WISCONSIN DWD

Division of Worker's Compensation Health Cost Dispute Applications

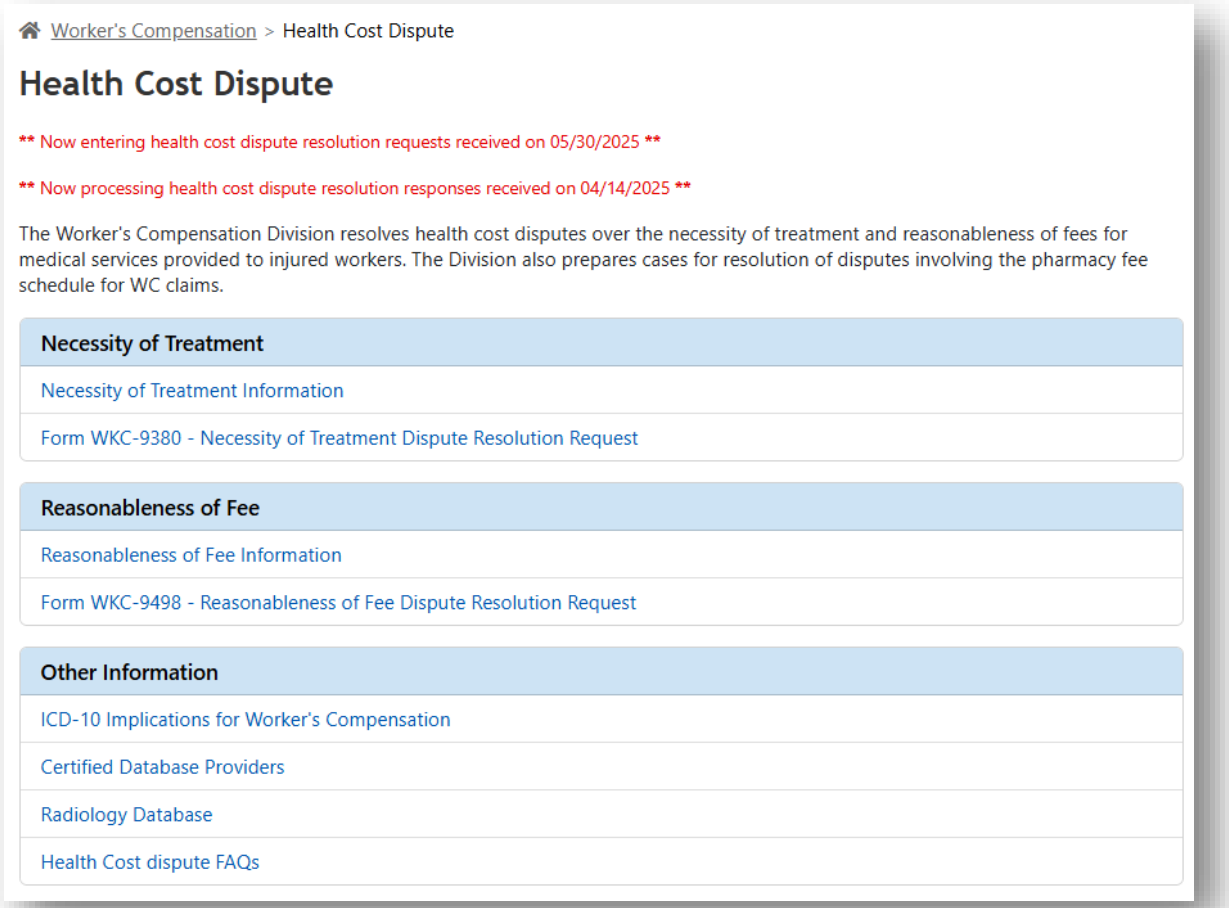
Guidance for Completing forms WKC-9380 and WKC-9498

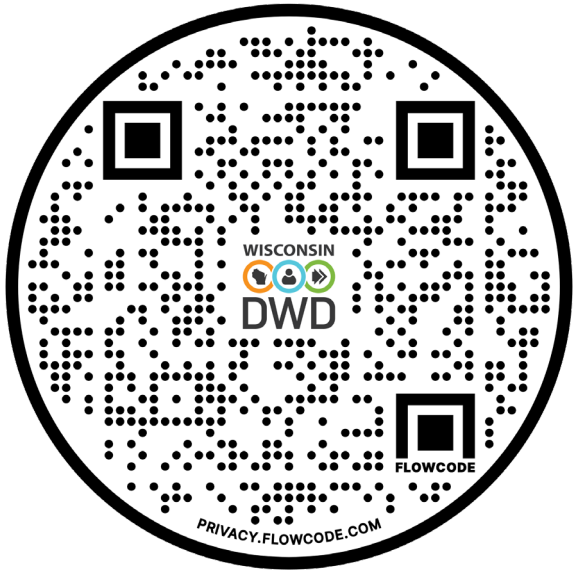
Health Cost Dispute Applications

- **Reasonableness of Fee (Form WKC-9498)**
  - A dispute regarding the reasonableness of the fees.

- **Necessity of Treatment (Form WKC-9380)**
  - **Independent Review (Section 1)**
    - A dispute regarding medical necessity.
  - **Request for a Default Order (Section 2)**
    - If an insurer or self-insurer provides the notice after the 60-day period, or after 60 days the provider has not received payment or a reply from the insurer or self-insurer.

