Chapter 5: MEDICAL FEES; REIMBURSEMENT LEVELS; REPORTING REQUIREMENTS

This chapter outlines billing procedures and reimbursement levels for health care providers who treat injured employees. It also describes the dispute resolution process when there is a dispute regarding reimbursement and/or appropriateness of care. Finally, this chapter sets standards for health care reporting.

SECTION 1. GENERAL PROVISIONS

1.01 APPLICATION

1. This chapter is promulgated pursuant to 39-A M.R.S.A. §§ 208 and 209-A. It applies to all medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided for treatment of a claimed work-related injury or disease on or after the effective date of this chapter, regardless of the employee's date of injury or illness. Treatment does not include expenses related to nurse case management services or to examinations performed pursuant to 39-A M.R.S.A. §§ 207 and 312.

1.02 PAYMENT CALCULATION

1. Pursuant to Title 39-A M.R.S.A. §209-A, the medical fee schedule must be consistent with the most current medical coding and billing systems, including the federal Centers for Medicare and Medicaid Services resource-based relative value scale, severity-diagnosis related group system, ambulatory payment classification system and healthcare common procedure coding system; the International Statistical Classification of Diseases and Related Health Problems report issued by the World Health Organization and the current procedural terminology codes used by the American Medical Association.

2. Payment is based on the fees in effect on the date of service.

1.03 DEFINITIONS

1. Acute Care Hospital: A health care facility with a General Acute Care Hospital Primary Taxonomy in the NPI Registry at https://nppes.cms.hhs.gov/NPPES.
2. Ambulatory Payment Classification System (APC): Medicare’s grouping methodology for determining payment for outpatient services. Medicare assigns procedure codes to APC groups which are then given relative weights.
3. Ambulatory Surgical Center (ASC): A health care facility with an Ambulatory Surgical Clinic/Center Primary Taxonomy in the NPI Registry at https://nppes.cms.hhs.gov/NPPES.
4. Bill: A request by a health care provider that is submitted to an employer/insurer for payment of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided for treatment of a work-related injury or disease.
5. Board: The Maine Workers' Compensation Board pursuant to 39-A M.R.S.A. §151.

6. Critical Access Hospital: A health care facility with a Critical Access Hospital Primary Taxonomy in the NPI Registry at https://nppes.cms.hhs.gov/NPPES.

7. Follow-up Days (FUD): The number of days of care following a surgical procedure that are included in the procedure's maximum allowable payment but does not include care for complications, exacerbations, recurrence, or other diseases or injuries.

8. Health Care Provider: An individual, group of individuals, or facility licensed, registered, or certified and practicing within the scope of the health care provider's license, registration or certification. This paragraph may not be construed as enlarging the scope and/or limitations of practice of any health care provider.

9. Health Care Records: includes office notes, surgical/operative notes, progress notes, diagnostic test results and any other information necessary to support the services rendered.

10. Implantable: An object or device that is made to replace and act as a missing biological structure that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to operate, program, and recharge the implantable.

11. Incidental Surgery: A surgery which is performed on the same patient, on the same day, by the same health care provider but is not related to the diagnosis.

12. Inpatient Services: Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.

13. Maximum Allowable Payment (MAP): The sum of all fees for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids established by the Board pursuant to this chapter.

14. Medicare Severity-Diagnosis Related Group (MS-DRG): Medicare's grouping methodology for determining payment for inpatient services. Medicare assigns services to an MS-DRG based on patient demographics, diagnosis codes, and procedure codes which is then given a relative weight.

15. Modifier: A code adopted by the Centers for Medicare & Medicaid Services that provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

16. Outpatient Services: Services provided to a patient who is not admitted for inpatient or residential care (includes observation services).

17. Procedure Code: A code adopted by the Centers for Medicare & Medicaid Services that is divided into two principal subsystems, referred to as level I and level II of the Healthcare Common Procedure Coding System (HCPCS). Level I is comprised of Current Procedural Terminology (CPT®), a numeric coding system maintained by the American Medical Association (AMA). Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes. The CPT® manual is published by and may be purchased from the AMA, PO Box 930876, Atlanta, GA 31193-0876.

