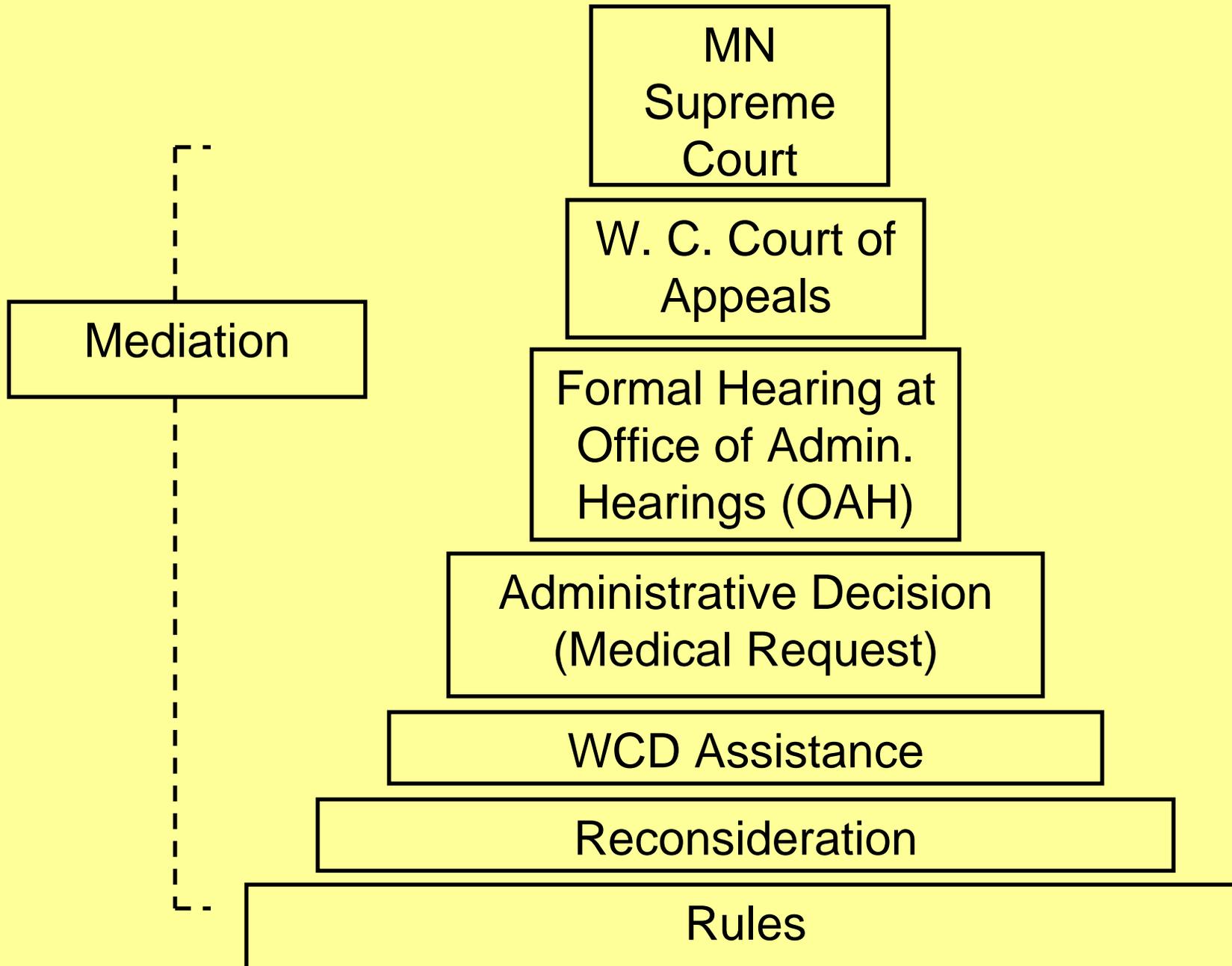


A Dispute Resolution Hierarchy

**Benefit Management
and Resolution Unit
Workers' Compensation Division
Minnesota Department of Labor and Industry**

**(651) 284-5005
1-800-342-5354**

A Dispute Resolution Hierarchy

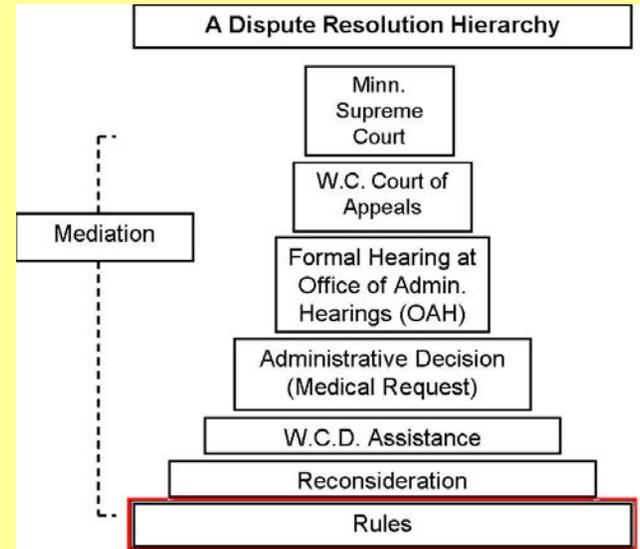


Rules

Rules require providers to:

- bill in the required format
- use standard codes
- provide appropriate records supporting the charges, and demonstrate relationship to work injury

Rules *“require communication”*



