ADVISORY NO. 415
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TOPIC: DWC-026s from Health Care Insurers/Requests for Reimbursement — How to Respond

The recent flood of requests from Group Health Care Insurers (HCIs) for reimbursement for past medical bills paid on purportedly compensable claims prompts us to provide a comprehensive analysis and outline of the issues and procedures involved. These claims come in the form of a DWC Form-026 (attached).

Background: While there has been a sudden and substantial influx of these requests, this issue for the HCI's has been simmering for years. Effective 9/1/01, certain HCI's were granted the authority to collect from the TWCC otherwise confidential claim information ("Claims Data"), in electronic form in order to identify subclaims that may exist. **§402.084(b)(8) and (d)**. The TWCC failed in the following four years to adopt rules to implement the use of this data in helping HCI's pursue their subclaimant status, which had been in the Act at least since 1989. Thus, the Legislature amended **§402.084** in 2005 by adding subsections (c-1) through (c-7). These subsections detailed the process by which an HCI could gain access to and use the confidential workers' compensation Claims Data.

Once the confidentiality hurdle was overcome, the HCI's then needed a process to actually submit a subclaim to the workers' compensation carrier ("Carrier") and the DWC. The Division failed to adopt Rules for this process (The recent stakeholders meeting was so heated that it was prematurely adjourned.). So, the Legislature passed **§409.0091** this past session, effective 9/1/07 (attached). This new section sets out the process by which HCI's may seek reimbursement from Carriers for payment of medical bills the HCI's believe to be related to a workers' compensation claim. It also details the responsibilities and defenses available to the Carrier in responding to the request.

It is argued that this concept is not wholly disadvantageous to workers' compensation carriers. When compensability or other liability issues are unresolved, medical treatment may cease or be difficult to obtain. The right to reimbursement (limited to claims that are, in fact, compensable), encourages HCI's to pay for medical services. It is suggested that this is good for the claimant and the Carrier, as delayed medical care may extend disability and recovery periods. The Carrier does retain most defenses as to the entitlement to and amount of reimbursement. Remember, reimbursement is only made on compensable claims and in an amount not to exceed what the Carrier would have paid. However, the Carrier must remain vigilant and assert the appropriate defenses so that it pays only if it should and only in an amount that it should, no more, no less.

The Procedures: The DWC has **not** promulgated rules describing the process for the parties as of yet. Pending adoption of procedural rules, the following procedures and timeframes come from the statute itself. In the meantime, we recommend utilization of your current EOB/medical bill processing documentation, and letters when other communication is necessary.

1. The HCI must file the DWC Form-026 with the Carrier not later than 6 months after receiving the Claims Data that DWC must send to the HCI under Section 402.084(c-3) AND not later than 18 months after the HCI paid for the services. Except**:** If the DWC Claims Data was provided to the HCI before 1/1/07 and no prior request for reimbursement has been presented and denied, the HCI may still timely file DWC-026 between 9/01/07 and 3/1/08, inclusive. This allows a 6-month window to file older requests that would otherwise be barred. Since Claims Data was not available to HCI's prior to 2001, it is unlikely a request would have a date of service prior to 2001.

Note that this timeline is not based upon the date of injury or the date of service. The operative facts for timeliness of the request are: (1) the date of notice to the HCI of the work-related injury provided by the Claims Data supplied by the DWC under §402.084, and (2) the date the HCI paid the Provider for the medical services.

2. The Carrier may have up to 90 days to respond in writing. That period is extended to 120 days or by mutually agreed amount, if the Carrier makes a request for additional information under subsection (l).

3. The Carrier may request additional information from the HCI, giving the HCI at least 30 days to respond. The parties may mutually agree in writing to additional periods of compliance.

4. Within the given time period for a response and for requests for additional information, the Carrier may determine entitlement to reimbursement. Possible defenses:

--Claim not compensable
--Relatedness/Extent of injury
--Not a medical benefit under workers' compensation
--Not medically necessary (Determined retrospectively in these cases)
--This service was previously prospectively or retrospectively denied as not medically necessary. This would bar the claim.

Defenses the Carrier expressly may not raise:

--That HCI has not sought reimbursement from the Provider or its insured
--That HCI or Provider did not request preauthorization (This is ok, as the service is always subject to retrospective medical necessity review.)
--That Provider did not submit the bill to the Carrier within 95 days of the DOS per §408.027
[**Note**: This exception is limited to this statutory reference. Per TDI bulletin and DWC Rule, §408.027 applies only to DOS on or after 9/1/05. Although it may have been an oversight, the Carrier may be able to defend older, stale claims on the basis the Provider did not present the bill to the Carrier within 11 months and 1 day for DOS as of 7/15/00 and before 9/1/05, per Rule 134.801(c). In addition It may be that §408.0272, effective for DOS 9/1/07, which provides that submission to a group health insurer or HMO within the 95 days satisfies §408.027, may not serve as an exception for an HCI.]