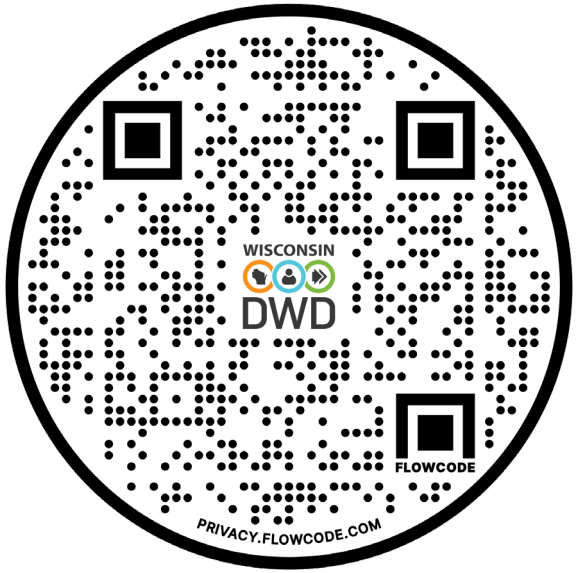
Health Cost Dispute Applications





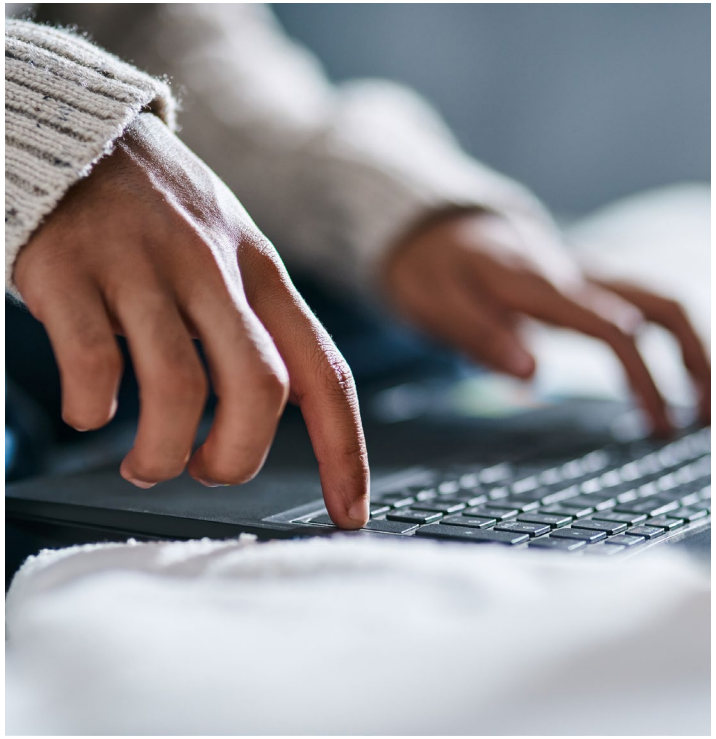
Health Cost Dispute Applications

- Use the most recent version of the application form.
- Forms and information on the dispute types can be found on the **Health Cost Dispute webpage**.
- Application packets (dispute resolution requests) can be faxed to 1-608-260-3143 or mailed to the Department's PO Box address.
- By law, providers must send a copy of the application packet to the insurer.



Health Cost Dispute Applications

- If you do not know the insurer, you can use Coverage Lookup on the WCRB website: **wcrb.org**
  - Coverage Look-Up
    - New Search
      - DOI must be correct
        - Search by name or address. The less info, the better.
- Insurer vs. Third-party Administrator (TPA) or Claim Handling Office (CHO)



Reasonableness of Fee - form WKC-9498

Application packet must include:

- Health Cost Dispute application form WKC-9498
- Health insurance claim forms
- Medical notes
- Explanation of benefits/review/reimbursement
- Prior correspondence
- Any additional supporting documentation

Reasonableness of Fee - form WKC-9498

SECTION 1 - Follow form guidance

- Enter dates for A and B.
- A. The date the insurer or self-insurer first disputes the reasonableness of the fee charged is *usually* the process date of the first explanation of review (EOR) received from the insurer.

SECTION 1 - Provide the dates requested in paragraphs A & B in the column at right	DATE
A. Date health care provider first billed insurer or self-insurer. NOTE: The provider has 6 months to file a dispute resolution request with the department from the date the insurer or self-insurer first disputes the reasonableness of the fee charged.	5/20/22
B. Date insurer or self-insurer first disputes the reasonableness of the fee charged. NOTE: If this date is not within 30 days of the billing date shown in Section 1A, the insurer shall compute and pay interest from this date if the provider prevails.	6/20/22

Reasonableness of Fee - form WKC-9498

SECTION 2 - Follow form guidance

- Select YES or NO.

SECTION 2	YES	NO
A. In disputing the fees listed in Section 4, did the insurer state it was using a database certified by the department?	■	☐
B. Is the provider alleging that a fee greater than the formula amount from a certified database is justified because the service provided in this case was more difficult or complicated to provide than the usual case?	☐	■
C. If the answer to B is yes, at least 20 days prior to filing this dispute, did the provider explain to the insurer the reason for the higher fee?	☐	☐
D. If the answer to C is yes, did the insurer respond to the explanation?	☐	☐
E. Is the provider continuing to treat this patient for the injury?	☐	■

Reasonableness of Fee - form WKC-9498

SECTION 3 – Follow form guidance

- Select YES or NO.
- #1, 1A, & 1B – If you select YES, include a copy of the document in the application.
- #2 - You may need to confirm with the insurer the correct address to use when sending them a copy of the dispute resolution request.

SECTION 3	YES	NO
1. **As required by law**, I am enclosing all correspondence and medical records relating to this dispute.	☑	☐
A. I am including the insurer's or self-insurer's initial notice refusing to pay.	☑	☐
B. I am including my written response explaining to the insurer why the fee was justified.	☑	☐
2. **As required by law,** I am sending one copy of this dispute resolution request with all attachments to the insurer or self-insurer at the same time I filed this request with the department.	☑	☐

Reasonableness of Fee - form WKC-9498

Dispute Resolution Request Information

- Complete the contact information at the bottom of page 1.
- This is who the department will contact if there are questions about the application packet.
- Applications that need correction/completion will be returned to the fax, email, or mailing address provided.

Dispute Resolution Request Information	
Provider or representative name John Doe	Date 10/15/2024
Telephone number and/or email for questions regarding this dispute resolution request 608-555-5555 or JohnD@provideroffice.com	
Fax number or email for returning applications to provider for completion/correction 608-555-6666	

Reasonableness of Fee - form WKC-9498

SECTION 4 - Follow form guidance

- List the name of the insurer. Providers often communicate with a third-party, such as a third-party administrator (TPA) or bill review company. You can often find the insurer listed on the EOR/EOB.