Rules

Once proper billing and an appropriate record are received the rules require payers to act within 30 days to:

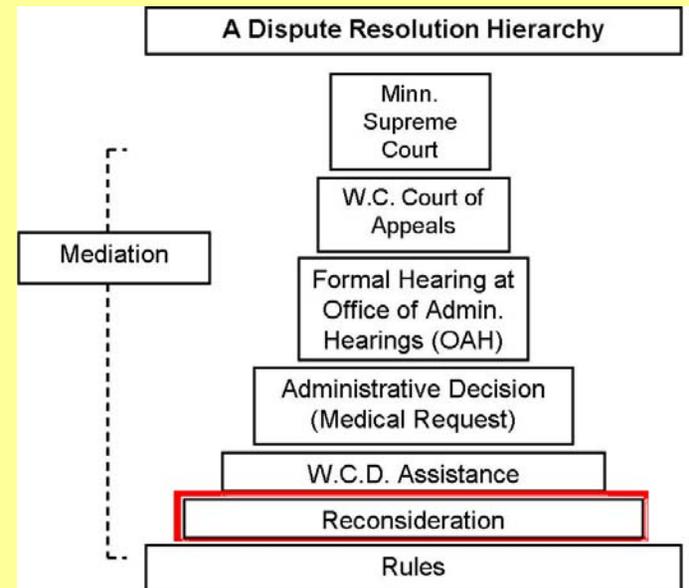
- pay the charge
- deny the charge providing a reason for denial, or
- request additional information

Rules *“require communication”*

Reconsideration

Asking the payer to reconsider is a step you *might* take when:

- When you disagree with the payer's reason for denying or reducing a charge.
- When you don't understand the reason for a denial or reduction.

