MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

P.O. Box 58
Jefferson City, MO 65102-0058

APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENT OF MEDICAL FEES

☐ Original ☐ Amended

W.C. Injury Number	
Medical Fee Dispute No.	

Use only if partial payment has been made by the employer or insurer and the amount of the fee billed by the health care provider is in dispute. See instructions on reverse side.

Application is made for additional payment of health care services rendered to the employee above the amount already paid in the underlying workers' compensation case. The additional fee or charge owed on the medical or health care bill is being disputed by the employer/insurer.

1. Health Care Provider Name	Address *(Street, City & County)*	State	ZIP Code	Phone No.

2. Employee (Patient's) Name	Address *(Street, City & County)*	State	ZIP Code	Date of Accident/Occupational Disease / Social Security No. XXX-XX-

3. Name of Employer	Address *(Street, City & County)*	State	ZIP Code	Phone No.

4. Name of Insurer/Third Party Administrator	Address *(Street, City & County)*	State	ZIP Code	Phone No.

5. Brief Description of Disputed Services Rendered	Date Services Provided	Name and Title of Person Who Authorized Services	Date Authorization was Given	Date Notice of Dispute Received From Employer/Insurer	Amount Billed	Adjustment	Amount Paid	Amount Disputed
A.					$	$	$	$
B.					$	$	$	$
C.					$	$	$	$
D.					$	$	$	$
E.					$	$	$	$

Total Amount Disputed $ 0

(If needed, attach sheet with additional information.)

6. Explanation of Reasonableness for each disputed service: *(Please attach additional page and supporting documentation.)*

7. Signature of Health Care Provider*	Attorney Address	Attorney Phone No.

8. Health Care Provider's Attorney Signature & Date**	Bar No.	Attorney Fax No.
	Attorney Email Address	

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Application for Payment of Additional Reimbursement of Medical Fees has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP

* **Please be advised that corporations and limited liability companies appearing before the Division must be represented by an attorney admitted to practice in the State of Missouri. *See Reed v. Labor and Ind. Rel. Commn.*, 789 S.W.2d 19, 20 (Mo. banc 1990).**

** **If the Health Care Provider is a corporation or a LLC, and this Application is not signed by an attorney, this Application will be rejected.**

Please attach additional information on separate sheet if necessary.

INSTRUCTIONS

This form is to be used in medical fee disputes involving the "Reasonableness of the Amount of Fee Charged." Be sure you understand the different types of medical fee disputes, and choose the applicable procedure and form to avoid delay or confusion in the handling of your file.

A dispute involving the "Reasonableness of the Amount of Fee Charged" is between the employer/insurer and the health care provider as to whether the fee charged by the health care provider is fair and reasonable. Pursuant to §287.140.3, RSMo, "A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier."

In these instances, the employer/insurer recognizes that the underlying workers' compensation claim is compensable, and has authorized the health care provider to provide treatment to the injured employee. The issue in dispute is limited to the amount of the fee charged by the health care provider. The employee is not a party to this dispute, and his/her right to workers' compensation benefits may not be jeopardized by such dispute.

The administrative procedures involved in this dispute are as follows:

STEP ONE: The health care provider is notified by the employer/insurer that the amount of the medical fee charged is in dispute. Per §287.140.4 RSMo such notice shall be presumed to occur no later than five business days after transmission by certified United States mail. Section 287.140.4 RSMo provides that an Application for Payment of Additional Reimbursement shall be filed not later than one year from the date the first notice of the dispute of the medical charge was received by the health care provider if such services were rendered after July 1, 2013. An Application for Payment of Additional Reimbursement shall be filed not later than two years from the date the first notice of the dispute of the medical charge was received by the health care provider if such services were rendered before July 1, 2013.

STEP TWO: If the parties are unable to resolve their dispute as to the reasonableness of the medical fee charged by the health care provider, the health care provider files with the Division of Workers' Compensation, 3315 West Truman Boulevard, P.O. Box 58, Jefferson City, Missouri 65102-0058, Form WC-MD-02 Application for Payment of Additional Reimbursements of Medical Fees. Corporations and limited liability companies appearing before the division must be represented by an attorney admitted to practice in the State of Missouri. The health care provider shall serve through personal service or by certified mail, return receipt requested, a copy of the application upon the person or corporation against whom the application has been filed. The health care provider shall file proof of service with the division.

STEP THREE: The Division of Workers' Compensation creates and assigns a medical fee dispute number.

STEP FOUR: If the total amount of the additional reimbursement sought is $1,000 or less, either party may file a written request for administrative ruling which initiates the administrative ruling procedure.

STEP FIVE: If the total amount of the additional reimbursement sought is more than $1,000 and the parties are unable to resolve their disputes, the health care provider may file Form WC-MD-03 Application for Evidentiary Hearing. The health care provider shall forward a copy of the application for an evidentiary hearing to all parties.

STEP SIX: The employer or insurer shall file an answer on a division-approved Form WC-198 Answer to Application for Payment of Additional Reimbursement of Medical Fees for an evidentiary hearing within 30 days from the date of the application, unless good cause is found by the division to extend the filing of the answer.

STEP SEVEN: An evidentiary hearing shall be scheduled in front of an administrative law judge. The administrative law judge conducting the hearing shall issue an award within 30 days of the last day of the hearing.

STEP EIGHT: Either party may file Form MOIC-2567 Application for Review with the Labor and Industrial Relations Commission within 20 days from the date of the award of the administrative law judge.