SECTION 4	NAME	Mailing Address for Dispute Correspondence	Injury Date
Employee/Patient	Maxwell House	Apt 56 1234 Street Name City, State, Zip Code	4/3/21
Employer (at the time of injury)	Employer Name	789 Street Name City, State, Zip Code	Social Security Number* 555-66-7777
Insurer or Self-Insurer	Zurich Amer Ins Co C/O Sedgwick	PO Box 123 City, State, Zip Code	Certified Database Used by the Insurer FAIR Health, Inc.
Health Care Provider	Facility Name	1111 Street Name City, State, ZipCode	

Reasonableness of Fee - form WKC-9498

SECTION 4 cont. - Follow form guidance

- Department notice letters, requests for additional information, and orders will be mailed to the provider's address listed on this form.
  - This address can be different than the service location or billing address.
- **Injury date** – Is the injury date the same as the date on the EOR?

SECTION 4	NAME	Mailing Address for Dispute Correspondence	Injury Date 4/3/21
Employee/Patient	**Maxwell House**	Apt 56 1234 Street Name City, State, Zip Code	
Employer (at the time of injury)	Employer Name	789 Street Name City, State, Zip Code	Social Security Number* 555-66-7777
Insurer or Self-Insurer	Zurich Amer Ins Co C/O Sedgwick	PO Box 123 City, State, Zip Code	Certified Database Used by the Insurer FAIR Health, Inc.
Health Care Provider	Facility Name	1111 Street Name City, State, ZipCode	

Reasonableness of Fee - form WKC-9498

SECTION 5 – Follow form guidance

- List the zip code of the physical location services were provided.
- List the CPT®, HCPCS Level II, DRG, or Revenue codes for the charges is dispute. If there is a CPT® or HCPCS Level II code, list that code instead of the Revenue code (e.g., J-codes).

SECTION 5	Treatment Zip Code: 53704		The provider's fee is based upon the **zip code** where the service was provided.					
CPT, HCPCS II, DRG CODE	CPT MODIFIER	NUMBER OF TREATMENTS	NUMBER OF UNITS	SERVICE DATES		AMOUNTS ($)		
				FROM	TO	CHARGED	PAID	DISPUTED^
99214	25	1	1	05/19/2023	05/19/2023	500.00	325.00	175.00
99212		1	1	06/01/2023	06/01/2023	235.00	135.58	99.42
99212		1	1	07/10/2023	07/10/2023	235.00	128.00	107.00
A3041		1	1	07/10/2023	07/10/2023	85.00	35.00	50.00
97140		2	2	06/01/2023	07/10/2023	205.00	150.00	55.00

Reasonableness of Fee - form WKC-9498

SECTION 5 – Follow form guidance

- The disputed amount must equal the charged amount minus the paid amount.
- When entering codes from a bill and the disputed amount for a single code is zero, you do not need to list that code on the form.
- Do not list negative disputed amounts.

SECTION 5	Treatment Zip Code: 53704		The provider's fee is based upon the **zip code** where the service was provided.					
CPT, HCPCS II, DRG CODE	CPT MODIFIER	NUMBER OF TREATMENTS	NUMBER OF UNITS	SERVICE DATES		AMOUNTS ($)		
				FROM	TO	CHARGED	PAID	DISPUTED^
99214	25	1	1	05/19/2023	05/19/2023	500.00	325.00	175.00
99212		1	1	06/01/2023	06/01/2023	235.00	135.58	99.42
99212		1	1	07/10/2023	07/10/2023	235.00	128.00	107.00
A3041		1	1	07/10/2023	07/10/2023	85.00	35.00	50.00
97140		2	2	06/01/2023	07/10/2023	205.00	150.00	55.00
								0.00

Reasonableness of Fee - form WKC-9498

SECTION 5 cont. – Follow form guidance

- Regarding the amounts in dispute, you can include a separate note or cover letter any accepted discounts (multiple procedure, modifiers, contracts).
- One application can include multiple dates of service for the same patient/date of injury. You do not need a separate application for each date of service.
- Multiple treatment dates for the same code can be consolidated to one line.

SECTION 5	Treatment Zip Code: 53704		The provider's fee is based upon the **zip code** where the service was provided.					
CPT, HCPCS II, DRG CODE	CPT MODIFIER	NUMBER OF TREATMENTS	NUMBER OF UNITS	SERVICE DATES		AMOUNTS ($)		
				FROM	TO	CHARGED	PAID	DISPUTED^
99214	25	1	1	05/19/2023	05/19/2023	500.00	325.00	175.00
99212		1	1	06/01/2023	06/01/2023	235.00	135.58	99.42
99212		1	1	07/10/2023	07/10/2023	235.00	128.00	107.00
A3041		1	1	07/10/2023	07/10/2023	85.00	35.00	50.00
97140		2	2	06/01/2023	07/10/2023	205.00	150.00	55.00
								0.00
								0.00
								0.00
								0.00
					TOTAL	$1260.00	$773.58	$ 486.42

^DISPUTED amount must equal CHARGED amount minus PAID amount.

Reasonableness of Fee - form WKC-9498

SECTION 5

Example 1: Professional Fees. Multiple dates of service can be listed for the same patient and same date of injury. A spreadsheet in the same format is also acceptable.

SECTION 5	Treatment Zip Code: 53704		The provider's fee is based upon the **zip code** where the service was provided.					
CPT, HCPCS II, DRG CODE	CPT MODIFIER	NUMBER OF TREATMENTS	NUMBER OF UNITS	SERVICE DATES		AMOUNTS ($)		
				FROM	TO	CHARGED	PAID	DISPUTED^
99214	25	1	1	05/19/2023	05/19/2023	500.00	325.00	175.00
99212		1	1	06/01/2023	06/01/2023	235.00	135.58	99.42
99212		1	1	07/10/2023	07/10/2023	235.00	128.00	107.00
A3041		1	1	07/10/2023	07/10/2023	85.00	35.00	50.00
97140		2	2	06/01/2023	07/10/2023	205.00	150.00	55.00
								0.00
								0.00
								0.00
								0.00
					TOTAL	$1260.00	$773.58	$ 486.42

^DISPUTED amount must equal CHARGED amount minus PAID amount.