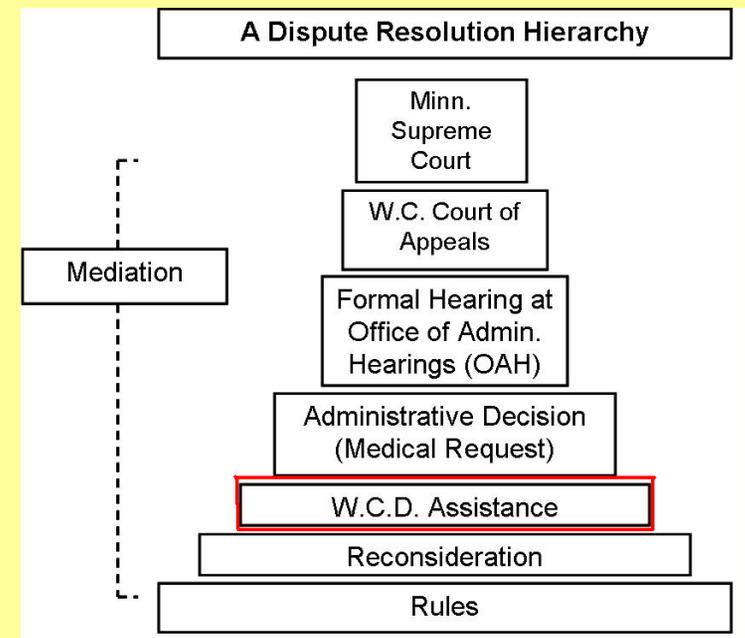


Reconsideration

Asking the payer to reconsider is a step you will need to take when:

- When the payer has issued a denial and requested additional information.
- Reconsideration is about communication.
- The successful communication of information between provider and payer generally resolves billing and payment issues.

Assistance



Situations payers or providers may want to call about:

- When you have a question about the fee schedule or treatment parameters.
- When you believe a payment or billing standard is being incorrectly applied and discussing it has not resolved it.

Assistance

more situations to call about....

- When there are a large number of accounts involved and the same disputed issue
 - We can help you decide how to efficiently resolve disputes
- When past experience is that the particular issue or similar issues have resolved in the past by compromise with a payer
- you do not necessarily need to wait until
 - the other side approaches you, you can begin negotiations

Assistance

Some provider specific issues to call about:

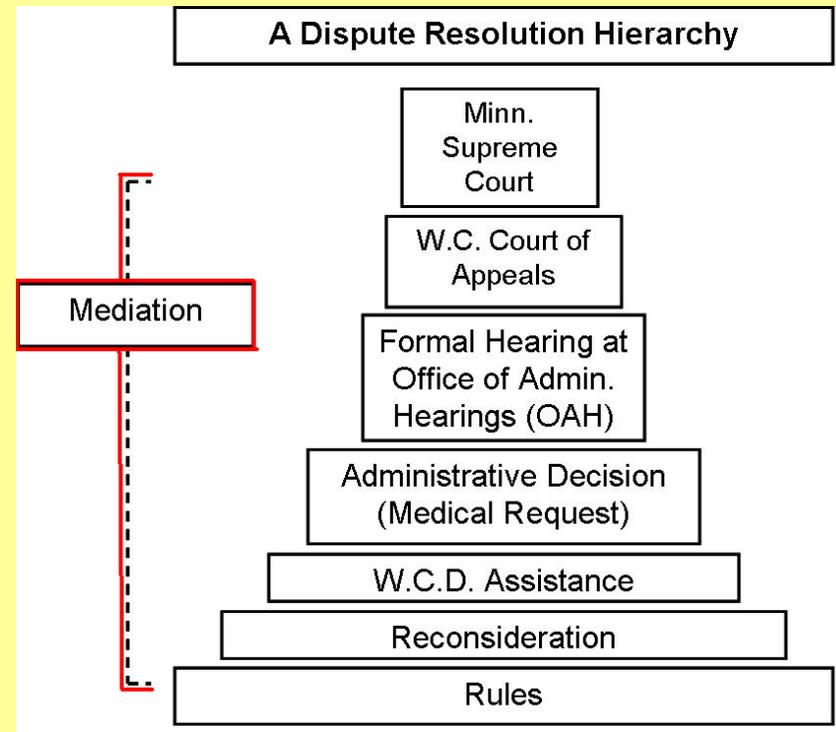
- When the health care provider does not understand the payer's reasons for denial or reduction
- When you are unable to determine who the insurer is through your contacts with the employee, the employer, and our insurance verification service.
- When bills have been submitted and there has been not been a response

Assistance

We may be able to:

- provide the information you need to resolve the issue on your own
- contact the payer to resolve the issue on your behalf
- assist you and the payer to arrive at a compromise resolution of the matter