18. Specialty Hospital: A health care facility with a Long Term Care Hospital, Psychiatric Hospital, or Rehabilitation Hospital Primary Taxonomy in the NPI Registry at https://nppes.cms.hhs.gov/NPPES.

19. Usual and Customary Charge: The charge on the price list for the medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids that is maintained by the health care provider.

1.04 LEGAL DISCLAIMERS

1. This chapter includes data that is proprietary to the AMA, therefore, certain restrictions apply. These restrictions are established by the AMA and are set out below:

   A. The five character codes included in this chapter are obtained from the Current Procedural Terminology (CPT®), Copyright by the AMA. CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

   B. The responsibility for the content of this chapter is with the Board and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this chapter.

   C. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT®. Any use of CPT® outside of this chapter should refer to the most current CPT® which contains the complete and most current listing of codes and descriptive terms.

1.05 AUTHORIZATION

1. Nothing in the Act or these rules requires the authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206.

2. Without a contract directly between a health care provider and an employer/insurer requiring pre-authorization of services, an employer/insurer is not permitted to require pre-authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206 as a condition of payment.

1.06 BILLING PROCEDURES

1. Bills must specify the license number, registration number, certificate number, or National Provider Identifier of the health care provider, the employer, 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.

2. In the event a patient fails to keep a scheduled appointment, health care providers are not to bill for any services that would have been provided nor will there be any reimbursement for such scheduled services.

3. A bill must be accompanied by health care records to substantiate the services rendered. Fees for copies of health care records are outlined below.

1.07 REIMBURSEMENT

1. The injured employee is not liable for payment of any medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206. Except as provided by 39-A M.R.S.A. §206(2)(B), health care providers may charge the patient directly only for the treatment of conditions that are unrelated to the compensable injury or disease. See 39-A M.R.S.A. §206(13).

2. An employer/insurer is not liable for charges for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206 in excess of the maximum allowable payment under this chapter.

3. The employer/insurer must pay the health care provider's usual and customary charge or the maximum allowable payment under this chapter, whichever is less, within 30 days of receipt of a properly coded bill unless the bill or previous bills from the same health care provider have been controverted or denied.

4. 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. A copy of the notice of controversy must be sent to the health care provider from whom the bill originated. 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 provision of medical services.

5. 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.

6. Payment of a medical bill is not an admission by the employer/insurer as to the reasonableness of subsequent medical bills.

7. Nothing in this chapter precludes a health care provider and employer/insurer from entering into a payment agreement to promote the quality of care and/or the reduction of health care costs. Any such payment agreement must be directly between the health care provider and the employer/insurer and is not assignable. Such payment agreements will supersede the limitation amounts specified herein. An employee retains the right to select health care providers for the treatment of an injury or disease for which compensation is claimed regardless of any such payment agreements.

8. Payment to out-of-state health care providers who treat injured employees pursuant to 39-A M.R.S.A. § 206 are subject to this chapter.

9. Modifiers which affect reimbursement are as follows:

   -22 Increased Procedural Services: pay 150% of the maximum allowable payment under this chapter.

   -50 Bilateral Procedure: pay 150% of the maximum allowable payment under this chapter for both procedures combined.

   -51 Multiple Procedures: the total reimbursement for all services is the maximum allowable payment under this chapter for the primary procedure in addition to 50% for the secondary procedure, 25% for the tertiary procedure and 10% for each lesser procedure thereafter.

   -52 Reduced Services: pay 50% of the maximum allowable payment under this chapter if the procedure was discontinued after 1) the employee was prepared for the procedure and

2) the employee was taken to the room where the procedure was to be performed. Pay 100% of the maximum allowable payment if the procedure was discontinued after 1) the employee received anesthesia or 2) the procedure was started (e.g. scope inserted, intubation started, incision made).

-53Discontinued Procedure: pay 25% of the maximum allowable payment under this chapter.

-54 Surgical Care Only: pay the intra-operative percentage of the maximum allowable payment under this chapter.