Reasonableness of Fee - form WKC-9498

SECTION 5

Example 2: Hospital Outpatient Facility Fees. A spreadsheet in the same format is also acceptable.

SECTION 5	Treatment Zip Code: 53704		The provider's fee is based upon the **zip code** where the service was provided.					
CPT, HCPCS II, DRG CODE	CPT MODIFIER	NUMBER OF TREATMENTS	NUMBER OF UNITS	SERVICE DATES		AMOUNTS ($)		
				FROM	TO	CHARGED	PAID	DISPUTED^
99214		1	1	05/19/2023	05/19/2023	935.00	485.00	450.00
J1033		1	4	05/19/2023	05/19/2023	84.00	40.00	44.00
61011		1	1	05/19/2023	05/19/2023	5600.00	2,000.00	3,600.00
61012	51	1	1	05/19/2023	05/19/2023	5,600.00	1,000.00	4,600.00
250		1	2	05/19/2023	05/19/2023	1,200.00	0.00	1,200.00
252		1	2	05/19/2023	05/19/2023	1,100.00	0.00	1,100.00
								0.00
								0.00
								0.00
					TOTAL	$14519.00	$3525.00	$10,994.00

^DISPUTED amount must equal CHARGED amount minus PAID amount.

Reasonableness of Fee - form WKC-9498

SECTION 5

Example 3: Inpatient stay, DRG code. You can use one code for all charges in the dispute. A spreadsheet in the same format is also acceptable.

The DRG code can be found in Box 71 PPS Code on the UB-04.

SECTION 5	Treatment Zip Code: 53704		The provider's fee is based upon the **zip code** where the service was provided.					
CPT, HCPCS II, DRG CODE	CPT MODIFIER	NUMBER OF TREATMENTS	NUMBER OF UNITS	SERVICE DATES		AMOUNTS ($)		
				FROM	TO	CHARGED	PAID	DISPUTED^
042		1	1	03/01/2024	03/01/2024	143,000.00	85,000.00	58,000.00
								0.00
								0.00
								0.00

Necessity of Treatment, Request for Independent Review – form WKC-9380

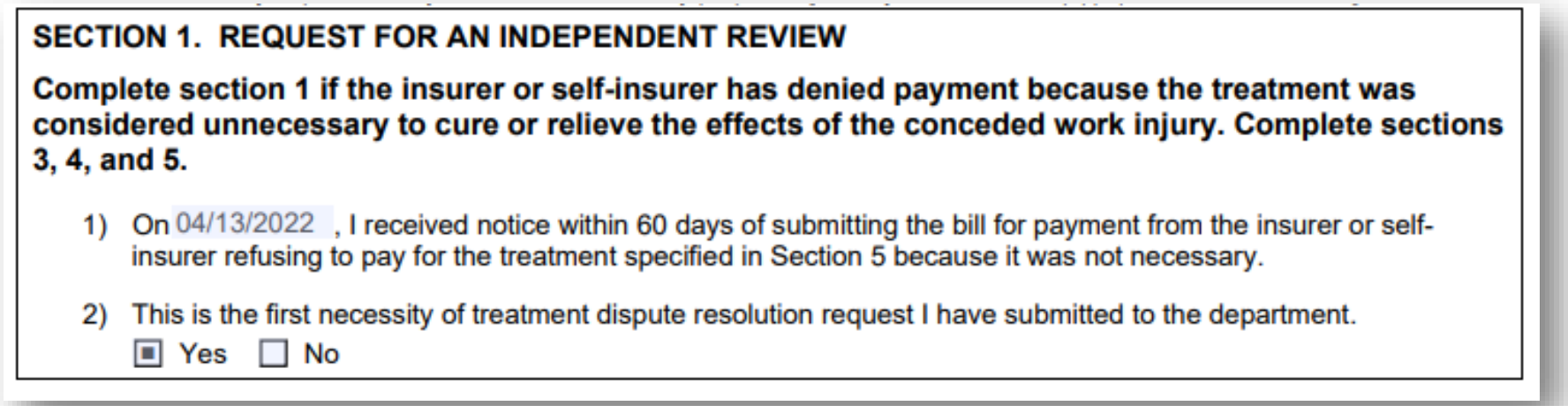
Application packet must include:

- Health Cost Dispute Application – Form WKC-9380, sections 1, and 3 thru 5
- Health insurance claim forms.
- All Medical notes.
- Explanation of Benefits/Review/Reimbursement.
- Explanation to insurer/self-insurer in writing explaining why the treatment was necessary, including a diagnosis of the condition.
- Prior correspondence.
- Any additional supporting documentation.

Request for Independent Review - form WKC-9380

SECTION 1 – Follow form guidance

- Enter the date you received the notice of the denial due to necessity of treatment being an issue and whether it is the first application you submitted to the department for independent review.



SECTION 1. REQUEST FOR AN INDEPENDENT REVIEW

Complete section 1 if the insurer or self-insurer has denied payment because the treatment was considered unnecessary to cure or relieve the effects of the conceded work injury. Complete sections 3, 4, and 5.

1) On 04/13/2022 , I received notice within 60 days of submitting the bill for payment from the insurer or self-insurer refusing to pay for the treatment specified in Section 5 because it was not necessary.

2) This is the first necessity of treatment dispute resolution request I have submitted to the department.
☑ Yes ☐ No