Mediation

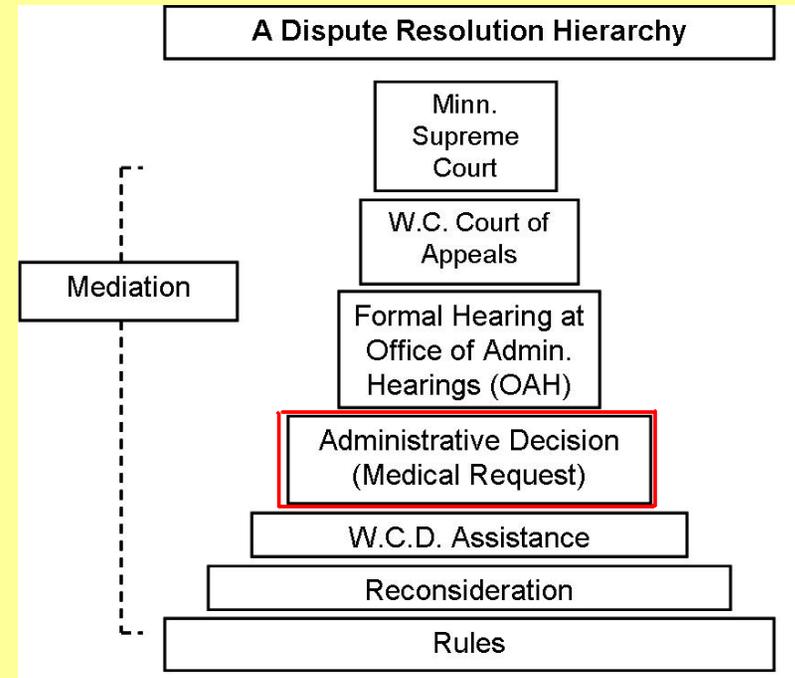


- The parties might be talking or negotiating directly about a small bill
- The parties might be involved in complex situations with attorneys and court hearings

Mediation

- Mediation can be an effective and appropriate dispute resolution strategy anywhere along the continuum
- Learn more about the mediation services we provide in the presentation on Mediation that is also posted on this website.

Administrative Decision (Decision and Order)



- Starts with the Medical Request
 - a multi purpose form to resolve disputes about medical benefits
- Followed by Medical Response
- Our staff attempt to resolve, if not certify a dispute

Administrative Decision (Decision and Order)

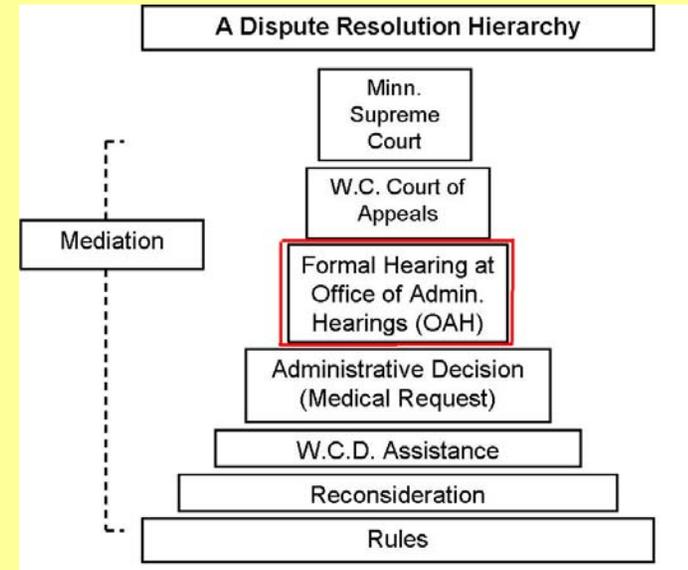
- Administrative Decision
 - Non-conference process
 - Administrative conference process
- Non-conference process
 - Parties submit documents
 - Documents carefully reviewed, considered and decision made based on preponderance of the information submitted
 - If no party requests formal hearing within 30 days, Order becomes binding

Administrative Decision (Decision and Order)

- Administrative conference process
 - Informal conference
 - Opportunity to meet and discuss, present information
 - Agreements may be reached
 - If no agreement, order issued within 30 days
 - Documents carefully reviewed, considered and decision made based on preponderance of the information submitted
 - If no party requests formal hearing within 30 days, Order becomes binding