-55 Post-operative Management Only: pay the post-operative percentage of the maximum allowable payment under this chapter.

-56 Pre-operative Management Only: pay the pre-operative percentage of the maximum allowable payment under this chapter.

-59 Distinct Procedural Service: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-62 Two Surgeons: pay each surgeon 75% of the maximum allowable payment under this chapter.

-66 Surgical Team: pay 100% of the maximum allowable payment under this chapter for the surgical procedure and 25% of the maximum allowable payment under this chapter for the surgical procedure for each additional surgeon in the same specialty as the primary surgeon. If the surgeons are of two different specialties, each surgeon must be paid 100% of the maximum allowable payment under this chapter.

-73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia: pay 50% of the maximum allowable payment under this chapter.

-80 Assistant Surgeon: pay 25% of the maximum allowable payment under this chapter.

-81 Minimum Assistant Surgeon: pay 10% of the maximum allowable payment under this chapter.

-82 Assistant Surgeon (when qualified resident surgeon not available): pay 25% of the maximum allowable payment under this chapter.

-AD Surgical Anesthesia: Physician medically supervised more than 2 to 4 concurrent procedures: pay 50% of the maximum allowable payment under this chapter.

-QK Surgical Anesthesia: Physician medically directed 2, 3, or 4 concurrent procedures: pay 50% of the maximum allowable payment under this chapter.

-QX Surgical Anesthesia: CRNA was medically directed by a physician (2, 3, or 4 concurrent procedures): pay 50% of the maximum allowable payment under this chapter.

-QY Surgical Anesthesia: Physician medically directed a CRNA in a single case: pay 50% of the maximum allowable payment under this chapter.

1.08 FEES FOR REPORTS/COPIES

1. A health care provider may include a charge on its bill for completing the initial diagnostic medical report (Form M-1) or other supplemental report. The charge is to be identified by billing CPT® Code 99080.

2. The maximum fee for completing the initial M-1 form or other supplemental report is:
   Each 10 minutes: $ 30.00

3. A health care provider may include a charge on its bill for copies of the health care records required to accompany the bill. The charge is to be identified by billing CPT® Code S9981 (units equal total number of pages). The maximum fee for copies is $5 for the first page and 45¢ for each additional page, up to a maximum of $250.00.

4. Health care providers must at the written request of the employer/insurer or the employer/insurer's representative furnish copies of the health care records to the employer/insurer or the employer/insurer's representative and to the employee's representative (if none, to the employee) within 10 business days from receipt of a properly completed Form 220. An itemized invoice must accompany the copies sent to the employer/insurer. The maximum fee for copies is $5 for the first page and 45¢ for each additional page, up to a maximum of $250.00. The copying charge must be paid by the party requesting the records.

5. Health care providers must at the written request of the employee or the employee's representative furnish copies of any written information (may include billing records) pertaining to a claimed workers' compensation injury or disease regardless of whether the claimed injury or disease is denied by the employer/insurer. Copies must be furnished within 10 business days from receipt of the written request. An itemized invoice must accompany the copies. The maximum fee for copies is $5 for the first page and 45¢ for each additional page, up to a maximum of $250.00. The copying charge must be paid by the party requesting the records.

1.09 FEES FOR MEDICAL TESTIMONY

1. Health care providers may charge for preparing to testify at depositions and hearings and for attendance at depositions and hearings for the purpose of giving testimony.

2. The maximum fee for preparing to testify at depositions and hearings is:
   First 30 minutes: $180.00
   Each additional 15 minutes: $ 90.00

3. The maximum fee for attendance at depositions and hearings for the purpose of giving testimony is:
   First hour or any fraction thereof: $400.00
   Each subsequent 15 minutes: $ 90.00

4. Travel time for attendance at depositions and hearings for the purpose of giving testimony is paid on a portal to portal basis when a deposition or hearing is more than ten

miles from the health care provider's home base. The maximum fee for portal-to-portal travel for the purpose of giving testimony is:
Each 60 minutes: $300.00

5. Health care providers may request advance payment of not more than $400.00 in order to schedule attendance at depositions and hearings. The advance payment will be applied against the total fees for medical testimony (preparation, travel, and attendance).

