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Workers Compensation Health Costs Dispute Process

Practitioners should be aware of a process under Wisconsin's workers compensation law for resolving health costs disputes within the context of a workers compensation proceeding. Since both the statutory requirements and time restraints associated with this process can be complicated, the doctor is advised to review the applicable law. The law describing this process is contained in both the Wisconsin statutes and Wisconsin Administrative Code provisions. Particular attention should be given to Wis. Stats. §102.16(2)(b) and 102.16(2)(m); as well as, Wisconsin Administrative Code DWD 80.72 and 80.73 . The Administrative Code provides details for the application of the general provisions from the statutes.

This process is often referred to as the "tie breaker" proceeding since it generally provides for a "neutral" doctor to resolve disputes relating to either the reasonableness of a doctor's fee or the necessity of treatment. The panel of "neutral" doctors are pre-determined by the workers compensation department. A doctor submitting a dispute under this process cannot choose the "neutral" doctor since the department chooses that individual to address each dispute. The current panel of doctors can be found by contacting the workers compensation division since the panel of available doctors will periodically change.

The Statutes and Administrative Code permit the department, on its own initiative, or an "interested party"; such as the actual doctor, patient, or insurer, to initiate the health cost dispute process. The process can only address the necessity of treatment or the reasonableness of fees in dispute. There is no formal hearing

associated with this process since the dispute is basically resolved by the neutral physician through a “paper review”. The time limits and requirements of each form of dispute are addressed below:

A. Reasonableness of Fees Dispute

The doctor can submit a fee dispute to the Department of Workforce Development (DWD) using form WKC-9498. The medical cost dispute unit of the Department of Workforce Development oversees these types of disputes. The details relating to this dispute process are contained within Wisconsin Administrative Code DWD 80.72. Before submitting a fee dispute, all treatment for the employee's injury must be completed. Both the doctor submitting the dispute form and the insurer are bound by the Department's ultimate determination unless that determination is set aside by further judicial review. When submitting the dispute form, the doctor is prohibited from collecting the disputed fee or commencing a collection action to recover the disputed fee.

With respect to time restraints, a provider who does not agree with the information provided by the insurer must, within twenty (20) days prior to submitting a dispute, submit a written justification to the insurer noting the factual error(s) or explaining the extent to which the service provided in the disputed case was more difficult or more complicated than in the usual case, or both. The insurer then has fifteen (15) days after receiving this justification notice in which to respond. The provider must submit the written request for Department review within six (6) months after an insurer refuses to pay. The provider must also provide a copy of the request and all attachments to the insurer or self-insurer which were made prior to submitting the Departmental request.

Generally, the provider has six (6) months in which to file a dispute resolution request with the DWD. That time runs from the date when the insurer or self-insurer

first refuses to pay the bill. The insurer must dispute a bill within thirty (30) days of the doctor's billing date or the insurer will be responsible for paying interest (interest at 12% per annum) from that time the provider ultimately prevails in recovering additional fees.

Following the submission of the fee dispute, the insurer or self-insured employer must provide the Department information on the fee which has been denied. This must include information on the fees charged by other health service providers for comparable services and the comparable fees from a database that is certified by the Department. If the insurer fails to submit this information, the Department shall order the disputed fee paid. If the information is submitted, the Department relies upon that information to determine the reasonableness of the disputed fees. In analyzing any database, the Department can allow a 1.4+ standard deviation from the mean as demonstrated by the accepted database. The provider has the ability to challenge the database relied upon by the insurer based upon CPT codes.

Before initiating this process, it is suggested that the doctor request a detailed explanation from the insurer as to the reason for denying the specific charges of the patient. The doctor should seek information on the specific database relied upon by the insurer in disputing the amount of the fee. The doctor is encouraged to regularly request this information from the insurer on at least a rotating, monthly basis. Repeat requests should be made since interest can be added to the amount of the disputed fee should the insurer fail to timely respond within thirty days of such a request. The doctor should also be aware that there are time limits and rights to appeal the ultimate resolution of the matter and that any challenge should generally be made within thirty (30) days of the final determination.

B. Disputes Relating to Necessity of Treatment

Administrative Code DWD 80.73 addresses the details associated with a dispute of this nature. This process is initiating by the provider submitting written notice of the dispute to the doctor within sixty (60) days after receiving a bill where the necessity of treatment is disputed. When the provider objects to paying for treatment, the provider must also submit a notice to the doctor specifying various matters relevant to the dispute. This sixty (60) day period may be extended by the Department upon request from the insurer. If the sixty day requirement is not met, the provider can request that the Department issue an Order requiring the insurer to pay the full amount of the treatment in dispute.

After receiving the sixty (60) day notice, the doctor must provide to the insurer, at least thirty (30) days prior to submitting a formal dispute, an explanation as to why the treatment was necessary to cure and relieve the effects of the injury. This notice must also include a diagnosis of the condition for which the treatment was provided. After receiving this explanation, the insurer then has thirty (30) days in which to accept or reject the provider's explanation. If the insurer rejects the explanation and such treatment is later determined to be necessary, the insurer must pay the interest at 12% from the day after the thirty (30) day period lapses to the date of the actual payment to the provider.

Following this thirty (30) day notice, the doctor can then submit the dispute to the Department as to the necessity of treatment. The doctor must ultimately apply to the Department within nine (9) months from the date the doctor received the notice from the provider disputing the necessity of treatment. The information submitted to the

Department shall include copies of all correspondence relating to the dispute and any other relevant materials, including the identity and credentials of any individual who has reviewed the case. The insurer then has twenty (20) days in which to "answer" the information submitted by the provider. Once the twenty (20) day period for answering has run, the Department will submit the dispute to the neutral chiropractor. That expert will then render an opinion within ninety (90) days. After the expert renders his opinion, the insurer then has thirty (30) days in which to submit clear and convincing evidence showing that the expert's opinion was incorrect. The Department will then adopt or modify the expert's opinion and issue an appropriate Order.

The Department's final Order may charge the insurer the full cost of obtaining the written opinion of the expert for the first dispute involving the necessity of treatment unless the Department determines that the doctor's position in the suit was frivolous or based on fraudulent representations. In any subsequent disputes involving the same doctor, the doctor shall charge the full cost of obtaining the expert's opinion to the losing party in the dispute. Any party ultimately disagreeing with the Department's decision has the right to seek judicial review; even though the chance of success upon judicial review is very unlikely.