REASONABLENESS OF FEE
DISPUTE RESOLUTION REQUEST

Direct all inquiries to the Health Cost Dispute Unit.

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

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 260-3143
https://dwd.wisconsin.gov/wc
e-mail: wchealthcostdispute@dwd.wisconsin.gov

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

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.	
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.	

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?	☐	☐

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.	☐	☐

Dispute Resolution Request Information
Provider or representative signature
Date signed
Telephone number for questions regarding this dispute resolution request

PLEASE CONTINUE TO PROVIDE INFORMATION ON THE REVERSE SIDE

SECTION 4	NAME	Mailing Address for Dispute Correspondence	Injury Date
Employee/Patient			
Employer (at the time of injury)			Social Security Number*
Insurer or Self-Insurer			Certified Database Used by the Insurer
Health Care Provider (facility or individual)			

*Provision of the Social Security Number (SSN) is voluntary; not providing it could result in an information processing delay.

SECTION 5	Treatment Zip Code:	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
				TOTAL		$	$	$

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

REASONABLENESS OF FEE DISPUTE RESOLUTION REQUEST

Please read the following information before filling out the application form.

1. Complete form WKC-9498 if the insurer disputes the reasonableness of the fee charged for treatment. Do not use this form if you have not received a payment or denial from the insurer within 60 days of submitting a bill or if the insurer or self-insurer has denied the treatment as unnecessary to cure or relieve the effects of a conceded work injury - use form WKC-9380 instead for a Necessity of Treatment dispute resolution request.

2. Once a health care provider has been notified that the fee for treatment is in dispute, the provider may not collect or bring an action for collection of the disputed fee against the person who received the treatment.

3. A health service provider may not submit a fee dispute to the department under this subsection before all treatment by the health service provider of the employee's injury has ended if the amount in controversy, whether based on a single charge or a combination of charges for one or more days of service, is less than $25.00.

4. If the database to which the insurer or self-insurer subscribes is unable to provide the information, the department may use any other information that it considers to be "reliable and relevant" to resolve the dispute.

5. Please see s. 102.16, Wis. Stats., and s. DWD 80.72, Wis. Admin. Code, for additional information on the reasonableness of fee dispute resolution process.

APPLICATION INSTRUCTIONS (Form WKC-9498)

Provide all requested information. Failure to provide the requested information may result in the application being returned for completion.

SECTION 1

- Provide the requested dates.

SECTION 2

- Select yes or no for questions A through E.

SECTION 3

- You are required to include all correspondence and medical records related to the health cost dispute.
- 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.

SECTON 4

- List the employer's insurer. The insurer is not the same as the Third-Party Administrator (TPA) or bill review company.
- List the addresses to be used for correspondence regarding the dispute resolution request.

SECTION 5

- Make additional copies if more space is needed for the fees in dispute. A spreadsheet in the same format is acceptable.
- The Treatment Zip Code is the location where services were provided, not the billing department's zip code.
- Provide the CPT code, ADA code, DRG code, or other similar coding for the charge(s) in dispute.
- The Disputed Amount must equal the Amount Charged less the Amount Paid.