6. Health care providers will receive a maximum of $350.00 per canceled deposition when the cancellation occurs less than 24 hours prior to the scheduled start of the deposition. Health care providers will receive a maximum of $300.00 per canceled deposition when the cancellation takes place less than 48 but more than 24 hours prior to the scheduled start of the deposition. The party canceling the deposition is responsible for the fee.

1.10 EXPENSES

1. The employer/insurer must pay the employee's travel-related expenses incurred for treatment (includes travel to the pharmacy) related to the claimed injury in accordance with Board Rules and Regulations Chapter 17.

2. The employer/insurer must pay the employee's travel-related expenses within 30 days of receipt of a request for reimbursement.

3. The employer/insurer must reimburse the employee's out-of-pocket costs for medicines and other non-travel-related expenses within 30 days of a request for reimbursement accompanied by receipts.

1.11 MEDICAL INFORMATION

1. Authorization from the employee for release of medical information by health care providers to the employee or the employee's representative, employer or the employer's representative, or insurer or insurer's representative is not required if the information pertains to treatment of an injury or disease that is claimed to be compensable under this Act regardless of whether the claimed injury or disease is denied by the employer/insurer.

2. Nothing in the Act or these rules requires any personal or telephonic contact between any health care provider and a representative of the employer/insurer.

3. Health care providers must complete the M-1 form in accordance with Title 39-A M.R.S.A. §208.

4. Pursuant to Title 39-A M.R.S.A. §208, in the event that an employee changes or is referred to a different health care provider or facility, any health care provider or facility having health care records regarding the employee, including x rays, must forward all health care records relating to an injury or disease for which compensation is claimed to the next health care provider. When an employee is scheduled to be treated by a different health care provider or in a different facility, the employee must request to have the records transferred.

1.12 PERMANENT IMPAIRMENT RATINGS

1. Permanent impairment will be determined by the use of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, copyright 1993.

2. Permanent Impairment examinations performed by the employee's treating health care provider will have a maximum charge of $450.00.

SECTION 2. PROFESSIONAL SERVICES

2.01 PAYMENT CALCULATION

1. Pursuant to Title 39-A §209-A, the medical fee schedule for services rendered by individual health care providers must reflect the methodology underlying the federal Centers for Medicare and Medicaid Services resource-based relative value scale.

2. Fees for anesthesia services are calculated for procedure codes by multiplying the applicable conversion factor times the sum of the base unit (relative value unit (RVU) of the procedure code plus any modifying units) and time unit. The definition of the unit components are as outlined below. The conversion factor for anesthesia services is $50.00.

3. Fees for all other professional services are calculated for procedure codes by multiplying the applicable conversion factor times the non-facility total RVU. The conversion factor for all other professional services is $60.00.

4. Fees for professional services (excluding anesthesia) are as outlined in Appendix II. In the event of a dispute regarding the fee listed in Appendix II, the listed relative weight times the base rate controls.

2.02 ANESTHESIA GUIDELINES

1. Definition of the Unit Components

   A. Base Unit: RVU of the five digit anesthesia procedure code (00100-01999) listed in Appendix II plus the unit value of the physical status modifier plus the unit values for any qualifying circumstances.

   Physical Status Modifiers. Physical Status modifiers are represented by the initial letter 'P' followed by a single digit from 1 to 6 as defined in the following list:

		UNIT VALUE
P1:	A normal healthy patient	0
P2:	A patient with mild systemic disease	0
P3:	A patient with severe systemic disease	1
P4:	A patient with severe systemic disease that is a constant threat to life	2
P5:	A moribund patient who is not expected to survive without the operation	3
P6:	A declared brain-dead patient whose organs are being Removed for donor purposes	0

   Qualifying Circumstances. More than one qualifying circumstance may be selected. Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as the extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly affect the character of the anesthesia service provided. These procedures would not be reported alone, but would be reported as additional procedure numbers qualifying as an anesthesia procedure or service.

