

Questions and Answers Regarding the Medical Fee Schedule Effective September 1, 2018

SECTION 1. GENERAL PROVISIONS

1.05 AUTHORIZATION

Q: I am receiving more and more calls to pre-authorize appointments. My concern with this is that if they end up seeing a doctor for something other than the work injury, we get stuck with the bill. I have therefore, not been pre-authorizing the visits, but confirming there is an open and active WC claim for a specific body part. The providers are now questioning me and asking me to email them proof of what I am telling them. Is there a specific rule or place on the WCB website where I can refer them?

A: Please refer providers to Board Rules Chapter 5, Section 1.05 that makes it clear pre-authorization of services is not required. As far as “getting stuck with the bill, you have 30 days by rule to review any bill to determine if reasonable/related (Board Rules Chapter 5, Section 1.07).

Q: I recently received a denial on a patient indicating services are being denied for no pre-authorization. Can workers’ compensation claims be denied for no pre-authorization?

A: Board Rules Chapter 5, Section 1.05 states that an employer/insurer is not permitted to require pre-authorization as a condition of payment.

1.06 BILLING PROCEDURES

Q: What are the timely filing requirements for workers’ compensation?

A: An employer/insurer cannot put a time limit on the submission of workers’ compensation bills. The time for filing petitions is governed by 39A M.R.S.A. § 306. A petition is barred unless filed within 2 years after the date of injury or the date the employee's employer files a required first report of injury, whichever is later. If an employer or insurer pays benefits under the Act, with or without prejudice, within the 2 year period, the period during which an employee or other interested party must file a petition is 6 years from the date of the most recent payment.

Q: I remember that not all farmers need to have workers comp insurance, but what does that mean if a person gets injured at the job? Is the employer themselves responsible since they don’t have insurance?

Questions and Answers Regarding the Medical Fee Schedule Effective September 1, 2018

A: If the farm doesn't have a workers' compensation insurance policy, you should bill the farm's liability insurance policy. See 39-A M.R.S.A. §401.

Q: Can a provider bill a "no show fee"? Looking on the fee schedule it states, "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." Would that include a no show fee?

A: If the patient agreed to your financial policy that includes a "no show fee" then you can bill the patient directly for the fee. That is a contractual matter between the provider and the patient and nothing to do with workers' compensation.

Q: Can an employer require all workers comp information be relayed through them instead of directly to workers comp insurance?

A: No. By rule you must submit the bill to the workers' compensation insurer.

1.07 REIMBURSEMENT

Q: What injuries or diseases are compensable under the Maine Workers' Compensation Act of 1992?

A: There is no set list of injuries/illnesses that are compensable under the Act. An employee may claim any injury/illness as work-related. The claim administrator will investigate the claim and file the required denial if compensability is in question.

Q: There's only one Professional Fee tab on the excel document and one rate per HCPCS. We expected to see a Facility and Non-Facility Professional fee listed for each. Are we missing anything?

A: Professional charges are all paid the same regardless of place of service.

Q: We have a patient that was seeing a physician that her company uses for their work injuries. That physician said he didn't know how to help her further and she is now presenting to her PCP (one of our providers). It is for her work injury which is filed with XXXXX. Can they deny payment to us? The other office told the patient that she had to be referred to us in order to be paid.

A: The patient directs his/her own care after 10 days. The employer can object as outlined in 39-A M.R.S.A. §206.

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Q: Would you or any of your team happen to have the workers' comp fee schedule in an excel format?

The fee schedule is always available in Excel format on the home page; click on the 1-1-19 hyperlink:

RECENTLY ADOPTED RULES EFFECTIVE JANUARY 1, 2019

The Board has recently amended Board Rules Chapter 5, aka the medical fee schedule. The amendments are effective January 1, 2019. To view the changes, please visit our [Rules](#) webpage. In conjunction with the amendments, the annual update has been completed for dates of discharge/service on or after [1-1-19](#). Questions or concerns regarding the annual update may be addressed Kimberlee.McCarson@maine.gov

Q: Tick season is upon us and it appears we are not able to confirm a few CPT codes that are coming from the vendors. For example:

Invoice #1: 86618 – Lyme Disease Serology for \$338.00

This has also been referenced as “Tick Antibody Panel”

Invoice #2: 90665 – Lyme Disease Vaccine for \$68.00

Can you please provide me with some assistance of how we are to handle/pay these where they are not in the Maine Fee Schedule?

A: 86618 is a valid procedure code. Valid codes for professional services without a max fee are paid at the provider's usual and customary charge. 90665 is a deleted code. I have contacted the provider and the provider will fax you a corrected bill.

Q: I have attached two bills from XXX. One is clearly for professional charges for the surgeon but the other has a modifier SG. I spoke to the provider's billing office and the bill with the SG modifier is indicating that the bill is for ASC facility charges. Am I supposed to be paying this bill as if it was being billed on a UB-04?

A: The provider is not billing per the rules; you may disregard the bill and no NOC is required. Board Rules Chapter 5, Section 4.01 states, “Bills for hospital outpatient and ambulatory surgical services must be submitted on a UB-04 form. Outpatient hospital facility services performed on the same day for the same patient must be reported on a single UB-04 form.”

Questions and Answers Regarding the Medical Fee Schedule Effective September 1, 2018

Q: Can the Provider(s) file appeal(s) for payments dispute directly to the Department of Workers' Compensation without providing the Payer(s) an opportunity to response?

