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Chapter 5: MEDICAL FEES; REIMBURSEMENT LEVELS; REPORTING REQUIREMENTS

~~SUMMARY:~~ This ~~Chapter~~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~~chapter sets standards for health care reporting.

SECTION 1. GENERAL PROVISIONS

1.01 ~~DATE OF INJURY~~APPLICATION

1. ~~This Chapter~~chapter is promulgated pursuant to 39-A M.R.S.A. §§ 208 and 209-A. It ~~shall apply~~applies to all ~~bills for 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 rule~~chapter, regardless of the employee's date of injury:

~~1.02 PAYMENT UNDER PILOT PROJECTS~~

~~Payment of medical costs for a work related injury made pursuant or illness. Treatment does not include expenses related to a comprehensive health insurance policy created~~nurse case management services or to examinations performed pursuant to 39-A M.R.S. §403(2) shall be considered a payment under a decision pursuant to a petition for purposes of 39-A M.R.S. §306A. §§ 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”:~~Care Hospital: A health care facility as defined with a General Acute Care Hospital Primary Taxonomy in 22 M.R.S. § 7932 (2-A). An acute care hospital must be licensed by the Department of Health and Human Services

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~~pursuant to 10-144 COMAR Chapter 112. 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 ~~CPT[®]/HCPCS~~ procedure codes (defined in §1.04(17) of this rule) to an APC ~~group~~ groups which ~~is~~ are then given a relative ~~weight~~ weights.
3. ~~“Ambulatory Surgical Center (ASC)”~~: A health care facility ~~as defined with an Ambulatory Surgical Clinic/Center Primary Taxonomy in 22 M.R.S. § 7932(9). An ASC must be licensed by the Department of Health and Human Services pursuant to 10-144 COMAR Chapter 125. 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 ~~services~~ medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided ~~in relationship to~~ for treatment of a ~~compensable work-related injury or illness~~ disease.
5. ~~“Board”~~: The Maine Workers' Compensation Board pursuant to 39-A M.R.S.A. § 151.
6. ~~“By Report (BR)”~~: ~~When a procedure has not been assigned a maximum allowable payment amount, designated by a “BR,” it shall be justified by a written report.~~
6. ~~“Critical Access Hospital”~~: A health care facility ~~as defined with a Critical Access Hospital Primary Taxonomy in 22 M.R.S. § 7932 (10). A critical access hospital must be licensed by the Department of Health and Human Services pursuant to 10-144 COMAR Chapter 112, subchapter XXVII. NPI Registry at <https://nppes.cms.hhs.gov/NPPES>.~~
7. ~~“Follow-up Days (FUD)”~~: ~~The maximum~~ number of days of care following a surgical procedure that are included in the ~~procedures~~ procedure’s maximum allowable payment but does not include care for complications, exacerbations, recurrence, or other diseases or injuries.
8. ~~“Health Care Provider/Practitioner”~~: ~~a person~~: An individual, group of individuals, or facility licensed, registered, or certified ~~by the State of Maine~~ 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/~~Practitioner~~.
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.
- 9-10. ~~“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.

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- ~~10.11.~~ “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.
- ~~11.12.~~ “Inpatient services”: Services: Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.
- ~~12.13.~~ “Maximum Allowable Payment (MAP)”: The maximum feesum of all fees for a procedure listed in Appendices III, IV, or V which has been medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids established by the Maine Workers' Compensation Board or the health care provider's usual and customary charge, whichever is less 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.
- ~~13.15.~~ Modifier: A system code adopted by the Centers for Medicare and Medicaid Services which groups related hospital admissions based on diagnosis codes, surgical procedures and patient demographics 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.
- ~~7.~~ “Modifier”: A used to indicate that the service rendered differs in some material respect from the service described in the 2005 edition of the CPT[®]. Applicable modifiers are set forth in Appendix A of the 2005 edition of the CPT[®] manual. The CPT[®] manual is published by and may be purchased from the American Medical Association, PO Box 930876, Atlanta, GA 31193-0876.
- ~~8.~~ “Outlier payments”: Outlier payments are payments that are required when facilities incur an abnormal amount of costs while taking care of a patient. There is a threshold in place, which the costs must exceed, in order for the hospital to be eligible to charge for outlier payments.
- ~~14.16.~~ “Outpatient services”: Services: Services provided to a patient who is not admitted for inpatient or residential care: (includes observation services).
- ~~15.17.~~ “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[®]-4), ([®]), 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[®]-4[®] codes. The CPT[®] manual is published by and may be purchased from the American Medical Association AMA, PO Box 930876, Atlanta, GA 31193-0876.
- ~~18.~~ 2. The Maine Workers' Compensation Medical Fee Schedule Specialty Hospital: A health care facility with a Long Term Care Hospital, Psychiatric Hospital, or

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Rehabilitation Hospital Primary Taxonomy in the NPI Registry at <https://nppes.cms.hhs.gov/NPPES>.

