



# TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Subsequent Injury Fund (MS-15)

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## SIF Reimbursement Request Form - Overturned Order or Designated Doctor Opinion

### I. REQUEST

1. Reimbursement Amount Requested	2. Request Date
3. Contact Name	
4. Contact Phone Number	5. Contact Email Address

### II. CLAIM INFORMATION

6. Injured Employee's Name (First, Middle, Last)	
7. Employee's Date of Injury	8. DWC Claim Number

### III. PAYEE (Insurance carrier)

9. Name of Payee	10. Payee Federal Tax ID No.
11. Address of Payee (Street or P.O. Box, City, State, ZIP Code)	

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**IV. TELL US ABOUT THE TOTAL AMOUNT OF REIMBURSEMENT REQUESTED**

<b>12. Type of Benefits Overpaid</b> (check all that apply)					
<input type="checkbox"/> Temporary Income Benefits	<input type="checkbox"/> Impairment Income Benefits	<input type="checkbox"/> Supplemental Income Benefits	<input type="checkbox"/> Lifetime Income Benefits	<input type="checkbox"/> Death Benefits	<input type="checkbox"/> Medical Benefits

**13. For each type of benefit requested state:**

- the benefit period or dates of service;
- the date(s) benefits were paid;
- total amount paid;
- the benefit rate (including support for the benefit rate such as the average weekly wage);
- calculation of reimbursement requested; and
- for medical benefits, include a brief description and diagnostic code(s) of the non-compensable injury.

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**V. TELL US ABOUT THE REASON FOR SEEKING THIS REIMBURSEMENT**

**14. Which DWC order, DWC decision, or designated doctor opinion required these benefit payments?** (For an order or decision, list brief description of findings and date issued. For each relevant designated doctor opinion, list date of exam and maximum medical improvement (MMI), impairment rating (IR), extent of injury, return to work, and disability findings, as applicable.)

**15. Which final order or decision overturned or modified the DWC order, DWC decision, or designated doctor opinion(s) identified in question 14?** (include the date issued and findings)

**16. Which elements of the decision or opinion in question 14 were overturned or modified?**

(check all that apply)

MMI     IR     Extent     Compensability     Disability     Other \_\_\_\_\_

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## VI. REQUIRED ATTACHMENTS:

Include the following documents with each request:

- DWC order or decision that required benefit payments, as applicable.
- Designated doctor opinion(s) that required payment of benefits (DWC Form-068, DWC Form-069, DWC Form-073), as applicable.
- Final order or decision that overturned or modified the benefit payment obligation.
- Other relevant orders or decisions, if any.
- W-9 for the insurance carrier.

If the request is based on an overpayment of income benefits, provide:

- Wage statement signed and completed by claim employer (DWC Form-003 or DWC Form-003SD) or other supporting documentation for the average weekly wage.
- A detailed payment record for all income benefits paid that includes the following:
  - date of payment;
  - amount of payment;
  - type of benefit paid;
  - payee; and
  - benefit period.
- Other documentation verifying disability status, if applicable.

If the request is based on an overpayment of medical benefits, provide:

- Medical bills or explanation of benefits statements (EOBs) with relevant diagnostic codes.
- A detailed payment record that includes the following:
  - date of payment;
  - amount of payment;
  - description of injury including diagnostic code(s) that relate to the non-compensable injury;
  - the health care provider that rendered the services; and
  - dates of service.

Unless otherwise requested, please limit submission to the above items.

To expedite review of this request, please fax to (512) 804-4759 or use electronic file transfer.

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## Frequently Asked Questions

### Who can file DWC Form-095?

Insurance carriers and their authorized representatives may use this form to expedite the insurance carrier's request for reimbursement from the Subsequent Injury Fund.

### Can I use this form to submit a request for reimbursement of any overpayments?

Use the form appropriate to the cause of the unrecoupable reimbursable overpayment. DWC Form-095 should be used when the insurance carrier made an unrecoupable overpayment of benefits based on an interlocutory order or decision of the commissioner or court. It can also be used when the insurance carrier made an unrecoupable overpayment of benefits based on an opinion rendered by a designated doctor (DD) if that opinion is reversed or modified by a final arbitration award or a final order or decision of the commissioner or court.