Request for Independent Review - form WKC-9380

SECTION 3 – Follow form guidance

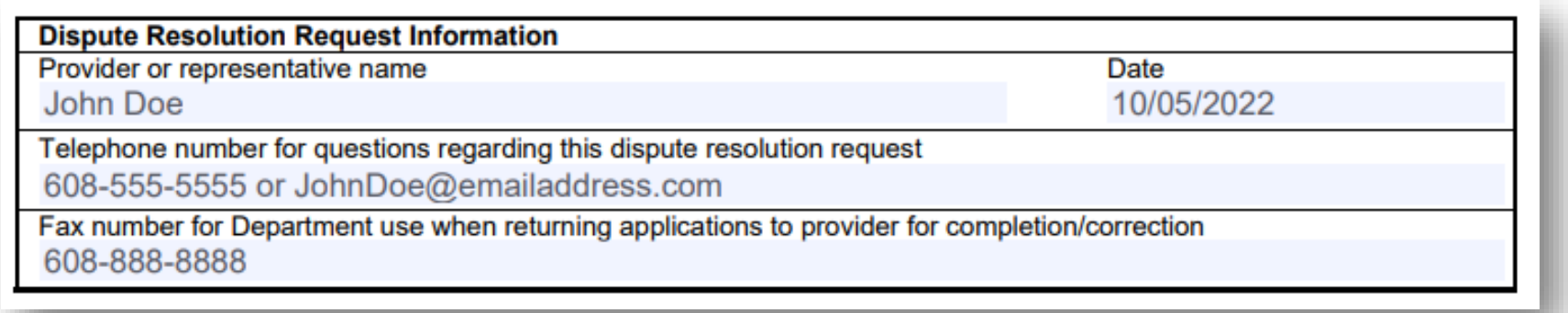
- Check YES or NO.
- A request for an Independent Review should look like this:

SECTION 3.	YES	NO
1. **As required by law**, I am enclosing copies of all correspondence and medical records relating to this dispute. This includes:	☒	☐
A. The insurer's or self-insurer's initial notice refusing to pay.	☒	☐
B. My written response explaining to the insurer why the treatment was necessary.	☒	☐
2. **As required by law**, I am sending one copy of this dispute resolution request with all attachments to the insurer or self-insurer at the time I filed this request with the department.	☒	☐

Request for Independent Review - form WKC-9380

Contact Information

- Complete the information at the bottom of page 1.
- This is the person the department will contact if there are questions about the application packet. Email can be provided.
- Applications that need correction/completion will be returned to the fax, email, or address provided.



Dispute Resolution Request Information	
Provider or representative name John Doe	Date 10/05/2022
Telephone number for questions regarding this dispute resolution request 608-555-5555 or JohnDoe@emailaddress.com	
Fax number for Department use when returning applications to provider for completion/correction 608-888-8888	

Request for Independent Review - form WKC-9380

SECTION 4 – Follow form guidance

- Department notice letters, requests for additional information, and orders will be mailed to the provider addresses listed on this form.

SECTION 4.	NAME	MAILING ADDRESS FOR DISPUTE CORRESPONDENCE
Employee/Patient	John Doe	1111 Street Name City, State, Zip Code
Employer (at the time of injury)	Employer Name	3333 Street Name City, State, Zip Code
Insurer or Self-Insurer	Insurer Name C/O TPA (if applicable)	4444 Street Name City, State, Zip Code
Health Care Provider	Individual Provider	PO Box 1234 City, State, Zip Code Code
Injury Date: 04/01/2022		Employee Social Security Number*:
Are you continuing to treat this patient for the injury? ☐ Yes ☒ No		

*Provision of the Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Request for Independent Review - form WKC-9380

SECTION 4 – Follow form guidance

- List the name of the insurer. Providers often communicate with a third-party, such as a third-party administrator (TPA) or bill review company. You can often find the insurer listed on the EOR/EOB. Search on www.WCRB.org if needed.

SECTION 4.	NAME	MAILING ADDRESS FOR DISPUTE CORRESPONDENCE
Employee/Patient	John Doe	1111 Street Name City, State, Zip Code
Employer (at the time of injury)	Employer Name	3333 Street Name City, State, Zip Code
Insurer or Self-Insurer	Insurer Name C/O TPA (if applicable)	4444 Street Name City, State, Zip Code
Health Care Provider	Individual Provider	PO Box 1234 City, State, Zip Code Code
Injury Date: 04/01/2022		Employee Social Security Number*:
Are you continuing to treat this patient for the injury? ☐ Yes ☒ No		

*Provision of the Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Request for Independent Review - form WKC-9380

SECTION 5 – Follow form guidance

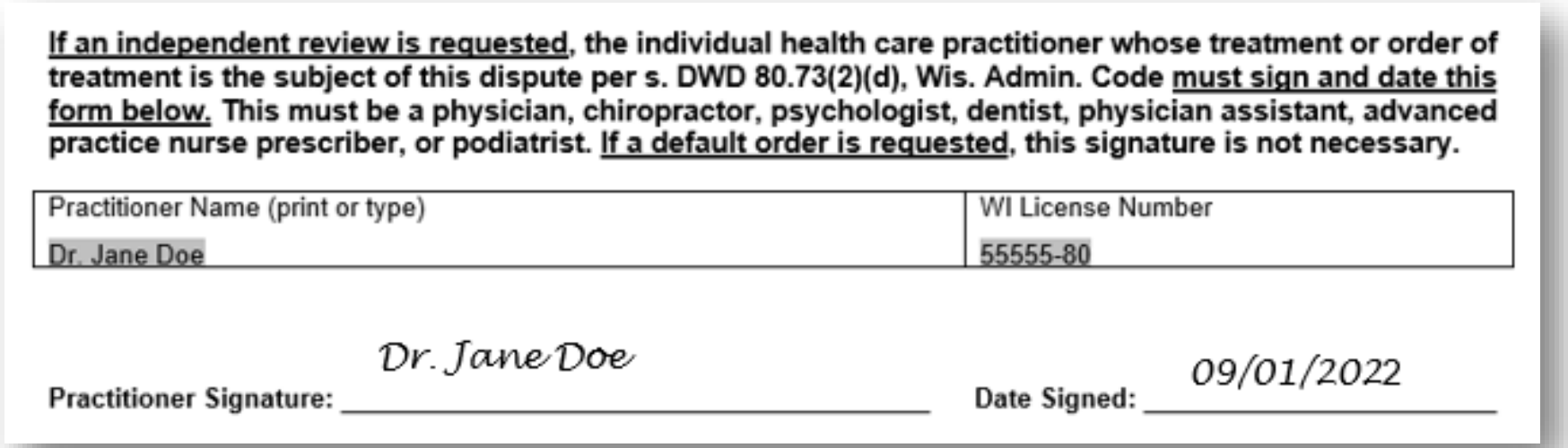
- A Request for an independent review might look like the example below. A spreadsheet in the same format is also acceptable.