- 16.19. 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 REIMBURSEMENT~~

- ~~1. An employer/insurer is not liable under the Workers' Compensation Act for charges for health care services to an injured employee in excess of amounts listed in Appendices III, IV, or V of this chapter.~~
- ~~2. The employer/insurer shall pay the health care provider's usual and customary charge or the maximum allowable payment under this Medical Fee Schedule, 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 or the underlying injury has been controverted or denied. If an employer/insurer controverts whether a health care provider's bill is reasonable and proper under § 206 of the Act, the employer/insurer shall send a copy of the notice of controversy to the health care provider.~~
- ~~3. Payment of a medical bill is not an admission by the employer/insurer as to the reasonableness of subsequent medical bills.~~

~~1.05 MEDICAL EXAMINATIONS~~

~~Medical examinations not for purposes of treatment are not subject to this Medical Fee Schedule.~~

~~1.06 BILLING PROCEDURES~~

- ~~1. Bills submitted by employees, their representatives or health care providers to employers/insurers for reimbursement of medical services must specify the date and type of service, the appropriate procedure code, the condition treated, and the charges for each service.
Bills properly submitted on forms mandated by the Bureau of Insurance pursuant to 24 A.M.R.S. §2753 shall be sufficient to comply with this requirement.
Uncoded bills may be returned for coding.~~
- ~~2. The amount billed for a procedure, for which the Medical Fee Schedule does not provide a maximum allowable payment amount, as indicated by a "BR," shall be justified by a written report. The health care provider may not charge a fee for this report.~~
- ~~3. The employer/insurer shall undertake reasonable investigations to ascertain whether a service is subject to the maximum allowable payment contained in the Medical Fee Schedule. When there is a dispute regarding medical bills and the provision of medical services, the employer/insurer shall pay the undisputed amount, if any.~~

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~~The employer/insurer shall send written notice to the health care provider from whom the bill originated that the requested fee has been adjusted and the explanation for such adjustment. Notice is not required when bills are reduced to the fee schedule maximum allowable payment.~~

~~The notification to the health care provider shall be made at the time the employer/insurer pays the fee to which it believes the health care provider is entitled.~~

- ~~4. If the health care provider disputes any payment received or denied, the health care provider, employee or other interested party shall be entitled to file Form 190 or 190(A), Petition to Fix the Amount to be Allowed.~~

~~Any health care provider, employee, or other interested party shall be entitled to file Form 190 or Form 190(A) for determination of any issue regarding medical services and/or medical billing.~~

~~Forms 190 and 190 (A) may be obtained by contacting the Workers' Compensation Board, Office of Medical/Rehabilitation Services, 27 State House Station, Augusta, Maine 04333 0027, Tel: 207 287 7080.~~

~~Health care providers, employees or other interested parties are permitted to reproduce Forms 190 and 190 (A) in Appendix II for their use.~~

- ~~5. The injured employee is not liable for payment of any health care services for the treatment of a work related injury or disease. Except as provided by 39 A.M.R.S. §206(2) (B), the health care provider 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. §206 (13).~~

~~NOTE: Health care providers may use the most current procedure codes when billing workers' compensation claims. If the codes utilized are not included in the current Medical Fee Schedule, the item will be considered a "BR" procedure, one which is not assigned a maximum allowable payment, and must be justified by report.~~

~~1.07 FEES FOR REPORTS~~

- ~~1. A health care provider may charge a fee for completing the initial Practitioner's Report (Form M-1) required by the Workers' Compensation Board pursuant to 39 A.M.R.S. §208.~~
- ~~2. The maximum fee for copies shall be \$10 for the first page and 35 cents per page thereafter. An itemized invoice shall accompany the copies. The copying charge shall be paid by the party requesting the records.~~
- ~~3. A health care provider or facility shall, at the written request of the employer/insurer or the employee, furnish copies of the health care records for that particular worker's compensation injury or illness within 10 business days from receipt of the request. Supplemental reports shall be identified by using CPT[®] Code 99080 and appropriately billed on a CMS 1500 form.~~
- ~~4. The maximum fee for preparing a narrative report or the initial M-1 shall be:~~