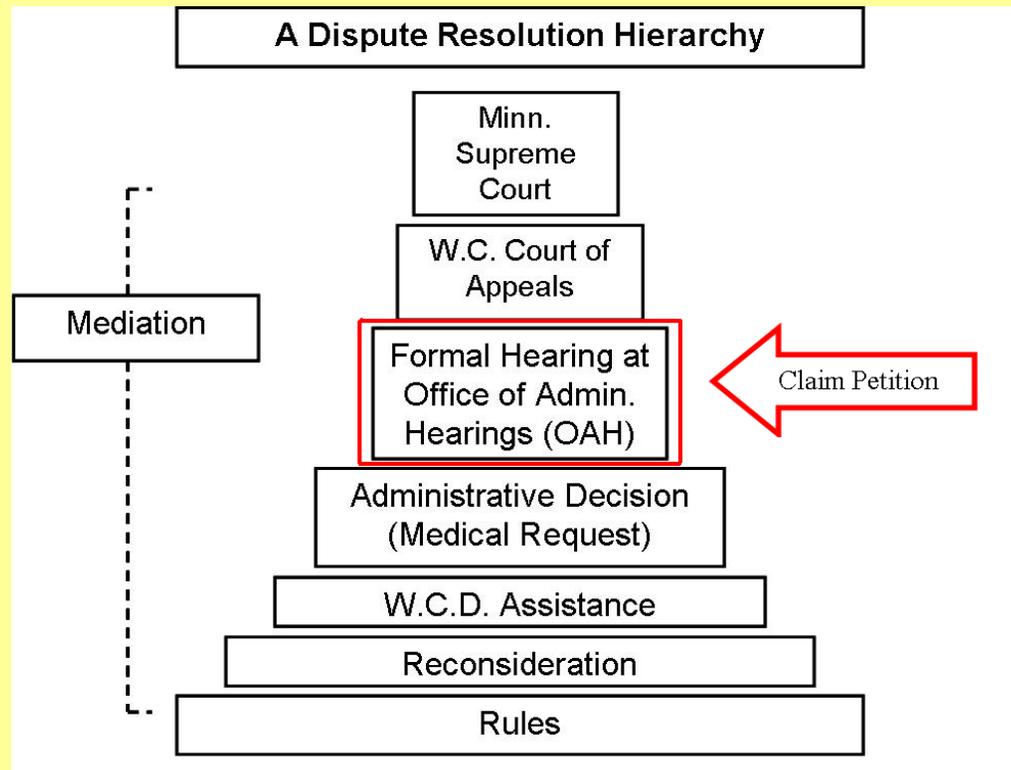
Formal Hearing at OAH

- Following a timely request after an Administrative Decision (within 30 days after a Decision and Order)
- A formal hearing (a trial) is scheduled at the Office of Administrative Hearings.

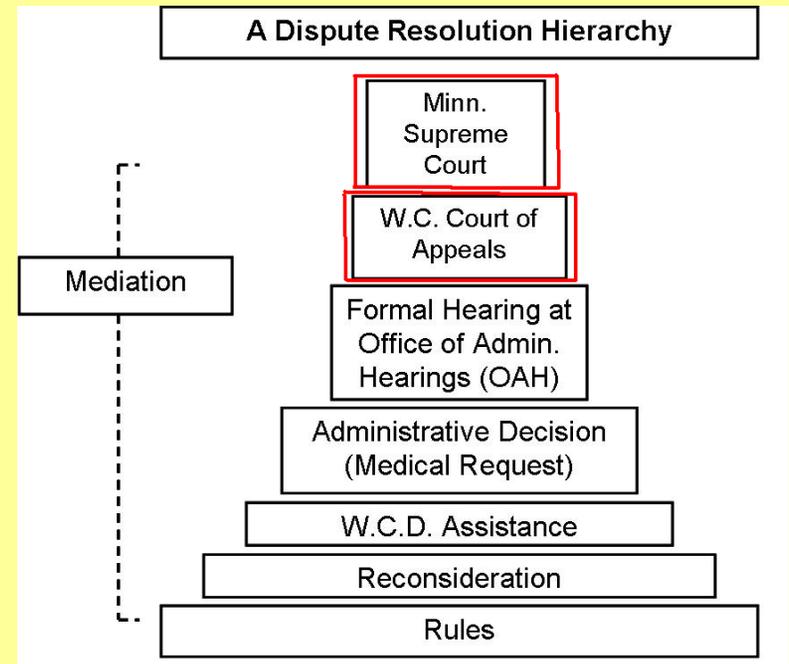


Request for Formal Hearing

- An Employees' Claim Petition is the other method of requesting a formal hearing (it may include monetary benefits, as well)



