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.

Medical Fee Schedule Annual Update Completed

The Board has completed the annual update of its Medical Fee Schedule in accordance with Title 39-A M.R.S.A. Section 209-A. NCCI estimates that the changes effective October 1, 2016 for inpatient facility services will increase Maine workers' compensation system costs by 0.1%. NCCI estimates that the changes effective January 1 and April 1, 2017 for professional and outpatient facility services will increase costs 0.2% and 0.5% respectively.

From the (e)Mail Bag: 2017 Annual Update

Q: Is there a summary available of the changes made to the fee schedule for the 2017 annual update?
A: The annual update revised the fees for professional, inpatient facility and outpatient facility services to incorporate the relative weights for these services from the CMS final rule.

Q: Were there any adjustments made to the medical fee schedules effective 10-1-16 and 1-1-17 that were not just the usual rate recalculations?
A: All changes to the MFS other than just updating the relative weights for professional, inpatient facility and outpatient facility services requires rulemaking. The MFS is due for a periodic update in 2017. Watch for the proposed rules and rulemaking schedule to be posted on the Board's website.

From the (e)Mail Bag: 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 39-A 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: Is there is a specific requirement regarding the order of procedures for 1500 billing? A certain insurer stated workers comp will reimburse based on the order of the procedures so that the first pro fee billed on line one would be paid at 100% of the fee schedule, the second at 50%, the third at 25% and then the remaining at 10%.
A: An employer/insurer cannot require you to list procedures in any particular order since neither the 1500 instructions nor the WC Board rules requires such. The medical fee rule only addresses the reimbursement of multiple procedures as follows: 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. The primary procedure is the one billed without the 51 modifier. The remaining procedures performed on the same day by the same individual at the same session (that are not add-on codes or modifier 51 exempt) should each be reported with modifier 51. In its current form, the medical fee rule does not address how to determine the secondary, tertiary, and other lesser procedures. This is an area that the Board may wish to address in its next revision of Chapter 5.

Q: Could there be multiple primary procedures on the same claim for codes within the same family when billed on the same claim? For example, if we have codes for the nervous system and then codes for the skeletal system, etc. Or is there only one primary procedure per claim based on the RVUs?
A: There should be one primary procedure per claim. Per the AMA guidelines for modifier 51, "When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s)." Modifier 51 should not be appended to codes designated by the AMA as "add-on" codes or codes exempt from modifier 51.

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From the (e)Mail BagContinued:
Definition and Duties of Health Care Providers

Q: Does the definition of health care provider include provider types other than MD, DO, DC, DPM, etc.?
A: Yes, per the definition, health care provider is defined as an individual, group of individuals, or facility licensed, registered, or certified and practicing within the scope of the health care provider's license, registration or certification. Therefore the definition of healthcare provider is not limited to certain provider types and allows for a variety of professional and institutional providers.

Q: Can a therapist be considered the primary provider if a doctor's only involvement after evaluation was to refer the patient to a therapist and the therapist then provided all the rest of the treatment? If yes, does this then obligate the therapist to complete the M-1 form when appropriate?
A: The M-1 form is not limited to primary health care providers. It must be completed by all health care providers treating the employee per Title 39-A M.R.S.A Section 208.

Q: Can a therapist complete and submit the M-1? If yes and a therapist is responsible for completing the M-1 form when needed, can he/she also be responsible for taking the employee out of work if the condition warrants it?
A: Yes. The definition of a health care provider is an individual, group of individuals, or facility licensed, registered, or certified and practicing within the scope of the health care provider's license, registration or certification. Health care providers must complete the M-1 form in accordance with Title 39-A M.R.S.A. §208. The form must include the employee's work capacity, likely duration of incapacity, return to work suitability and treatment required.

Q: Can a therapist's M-1 form differ from the M-1 form completed by the doctor?
A: Yes. The fact that different healthcare providers may render different opinions is recognized in the rules in Chapter 8, Section 11 which allows an employer to discontinue benefits regardless of the employee's actual earnings if the employee returns to work without restrictions or limitations, due to the injury for which benefits are being paid, according to the employee's treating health care providers; and there are no conflicting medical records with respect to the lack of restrictions or limitations due to the injury for which benefits are being paid.

Q: Is an M-1 required for an inpatient stay? What if a patient is being seen by a doctor but then has nurse visits for wound care only, would those visits require an M-1?
A: Except for claims for medical benefits only, within 5 business days from the completion of a medical examination or within 5 business days from the date notice of injury is given to the employer, whichever is later, an M-1 form is due. Additional M-1s are due every thirty days when ongoing treatment is being provided. A final M-1 form is due within 5 working days of the termination of treatment. An M-1 is not completed for each visit.

Q: If a patient is being seen by one of our practices and the doctor does an M-1 that is current, then the patient does a follow-up with their PCP but it is still within the 30 days is a new M-1 needed?
A: Each health care provider has the same duties under Title 39-A M.R.S.A. Section 208.

Q: If a person is brought in directly to the ER for a WC injury, is an M-1 done at the hospital or only once they see a PCP with a plan of care?
A: There is one due within 5 business days of the examination for each health care provider.

Q: If a person is at a practice with a doctor but has PT do you need an M1- from the doctor and the PT that they referred to?
A: Each health care provider must complete the M-1s in accordance with Section 208.

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

New Tool: Reimbursement levels for health care providers

The following flowchart has been created to assist both health care providers and payors in determining the correct reimbursement levels for health care providers who treat injured employees. A full page printable version is available on the Board's website. Thank you to all that provided feedback during the chart's development.

Reimbursement levels for health care providers