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Each 10 minutes: _____ \$30.00

~~1.08 FEES FOR DEPOSITIONS~~

- ~~1. The maximum fee for preparing to testify at depositions and hearings shall be:
First ½ hour: _____ \$180.00
Each subsequent 1/4 hour: _____ \$90.00~~
- ~~2. Maximum fees for attendance at depositions and hearings for the purposes of giving testimony shall be:
First hour or any fraction thereof: _____ \$400.00
Each subsequent 1/4 hour: _____ \$90.00
(Use Code 99075)~~
- ~~3. "Portal to portal" reimbursement is permitted. Fees for "portal to portal" travel should be limited to:
A. Actual, reasonable and necessary travel costs. Travel costs must be agreed upon in advance by the employer/insurer.
B. Actual and necessary travel time shall be reimbursed at \$300.00 per hour. These reimbursement levels apply when a deposition is more than ten miles from the health care provider's home base.~~
- ~~4. Health care providers shall 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 shall receive a maximum of \$300 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 incurred cost.~~

~~1.09 EXPENSES~~

- ~~1. The employer/insurer must pay the employee's travel related expenses incurred for treatment related to the claimed injury as follows:
A. \$44 per mile for mileage reimbursements.
B. 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.
C. \$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.
D. Actual charges for tolls, accompanied by a receipt.~~

~~1.10 HEALTH CARE REPORTING OF PROVIDERS PURSUANT TO TITLE 39-A M.R.S. §208~~

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1. ~~Except for medical only claims, the primary health care provider shall submit medical reports for the initial service/visit to the employer/insurer and employee on the Practitioner's Report (Form M-1) within five days pursuant to 39-A M.R.S. §208(2)(A). Failure to submit the Practitioner's Report (Form M-1) within the five business day time line may result in assessment of penalties up to \$500.00 per violation.~~
2. ~~The primary health care provider shall submit updated medical reports to the employer/insurer and the employee on the Practitioner's Report (Form M-1) every 30 days as long as the health care provider has evaluated/treated the patient within the previous 30 days.~~
3. ~~Within five business days from the termination of treatment, a final medical report shall be submitted by the primary health care provider to the employer/insurer and employee on the Practitioner's Report (Form M-1).~~
4. ~~If the treating health care provider refuses to release information, the health care provider shall notify the employer/insurer of the reasons for withholding this information.~~
5. ~~Health care providers are permitted to reproduce the Practitioner's Report (Form M-1 in Appendix I) for their use.~~

1.11 PERMANENT IMPAIRMENT RATINGS

1. ~~Permanent impairment shall be determined by the use of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, copyright 1993.~~
- 2.1. ~~Permanent Impairment examinations performed by the employee's treating health care provider will have a maximum charge of \$450.00.~~

1.04 LEGAL DISCLAIMERS

1. ~~This chapter includes data that is proprietary to the American Medical Association~~AMA, therefore, certain restrictions apply. These restrictions are established by the AMA and are set out below:
 - A. ~~The five character codes included in the Maine Workers' Compensation Medical Fee Schedule~~this chapter are obtained from the 2005 ~~Current Procedural Terminology, (CPT®), Copyright 2004 by the American Medical Association (CPT®).~~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 ~~performed by physicians.~~
 - B. ~~The responsibility for the content of the Maine Workers' Compensation Medical Fee Schedule~~this chapter is with the ~~State of Maine Workers'~~

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~~Compensation~~ 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 ~~the Maine Workers' Compensation Medical Fee Schedule~~. 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 ~~the Maine Workers' Compensation Medical Fee Schedule~~ this chapter should refer to the most current ~~Current Procedural Terminology~~ CPT® which contains the complete and most current listing of ~~CPT®~~ CPT®-codes and descriptive terms. ~~Applicable FARS/DFARS apply.~~

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 ~~2005 Current~~ 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).

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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 ~~Terminology, Copyright 2004 by the~~ 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.

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-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).

-53 Discontinued 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.

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-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

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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
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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.

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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 (CPT[®]) is adopted herein by reference Association's Guides to the Evaluation of Permanent Impairment, 4th edition, copyright 1993.