		UNIT VALUE
99100 -	Anesthesia for patient of extreme age, under one year and over seventy	1
99116 -	Anesthesia complicated by utilization of total body hypothermia	5
99135 -	Anesthesia complicated by utilization of controlled hypotension	5
99140 -	Anesthesia complicated by emergency conditions (an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)	2

B. Time Unit: Health care providers must bill time units only. One time unit is allowed for each 15 minute time interval, or significant fraction thereof (7.5 minutes or more) of anesthesia time. If anesthesia time extends beyond three hours, one time unit for each 10 minute time interval, or significant fraction thereof (5 minutes or more) is allowed after the first three hours. Documentation of actual anesthesia time is required, such as a copy of the anesthesia record.

2. **Calculation Examples**

A. In a procedure with a RVU of 3 (no modifiers) requiring one hour of anesthesia time, the total units are determined as follows:

Base Unit	3.0 units
Time Unit	+ 4.0 units
Total Units	= 7.0 units

B. In a procedure with a RVU of 10, modifying units of 1 and qualifying circumstances of 2, requiring four hours and thirty minutes of anesthesia time, the total units are determined as follows:

Base Unit	13.0 units
Time Unit (First three hours)	+ 12.0 units
Time Unit (Subsequent 90 minutes)	+ 9.0 units
Total Units	= 34.0 units

C. In both cases, the maximum allowable payment is determined by multiplying the total units by the conversion factor.

Total Units X Conversion Factor = Maximum Allowable Payment

CONVERSION FACTOR = $50.00

2.03 SURGICAL GUIDELINES

1. For surgical procedures that usually mandate a variety of attendant services, the reimbursement allowances are based on a global reimbursement concept. Global reimbursement covers the performance of the basic service and the normal range of care

required before and after surgery. The normal range of post-surgical care is indicated under “FUD” in Appendix II. The maximum allowable payment for a surgical procedure includes all of the following:

A. Any visit that has as its principal function the determination that the surgical procedure is needed.

B. All visits which occur after the need for surgery is determined and are related to or preparatory to the surgery.

C. Surgery.

D. Post-surgical care including removal of sutures.

2. The following four exceptions to the global reimbursement policy may warrant additional reimbursement for services provided before surgery:

A. When a pre-operative visit is the initial visit and prolonged detention or evaluation is necessary to prepare the patient or to establish the need for a particular type of surgery.

B. When the pre-operative visit is a consultation.

C. When pre-operative services are provided that are usually not part of the preparation for a particular surgical procedure. For example, bronchoscopy prior to chest surgery.

D. When a procedure would normally be performed in the office, but circumstances mandate hospitalization.

3. Additional charges and reimbursement may be warranted for additional services rendered to treat complications, exacerbation, recurrence, or other diseases and injuries. Under such circumstances, additional reimbursement may be requested.

4. An incidental surgery will not be paid under the Workers' Compensation system.

2.04 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

1. The employer/insurer must pay for all durable medical equipment, prosthetics, orthotics, and supplies that are ordered and approved by the treating health care provider.
2. Fees for durable medical equipment, prosthetics, orthotics, and supplies are as outlined in Appendix II.

SECTION 3. INPATIENT FACILITY FEES

3.01 BILLING

Bills for inpatient services must be submitted on a CMS Uniform Billing (UB-04) form. Health care providers are not required to provide the MS-DRG. Inpatient bills without the MS-DRG do not constitute uncoded bills.

3.02 ACUTE CARE HOSPITALS

The base rate for inpatient services at acute care hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $9,021.06.

2. On April 1, 2016, the base rate shall be $9,119.12.

3. On April 1, 2017, the base rate shall be $9,217.18.

3.03 CRITICAL ACCESS HOSPITALS

The base rate for inpatient services at critical access hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $10,525.95.

2. On April 1, 2016, the base rate shall be $10,144.90.

3. On April 1, 2017, the base rate shall be $9,763.86.

3.04 RESERVED

3.05 PAYMENT CALCULATION

Pursuant to Title 39-A §209-A, the medical fee schedule for services rendered by health care facilities must reflect the methodology and categories set forth in the federal Centers for Medicare and Medicaid Services severity-diagnosis related group system for inpatient services. Inpatient fees are calculated by multiplying the base rate times the MS-DRG weight. In the event of a dispute regarding the fee listed in Appendix III, the listed relative weight times the base rate controls. For inpatient services that take place during two different calendar years, payment is calculated based on the discharge date.

