Availity® Health Information Network

Texas Workers' Compensation Companion Guide

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Availity, L.L.C.
P.O. Box 550857
Jacksonville, FL 32255-0857

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Chapter 1: About this Guide

The purpose of this guide is to describe the processing flow of Texas Workers' Compensation claims.

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Chapter 2: Overview

The Texas Division of Workers' Compensation (TWCC) adopted electronic billing and reimbursement rules (eBill rules) on July 21, 2006.

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 primary benefit of eBilling is that insurance carriers provide an electronic acknowledgement to health care providers that the bill was received. Other benefits include streamlined bill processing and reduced billing and coding errors.

By the strict interpretation of the law, as long as a provider submits an 837 electronically, they are in compliance. However, most payers require that medical reports (attachments) accompany the 837.
Most clearinghouses are relying on a fax cover sheet solution to support sending attachments.

Chapter 3: Process Flow for Claims Attachment

Step by step process:

- Availity processes Workers' Compensation claims the same as all other ANSI 837 files. The same HIPAA validation process and editing apply.
- The receiver returns a .PDF file that contains information from the original claim submitted.
- The PDF file is delivered to the sender's ReceiveFiles mailbox, which is the same location as all other response reports.

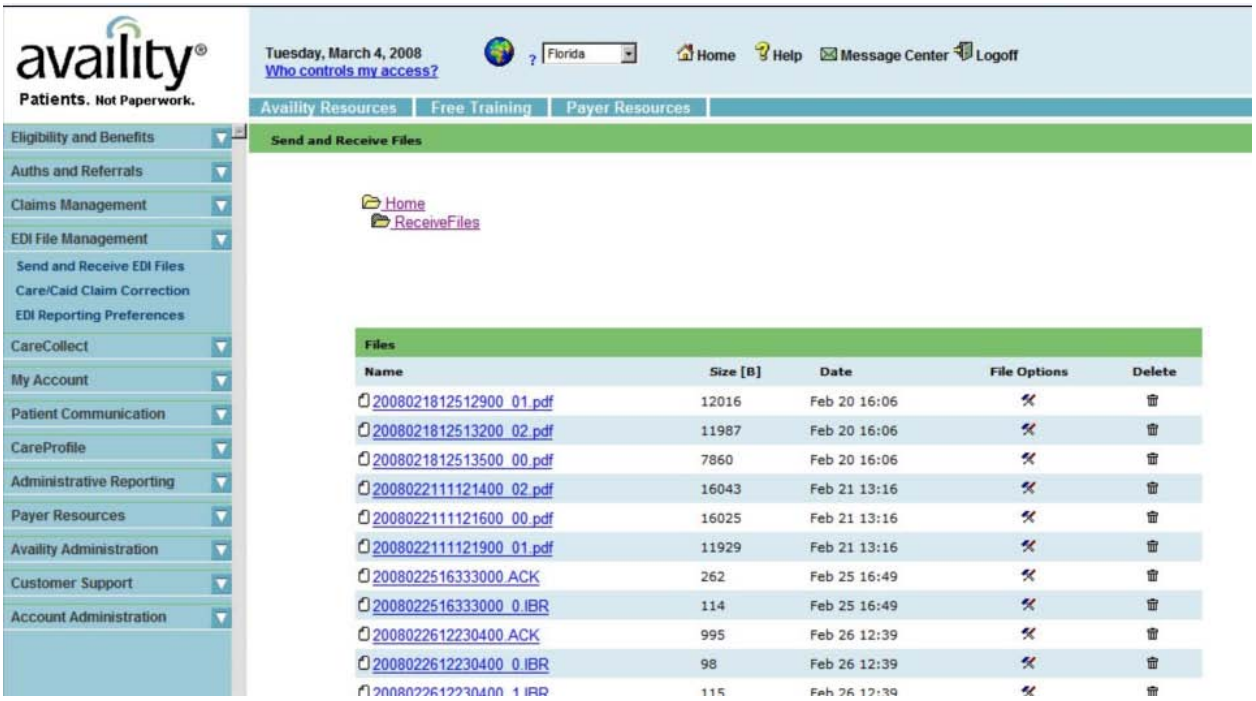
The PDF file contains fax cover sheets that must be used to fax the claim attachments to the payer. The cover sheet has a bar code specific to each claim, which identifies the claim to which the attachments are associated. Upon receiving the PDF file, the sender should print and match the claim attachments to the appropriate fax cover sheet and fax them to the phone number indicated on the cover sheet. The claim attachments 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)
- Date(s) of Service

The sender also receives ACK, IBR, EBR, and DPR reports for these claims in the same format and timeframe as other 837 claim response files. The IBR report will be received if this option is selected in the EDI preferences.