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SECTION 2. PROFESSIONAL SERVICES

2.01 PAYMENT FOR PROFESSIONAL SERVICES

~~Payments for professional services are based on the Medicare Resource Based Relative Value System. Payments are calculated for procedure codes by multiplying the applicable conversion factor times the Work relative value unit plus the PE relative value unit plus the MP relative value unit. The conversion factor for anesthesia codes is \$50.00.~~

2.02 PROCEDURE CODES

~~1. For purposes of this section, health care services shall be identified by current procedural terminology codes (CPT[®] codes) and descriptions listed in the 2005 edition of the *Current Procedural Terminology* published by the American Medical Association, P.O. Box 10946, Chicago, Illinois.~~

2.03 MODIFIERS

- ~~1. Modifier codes shall be used in the manner set forth in Appendix A of the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois.~~
- ~~2. Applicable modifier codes are set forth in Appendix A of the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois.~~
2. Permanent Impairment examinations performed by the employee's treating health care provider will have a maximum charge of \$450.00.

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.

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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.~~

2.0402 ANESTHESIA GUIDELINES

1. ~~The anesthesia guidelines in the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois are incorporated by reference into this rule.~~
2. ~~To be eligible for reimbursement, the anesthesia service shall include: performance of a pre-anesthetic examination and evaluation; prescription of the anesthesia care required; personal participation in, or medical direction of, the entire plan of care; continuous physical presence of the anesthesiologist or, in the case of medical direction, of the qualified individual (one who is qualified to perform those tasks not personally performed by the anesthesiologist, such as a CRNA, resident or other individual authorized by the hospital or facility to perform such services) being medically directed; proximate presence or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies and medical direction of not more than four concurrent anesthesia procedures.~~
3. ~~Reimbursement will be determined by the addition of the base unit, time units and modifying units (if any) and multiplying this total value by a conversion factor of \$50.00 per unit. The definition of the unit components will follow.~~
4. ~~With respect to anesthesia care team payments for claims from two separate billing entities, the total payment to the anesthesia care team is the same as the payment level for an individually performing anesthesiologist or health care provider, with 50% of the total payment paid to each of the billing entities.~~
- 5.1. ~~Definition of the Unit Components~~

- A. ~~One time unit is allowed for each 15 minute time interval, or fraction thereof (7.5 minutes or more) of anesthesia time. If anesthesia time extends beyond three hours, 1.0 unit for each 10 minutes or significant fraction thereof (5 minutes or more) is allowed after the first three hours. Documentation of actual anesthesia time may be required, such as a copy of the anesthesia record in the hospital file.~~
- B. ~~Modifying Units: Physical status modifying units will be reimbursed if the patient is ranked in one of the following:~~

RANK _____ 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

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letter 'P' followed by a single digit from 1 to 6 as defined in the following list:

	UNIT VALUE
P 1 _____ <u>P1: A normal healthy patient</u>	0
P 2 _____ <u>P2: A patient with mild systemic disease</u>	0
P 3 _____ <u>P3: A patient with severe systemic disease</u>	1
P 4 _____ <u>P4: A patient with severe systemic disease that is a constant threat to life</u>	2
P 5 _____ <u>P5: A moribund patient who is not expected to survive without the operation</u>	3
P 6 _____ <u>P6: A declared brain-dead patient whose organs are being Removed for donor purposes</u>	0
P 3 _____ <u>P 3</u>	1
P 4 _____ <u>P 4</u>	2
P 5 _____ <u>P 5</u>	3
P 6 _____ <u>P 6</u>	0

Qualifying Circumstances ~~(more)~~ 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 the patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly ~~impact~~ impact or affect the character of the ~~anesthetic~~ 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.

CPT[®]

99100 _____ - <u>Anesthesia for patient of extreme age, under one year and over seventy</u>	1
99116 _____ - <u>Anesthesia complicated by utilization of total body hypothermia</u>	5
99135 _____ - <u>Anesthesia complicated by utilization of controlled hypotension</u>	5
99140 _____ <u>99140</u>	2

6. ~~Reimbursement for Pain Management Services: Reimbursement for pain management services (evaluation and management, medical or surgical services) will be separate from any reimbursement for anesthesia services. Reimbursement for services for pain management will be based on the appropriate evaluation and management, medical or surgical fee schedule.~~