5. Within the given time period for a response and for requests for additional information, and subject to any liability defense, the Carrier also determines the amount of reimbursement due. Bill should be reviewed by the bill review vendor and reduced:

--to the lesser of the appropriate Fee Guideline allowance (including "fair and reasonable" in the absence of a MAR) or the amount actually paid by the HCI
--by any documented amount Carrier previously paid the Provider for the same dates of service
--arguably, by any amount received by the Provider as a part of any deductible and/or co-payment (In absence of a Rule, current dispute exists as to which party must prove this was or was not actually collected by the Provider)
--with no claim for interest allowed

Note: The Carrier is actually not required to take any action within the time given for a response. Any action or failure to act by the Carrier under §409.0091 may not be subject to examination or administrative action by TDI, DWC or of any cause of action by any person (except for judicial review on the merits of the request).

6. In the absence of a written mutual agreement to extend the time, the HCI must file a written subclaim with the DWC not later than 120 days after: (1) the Carrier fails to respond to the DWC-026 (If no response to its request has been received within the 90-day, 120-day or

mutually agree response period, the HCI may assume a failure to respond.); or (2) receipt of the Carrier's denial or reduction of the reimbursement request. Except: If the DWC Claims Data was provided to the HCI before 1/1/07 and the request for reimbursement has been presented to and denied by the Carrier, the HCI may still timely file a subclaim with the DWC between 9/01/07 and 3/1/08, inclusive. This allows a 6-month window to file older claims that would otherwise be barred.

7. Any dispute that arises from this process must go through the appropriate dispute resolution process. Fee disputes would go the medical fee dispute resolution. Medical necessity disputes would go through the current TDI-HWCN IRO process. Liability disputes would be handled through the BRC/CCH/AP process. The Hearing Officer is expressly granted the power to issue orders regarding compensability, eligibility for benefits or for reimbursement under this section (presumably subject to medical fee and/or medical necessity dispute resolution).

Rules for the administration of this process are in the initial stages of development. In the absence of adopted rules, the Division has been setting some of these disputes for BRC in an attempt to obtain settlements. The Carrier should review the request as indicated by the statute and be prepared to offer payment, address any disputed issues and consider settlement possibilities, if appropriate.

"What am I supposed to do with these requests?" Lightening Round

1. **Review the request for reimbursement to determine if it is timely.**
   - ❖ This may require the HCI to provide additional information such as the date the HCI received the Claims Data from DWC for this claim.

2. **Review the request to determine whether the HCI has provided the required identifying information.**
   - ❖ The information required about the health care paid is included in the DWC Form-026
   - ❖ If you have sufficient information to process the claim, even without all the information in the DWC-026, process the request for reimbursement as you would any bill from a Provider.
   - ❖ If you do not receive the information required above, and the information that was provided is insufficient to allow you to process the request for reimbursement, you may request the HCI provide additional information.

3. **Review the charges to determine whether the HCI is entitled to reimbursement for the healthcare paid by the HCI.**
    - ❖ Raise any viable liability and medical necessity defenses.

4. **If you determine reimbursement is owed for this DOS, notify the HCI of the reimbursement being issued, and the basis for the amount of reimbursement allowed.**
    - ❖ Issue an EOB indicating the payment with proper Payment Adjustment Codes.

5. **If no reimbursement is owed, notify the HCI of your denial and reasons for denial.**
    - ❖ Issue an EOB or provide a letter documenting the reasons the request for reimbursement was denied.
    - ❖ Attach all relevant documentation supporting denial of the reimbursement request, including PLN-1's, PLN-11's, and/or EOBs of prior payments to the HCP for the same services on the same DOS.

6. **If the HCI is dissatisfied with your action and files a subclaim, be prepared to respond to the issues before the Division of Hearings, Medical Fee Dispute Resolution and/or the HWCN-TDI IRO process. But until rules are adopted for this process, expect BRC settings to discuss the issues.**

This process is obviously a work in progress. FO&L will keep you apprised of any new developments. Be prepared to offer suggestions and comments to the rules that will be proposed and adopted to implement this statute in the near future. Please call us if you have any additional questions and let us know your experience with this process as it develops.