SECTION 5.	DATES		AMOUNT ($)
SPECIFIC TREATMENT IN DISPUTE	FROM	TO	CHARGED
Physical Therapy 97110, 10 units	04/01/2022	06/23/2022	$700.00
Manual Therapy 94000, 8 units	04/01/2022	06/23/2022	$550.00
Chiropractic Visits 98999, 28 units	04/20/2022	08/28/2022	$5,000.00
			$
			$
			$
			$
		TOTALS	$6,250.00

Request for Independent Review - form WKC-9380

Signature Section

- A Request for an independent review **must** be signed by the health care practitioner whose treatment is in dispute.



If an independent review is requested, the individual health care practitioner whose treatment or order of treatment is the subject of this dispute per s. DWD 80.73(2)(d), Wis. Admin. Code must sign and date this form below. This must be a physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist. If a default order is requested, this signature is not necessary.

Practitioner Name (print or type)	WI License Number
Dr. Jane Doe	55555-80

Practitioner Signature: Dr. Jane Doe _____ **Date Signed:** 09/01/2022 _____

Necessity of Treatment, Request for a Default Order – Form WKC-9380

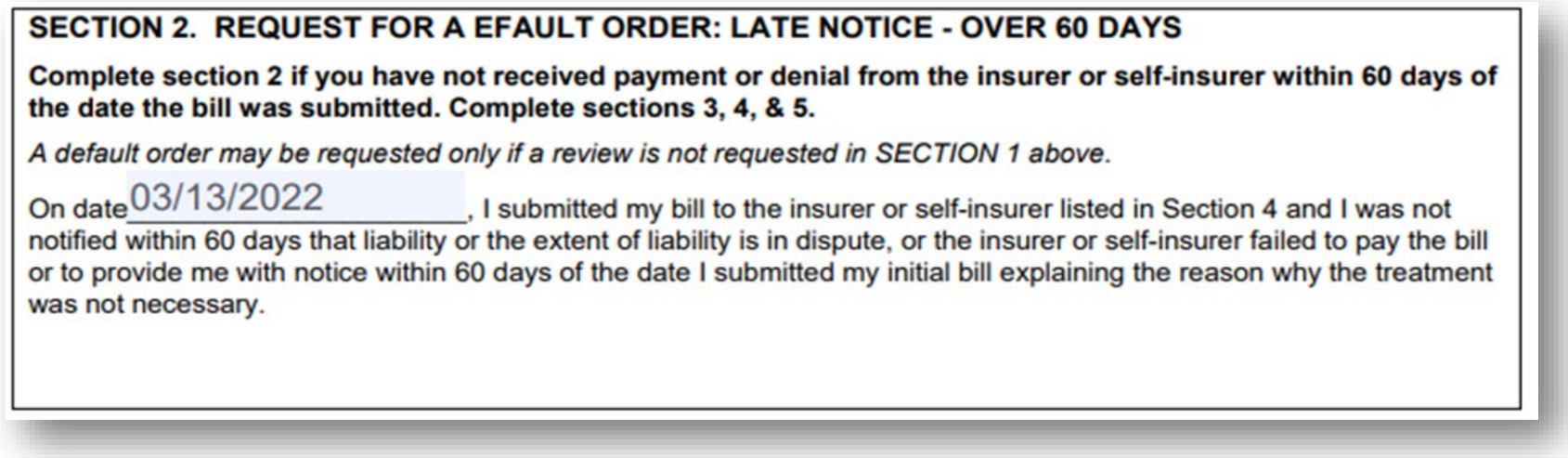
Application packet must include:

- Health Cost Dispute Application – Form WKC-9380, sections 2-5.
- Health insurance claim forms.
- Medical notes.
- Prior correspondence.
- EOR/EOB, if received
- Any additional supporting documentation.

Request for a Default Order - form WKC-9380

SECTION 2 - Follow form guidance

- Enter the date you first submitted a complete bill to the insurer.



SECTION 2. REQUEST FOR A EFAULT ORDER: LATE NOTICE - OVER 60 DAYS

Complete section 2 if you have not received payment or denial from the insurer or self-insurer within 60 days of the date the bill was submitted. Complete sections 3, 4, & 5.

A default order may be requested only if a review is not requested in SECTION 1 above.

On date 03/13/2022, I submitted my bill to the insurer or self-insurer listed in Section 4 and I was not notified within 60 days that liability or the extent of liability is in dispute, or the insurer or self-insurer failed to pay the bill or to provide me with notice within 60 days of the date I submitted my initial bill explaining the reason why the treatment was not necessary.

Request for a Default Order - form WKC-9380

SECTION 3 – follow form guidance

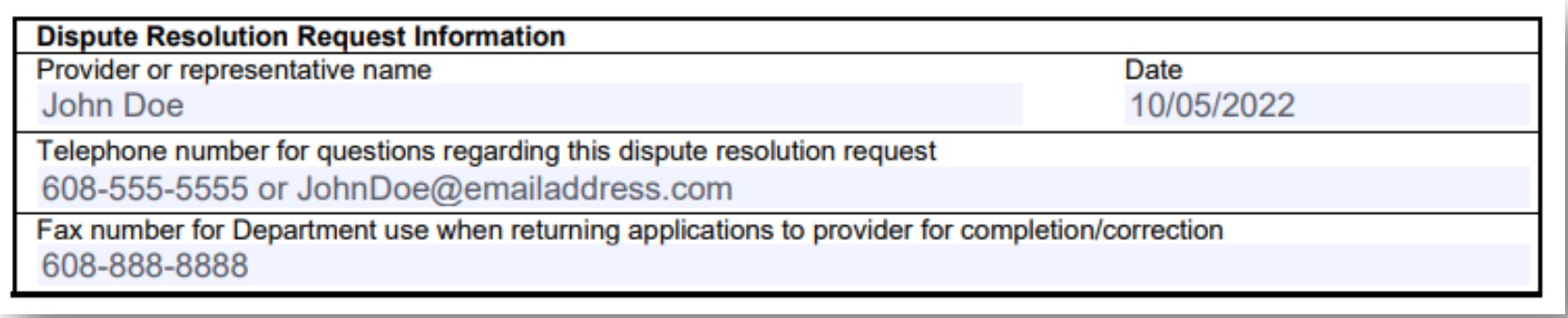
- A request for a default order might look like this:

SECTION 3.	YES	NO
1. **As required by law**, I am enclosing copies of all correspondence and medical records relating to this dispute. This includes:	☑	☐
A. The insurer's or self-insurer's initial notice refusing to pay.	☐	☑
B. My written response explaining to the insurer why the treatment was necessary.	☐	☑
2. **As required by law**, I am sending one copy of this dispute resolution request with all attachments to the insurer or self-insurer at the time I filed this request with the department.	☑	☐

Request for a Default Order - form WKC-9380

Contact Information

- Complete the information at the bottom of page 1.
- This is the person the department will contact if there are questions about the application packet. Email can be provided.
- Applications that need correction/completion will be returned to the fax, email, or address provided.