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- ~~7. Cost Containment: Nothing in this section shall preclude an employer/insurer from entering into payment agreements to promote the continuity of care and the reduction of health care costs. Such payment agreements, if less, will supersede the limitation amounts specified herein.~~
- ~~8. Supplemental Skills: When warranted by the necessity of supplemental skills, values for the services of two or more health care providers and/or anesthetists will be allowed. Substantiate by report.~~
- ~~9. Monitoring Services: When an anesthesiologist or anesthetist is required to participate in and be responsible for monitoring the general care of the patient during a surgical procedure but does not administer anesthesia, these services are charged on the basis of the extent of the services rendered. Payment is to be made on the basis of the time units the anesthesiologist or anesthetist is in constant attendance for the sole purpose of the monitoring services; Relative Unit Values are not to be added.~~
- ~~10. Anesthesia Administered, Other Than By An Anesthesiologist or Anesthetist: Anesthesia fees are not payable when local infiltration, digital block, or topical anesthesia is administered by the operating surgeon or surgical assistants. Such services are included in the Unit Value for the surgical procedure.~~
- ~~11. Other Fees: The Unit Values for surgery, X-rays, laboratory procedures, consultation and other medical services, and office and hospital visits are listed in the following sections: Surgery, Radiology, Pathology, Medicine and Other. A consultation fee is not payable to an anesthesiologist examining the patient prior to administering anesthesia to that patient. No additional charge is to be made for routine follow-up care and observation.~~
- ~~12. Special Report: A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition of description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items which may be included are:
 - ~~• Complexity of symptoms~~
 - ~~• Final diagnosis~~
 - ~~• Pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate)~~
 - ~~• Diagnostic and therapeutic procedures (including major and~~~~

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supplementary surgical procedures, if appropriate)

- ~~Concurrent problems~~
- ~~Follow-up care~~

~~1399140 - Anesthesia complicated by emergency conditions~~
~~(an emergency is defined as existing when delay~~
~~in treatment of the patient would lead to a signifi-~~
~~cant 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 ~~Relative Value Unit~~RVU of 3.0 ~~(no modifiers)~~ requiring one hour of anesthesia time, the total ~~value should be~~ units are determined as follows:

	Base Unit	3.0 units	
	60 min divided by 15 min <u>Time Unit</u>		+ 4.0
units	Total value <u>Units</u>		= 7.0 units

B. In a procedure with a ~~Relative Value Unit~~RVU of 10.0 RVU of 10, modifying units of 1 and qualifying circumstances of 2, requiring four hours and thirty minutes of anesthesia time, the total ~~value should be~~ units are determined as follows:

Relative Value

	Base Unit	10 13.0 units
	<u>Time Unit (First three hours)</u>	+ 12.0 units
	<u>Time Unit (Subsequent 90 minutes)</u>	+ 9.0 units
Total value	Units	= <u>34</u> <u>Units</u>

C. In both cases, the maximum allowable payment is determined by multiplying the total ~~value~~ units by the conversion factor. ~~In billing, list the Relative Value Unit (showing the procedure code and all modifiers) and Time Units separately, as in the following:~~

Procedure Code + Modifier(s)	= Base Unit
Anesthesia Time	= Time Units

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$$\frac{\text{Total Value}}{\text{Total units}} \times \text{Conversion Factor} = \text{Maximum Allowable Fee/Payment}$$

CONVERSION FACTOR = \$50.00

2.0503 SURGICAL GUIDELINES

1. ~~The surgical guidelines in the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois are incorporated by reference into this rule.~~

21. 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 ~~III. AII.~~ The maximum allowable payment for a surgical procedure shall include includes all of the following:

~~A. All office and hospital.~~ 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.

BC. Surgery.

~~CD.~~ Post-surgical care. The number of follow-up days is indicated in the Medical Fee Schedule which will determine the normal range of post surgical care for that particular procedure.

~~D.~~ Removal including removal of sutures.

3. ~~An office visit shall not be billed in addition to the surgical procedure when the principal function of the office visit is the determination that the surgical procedure is needed.~~

42. 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~~ consultation.

