1. **An Administrative Law Judge may order all of the following benefits except:**
2. Weekly incapacity benefits
3. **Compensation for pain and suffering**
4. Payment of medical bills pursuant to the MFS
5. Interest
6. All of the above
7. None of the above

**Explanation:**  Worker’s Compensation is a “creature of statute”, meaning the parties (including the Board) only have the authority granted to them by the Statute.  An ALJ may order any benefit pursuant to the statute.  Compensation for pain and suffering is not a benefit in the statutory scheme.

1. **The Medical Fee Schedule incorporates which of the following by reference:**
2. Medicare’s RBRVS payment system, MS-DRG system, and APC system
3. Medicare’s NCCI Edits
4. **AMA’s Current Procedural Terminology**
5. State Treasurer's Unclaimed Property Law
6. All of the above
7. None of the above

**Explanation:** The AMA’s CPT is incorporated by reference in Chapter 5, Section 1.04. The fee schedule adopts Medicare’s codes and weights in its appendices but does not adopt any other aspect of Medicare’s payment systems, edits, etc. Maine has its own claims processing manual for workers’ compensation claims, i.e. Board Rules Chapter 5.

1. **Which of the following can be reported as medical treatment on form WCB-11:**
2. Nurse case management services
3. Medical bill review services
4. Utilization review services
5. A Section 207 examination
6. All of the above
7. **None of the above**

**Explanation:**  Per Chapter 5, Section 1.01, none of the above can be reported as treatment.

1. **Health care providers have how long to appeal a WC payment for medical goods and services:**
2. 30 days from receipt of payment
3. 60 days from receipt of payment
4. 90 days from receipt of payment
5. **As outlined in Section 306 of the WC Act**
6. Providers may appeal a WC payment at any time
7. Providers may not appeal a WC payment

**Explanation:** The appeal process offered by most medical bill review companies is not regulated by the Board. Section 306 sets forth the Statute of Limitations/Time for Filing Petitions.

1. **Which of the following elements, when missing, constitutes an uncoded bill:**
2. The National Provider Identifier of the health care provider
3. The patient/employee’s date of birth
4. The insured/employer’s address
5. The applicable diagnosis codes
6. All of the above
7. **None of the above**

**Explanation:**  Pursuant to Chapter 5, Section 1.06, Subsection 1, “Bills must specify the billing entity’s tax identification number, the license number, registration number, certificate number, or National Provider Identifier of the health care provider, the employer, the date of injury/occurrence, the date of service, the work-related injury or disease treated, the appropriate procedure code(s) for the work-related injury or disease treated, and the charges for each procedure code. Bills properly submitted on standardized claim forms prescribed by the Centers for Medicare & Medicaid are sufficient to comply with this requirement. Uncoded bills may be returned for coding.”

Answer A is incorrect because the provider may not have an NPI if the provider does not bill Medicare.  The bill is still coded as long as the provider submits its license, registration, or certificate number as applicable.  Answers B and C are incorrect because these are not required billing elements per the rule.  Answer D is incorrect because diagnosis codes are not required.  The rule requires that the provider specify the work-related injury or disease treated.  This can be accomplished using words; a code is not required.

1. **The Explanation of Benefits/Explanation of Review form must contain:**
2. The billed procedure code and the paid procedure code
3. The amount paid
4. The identity of any managed care network discount applied
5. The provider’s appeal rights
6. All of the above
7. **None of the above**

**Explanation:** An Explanation of Benefits/Explanation of Review form is not required. Per Chapter 5, Section 1.07, the employer/insurer must pay pursuant to the fee schedule. If anything less than the maximum allowable per the fee schedule is paid, the employer/insurer must file a notice of controversy contemporaneous with the payment. A copy of the notice of controversy must be sent to the health care provider from whom the bill originated.

1. **To determine the maximum allowable payment per the MFS you must have which of the following:**
2. The provider’s tax identification number
3. Date of injury/occurrence
4. **Type of service**
5. The patient’s diagnosis
6. The assistance of the Board’s Office of Medical/Rehabilitation Services
7. All of the above

**Explanation:** The provider’s tax identification number and the date of injury/occurrence are required billing elements but are not used to determine the maximum allowable payment per the fee schedule. The patient’s diagnosis is only used to determine the maximum allowable payment per the fee schedule for an inpatient bill if the DRG is not provided (Note: the DRG is not mandatory. The type of service must be identified in order to determine the maximum allowable payment per the fee schedule (professional, inpatient facility, outpatient facility, other).

1. **Claim administrators may recoup provider overpayments:**
2. **With approval from the provider**
3. With approval from the employee
4. With approval from a WCB administrative law judge
5. With approval from the Maine Supreme Judicial Court
6. With approval from all of the above
7. Without approval

**Explanation:** Workers’ Compensation Board Decision No.96-0: Donald C. Pritchard, Jr. v. S.D. Warren Company and Sedgwick James of Northern New England states, “The present Act provides this employer with no mechanism to recover what the employer regards as an overpayment of compensation.” If a claim administrator requests a voluntary return of an overpayment, the provider may agree to refund the monies.