3.06 OUTLIER PAYMENTS

The threshold for outlier payments is $75,000.00 plus the fee established in Appendix III. If the outlier threshold is met, the outlier payment is the charges above the threshold multiplied by 75%.

3.07 IMPLANTABLES

Where an implantable exceeds $10,000.00 in cost, an acute care or critical access hospital may seek additional reimbursement. Reimbursement is set at the actual amount paid plus $500.00. Handling and freight charges must be included in the hospital's invoiced cost and are not to be reimbursed separately. When a hospital seeks additional reimbursement pursuant to this chapter, the implantable charge is excluded from any calculation for an outlier payment.

3.08 SERVICES INCLUDED

All services provided during an uninterrupted patient encounter leading to an inpatient admittance must be included in the inpatient stay. Services do not include costs related to transportation of a patient to obtain medical care.

3.09 FACILITY TRANSFERS

The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two hospitals:

1. A hospital transferring a patient is paid as follows: The MS-DRG reimbursement amount is divided by the number of days duration listed for the DRG; the resultant per diem amount is then multiplied by two for the first day of stay at the transferring hospital; the per diem amount is multiplied by one for each subsequent day of stay at the transferring hospital; and the amounts for each day of stay at the transferring hospital are totaled. If the result is greater than the MS-DRG reimbursement amount, the transferring hospital is paid the MS-DRG reimbursement amount. Associated outliers and add-ons are then added to the payment.
2. A hospital discharging a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons.
3. Facility transfers do not include costs related to transportation of a patient to obtain medical care.

3.10 OTHER INPATIENT FACILITY FEES

Inpatient services provided at specialty hospitals must be paid at 75% of the provider's usual and customary charge.

3.11 PROFESSIONAL SERVICES

Individual health care providers who furnish professional services in an inpatient setting must be reimbursed using the fees set forth in Appendix II. The individual health care provider's charges are excluded from any calculation of outlier payments.

SECTION 4. OUTPATIENT FACILITY FEES

4.01 BILLING

Bills for hospital outpatient and ambulatory surgical services must be submitted on a UB-04 form.

4.02 ACUTE CARE HOSPITALS

The base rate for outpatient services at acute care hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $120.14.

2. On April 1, 2016, the base rate shall be $131.86.

3. On April 1, 2017, the base rate shall be $143.59.

4.03 CRITICAL ACCESS HOSPITALS

The base rate for outpatient services at critical access hospitals shall be as follows:

1. On the effective date of this chapter, the base rate shall be $143.85.

2. On April 1, 2016, the base rate shall be $155.17.

3. On April 1, 2017, the base rate shall be $166.50.

4.04 AMBULATORY SURGICAL CENTERS

The base rate for surgical services at ambulatory surgical centers shall be:

1. On the effective date of this chapter, the base rate shall be $80.39.

2. On April 1, 2016, the base rate shall be $79.46.

3. On April 1, 2017, the base rate shall be $78.53.

4.05 PAYMENT CALCULATION

Pursuant to Title 39-A §209-A, the medical fee schedule for services rendered by health care facilities must reflect the methodology and categories set forth in the federal Centers for Medicare and Medicaid Services ambulatory payment classification system for outpatient services. Fees for procedure codes are calculated by multiplying the base rate times the APC weight. In the event of a dispute regarding the fee listed in Appendix IV, the listed relative weight times the base rate controls.

1. For procedure codes with no CPT®/HCPCS code or for procedure codes with a status indicator of N, there is no separate payment.
2. If the ACH Fee, CAH Fee or ASC Fee listed in Appendix IV is $0.00 for a procedure code with a status indicator other than N, then payment must be calculated at 75% of the health care provider's usual and customary charge.