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- 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.
53. 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. ~~Documentation substantiating the medical necessity of the additional services rendered must be submitted with the medical bill.~~
64. An incidental surgery ~~which is not part of the primary procedure performed and for which there is no diagnostic evidence relating it to the injury,~~ shall will not be paid under the Workers' Compensation system.
7. ~~Reimbursement for the concurrent services of two or more health care providers may be warranted for:~~
- A. ~~Identifiable medical services provided preoperatively, during the surgical procedure or in the post-operative period.~~
 - B. ~~Modifier 80 shall identify the procedure or the procedures which may be performed by the Surgical Assistant. Reimbursement for surgical assistants is limited to health care providers who assist with surgery and must not exceed 25% of the total surgical procedure.~~
 - C. ~~Two Surgeons~~
 - (1) ~~Under certain circumstances, the skills of two surgeons (usually with different specialties) may be required to complete a surgery. For example, a neurosurgeon and an orthopedist to complete a laminectomy and an arthrodesis.~~
 - (2) ~~Reimbursement will be made according to the information on the health care provider's medical bill and the substantiating documentation submitted. Each provider must submit an individual claim for services.~~
 - D. ~~A Surgical Team. Some highly complex procedures require the concomitant services of several physicians, often of different specialties. Such complex services may also involve other highly skilled and specially trained personnel, as well as various types of sophisticated equipment. This type of complicated procedure may be carried out under the "surgical team" concept with a single, global reimbursement for the total service. The services included in the global reimbursement vary widely. The charges should be supported "By Report" and include itemization of the physician services, paramedical personnel and equipment included in the charge.~~

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8. ~~Multiple or Bilateral Procedures~~
 - A. ~~When multiple or bilateral procedures are provided at the same operative session, the first major procedure should be coded as listed on one line of the HCFA 1500 claim form and the additional procedure(s) on the following line(s) with modifier 50 or 51.~~
 - B. ~~The total reimbursement for all services shall be the maximum reimbursement allowance of the major procedure in addition to 50% for the secondary procedure, 25% for the tertiary procedure and 10% for each lesser procedure thereafter. The lesser procedure(s) should be coded using the appropriate modifier 50 (bilateral procedure) or 51 (multiple procedures).~~
 - C. ~~Except when specifically stated, initial dressings, immobilization, or casting is included in the basic allowance for the basic procedure.~~

9. ~~Primary, Secondary, or Delayed procedures: A primary procedure is one that is attempted or performed for the first time, irrespective of the relationship to the date of injury or the onset of the condition being treated. Secondary refers to a procedure performed when a condition has been previously treated. Delayed procedures have the same maximum allowable fee as the primary procedure.~~

~~2.06 RADIOLOGY GUIDELINES~~

1. ~~The radiology guidelines in the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois are incorporated by reference into this rule.~~
2. ~~The maximum allowable payment for a radiology procedure includes the professional component identified by the modifier 26 and the technical component identified by the modifier TC. These are found in Appendix III under Radiology.~~
3. ~~Bills from one entity do not need to indicate the breakdown of the technical and professional components. These charges shall be reimbursed as indicated by the total maximum allowable payment in radiology.~~
4. ~~When two bills are submitted for radiological procedure, the professional component shall be identified by using modifier 26. The technical component, identified by modifier TC, covers materials and facilities/space for the diagnostic or therapeutic service.~~
5. ~~Billings for radiologic services are not reimbursable without a report of findings.~~
6. ~~Duplication of X-Rays: Every attempt should be made to minimize the number of X-Rays taken. The treating health care provider or any other person or institution having possession of X rays, which pertain to the patient and are deemed to be needed for diagnostic or treatment purposes, should make those X rays available~~

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~~upon request.~~

~~2.07~~ **PHYSICAL MEDICINE GUIDELINES**

- ~~1. The physical medicine guidelines in the 2005 edition of the Physicians' Current Procedural Terminology published by the American Medical Association, P.O. Box 10946, Chicago, Illinois are incorporated by reference into this rule.~~
- ~~2. Reimbursement of physical medicine services, procedure code 97010-97999, applies when the care is provided by, under the direct supervision of or upon written referral by the treating health care provider defined in section 1.04(9) of this rule and when the care provided is within the scope of the health care provider's license.~~
- ~~3. The license number, certificate number, or National Provider Identifier of the health care provider providing physical medicine services shall be included on each bill for services rendered.~~
- ~~4. Separate Procedures: Some listed procedures are commonly carried out as an integral part of a total service and do not warrant a separate identification. When such a procedure is performed independently of other services to which the procedure is not immediately related, the maximum allowable payment in the Medical Fee Schedule is applicable for the "separate procedure" where identified as such.~~
- ~~5. Concurrent Care: When the condition of the patient requires the skills of two or more health care providers to treat different conditions, payment is due each health care provider who plays an active role in the treatment program. The services rendered by each provider shall be distinct, identifiable and adequately documented in the records and reports.~~
- ~~6. Alternating Health Care Providers: When health care providers of similar skills alternate in the care of a patient (e.g., partners of the same facility, covering health care providers on weekends or vacation periods), each health care provider shall charge individually for the services personally rendered and such charges shall be in accordance with the Medical Fee Schedule.~~
- ~~7. Failure of a Patient to Keep a Scheduled Appointment: In the event a patient fails to keep a scheduled appointment, the health care provider is not to bill for any services that would have been provided by said appointment nor shall there be any reimbursement for such scheduled services. This rule does not apply with regard to a deposition, testimony or Section 312-IME.~~

