TDI Division of Workers' Compensation

Subsequent Injury Fund Reimbursement Request Form – Overturned Order or Designated Doctor Opinion

I. SUBSEQUENT INJURY FUND (SIF) REQUEST INFORMATION

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

12. Type of Benefits Overpaid (check all that apply)

☐ Temporary Income Benefits ☐ Impairment Income Benefits ☐ Supplemental Income Benefits ☐ Lifetime Income Benefits ☐ Medical Benefits

13. For each type of benefit requested, state:

- the benefit period or dates of service;
- the dates benefits were paid;
- total amount paid;
- the benefit rate;
- calculation of reimbursement requested; and
- for medical benefits, include a brief description and diagnostic codes of the non-compensable injury.

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V. TELL US ABOUT THE REASON FOR SEEKING THIS REIMBURSEMENT

14. Which DWC order or decision required benefit payments? (For an order or decision, provide a brief description of findings and date issued. For each relevant designated doctor (DD) opinion, list the date of exam, 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 or decision, or DD opinions identified in question 14? (Include the date issued and findings.)

16. Which elements of the decision in question 14 were overturned or modified? (check all that apply)

☐ MMI ☐ IR ☐ Extent ☐ Compensability ☐ Other

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VI. REQUIRED ATTACHMENTS:

Include the following documents with each request:

- ☐ DWC order or decision that required benefit payments.
- ☐ 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 or authorized payee for any reimbursement that may be due.

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).
- ☐ 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.

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

- ☐ Medical bills or explanation of benefits statements with relevant diagnostic codes.
- ☐ A detailed payment record that includes the following:
    - date of payment;
    - amount of payment;
    - description of injury, including diagnostic code for services that relate to the non-compensable injury;
    - service provider; and
    - dates of service.

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

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Frequently Asked Questions

Who can file DWC Form-095?
Insurance carriers and their authorized representatives may use this form to request reimbursement from the SIF.

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. Use DWC Form-095 when the insurance carrier made an unrecoupable overpayment of benefits based on an interlocutory order or decision of the commissioner or court. You can also use this form when the insurance carrier made an unrecoupable overpayment of benefits based on an opinion rendered by a 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 Section 403.006(b)(2) and 28 Texas Administrative Code Section 116.11 apply when an unrecoupable overpayment of benefits is based on an interlocutory order or decision of the commissioner or court.
Texas Labor Code Sections 403.006(b)(4) and 408.0041(f-1) and 28 TAC Section 116.11 apply when an unrecoupable overpayment of benefits is based on an opinion rendered by a DD.

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 the type of benefit paid to the injured employee.

What response do you expect for question 13?
Provide a separate statement for each type of benefit requested. For TIBs, IIBs, or supplemental income benefits:

- The benefit period is the period for which benefits were originally paid.
- The dates 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 nonreimbursable 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 codes of the non-compensable injury.

Example of statements involving income benefits:

IIBs for 2/13/2018 to 3/5/2018 (three weeks) paid in a lump sum on 4/1/2018 totaling $1,260.
IIBs rate is $420 per week based on an average weekly wage of $600.
We request a reimbursement of three weeks of overpaid IIBs at $420 per week for a total of $1,260.

OR

TIBs for 1/1/2018 to 2/12/2018 paid in a lump sum on 4/1/2018 totaling $2,600.
TIBs rate until 1/14/2018 is $560 per week based on an average weekly wage of $800 and no post injury earnings.
The TIBs beginning 1/15/2018 is $350 per week based on an average weekly wage and nonpecuniary benefits of $1,000 and post injury earnings of $500 per week.
We request a reimbursement of two weeks of overpaid TIBs at $560 per week ($1,120) and four weeks and one day of overpaid TIBs at $350 per week ($1,450) for a total of $2,570.

Example of statement involving medical benefits:

> Medical benefits for services incurred 1/1/2018 to 2/12/2018 paid after the 3/8/2018 DD exam. $5,000 was paid in medical benefits.
> We request a reimbursement of $5,000 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 or decision of the commissioner, such as an interlocutory order or a contested case hearing decision and order, or it must be based on a DD's opinion. For the benefits reimbursement you are requesting, show which order, decision, or DD opinion required the benefit payments.

List the relevant orders or decisions or DD exam that required the benefit payments.

Example:

1/14/2017 DD Smith:

- MMI 1/14/2017.
- 10% IR.
- On extent: extends to include complete rotator cuff tear.
- Return to work with restrictions.
- Disability from 1/1/2017 to present.

What response do you expect for question 15?
List the relevant orders or decisions that reversed or modified the order, decision, or DD opinion that required the payments identified in question 14.

Example:

1/12/2018 Contested case hearing upheld on appeal:

- MMI 1/14/2017.
- 5% IR.
- Does not extend to conditions in dispute.

How do I submit this request?

- 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 at eFiling-Help@tdi.texas.gov; or
- Fax to 512-804-4759.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you.
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html