Dispute Resolution Request Information	
Provider or representative name John Doe	Date 10/05/2022
Telephone number for questions regarding this dispute resolution request 608-555-5555 or JohnDoe@emailaddress.com	
Fax number for Department use when returning applications to provider for completion/correction 608-888-8888	

Request for a Default Order - form WKC-9380

SECTION 4 – Follow form guidance

- Department notice letters, requests for additional information, and orders will be mailed to the insurer and provider addresses listed on this form.

SECTION 4.	NAME	MAILING ADDRESS FOR DISPUTE CORRESPONDENCE
Employee/Patient	John Doe	1111 Street Name City, State, Zip Code
Employer (at the time of injury)	Employer Name	3333 Street Name City, State, Zip Code
Insurer or Self-Insurer	Insurer Name C/O TPA (if applicable)	4444 Street Name City, State, Zip Code
Health Care Provider	Provider	PO Box 1234 City, State, Zip Code Code
Injury Date: 04/01/2022		Employee Social Security Number*:
Are you continuing to treat this patient for the injury? ☐ Yes ☒ No		

*Provision of the Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Request for a Default Order - form WKC-9380

SECTION 4 – Follow form guidance

- List the name of the insurer. Providers often communicate with a third-party, such as a third-party administrator (TPA) or bill review company. Search on www.WCRB.org if needed.

SECTION 4.	NAME	MAILING ADDRESS FOR DISPUTE CORRESPONDENCE
Employee/Patient	John Doe	1111 Street Name City, State, Zip Code
Employer (at the time of injury)	Employer Name	3333 Street Name City, State, Zip Code
Insurer or Self-Insurer	Insurer Name C/O TPA (if applicable)	4444 Street Name City, State, Zip Code
Health Care Provider	Provider	PO Box 1234 City, State, Zip Code Code
Injury Date: 04/01/2022		Employee Social Security Number*:
Are you continuing to treat this patient for the injury? ☐ Yes ☒ No		

*Provision of the Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Request for a Default Order - form WKC-9380

SECTION 5 – Follow form guidance

- A Request for a Default Order might look like one of the examples below. A spreadsheet in the same format is also acceptable.
- One application can include multiple dates of service for the same patient/date of injury. You do not need a separate application for each date of service.

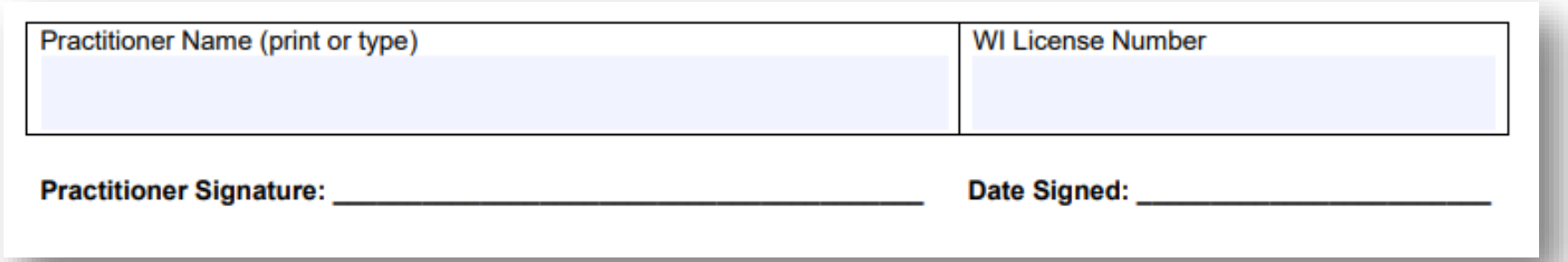
SECTION 5.	DATES		AMOUNT ($)
SPECIFIC TREATMENT IN DISPUTE	FROM	TO	CHARGED
Entire bill for surgery	10/10/2022	10/10/2022	$ 23,563.00
		TOTALS	$ 23,563.00

SECTION 5.	DATES		AMOUNT ($)
SPECIFIC TREATMENT IN DISPUTE	FROM	TO	CHARGED
99204	04/01/2022	04/01/2022	$358.00
12001	04/01/2022	04/01/2022	$838.00
			$
			$
			$
			$
			$
		TOTALS	$1,196.00

Request for a Default Order - form WKC-9380

Signature Section

- For a Request for a Default Order, a practitioner does not need to sign the form. This can be left blank.



Practitioner Name (print or type)	WI License Number

Practitioner Signature: _____ **Date Signed:** _____

Health Cost Dispute Resolution Process

1. The department receives a health cost dispute resolution request.
2. A notice letter is mailed to the insurer requesting a response to the dispute. A copy is mailed to the provider.
3. The insurer submits a response to the department. Responses are reviewed in the order they are received.
   - If the insurer doesn't respond, a second request letter may be sent.
   - If the insurer makes an additional payment, a letter will be mailed to the provider requesting confirmation of satisfactory payment.
4. Upon follow-up, the department reviews the documentation on file. Additional information may be requested.
5. A determination is made, and an order is issued resolving the dispute.

Health Cost Dispute Resolution Process Cont.