Appeals Courts



- An Order from a formal hearing at OAH is appealable to the WCCA
- A Decision by the WCCA is appealable to the Minn. Supreme Court
- Appeals Court Decisions can clarify the law and help eliminate future disputes

Medical Requests

When may providers file Medical Requests?

- The following table lists some general types of reasons for denials of bills in the left hand column.
- In the remaining columns it provides information about who the provider can bill under each circumstance and what the dispute resolution option is for both the employee and the provider.

Medical Requests

When may providers file Medical Requests?

Provider Dispute Resolution Options			
Denial Reason	Who Can Provider Bill?	Patient's Dispute Resolution Option	Provider's Dispute Resolution Options
Primary liability	Patient or Health Insurer	Claim Petition	None*
Causation	Patient or Health Insurer	Claim Petition or Medical Request	None*
Medical Necessity	W C Insurer Only	Claim Petition or Medical Request	Medical Request
Treatment Parameters	W C Insurer Only	Claim Petition or Medical Request	Medical Request
Fee Schedule	W C Insurer Only	Claim Petition or Medical Request	Medical Request

*No direct remedy, but provider can intervene in a proceeding brought by the patient/injured worker to establish his/her claim, or to secure payment of medical bills.

Medical Request

All medical requests must identify the

- employee, employer, insurer, date of injury, Social Security or worker identification number (WID)
- The requesting party must document the date the Medical or Rehabilitation Request form and attachments were served on all parties and potential intervenors.

Medical Request

All medical requests must identify:

- employee,
- employer,
- insurer,
- date of injury,
- Social Security number or worker identification number (WID)

Reset

Medical Request

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

CHECK BOX IF THIS REQUEST ADDS MEDICAL ISSUES TO

NOTE: Before filing this form, call the workers' compensation insurer, Management and Resolution at (651) 284-5032 (or 1-800-342-5354).

DO NOT USE THIS SPACE

<input type="checkbox"/> MEDICAL REQUEST		WID or SSN		DATE OF INJURY	
EMPLOYEE NAME		PHONE # (include area code)			
EMPLOYEE ADDRESS				INSURER/SELF-INSURER/TPA	
CITY	STATE	ZIP CODE	INSURER ADDRESS		
EMPLOYER NAME			CITY	STATE	ZIP CODE
EMPLOYER ADDRESS			CLAIM REPRESENTATIVE NAME		
CITY	STATE	ZIP CODE	INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- This form must be filled out completely; otherwise, it may be returned to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, vocational rehabilitation, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354. YES NO

1. THIS REQUEST IS BEING COMPLETED BY:

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Attorney	<input type="checkbox"/> Employer	<input type="checkbox"/> Insurer/TPA Self-insured	<input type="checkbox"/> Insurer's Attorney	<input type="checkbox"/> Health Care Provider
-----------------------------------	--	-----------------------------------	---	---	---
2. Are medical services being provided or managed by a certified managed care plan? YES NO. If yes, attach information showing that the dispute resolution process of the certified managed care plan has already been exhausted.
3. MEDICAL ISSUES (check only those that apply)

I request:

a. that health care provider bills be paid. (List all health care providers whose bills or services are in dispute. Attach extra sheets if needed. Itemized bills and supporting medical reports must be attached.)