1. **Claim administrators are allowed to pay a usual and customary fee for the following:**
2. A valid procedure code without a max fee
3. Physician-dispensed pharmaceuticals
4. Compound drugs
5. **For services provided in accordance with a written payment agreement**
6. All of the above
7. None of the above

**Explanation:** There is no statutory or regulatory or regulatory authority to pay a usual and customary *fee*. Unless there is a payment agreement pursuant to Chapter 5, Section 1.07, Subsection 7, the employer/insurer must pay the health care provider's usual and customary *charge* or the maximum allowable payment under the fee schedule, whichever is less (see Chapter 5, Section 1.07, Subsection 3).

1. **A bill for services received via regular mail may simply be returned to the provider and no denial is necessary when:**
2. **A bill is received without accompanying medical records**
3. A bill for inpatient services is received without the MS-DRG code
4. A bill is received for an injury and no claim is on file
5. A bill for professional services is not on the required billing form
6. All of the above
7. None of the above

**Explanation:** Pursuant to Chapter 5, Section 1.06, Subsection 3, “A bill must be accompanied by health care records to substantiate the services rendered.” Per Section 206.15 of the WC Act, “In the event the provider fails to properly complete and submit the prescribed form *or to follow any fee schedule approved by the board*, the insurer or self-insurer may withhold payment of medical and health care fees and the insurer or self-insurer is not required to file a notice of controversy but may simply notify the provider of the failure.”

Answer B is incorrect because the MS-DRG code is not a required billing element per Chapter 5, Section 1.06, Subsection 1. Answer C is incorrect assuming the bill is for a covered employer. Per Hearing Officer decision *Lewis Wilson v. Central Maine Towing, Inc. and The Phoenix Insurance Co.* if a bill for medical services is received and accompanied by an M-1 and/or other medical information that identifies the time, place, cause and nature of the injury, the employer may be deemed to have knowledge of the injury and therefore bills for covered employers may not be returned to the provider simply because the employer has failed to report the claim. Answer D is incorrect because there is no required billing form for professional services.

1. **Which of the following statements regarding prior approval/pre-authorization is true:**
2. Pre-authorization is required for treatment by a specialist
3. Pre-authorization is required for treatment by prayer or spiritual means
4. Pre-authorized services must be paid by the claim administrator
5. **A NOC must be filed if requested treatment is not reasonable/proper**
6. All of the above
7. None of the above

**Explanation:** Per Chapter 5, Section 1.05, pre-authorization of services is not required, however when there is a dispute whether a request for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids is reasonable and proper under §206 of the Act, the employer/insurer must file a notice of controversy. A copy of the notice of controversy must be sent to the originator of the request. A health care provider, employee, or other interested party is entitled to file a petition for payment of medical and related services for determination of any dispute regarding the request for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids.

1. **A Notice of Controversy must be filed with the Board when:**
2. A bill for an office visit is received during the surgical follow-up period via regular mail
3. A bill for an office visit is received during the surgical follow-up period via certified mail
4. To dispute the level of service provided
5. Both B and C
6. **All of the above**
7. None of the above

**Explanation:** Per Chapter 5, Section 1.07, Subsection 3, the employer/insurer must pay the health care provider's properly coded bill unless the bill or previous bills from the same health care provider have been controverted or denied. Subsection 4 of that same section states in part, “Changes to bills are not allowed. When there is a dispute whether the provision of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids is reasonable and proper under §206 of the Act, the employer/insurer must pay the undisputed amounts, if any, and file a notice of controversy.”

1. **A line by line determination of the maximum allowable payment is not appropriate for:**
2. A bill for the services of a certified registered nurse anesthesiologist
3. A bill for the services of an assistant surgeon
4. **A bill for surgery at an ambulatory surgical center**
5. A bill for an artificial leg and related equipment
6. All of the above
7. None of the above

**Explanation:** Bills for the services of a CRNA, services of an assistant surgeon or for DMEPOS are paid pursuant to the Board’s professional fee schedule. The maximum allowable payment per the fee schedule for professional services is determined on a line by line basis where the provider is entitled to the lesser of the max fee per Appendix II or its usual and customary charge. The maximum allowable payment per the fee schedule for facility services is calculated based on total charges.

1. **Changes to medical bills are not allowed except when:**
2. The provider has billed a higher level of service than what the medical records support
3. The provider has billed with a deleted procedure code
4. The provider has billed the incorrect number of units
5. The provider has billed amounts greater than the maximum allowed per the fee schedule
6. All of the above
7. **None of the above**

**Explanation:**  Pursuant to Chapter 5, Section 1.07, Subsection 4, “Changes to bills are not allowed.”   There are no exceptions.