# MRS News

## Newsletter from the Office of Medical/Rehabilitation Services
## Maine Workers' Compensation Board

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The general mission of the Maine Workers' Compensation Board is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.

## *Provider Spotlight: St. Mary's Health System and St. Joseph Healthcare*

Managed Care staff at two Covenant Health organizations, St. Mary's Regional Medical Center and St. Joseph's Healthcare, are identifying and collecting thousands of dollars in Maine Workers' Compensation medical bill underpayments. Dan Ruttenberg, Supervisor of the Managed Care Department, reports that approximately $267,000 has been identified and collected during the past 3 years for St. Mary's. The same program of identifying underpayments was implemented at St. Joe's about 6 months ago and the staff has already identified $320,000 and collected $170,000.

Dan has identified the following as the top reasons why Maine Workers' Compensation medical bills are underpaid:

- Payors apply Medicare logic when they are pricing bills versus the Maine WC fee schedule rules
- Outpatient facility bills are paid by applying the "lessor-of" logic at the line level versus the bill level
- Implants that are payable in addition to the DRG/APC are not paid, even though the invoices are attached to the bill
- Employers/Insurers are applying network discounts when they are unable to show they were a named beneficiary of the network payment agreement at the time the health care provider signed the payment agreement as required by Board Rule Chapter 5, Section 1.07
- Professional procedures with a "50" modifier (bilateral procedure) are not being paid at 150% of the fee schedule

## *Reconsiderations of Payments on Medical Bills*

If a health care provider is dissatisfied with the payment it has received on a medical bill, the health care provider may choose to submit a request for reconsideration. A reconsideration is an informal request for the payor to review the payment made on a medical bill.

A request for reconsideration should be in writing and include 1) a copy of the bill, 2) a copy of the original payment, 3) a detailed statement regarding the reason for the request, 4) the requested amount and 5) the name and contact information of the person submitting the request. The request may also include any documentation not submitted with the original medical bill to support the health care provider's position. If the request is submitted via certified mail, the payor must pay or deny the provider's request (by filing a Notice of Controversy with the Board) within 30 days in order for it not to be subject to potential penalties under Title 39-A M.R.S.A. Section 205(4).

Alternatively, a health care provider, employee, or other interested party is entitled to request dispute resolution by contacting one of the Board's Claims Resolution Specialists or by filing 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. Any request for dispute resolution should include the same elements as a request for reconsideration outlined above. The Board's website contains form fillable versions of Form WCB-190A, the Providers' Petition for Payment of Medical and Related Services and Form WCB-410, the Complaint for Penalties Pursuant to 39-A §205(4) for use.

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### *From the (e)Mail Bag*

**How should we handle WC claims that include diagnoses unrelated to the WC case? Do we suppress the unrelated diagnoses or create different encounters to bill the WC insurer and the health insurer separately?**
Both approaches are used by health care providers, however, best practice is to create separate encounters.

**When a patient presents for services claiming it is work-related and we have to call the employer to request WC insurance information, can we answer any questions the employer asks (patient name, injury, etc.)? We thought all information regarding the injury would be shared from the WC insurer to the employer and that we had to protect the patient's privacy.**
Worker's Compensation is not subject to the HIPAA privacy laws. Per Title 39-A Section 208 and Board Rule Chapter 5, Section 1.11, "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.

**We have a patient that Medicare paid for the claim. The patient has a $175.00 copay that is at a collection agency. The patient is now saying we should have billed the WC insurer. When we billed the WC insurer we were told that they reimbursed Medicare already. So does the patient still have the liability of the copay?**
No. The WC insurer is responsible to pay you the difference between what they reimbursed Medicare and what is due under the WC fee schedule.

**After we receive a NOC from a WC insurer and if the patient does not have health insurance, do we transfer the balance to the patient or do we check with the Board first to see if the denial is being disputed?**
You can transfer the balance to the patient. The patient may let you know that he/she is pursuing their case but my understanding is that you would proceed as normal; the patient may qualify for free care, etc. Attorneys will often ask you to hold off on billing their clients while the comp case is being pursued but according to our Executive Director, you are not obligated to do so.

**If we propose a service to a WC insurer and they come back saying they will only pay a certain amount and that amount is below the WC fee schedule, do we have the ability to force them to honor the fee schedule?**
You can refuse to provide the service for any amount less than the fee schedule amount if it is a Maine WC claim.

**I have one WC insurer that does not pay for an initial office visit if the patient has been seen in our office in the last 3 years. These visits are for a new injury to the patient. Is the insurer correct?**
Technically the insurer is correct since the Board never adopted a different definition of new v. established patient in its medical fee rule. Per CPT definitions, a new patient is one that hasn't been seen for 3 years. It doesn't matter if there is a new injury. The next proposed rule will include a definition of new v. established that will allow providers to receive a new patient visit fee when there is a new injury.

**Other questions and answers about the Medical Fee Schedule can be found online at:** Frequently Asked Questions **.**