~~2.08~~ **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES**

- ~~1. The employer/insurer shall~~must ~~pay for the purchase or rental of all compensable all~~ durable medical equipment, ~~medical prosthetics, orthotics, and supplies and other devices~~

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that are ordered and approved by the treating health care provider. ~~Reimbursement is set at the actual amount paid plus 20% or \$500.00, whichever is less.~~

1. ~~Durable medical equipment is equipment that:~~
 - a. ~~can withstand repeated use;~~
 - b. ~~is primarily and customarily used to serve a medical purpose;~~
 - c. ~~generally is not useful to a person in the absence of illness or injury; and~~
 - d. ~~is appropriate~~Fees ~~for use in the home.~~
2. ~~All requirements of the definition must be met before an item is considered to be durable medical equipment:~~
2. Medical, prosthetics, orthotics, and supplies of an expendable nature such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets and bags are not considered "durable" within the meaning of the definition. There are other items which, although durable in nature, may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs and eyes ~~are as outlined in Appendix II.~~
3. ~~Health care providers shall submit a substantiating invoice for any durable medical equipment, medical supply or device with a price greater than \$100.00 or upon the request of the employer/insurer.~~

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SECTION 3. INPATIENT FACILITY FEES

3.01 BILLING

Bills for inpatient services must be submitted on a CMS Uniform Billing (UB-04) form.

~~3.02 CRITICAL ACCESS HOSPITALS~~

~~Payments for inpatient services in a critical access hospital are based on the Health care providers are not required to provide the MS-DRG system. The payment is calculated by multiplying the base rate times. Inpatient bills without the MS-DRG weight, 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 is \$10,907.00 shall be as follows:

~~3.03 ACUTE CARE HOSPITALS~~

~~Payments for inpatient services in an acute care hospital are based on the MS-DRG system. The payment is calculated by multiplying the base rate times the MS-DRG weight. The base rate for inpatient services at acute care hospitals is \$8,923.00.~~

~~3.04 MAXIMUM REIMBURSEMENT~~

~~Except as provided in subsections 3.05 and 3.06, acute care hospitals shall be paid the maximum allowable payment established in Appendix IV or its usual and customary charge, whichever is less, for inpatient services.~~

- ~~**3.05**~~ 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

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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 ~~maximum allowable payment fee~~ established in Appendix ~~IV~~III. If the outlier threshold is met, the outlier payment ~~must be the maximum allowable payment plus the~~ is the charges above the ~~sum of the threshold and the maximum allowable payment~~ multiplied by 75%. ~~The total payment for the services is the outlier payment plus the maximum allowable payment.~~

3.06 ~~IMPLANTABLES~~07IMPLANTABLES

Where an implantable exceeds \$10,000.00 in cost, an acute care hospital or critical access hospital may seek additional reimbursement ~~beyond the maximum allowable charge.~~ Reimbursement is set at the actual amount paid plus ~~20% or \$500.00, whichever is less.~~ Handling and freight charges must be included in the hospital's invoiced cost and are not to be reimbursed separately. When ~~an acute care~~ a hospital seeks additional reimbursement pursuant to this ~~rule~~chapter, the implantable charge is excluded from any calculation for an outlier payment. ~~Handling and freight charges must be included in the acute care hospital's invoiced cost and are not to be reimbursed separately.~~

3.07 ~~SERVICES INCLUDED~~

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.

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3.0809 FACILITY TRANSFERS

The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two ~~acute care~~ 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.