NAME	ADDRESS	UNPAID BALANCE

b. a change of treating doctor:

FROM: NAME	ADDRESS	SPECIALTY
TO: NAME	ADDRESS	SPECIALTY

c. that prescribed treatment, surgery or equipment be provided. (Specify the requested surgery or equipment & attach supporting medical reports.)

d. that the employee's medical expenses be reimbursed (e.g., mileage, prescription drugs). Attach supporting medical reports.

e. a second opinion or consultation with

NAME	SPECIALTY
------	-----------

f. other (explain):

MN MQ03 (5/08) (over)

You must identify the issue

- Blanks and boxes provided for common dispute types
- Or use the “Other” section
- Be clear

Reset

Medical Request

CHECK BOX IF THIS REQUEST ADDS MEDICAL ISSUES TO A PENDING MEDICAL REQUEST

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

NOTE: Before filing this form, call the workers' compensation insurer. If that does not resolve the issue, call Workers' Compensation Benefit Management and Resolution at (651) 284-5032 (or 1-800-342-5354).



DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY		
EMPLOYEE NAME	PHONE # (include area code)		
EMPLOYEE ADDRESS		INSURER/SELF-INSURER/TPA	
CITY	STATE	ZIP CODE	INSURER ADDRESS
EMPLOYER NAME		CITY	STATE ZIP CODE
EMPLOYER ADDRESS		CLAIM REPRESENTATIVE NAME	
CITY	STATE	ZIP CODE	INSURER CLAIM # INSURER PHONE # EXT

INSTRUCTIONS:

- This form must be filled out completely; otherwise, it may be returned to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, vocational rehabilitation, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION. YES NO
For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354.

1. THIS REQUEST IS BEING COMPLETED BY:

Employee Employee's Attorney Employer Insurer/TPA Self-insured Insurer's Attorney Health Care Provider

2. Are medical services being provided or managed by a certified managed care plan? YES NO If yes, attach information showing that the dispute resolution process of the certified managed care plan has already been exhausted.

3. MEDICAL ISSUES (check only those that apply)
I request:

a. that health care provider bills be paid. (List all health care providers whose bills or services are in dispute. Attach extra sheets if needed. Itemized bills and supporting medical reports must be attached.)

NAME	ADDRESS	UNPAID BALANCE

b. a change of treating doctor:

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c. that prescribed treatment, surgery or equipment be provided. (Specify the requested surgery or equipment & attach supporting medical reports.)

d. that the employee's medical expenses be reimbursed (e.g., mileage, prescription drugs). Attach supporting medical reports.

e. a second opinion or consultation with

NAME	SPECIALTY

f. other (explain):

MN MQ03 (5/08) (over)

Medical Request

- Adequately identify the nature of the dispute.
- You may attach extra sheets of paper. You are not limited to the lines and boxes on the form for your documentation and explanations
- Remember it is possible the payer will resolve this at the time they file the Medical Response, or at the time we contact them about dispute certification.
 - You want the payer and us to understand what the issue is. Be clear.

You must identify other payers

- Including the policy number and contract number if known

IF YOU DO NOT COMPLETE SECTION 4 ENTIRELY, WE WILL NOT BE ABLE TO PROCESS YOUR REQUEST.

4. HAS ANYONE OTHER THAN THE WORKERS' COMPENSATION INSURER PAID HEALTH CARE PROVIDER BILLS RELATED TO THIS DISPUTE? YES NO

If yes, bills were paid by: employee Veterans Administration Dept. of Human Services (Welfare)
 Medicare Social Security Administration private health insurance other

In the space below, provide the name(s) of the person(s) or organization(s) checked above. Attach extra sheets if necessary.

NAME	ADDRESS	POLICY NUMBER

5. Explain the details of your request. Attach all documents, such as medical reports and bills, and also identify any applicable treatment parameter or other rule that support(s) your request. A decision may be based solely on these documents, the Workers' Compensation Division file, and the response to this form.

6. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, health care provider, attorneys, and any party named in #4 above who has paid medical expenses. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #6 on _____ (date)

PRINT NAME OF PERSON FILING THIS REQUEST	SIGNATURE				
ADDRESS	ATTORNEY REGISTRATION #				
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, SEND IT AND ALL ATTACHMENTS TO:

Benefit Management and Resolution Unit Workers' Compensation Division Department of Labor and Industry PO Box 64218 St. Paul, MN 55164-0218

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

You must support your claim

- Attach documents
 - Bills
 - Records
 - Statement of position

IF YOU DO NOT COMPLETE SECTION 4 ENTIRELY, WE WILL NOT BE ABLE TO PROCESS YOUR REQUEST.