3. When two or more procedure codes with a status indicator of T are billed on the same date of service, the highest weighted code is paid at 100% of the fee listed in Appendix IV and subsequent T status code procedures are paid at 50% of the fee listed in Appendix IV. Add-on codes are not subject to discounting.

4. When one or more procedure codes with a status indicator of N are billed without other outpatient services (i.e. non-patient referred specimens or the facility collects the specimen and furnishes only the outpatient labs on a given date of service, etc.), payment must be 75% of the provider's usual and customary charges.

4.06 OUTLIER PAYMENTS

The threshold for outlier payments is $2,500.00 per procedure code plus the fee listed in Appendix IV. If the outlier threshold is met, the outlier payment is the charges above the threshold multiplied by 75%.

4.07 IMPLANTABLES

Where an implantable exceeds $250.00 in cost, hospitals or ambulatory surgical centers may seek additional reimbursement (regardless of the status indicator). Reimbursement is set at the actual amount paid plus 20% or the actual amount paid plus $500.00, whichever is less. Handling and freight charges must be included in the facility's invoiced cost and are not to be reimbursed separately.

4.08 SERVICES INCLUDED

Outpatient services include observation in an outpatient status.

4.09 TRANSFERS

The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two facilities:

1. A hospital or ambulatory surgical center transferring a patient is paid the maximum allowable payment established in this section.

2. A hospital discharging a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons per Section 3.

3. Facility transfers do not include costs related to transportation of a patient to obtain medical care.

4.10 OTHER OUTPATIENT FACILITY FEES

Outpatient services provided by institutional health care providers other than hospitals and ambulatory surgical centers (e.g. clinical medical laboratories, free standing outpatient facilities, etc.) must be paid at 75% of the provider's usual and customary charge.

4.11 PROFESSIONAL SERVICES

Individual health care providers who furnish professional services in an outpatient setting must be reimbursed using the maximum fees set forth in Appendix II. The individual health care provider's charges are excluded from any calculation of outlier payments.

STATUTORY AUTHORITY: 39-A M.R.S.A. §§ 152(2) and 209

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AMENDED:

January 1, 1997 -	agency asserts §16 as effective retroactively to April 4, 1994
July 1, 1997 -	changed address in §9 (4), replaced Appendix III
May 1, 1999 -	updated CPT copyright year, replaced Appendices I, II, & III

NON-SUBSTANTIVE CORRECTIONS:

October 25, 1999 -	minor formatting; date corrections from paper filing in 4.1 - 4.4.

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July 1, 2002 -	refiled June 13, 2002 to include some codes missing from the previous filing
September 24, 2002 -	filing 2002-349 affecting §7 sub-§2

NON-SUBSTANTIVE CORRECTIONS:

January 8, 2003 -	character spacing only in §§ 1-19

AMENDED:

November 5, 2006 -	Amendments to Sections 4, 6(4), 10 & replaced Appendix III

REPEALED AND REPLACED:

December 11, 2011 -	filing 2011-430

CHAPTER 12 FORMAL HEARINGS

This chapter sets forth the procedure of the parties in preparation for attendance at formal hearings.

§ 18. **Limited Authorization for the Release of Certain Written Medical Information**

1. In the event that the employer/insurer contends that the medical records and information, pre-existing and subsequent to the workplace injury, for which claim is being made are relevant for determination of compensability and disability, it may obtain from the employee and the employee is obliged to within ~~a reasonable time~~ 14 calendar days execute a limited authorization for focused written medical records only employing the form set forth in Appendix III.

2. In the event that the employer/insurer contends that medical or counseling records related to psychological matters, substance abuse, or sexually transmitted disease matters are relevant to issues in the workers' compensation case, it may obtain such specific additional medical and other information as agreed upon among represented parties. In all other cases, specific additional medical and other information may be requested on written motion to the Hearing Officer showing the need for the information. The Hearing Officer may authorize the release of this information subject to appropriate terms and conditions as to reasonable protection of confidentiality.