### What statutes and rules apply to this type of reimbursement?

Texas Labor Code §403.006(b)(2) and 28 Texas Administrative Code §116.11 apply when unrecoupable overpayment of benefits is based on an interlocutory order or decision of the commissioner or court.

Texas Labor Code §§403.006(b)(4) and 408.004(f-1) and 28 Texas Administrative Code §116.11 apply when unrecoupable overpayment of benefits is based on an opinion rendered by a designated doctor.

### On question 12, if a payment was made as a temporary income benefit (TIB), then later credited as an impairment income benefit (IIB), which box do I check?

Unrecoupable overpaid benefits should be requested for reimbursement based on how they were paid.

### What response do you expect for question 13?

Provide a separate statement for each type of benefit requested. For temporary income benefits (TIBs), impairment income benefits (IIBs), supplemental income benefits (SIBs), lifetime income benefits (LIBs), or death benefits:

- The benefit period is the period for which benefits were originally paid.
- The date(s) benefits were paid could be "as they accrued," "as a lump sum on MM/DD/YYYY," "after MM/DD/YYYY," etc.
- Total amount paid should be the total from pay records, including any non-reimbursable overpayments or payments made in error, if any.
- The benefit rate should include the average weekly wage calculation it is based on, whether the benefit rate was impacted by post injury earnings, and if it was subject to the minimum or maximum benefit rate.
- The calculation of reimbursement should show how you arrived at the amount requested.

For medical benefits:

- the dates of service can be a range to cover multiple benefit payments;
- the period the benefits were paid is generally either "as they accrued" or "after MM/DD/YYYY;"
- the total amount paid is the total medical benefits requested;
- the benefit rate is not applicable; and
- the calculation of reimbursement requested should include a brief description and diagnostic code(s) of the non-compensable injury.

Example of statements involving income benefits:

IIBs for 02/13/2018 to 03/05/2018 (3 weeks) paid in a lump sum on 04/01/2018 totaling \$1,260.00.

IIBs rate is \$420.00 per week based on an average weekly wage of \$600.00.

We request a reimbursement of 3 weeks of overpaid IIBs at \$420.00 per week for a total of \$1,260.00.

OR

TIBs for 01/01/2018 to 02/12/2018 paid in a lump sum on 04/01/2018 totaling \$2,600.00.

TIBs rate until 01/14/2018 is \$560.00 per week based on an average weekly wage of \$800.00 and no post injury earnings.

The TIBs beginning 01/15/2018 is \$350.00 week based on an average weekly wage and non-pecuniary benefits of \$1,000.00 and post injury earnings of \$500.00 per week.

We request a reimbursement of 2 weeks of overpaid TIBs at \$560.00 per week (\$1,120.00) and 4 weeks and 1 day of overpaid TIBs at \$350.00 week (\$1,450.00) for a total of \$2,570.00.

Example of statement involving medical benefits:

Medical benefits for services incurred 01/01/2018 to 02/12/2018 paid after the 03/08/2018 DD exam. \$5,000.00 was paid in medical benefits. We request a reimbursement of \$5,000.00 paid for an M75.120-complete rotator cuff tear which was determined non-compensable.

**What response do you expect for question 14?**

For an overpayment to be reimbursable, it must be based on an interlocutory order, decision of the commissioner such a contested case hearing decision and order, or it must be made based on a DD's opinion. For the benefits you are requesting which order, decision, or DD opinion required the benefit payments?

List the relevant order(s), decision(s), or DD exam that required the benefit payments.

Example:

01/14/2017 DD Smith:

- MMI 01/14/2017.
- 10% IR.
- On extent: extends to include complete rotator cuff tear.
- Return to work with restrictions.
- Disability from 01/01/2017 to present.

**What response do you expect on question 15?**

List the relevant order(s) or decision(s) that reversed or modified the order, decision, or DD opinion that required payment identified in question 14.

Example:

01/12/18 CCH, upheld on appeal:

- MMI 01/14/2017.
- 5% IR.
- Does not extend to conditions in dispute.

**How do I submit this request by electronic file transfer?**

If you already have an account with DWC, you may use the same electronic file transfer account. If you need an account, please contact our office.