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NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #8 on _____ (date)

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An additional requirement for healthcare providers

- Providers must include evidence the denial was based on excessiveness

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4. HAS ANYONE OTHER THAN THE WORKERS' COMPENSATION INSURER PAID HEALTH CARE PROVIDER BILLS RELATED TO THIS DISPUTE? YES NO

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6. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, health care provider, attorneys, and any party named in #4 above who has paid medical expenses. Provide the names and addresses below. Attach extra sheets if necessary.		
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You must send copies as instructed on the form

- Provide the names and addresses of every party served.

IF YOU DO NOT COMPLETE SECTION 4 ENTIRELY, WE WILL NOT BE ABLE TO PROCESS YOUR REQUEST.

4. HAS ANYONE OTHER THAN THE WORKERS' COMPENSATION INSURER PAID HEALTH CARE PROVIDER BILLS RELATED TO THIS DISPUTE? YES NO

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Where to find the Medical Request form ...

http://www.dli.mn.gov/WC/Wcforms.asp

Workers' compensation forms

The Minnesota Department of Labor and Industry is implementing a new worker identification -- or WID -- number that may be used instead of a Social Security number to identify claims.
[View announcement](#) | [View frequently asked questions \(FAQs\)](#)

▶ **The following forms are now available as PDFs for viewing or printing.** The forms have also been converted to fill-in PDFs that allow users to type directly into the form and then print it. The fill-in PDFs replace the Informs versions previously posted here.

Experience faster data entry for dates, phone numbers and Social Security numbers by entering numbers only. The fill-in PDF will automatically enter the slashes for dates, the parentheses and hyphen for phone numbers, and the hyphens for the Social Security number. [Learn more about the agency's electronic forms.](#)

To view the PDF versions, first-time users need the **FREE Adobe Acrobat Reader**. If you have trouble viewing a PDF: "Right-click" on the link and select "Save link as" or "Save target as," directly to your local disk, then open the document directly with Acrobat Reader.

Note: The free Adobe Acrobat Reader does not have the option to save the data typed into the fill-in PDF. For the option to save, visit <http://www.adobe.com> for more information about the Adobe Acrobat software.

▶ **Minnesota Workers' Compensation System Employee Information Sheet**
 This guide briefly explains how workers' compensation benefits are paid to an injured worker. It's available in English and Spanish at the link above.

Workers' compensation forms (required by either statute or rule)

Spanish forms, denoted by "[Spanish]" are to be used for communication purposes only; they should not be filed with the department.

Form name	Last update	Notes
Affidavit of Significant Financial Hardship (AS01)	May 2008	PO; TENN; WID
Annual Claim for Reimbursement From the Secondary Injury Fund (AR04)	May 2008	PO; WID
Annual Claim for Reimbursement of Supplementary Benefits (AC03)	May 2008	PO; WID
Claim Petition for Dependency Benefits or Payment to Estate (CP03) -- [filing instructions]	May 2008	PO; TENN; WID
Disability Status Report (DS01)	May 2008	PO; WID
Employee or Insurer's Objection to Requested Attorney Fees and/or Costs (RT01)	May 2008	PO; TENN; WID
Employee's Claim Petition (EC04) -- [filing instructions]	May 2008	PO; TENN; WID
Employee's Objection To Discontinuance (ED02)	May 2008	PO; TENN; WID
Employee's Request for Administrative Conference (EQ05) -- [more info]	May 2008	PO; TENN; WID
Excess Fee Exhibit (PF04)	May 2008	PO; WID
First Report of Injury (FR01) -- [more info]	May 2008	PO
Health Care Provider Report (HC01) -- [more info]	May 2008	WID
Interim Status Report (IS02) -- [more info]	May 2008	WID
Medical Request (MQ03) -- [filing instructions]	May 2008	PO; TENN; WID

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