NECESSITY OF TREATMENT
DISPUTE RESOLUTION REQUEST

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 264-6819
Fax: (608) 260-3143
http://dwd.wisconsin.gov/wc
e-mail: wchealthcostdispute@dwd.wisconsin.gov

Direct all inquiries to the Health Cost Dispute Unit.

Mail application packets to the Department's P.O. Box address.

INSTRUCTIONS: Complete Section 1 **or** Section 2 **AND** sections 3, 4 & 5.

You are the **RESPONDENT** in this matter.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

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 (date)_____, 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

SECTION 2. REQUEST FOR A DEFAULT 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_____, I submitted my bill for treatment to the insurer or self-insurer listed in Section 3.

Check the applicable box(es):
☐ I was not notified within 60 days that liability or extent of liability is in dispute.
☐ 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.

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.	☐	☐

PLEASE CONTINUE TO PROVIDE INFORMATION ON THE REVERSE SIDE

SECTION 4.	NAME	MAILING ADDRESS FOR DISPUTE CORRESPONDENCE
Employee/Patient		
Employer (at the time of injury)		
Insurer or Self-Insurer		
Health Care Provider		

Injury Date:	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.

SECTION 5.	DATES		AMOUNT ($)
SPECIFIC TREATMENT IN DISPUTE	FROM	TO	CHARGED
			$
			$
			$
			$
			$
			$
			$
		TOTALS	$

<u>If an independent review is requested</u>, the below signature <u>must</u> be of the individual health care practitioner whose treatment or order of treatment is the subject of this dispute per § DWD 80.73(2)(d), Wis. Admin. Code. This must be a physician, chiropractor, psychologist, dentist, physician assistant, advanced practice nurse prescriber, or podiatrist

Practitioner Name (print or type)	WI License Number	Contact Telephone Number

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

State of Wisconsin
Department of Workforce Development, Worker's Compensation Division
P.O. Box 7901, Madison, WI 53707; (608) 266-1340

NECESSITY OF TREATMENT DISPUTE RESOLUTION REQUEST APPLICATION INSTRUCTIONS

Please read the following information before filling out application form WKC-9380. If partial payment has been received, use form WKC-9498 instead for a Reasonableness of Fee dispute resolution request.

The department will charge either the insurer or you for its cost of obtaining an independent, impartial, expert medical opinion on the necessity of treatment. If this is the first necessity of treatment dispute resolution request you have submitted to the division, the insurer or self-insurer will pay the full cost. In all subsequent disputes which you file, the losing party will pay the full cost of obtaining the expert's opinion.

Please see s. 102.16, Wis. Stats., and s. DWD 80.73, Wis. Admin. Code, for additional information on the necessity of treatment dispute resolution process.

SECTION 1. REQUEST FOR AN INDEPENDENT REVIEW

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 1, 3, 4, and 5 of form WKC-9380.

1. Enter the date you received notice from the insurer or self-insurer refusing to pay for the treatment in dispute because it was not necessary. This notice should inform you of the following:
    a. The name of the patient-employee, the name of the employer at the time of injury, and the date of the treatment in dispute.
    b. The amount charged for the treatment and the amount in dispute.
    c. The reason that the insurer or self-insurer believes the treatment was unnecessary.
    d. The organization and credentials of any person who provided supporting documentation to the insurer or self-insurer.
    e. Your right to submit a dispute resolution request to the department within 9 months from the date on which you received the notice denying payment, including a description of how costs will be assessed.
    f. The address to use in directing correspondence to the insurer or self-insurer.
    g. You may not collect the disputed fee from the employee-patient once you receive notice from the insurer or self-insurer that the treatment was in dispute.
2. Check yes or no if this is the first necessity of treatment dispute resolution request you are submitting to the department.

SECTION 2. REQUEST FOR A DEFAULT ORDER: LATE NOTICE – OVER 60 DAYS

If you have not received payment or denial from the insurer or self-insurer within 60 days of the date that the bill was submitted, fill out sections 2, 3, 4, and 5 of form WKC-9380.

1. Enter the date you submitted the bill to the insurer.
2. Check the applicable boxes.

SECTION 3

1. You are required to include all correspondence and medical records related to the health cost dispute.
2. You are required to send a copy of the dispute resolution request with all attachments to the insurer at the same time the request is filed with the department.

SECTION 4

1. List the employer's insurer. The insurer is not the same as the third-party administrator (TPA) or bill review company.
2. List the addresses to be used for correspondence regarding the dispute resolution request.

SECTION 5

1. Make additional copies if more space is needed for the fees in dispute. A spreadsheet in the same format is acceptable.

If an independent review is requested, the signature must be of an individual health care practitioner. If a default order is requested, the signature can be a representative of the health care provider.