Medical Fee Schedule Dispute Request Form

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Dispute Request

Name of Contacting Party	
Title	
Mailing Address	
Email Address	Primary Phone

Dispute Information

Other Party Involved in Dispute	Other Party Primary Phone
Name of Injured Worker	Date of Injury
Name of Employer	Date of Service

Issue(s) in Dispute (Check all that apply):

- ☐ CPT
- ☐ Ground Rule Reference
- ☐ PPO Contract w/Medical Fee Schedule Component
- ☐ Supply
- ☐ Other: _____

Dollar Amount in Dispute:

Payment you received _____ Payment you feel you should have received _____

Please provide a detailed explanation of the dispute:

_____

Please attach the three required supporting documents that are applicable in your dispute:

- Original and Resubmitted Bill(s)
- Explanation of Reimbursement/Benefit
- Supporting Documentation

☐ Correspondence and/or Specific Information Regarding the Dispute (Optional - Check box if attached)

This Dispute Resolution process shall be subject to the prompt payment or limitation of claims provisions of Va. Code Section 65.2-605.1.

Medical Fee Schedule Dispute Request Form Instructions

Medical Fee Schedule (MFS) Dispute Resolution

Payment for services that the employer does not contest, deny, or consider incomplete shall be made to the health care provider within 60 days after receipt of each separate itemization of the health care services provided. Whenever there is a disagreement on the application or interpretation of the MFS Rules between a provider and a payer, either party may submit a MFS Dispute Request Form along with supporting documentation to the Medical Fee Services Department for administrative review and determination.

Instructions

Please complete the MFS Dispute Request Form and forward directly to the Commission. This form may be filed electronically via the Commission's website at http://workcomp.virginia.gov. To file electronically, the user must complete a PDF fillable form and submit supporting documentation. This form may also be filed by mail or in-person at 333 E. Franklin St., Richmond, Virginia 23219.

For questions or assistance with completing this form, please contact the Virginia Workers' Compensation Commission toll-free at 1-877-664-2566.

Medical Fee Schedule Dispute Resolution Process

Providers or payers may not dispute a payment because of dissatisfaction with an MFS scheduled reimbursement amount. Any dispute between a provider and payer over application of the medical fee schedule can be submitted to the Virginia Workers' Compensation Commission for determination. A request for determination of such disputes must include the following:

1.	a MFS Dispute request;
2.	copies of the original and resubmitted bills;
3.	copies of the explanation of reimbursement/benefit;
4.	copies of supporting documentation; and
5.	copies of correspondence and/or specific information regarding the dispute.

The Medical Fee Services Department will issue a Notice of Request for MFS Dispute Response to the respondent. The respondent will have 30 days to respond to the Medical Fee Services Department. The Medical Fee Services Department will make an administrative decision, and provide written notification of its decision to both the provider and the payer within 30 days of receipt of all requested information. Requests for Medical Fee Schedule determinations may be sent to:

Virginia Workers' Compensation Commission
Attn: Medical Fee Services Department
333 E. Franklin St.,
Richmond, Virginia 23219
Fax (804) 823-6932
medicalfeeservices@workcomp.virginia.gov