For more details on sending and receiving files, please refer to our EDI Guide document, Chapter 4: Uploading and Downloading EDI Files.

Example of .pdf files in the Receive Files mailbox:



Sample of a fax cover sheet:

Availity, L.L.C. Subject: **Workers' Compensation Attachment**

Date: 07/01/2008
To: **Customer Support (Fax: (404) 877-3299)**
From: KSF ORTHOPAEDIC CENTER, PA
Contact: CUSTOMER SERVICE (Phone: (281) 440-6960)

Attachment Details:

Trace Id:	117655556_0 / 183000609501987		
Document Control Number:	22-1		
Submitter:	Availity, L.L.C. (93715944)		
Payer:	CCMSI WORKER COMP (WK010)		
Patient Name:	FIRST LAST		
Patient Control Number:	22		
Billing Provider Name:	KSF ORTHOPAEDIC CENTER, PA		
Billing NPI:	1649252990	Billing Tax Id:	741889584
Rendering Provider Name:	ANDREW KANT		
Date(s) of Service:	10/05/2007	Total Charge Amount:	$25.00

(Source: PHNX)

Note:
The 'From' field is populated by the 2010AA Loop, NM103/NM104.
The 'Submitter Contact' field is populated by the 2010A loop, PER02 and PER04.
If the PWK segment at the 2300 Loop is not present, the PDF file will not be generated.

The following provisions regarding medical documentation adopted to be effective May 2, 2006, 31 TexReg 3544:

§133.210. Medical Documentation.

(a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results. TDI - DWC Rules – (05/20/08) Chapter 133 8

(b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

(1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

(2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

(3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;

(4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and

(5) for hospital services: an itemized statement of charges.

Chapter 4: 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-mandated ANSI X12N 837P implementation guides. This companion guide provides specific direction for the usage of and conditions for the Texas workers' compensation implementation.

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

Workers' Compensation Jurisdictional Usage Analysis

Format	Loop/Segment/ Field	HIPAA/WC Usage	Comments/Reason for Variance
837 Professional, Institutional	2010BA Subscriber Information N3 Address and N4 City State Zip	HIPAA Situational, WC Jurisdictionally Required; Used to convey employer information	Required 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 helps the carriers in processing these electronic bills.
837 Professional, Institutional	2300 Claim Information DTP Date of Accident	HIPAA Situational, WC Jurisdictionally Required	Required 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, Institutional	REF State License (several loops; including 2010AA, 2010AB, 2310A, and 2310B)	HIPAA Situational, WC Jurisdictionally Situational	Required 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, 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.
837 Professional, Institutional	2300 Claim Information PWK Segment	HIPAA Situational, WC Situational	The PWK segment is required if there is paper documentation needed to support the claim. Claims that require documentation and are submitted without the PWK will still be processed but may be denied by the Payer.
837 Professional, Institutional	2300 Claim Information PWK	HIPAA Situational, WC Situational	PWK01 = 0Z, this is the default value. PWK02 = FX PWK05 = AC PWK06 should have a unique control number for each claim. This field will support up to 80 characters and will accept the special characters '_' and '-'.
837 Professional, Institutional	2000B Subscriber Hierarchical SBR Segment	HIPAA Situational, WC Situational	The Claim Filing Indicator Code, SBR09, must equal 'WC'. This indicates the claim is Workers' Compensation. If the SBR09 does not equal 'WC', the claim will be rejected.

Chapter 5: Payers IDs

Workers' Compensation Payers IDs :

Payer ID	Payer Name
WK001	Walmart Texas Worker Comp
WK002	Texas Mutual Insurance Co.
WK006	JI Specialty Services
WK007	MCMC, LLC
WK008	Republic Indemnity Company of America
WK009	Ryder Services, Inc.
WK010	CCMSI

Chapter 6: Other Useful Documents

For further detailed information about Workers' Compensation please view the following:
http://www.tdi.state.tx.us/wc/ebill/index.html