STATUTORY AUTHORITY: 39-A M.R.S.A. §§ 152, 315

EFFECTIVE DATE:
January 15, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT CHAPTER:
April 7, 1993

AMENDED:
November 27, 1994

EFFECTIVE DATE (ELECTRONIC CONVERSION):
April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:
September 12 and October 9, 1996 - header added, "Sec." changed to §, spelling corrections, minor formatting.

AMENDED:
October 6, 1997 - Section 19.
May 23, 1999 - changes to Sections 4, 11, 14, Joint Scheduling Memorandum.

NON-SUBSTANTIVE CORRECTIONS:
October 26, 1999 - minor punctuation and formatting.

AMENDED:

November 20, 1999 - Sections 8 and 9(2).
September 29, 2002 - Section 1, filing 2002-359

NON-SUBSTANTIVE CORRECTIONS:

January 9, 2003 - character spacing, capitalization only.

AMENDED:

December 26, 2007 – Sec. 6(2)(B) added, filing 2007-531
October 11, 2009 - Sec 1(2) amended - fees increased; filing 2009-536

CHAPTER 17 EXPENSES AND FEES

§ 1. Expenses Related To Independent Medical Examinations under 39-A M.R.S.A. §312

Expenses incurred by the employee attending an independent medical examination are to be paid for by the employer. The following rates of reimbursement shall apply for travel:

1. $.44 per mile for mileage reimbursements.

2. Actual costs or a maximum of $120.00 per evening for overnight lodging. Reimbursement for overnight lodging is allowed only when the employee has traveled 100 miles or more, one way, from the employee's place of residence.

3. $6.00 for breakfast, $6.00 for lunch, and $16.00 for dinner. Reimbursement for meals is allowed only when the employee has traveled 50 miles or more, one way, from the employee's place of residence.

4. Actual charges for tolls, accompanied by a receipt.

§ 2. Expenses Related To Medical Treatment

The employer/insurer must pay the employee's travel-related expenses incurred for medical treatment related to the claimed injury as follows:

1. $.44 per mile for mileage reimbursements.

2. Actual costs accompanied by a receipt or a maximum of $120.00 per evening for overnight lodging. Reimbursement for overnight lodging is allowed only when the employee has traveled 100 miles or more, one way, from the employee's place of residence.

3. $6.00 for breakfast, $6.00 for lunch, and $16.00 for dinner. Reimbursement for meals is allowed only when the employee has traveled 50 miles or more, one way, from the employee's place of residence.

4. Actual charges for parking, tolls, and public transportation accompanied by a receipt.

§ 3. Mileage Reimbursement Pursuant To 39-A M.R.S.A. § 315

Reasonable mileage expense reimbursement pursuant to 39-A M.R.S.A. § 315 shall be 44 cents per mile.

§ 4. Expenses for Employees Attending a Board Appointed Examination Pursuant To 39-A M.R.S.A. § 611

Expenses incurred by the employee attending a Board appointed examination pursuant to Section 611 are to be paid for by the employer. The following rates of reimbursement shall apply for travel:

1. $.44 per mile for mileage reimbursements.

2. Actual costs or a maximum of $120.00 per evening for overnight lodging. Reimbursement for overnight lodging is allowed only when the employee has traveled 150 miles or more, one way, from the employee's place of residence.

3. $6.00 for breakfast, $6.00 for lunch, and $16.00 for dinner. Reimbursement for meals is allowed only when the employee has traveled 50 miles or more, one way, from the employee's place of residence.

4. Actual charges for tolls, accompanied by a receipt.

5. Employees may be advanced funds to cover the expenses of travel by making a request to the employer. The employer shall make every effort to honor such requests in a timely manner.

EFFECTIVE DATE:
August 2, 1986

REPEALED AND REPLACED:
May 10, 1988

AMENDED:
October 9, 1989
December 1, 1990 - Section3
February 11, 1992 - Section3

EFFECTIVE DATE (ELECTRONIC CONVERSION):
April 28, 1996

NON-SUBSTANTIVE CORRECTIONS:
September 12 and October 9, 1996 -- header added, “Sec.” changed to §, minor spelling.
January 9, 2003 - character spacing only.

REPEAL AND REPLACE:
August 18, 2014 - filing 2014-167 – 186