Amend **CSSB 929** on third reading by adding the following appropriately numbered SECTIONs to the bill and renumbering the existing SECTIONs accordingly:

SECTION ___. Subsection (d), Section 408.027, Labor Code, is amended to read as follows:

(d) If an insurance carrier contests the compensability of an injury and the injury is determined not to be compensable, the carrier may recover the amounts paid for health care services from the employee's accident or health benefit plan, or any other person who may be obligated for the cost of health care services. If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which a workers' compensation carrier denies compensability, and the injury is later determined to be compensable, the accident or health insurance carrier or other person may recover the amounts paid for such services from the workers' compensation insurance carrier. If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which a workers' compensation carrier or employer accepts compensability, the accident or health insurance carrier or other person may recover reimbursement from the insurance carrier as described in Sections 409.009 and 409.0091.

SECTION ___. Subchapter A, Chapter 409, Labor Code, is amended by adding Section 409.0091 to read as follows:

Sec. 409.0091. REIMBURSEMENT PROCEDURES FOR CERTAIN ENTITIES. (a) This section applies only to a request for reimbursement by a health care insurer or authorized representative of a health care insurer. For purposes of this section, "health care insurer" refers to an insurance carrier or an authorized representative of an insurance carrier described by Section 402.084(c-1).

(b) Health care paid by a health care insurer is reimbursable as a medical benefit. For purposes of this section, "Medical benefit" has the meaning assigned by Section 401.011(31).

(c) A request for reimbursement or subclaim of the health care insurer is subject to the defense that the health care paid for

was not a medical benefit.

(d) It is not a defense to a subclaim by a health care insurer that:

(1) the subclaimant has not sought reimbursement from a health care provider or the subclaimant's insured;

(2) neither the subclaimant nor the health care provider obtained preauthorization under Section 413.014 or rules adopted under that section;

(3) the health care provider did not bill the insurance carrier, as provided by Section 408.027, by the 95th day after the date the health care paid for by the subclaimant was provided; or

(4) the health care provider did not comply with this subtitle or rules adopted under this subtitle.

(e) Subject to the time limits in Subsection (k), the health care insurer shall provide with any reimbursement request the following information to the insurance carrier:

(1) information identifying the workers' compensation case, including the division case number, patient/claimant name, patient/claimant social security number, and date of injury; and

(2) information describing the health care paid, including provider name, provider tax identification number, date of service, place of service, ICD-9 code, CPT code, amount charged by the provider, and the amount paid by the health care insurer.

(f) The insurance carrier shall reduce the amount of the reimbursable subclaim by any payments the insurance carrier had previously made to the same health care provider for the provision of the same health care on the same dates of service. When making such a reduction in reimbursement to the subclaimant, the insurance carrier shall provide appropriate documentation of the previous payments.

(g) For each medical benefit paid, the insurance carrier shall pay to the health care insurer the lesser of the amount payable under the applicable fee guideline on the date of service or the actual amount paid by the health care insurer. In the absence of fee guidelines for a specific service paid, the amount paid by the health care insurer shall be construed as a fair and reasonable

payment under Section 413.011(d). The health care insurer may not recover interest as a part of the subclaim.

(h) Upon receipt of a request for reimbursement under this section, the insurance carrier shall respond to the request in writing within 90 days. If the insurance carrier refuses, fails to pay, or reduces a request for reimbursement under this section, the health care insurer may file a written claim with the division as a subclaimant not later than 120 days from the date of receipt of the carrier's notice of refusal, failure to pay, or reduction in reimbursement.

(i) A subclaimant may request dispute resolution to address the insurance carrier's refusal or denial of reimbursement. The subclaimant must select one of the following options for dispute resolution:

(1) the subclaimant may file a dispute in accordance with Chapter 410; in a dispute under Chapter 410 that arises from a subclaim under this section or Section 408.027(d), health care benefits provided by a health care insurer are considered accrued medical benefits provided to the claimant for purposes of Section 410.168(a)(3) and a hearing officer may award the health care insurer, as a subclaimant, all or part of the subclaim and may order the insurance carrier to pay the subclaim as part of a dispute adjudication process under Chapter 410; or

(2) the subclaimant may request dispute resolution under Section 413.0311; the commissioner and the commissioner of insurance shall adopt rules to specify the appropriate dispute resolution process for subclaimant disputes under Section 413.0311.

(j) For a reduction in payment, a subclaimant may request medical dispute resolution to address the reduction in reimbursement under Chapter 413. The commissioner and the commissioner of insurance shall adopt rules to specify the appropriate dispute resolution process for subclaimant disputes under this subsection.

(k) Until December 31, 2008, a health care insurer must file a request for reimbursement with the insurance carrier not later than one year from the date that the health care insurer received

information under Section 402.084(c-3). Effective January 1, 2009, a health care insurer must file a request for reimbursement with the insurance carrier not later than six months from the date the health care insurer received information under Section 402.084(c-3). Effective January 1, 2009, a health care insurer must file a request for reimbursement for a health care claim not later than the second anniversary of the date the claim was paid.

SECTION ___. Subchapter C, Chapter 413, Labor Code, is amended by adding Section 413.0311 to read as follows:

Sec. 413.0311. INDEPENDENT REVIEW ORGANIZATION DISPUTE RESOLUTION FOR HEALTH CARE INSURER SUBCLAIMANTS. (a) This section applies to subclaimant disputes regarding reimbursements under Section 409.009 or 409.0091. If an insurance carrier refuses or denies reimbursement, the subclaimant may request dispute resolution from an independent review organization. Each independent review organization performing independent review must be certified under Chapter 4202, Insurance Code.

(b) Upon receipt of a denial or refusal for reimbursement, the subclaimant has the rights of discovery of an insurance carrier records or health care provider records that are available to the parties in a contested case hearing.

(c) The subclaimant shall request dispute resolution and present its written arguments and documentation supporting the determination that the paid health care services were medical benefits as defined under Section 401.011(31) to both the independent review organization and the insurance carrier.

(d) The insurance carrier shall make a written response to the independent review organization, with a copy provided to the subclaimant within 20 business days.

(e) The independent review organization shall review the facts and the parties' arguments and apply evidence-based medicine and generally accepted standards of medical care recognized in the medical community to determine whether the paid health care service constitutes a medical benefit. The independent review organization shall notify the parties of its determination within 60 days of receipt of the initial subclaimant request for dispute resolution.

(f) If the independent review organization determines that

a service is a medical benefit, the insurance carrier shall reimburse the subclaimant in the appropriate amount within 15 business days.

(g) The independent review organization review fee shall be paid by the subclaimant at the time of its request for dispute resolution. If the subclaimant prevails, in whole or in part in the dispute, the entire fee shall be reimbursed to the subclaimant by the insurance carrier together with the required medical benefit reimbursement under Subsection (f).

SECTION __. The change in law made by this Act applies only to a subclaim based on a compensable injury occurring on or after September 1, 2007. A subclaim based on a compensable injury occurring before that date is governed by the law in effect on the date the injury occurred, and the former law is continued in effect for that purpose. Except as otherwise provided by this Act, rules required to be adopted by the change in law made by this Act shall be adopted not later than December 31, 2007.

SECTION __. Any forms required under Section 409.0091, Labor Code, as added by this Act, shall be prescribed by the commissioner of workers' compensation not later than 60 days after the effective date of this Act.