsideration to take final action. When there is no change in the carrier's original denial reasons, the carrier shall submit its EOB in accordance with Rule 133.240(e)(1) (electronic remittance) and Rule 133.240(f) (paper form of EOB). When there is a change from the original in the carrier's denial reasons, the carrier shall submit its EOB in accordance with Rule 133.240(e) through (f).

Rule 133.250(g) provides that a healthcare provider shall not resubmit a request for reconsideration earlier than 35 days (formerly 26 days) from the date the carrier received the original request for reconsideration or after the carrier has taken final action on the reconsideration request.

Adopted new Rule 133.250(i) provides that all utilization review performed during a review of a request for reconsideration must comply with the same standards as when it was performed during the original medical bill review.

Rule 133.305 (Medical Dispute Resolution-General)

Amended Rule 133.305(a)(2) adopts the definition of "first responder" from section 504.055(a) of the Texas Labor Code. Amended Rule 133.305(a)(12) adopts the definition of "serious bodily injury" as it pertains to "first responder" from section 504.055(b) of the Texas Labor Code.

The amendment to Rule 133.305(c)(3) provides that the Division may assess an administrative fee against an insurance carrier if the Division requests and the insurance carrier fails to provide the Division with the required health care provider notice under section 408.0281 of the Texas Labor Code (reimbursement for pharmaceutical services pursuant to an informal or voluntary network agreement).

Amendment to Rule 133.305(c) provides that the Division may assess a "fee" pursuant to section 413.020 of the Texas Labor Code when a carrier or healthcare provider violates a medical bill provision. In the preamble, the Division states that it will not assess an administrative fee against an insurance carrier for a reduced or denied payment based on a contract that indicates the direction or management of health care through a health care provider arrangement authorized under Labor Code) §504.053(b)(2) (political subdivision or pool directly contracts with healthcare provider).Rule 133.305(c)(4), however, appears to indicate that the Division may assess a fee when the carrier has reduced or denied payment based on a contract that indicates the direction or management of healthcare through a healthcare provider arrangement that has not been certified as a workers' compensation network, in accordance with Chapter 1305 of the Texas Insurance Code or through a healthcare provider arrangement authorized under section

504.053(b)(2) of the Texas Labor Code. Section 504.053(c)(3) provides, however, that if the political subdivision or pool provides medical benefits in the manner authorized under (b)(2), then chapter 413, except for 413.042, of the Texas Labor Code does not apply. Since the Division's authority to assess a "fee" comes from section 413.020, it does not appear that the Division has authority to assess a fee for medical payments made by a political subdivision or pool pursuant to section 504.053(b)(2).