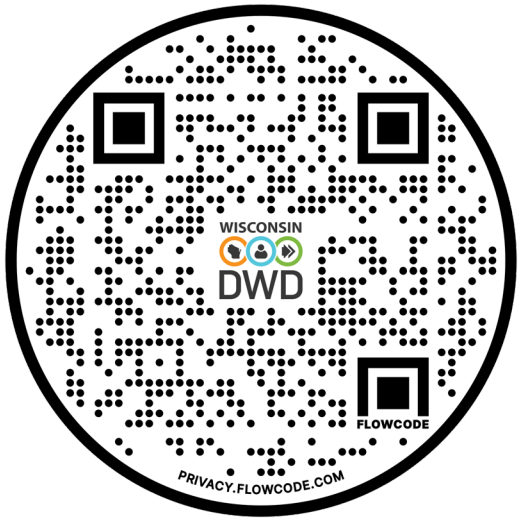
6. The department may set aside, reverse, or modify a determination within 30 days after the date of the determination. The department may set aside, reverse, or modify a determination within 60 days on grounds of a mistake.
7. If proper payment is not issued in a timely manner after an order is issued by the department, the provider may file with the circuit for entry in the judgement and lien docket to initiate collection against an insurer or self-insured employer for the ordered amount and/or the provider may also contact the Office of the Commissioner of Insurance to file a formal complaint against the insurance carrier.

Health Cost Dispute Q&A #1

Worker's Compensation > Health Cost Dispute > FAQ

Health Cost Dispute FAQs

- Does Wisconsin have a worker's compensation fee schedule?
- To whom should the provider send a bill for a Worker's Compensation injury?
- How can I contact an employer's Workers Compensation insurance carrier?
- What if the employer refuses to give me the name of the insurer?
- Can I bill an employee for unpaid medical bills?
- I sent a bill to the insurer some time ago and have not heard from them. What can I do to get paid?
- I received a copy of an order from the Division ordering the insurer to pay my fee but I have not received payment. What is my next step?
- The insurer will not tell me why they reduced my charges. What can I do to find out why?
- What happens if the worker's compensation carrier denies the claim as being not work related and the health insurer is then billed and denies coverage because the injury was work related?
- What happens if a provider or the insurer, or self-insured employer, rebuts a determination made by the Department?
- What happens to my health cost dispute request if the employee, to whom medical treatment is being rendered, is litigating the claim with the Department?
- How long can I expect it to take for a dispute to be resolved by the Department?
- Is it appropriate for a worker's compensation carrier to deny payment of treatment based on the Treatment Guidelines?



Health Cost Dispute Q&A #2

Can you send me a copy of the notice letter or order?

- Please request a copy from the division by emailing WCCopyRequest@dwd.Wisconsin.gov.
- Include in your request the dispute ID and the injured worker's:
  - Name
  - Social security number
  - Date of injury, and
  - Employer name at the time of injury.

Health Cost Dispute Q&A #2

We received an order from the division ordering the insurer to pay my fee, but I have not received payment. What is my next step?

- We ask that you contact the payer and seek prompt payment of the amount ordered. If the payer does not pay in a timely manner, write the department and ask for a certified copy of the order. The certified copy can be entered as a judgment in circuit court. You can address your request for a certified copy of the order to the attention of **WC Records Custodian.**
- You may also contact the Office of the Commissioner of Insurance (OCI) to file a formal complaint against the insurance carrier.

Office of the Commission of Insurance

Phone: 608-266-3585

Toll-free: 800-236-8517

Email: ociomplaints@wisconsin.gov

Health Cost Dispute Q&A #3

We received denials stating Wisconsin is a state that requires authorization and the insurance refuses to reprocess the claims. Can we submit these denials as a dispute?

- You can submit these denials as disputes. Preauthorization is not required for Wisconsin worker's compensation medical services.

What can we do if a claim is "under investigation" for a long time?

- You can file a health cost dispute resolution request, Necessity of Treatment – Request for a Default Order.

Health Cost Dispute Q&A #3

We always ask for reconsideration with the work comp insurer first, and often the results go past the time limits of the dispute. Would you advise we forego that and file a dispute immediately?

- We would not advise foregoing the reconsideration before the dispute is filed. However, if the 6-month or 9-month time frame is approaching and a response to the reconsideration has not been received, we do advise that a dispute be filed with the department. If the insurer decides to pay, the dispute can always be dismissed at the provider's request.

Health Cost Dispute Q&A #4

Is an insurance carrier allowed to send the provider a copy of the denial letters sent to the injured worker?

- Because a provider is not a party to the worker's compensation claim, the insurer is not required to provide the denial letter to the provider. If the claim denial is unclear as to who will be paying for the medical fees, we suggest reaching out to the injured employee who should have received a copy of the denial letter.
- If the injured employee is unclear, you can reach out to the department for more guidance as to who should be paying for the services, or a dispute can be filed with the department and an order would be issued resolving this issue.

Health Cost Dispute Q&A #4

Does the division apply the PPO reduction used by the insurer?

- The department has no statutory authority to determine whether a valid Preferred Provider Organization (PPO) or other such contract exists, the terms of any contract, or whether a specific situation is subject to a PPO-type contract.
- No contractual agreement between the provider and insurer, or self-insured employer, is taken into consideration when the department resolves a reasonableness of fee dispute.

Contact Us

Worker's Compensation Division
Department of Workforce Development
PO Box 7901
Madison, WI 53707
(608) 266-1340

Health Cost Dispute Unit Fax: (608) 260-3143
Applications & Responses to DWD letters

Health Cost Dispute WCHealthCostDispute@dwd.wisconsin.gov
General Questions & Status

Contact Us

Patient's Last Name	HCD Unit Staff	Phone	Email
A - FMA	**Kayla Van Valkenberg**	608-264-6819	Kayla.VanValkenberg@dwd.wisconsin.gov
FMB - LAZ	**Kathy (Kay) Sparling**	608-405-4086	Kathy.Sparling@dwd.wisconsin.gov
LBA - REH	**Ana Lopera**	608-405-4565	Ana.LoperaBarrera@dwd.wisconsin.gov
REI – Z	**Holly Hampton**	608-267-1360	HollyH.Hampton@dwd.wisconsin.gov

Health Cost Dispute Unit Fax: 608-260-3143
Health Cost Dispute Unit General Inbox Email:
WCHealthCostDispute@dwd.wisconsin.gov