~~3.09~~ PAYMENT FOR SERVICES WITHOUT A MAXIMUM CHARGE

~~Services provided by an acute care hospital that do not have a maximum charge in Appendix IV shall be paid at 75% of the hospital's usual and customary charge.~~

3.10 OTHER INPATIENT FACILITY FEES

~~Services provided at specialty hospitals shall be reimbursed using the 2007 Medicare pricer tool for the appropriate specialty hospital found at www.cms.gov/PCPricer/. The maximum reimbursement shall be the Grand Total Amount multiplied by 170%. Payment shall be made within 30 days after the specialty hospital provides the required medical and billing information.~~

~~3.11~~ PROFESSIONAL SERVICES NOT INCLUDED

~~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 ~~bill employers/insurers directly and must~~ be reimbursed using the ~~maximum~~ fees set forth in Appendix ~~III~~II. The individual health care provider's charges are excluded from any calculation of outlier payments.

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~~SECTION 4. OUTPATIENT AND AMBULATORY SURGICAL CENTERS~~

SECTION 4. OUTPATIENT FACILITY FEES

4.01 BILLING

Bills for hospital outpatient and ASC ambulatory surgical services must be submitted on a CMS Uniform Billing (UB-04) form.

4.02 ~~BASE RATE FOR ACUTE CARE HOSPITALS~~

The base rate for outpatient services at acute care hospitals is \$108.42, 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 ~~BASE RATE FOR CRITICAL ACCESS~~ CRITICAL ACCESS HOSPITALS

The base rate for outpatient services at critical access hospitals is \$132.53, 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 ~~BASE RATE FOR AMBULATORY SURGICAL CENTERS~~

The base rate for outpatient surgical services at ambulatory surgical centers is \$81.32, 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 ~~OBSERVATION INCLUDED~~

~~Outpatient services include observation in an outpatient status.~~

4.06 ~~MAXIMUM REIMBURSEMENT~~

~~Except as provided in subsections 4.07 and 4.08, acute care hospitals and ambulatory surgical centers shall be paid the maximum allowable payment established in Appendix V or its usual and customary charge, whichever is less, for outpatient services.~~

4.07 ~~PAYMENT CALCULATION~~

~~Payments for outpatient services in an outpatient hospital or an~~ 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

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~~ambulatory surgical center are based on the APC payment classification system. The payment must be for outpatient services. Fees for procedure codes are calculated by multiplying the base rate times the APC weight.~~

~~1. If the ACH Rate, CAH Rate or ASC Rate is In the event of a dispute regarding the fee listed as \$0.00 or null for a procedure code with status indicator of A, B, C, D, E, F, K, L, M, Q, S, T, V, X, Y then reimbursement must be paid at 75% of usual and customary charges. 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 or services with no CPT[®]/HCPCS code, 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 services 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 APC payment fee listed in Appendix IV and subsequent T status code items procedures are paid at 50% of the APC payment fee listed in Appendix IV. Add-on codes are not subject to discounting.~~

~~3. Procedure codes with a "Q" status indicator will not be discounted.~~

~~4.08~~ **OUTLIERS**

~~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 ~~maximum allowable charge as defined~~ fee listed in ~~paragraph 4.06~~ Appendix IV. If the outlier threshold is met, the outlier payment ~~must be the maximum allowable charge as defined in paragraph 4.06,~~ plus the charges above the threshold multiplied by 75%.

~~4.09~~ **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. ~~When an ambulatory surgical center or hospital seeks additional reimbursement pursuant to this rule, the implantable charge is excluded from any calculation for an outlier payment.~~ Handling and freight charges must be included in the facility's invoiced cost and are not to be reimbursed separately.

4.1008 SERVICES INCLUDED

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Outpatient services include observation in an outpatient status.

4.09 TRANSFERS

The following applies to patient facility transfers from an acute care hospital or ambulatory surgical center to an acute care hospital when a patient is transferred for continuation of medical treatment between two facilities:

1. An acute careA hospital or ambulatory surgical center transferring a patient is paid the maximum allowable chargepayment established in this section.
2. The acute careA hospital to which the discharging a patient is transferred is paid the maximum allowable charge established in sectionfull 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 NOT INCLUDED

Individual health care providers who furnish professional services in a hospital, ASC, or other facilityan outpatient setting must bill insurers directly and must bebe reimbursed using the maximum fees set forth in Appendix III. The individual medicalhealth care provider's charges are excluded from any calculation of outlier payments.

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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.
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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:

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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

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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

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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