A: A provider may choose to utilize the payer's appeal/request for reconsideration process but is not required to do so prior to submitting a Petition for Payment to the Board.

Q: I recently got an EOB and noticed the WC insurer wasn't paying what the ME fee schedule is. I called the insurance & they said the reason for under payment was because they're paying us out of network. My question to you is, since when has Workers' Compensation become an in/out of network plan?

A: In-network and out-of-network are concepts/terms not found in Maine Workers' Compensation. An employee directs his/her own care after the first 10 days. As far as payment, assuming there is no contract in place, payment should be per the MFS.

Q: If our vendor allows \$100 for a medication, but the EE goes to Injured Worker's Pharmacy and they send us a bill for \$1,000, do we have to file a NOC?

A: Assuming there is no contract in place, anytime you are not paying per the fee schedule then a NOC needs to be filed with the Board with copies sent to all parties (employee, employer, provider).

Q: If a worker's comp insurance filed a NOC denying the claim after a date of service with us, can they deny that payment? Or do they have to pay it?

A: The insurer does not have to pay a bill if it has denied the underlying claim. "In cases where the underlying injury has been controverted or denied, a copy of the notice of controversy must be sent to each health care provider that submits or has submitted a request for payment within 30 days of receipt" (Board Rules Chapter 5, Section 1.07(2)(B)).

Q: We are a ten day provider. Doesn't the WC insurer have an obligation to pay us without prejudice for any visits if the employer sent the employee to us?

Only visits related to an injury/illness claimed to be compensable under the Workers' Compensation Act should be submitted to the WC insurer. There is absolutely no clear claim of a work injury or causal relation to work in your records. If the employer has a policy to pay for non-work injuries/illnesses then send the bills to the employer.

Questions and Answers Regarding the Medical Fee Schedule Effective September 1, 2018

Q: I received a claim denial on a patient and wanted clarification on the reason for the denial. The reason listed was “This employee is excluded from coverage due to being an owner of the company.” I thought if a company has workers comp insurance it's for all employees regardless of how you are connected with the company.

A: an owner is specifically excluded from the WC policy unless the owner specifically elects to be included.

Q: If we are overpaid by a workers comp claim do we send that back, like we do for regular claims?

A: That depends on your internal policy. Per Workers' Compensation Board Decision No. 96-0: Donald C. Pritchard, Jr. V. S.D. Warren Company And Sedgwick James Of Northern New England, “The present Act provides this employer with no mechanism to recover what the employer regards as an overpayment of compensation.”

1.08 FEES FOR REPORTS/COPIES

Q: If the charge for medical records is not on the billing form, do we have to pay for medical records? As you are aware, there are a lot of providers that bill for the records on a separate invoice. Additionally, we also get invoices from third party vendors that have agreements with the hospitals and bill out for the copies with their own separate invoice.

A: The idea is that if the provider does not bill for the records that accompany the bill on the billing form itself then there is no payment due. Please keep in mind this is just for records accompanying the bills. Records that are requested will continue to come with an invoice for payment.

Q: The new rule requires the charge for medical records to be on the billing form. What about the charge for records that are requested?

A: Records provided in accordance with a records request can continue to be billed with a separate invoice.

Questions and Answers Regarding the Medical Fee Schedule Effective September 1, 2018

1.11 MEDICAL INFORMATION

Q: I'm a little confused on the extent that we can share information directly with the employer. Is this simply to allow for the M1 mailing or can the employer call the provider directly and ask for the treatment note?

A: By statute, the employer has always been able to get information related to the claimed injury without the employee's authorization (the employer is the insured, not the patient). Per 39-A M.R.S.A. §208, "Authorization from the employee for release of medical information by health care providers to the employer is not required if the information pertains to treatment of an injury or disease that is claimed to be compensable under this Act."

Q: Does my department need the patient's authorization on Board Form WCB-220 to release records to the employer or the employer's representative, or the insurer or the insurer's representative if the records are related to a workplace injury or illness?

A: Information related to the claimed injury/illness can be released without authorization (Act §208). The issue is when health care records contain information regarding the claimed injury/illness and information that is not related to the claimed injury/illness. Information not related to the claimed injury/illness cannot be released without the patient's consent so if you have a record that includes this information, it must be redacted.

Q: On the M-1 form, there are three different sheets; White, yellow and pink. Where do the copies go and which colors go where?

A: By statute, the form must go to the employer and employee (Act §208). A copy should also be included as part of the health care records accompanying the bill(s) sent to the WC insurer (Board Rules Chapter 5, Section 1.08(4)).

Q: We have a number of local providers, through their third party vendors that will not accept the Maine WCB authorization. Is there anything that says they should accept it or do we just have to suck it up?

A: The new medical fee rule effective 9-1-18 requires the healthcare provider accept the form (Board Rules Chapter 5, Section 1.11).

Questions and Answers Regarding the Medical Fee Schedule
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SECTION 2.PROFESSIONAL SERVICES

2.02 EVALUATION AND MANAGEMENT GUIDELINES

Q: We bill PT Eval codes 97161, 97162 and 97163. Does the definition of new patient have any effect on us?

A: That section of the rule deals with the E&M codes (e.g. 99201-99205 and 99211-99215).