

CHAPTER 5 MEDICAL FEES; REIMBURSEMENT LEVELS; REPORTING REQUIREMENTS

The Medical Fee Schedule is available online at

<http://www.maine.gov/wcb/Departments/omrs/medfeesched.html>. ~~The Medical Fee Schedule is available for purchase through Gossamer Press, 259 Main St., Old Town, ME 04468, Tel: (207) 827-9881, Fax: (207) 827-9861.~~

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

SECTION 1. GENERAL PROVISIONS

1.01 APPLICATION

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

1.02 PAYMENT CALCULATION

1. Pursuant to Title 39-A M.R.S.A. § 209-A, the Board has adopted this medical fee schedule which reflects the payment methodology developed by the federal Centers for Medicare and Medicaid Services. The Board has not adopted all components used by the federal Centers for Medicare and Medicaid Services. ~~Therefore, the a~~ Application of any fee schedule, payment system, claims processing rule, edit or other method of determining the reimbursement level for a service(s) not expressly adopted in this chapter is prohibited.
2. Payment is based on the fees in effect on the date of service.

1.03 DEFINITIONS

1. Acute Care Hospital: A health care facility with a General Acute Care Hospital Primary Taxonomy in the NPI Registry.

2. Ambulatory Payment Classification System (APC): Centers for Medicare & Medicaid Services' list of procedure codes, status indicators, ambulatory payment classifications, and relative weighting factors.
3. Ambulatory Surgical Center (ASC): A health care facility with an Ambulatory Surgical Clinic/Center Primary Taxonomy in the NPI Registry.
4. Bill: A request by a health care provider that is submitted to an employer/insurer for payment of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided for treatment of a work- related injury or disease.
5. Board: The Maine Workers' Compensation Board pursuant to 39-A M.R.S.A. § 151.
6. Critical Access Hospital: A health care facility with a Critical Access Hospital Primary Taxonomy in the NPI Registry.
7. Global Days: The number of days of care following a surgical procedure that are included in the procedure's maximum allowable payment but does not include care for complications, exacerbations, recurrence, or other diseases or injuries.
8. Health Care Provider: An individual, group of individuals, or facility licensed, registered, or certified and practicing within the scope of the health care provider's license, registration or certification. This paragraph shall not be construed as enlarging the scope and/or limitations of practice of any health care provider.
9. Health Care Records: includes office notes, surgical/operative notes, progress notes, diagnostic test results and any other information necessary to support the services rendered.
10. Implantable: An object or device that is made to replace and act as a missing biological structure that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to operate, program, and recharge the implantable.
11. Incidental supplies: Supplies and materials usually included with the office visit or other services rendered.
12. 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.

13. Inpatient Services: Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours or is expected to have a length of stay exceeding 23 hours, even though it later develops that the patient dies, is discharged, or is transferred to another facility and does not actually stay in the institution for more than 23 hours.
14. Maximum Allowable Payment (MAP): The sum of all fees for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids established by the Board pursuant to this chapter.
15. Modifier: A code adopted by the Centers for Medicare & Medicaid Services that provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.
16. Outpatient Services: Services provided to a patient who is not admitted for inpatient or residential care (includes observation services).
17. Procedure Code: A code adopted by the Centers for Medicare & Medicaid Services that is divided into two principal subsystems, referred to as level I and level II of the Healthcare Common Procedure Coding System (HCPCS). Level I is comprised of Current Procedural Terminology (CPT®), a numeric coding system maintained by the American Medical Association (AMA). Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes. The CPT® manual is published by and may be purchased from the AMA, PO Box 930876, Atlanta, GA 31193-0876.
18. Resource-Based Relative Value Scale (RBRVS): Centers for Medicare & Medicaid Services' list of procedure codes, modifiers, relative weighting factors, global surgery days, and global surgery package percentages.
19. Severity-Diagnosis Related Group System (MS-DRG): Centers for Medicare & Medicaid Services' list of Medicare severity diagnosis-related groups, relative weighting factors, and geometric mean length of stay days.
20. ~~Specialty Hospital: A health care facility with a Long Term Care Hospital, Psychiatric Hospital, or Rehabilitation Hospital Primary Taxonomy in the NPI Registry. Specialty Hospital also includes those distinct parts of a health care facility that are certified by the Centers for Medicare & Medicaid Services as a Long Term Care Hospital, Psychiatric Hospital, or Rehabilitation Hospital.~~

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

1.04 LEGAL DISCLAIMERS

1. This chapter includes data that is proprietary to the AMA, therefore, certain restrictions apply. These restrictions are established by the AMA and are set out below:
 - A. The five character codes included in this chapter are obtained from the Current Procedural Terminology (CPT®), Copyright by the AMA. CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.
 - B. The responsibility for the content of this chapter is with the Board and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this chapter.
 - C. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT®. Any use of CPT® outside of this chapter should refer to the most current CPT® which contains the complete and most current listing of codes and descriptive terms.

1.05 AUTHORIZATION

1. Nothing in the Act or these rules requires the authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206.
2. 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 billing entity's tax identification number; the license number, registration number, certificate number, or National Provider Identifier of the health care provider; the employer's name and address; the employee's name and address; the 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. Within 30 days after receipt of a bill that is missing one or more of the required elements set forth in paragraph 1 of this sub-section, an employer/insurer may pay the bill; return the bill for proper coding; or, file a Notice of Controversy as set forth in subsection 1.07. The employer/insurer must specify which element(s) are missing in the Notice of Controversy or communication requesting that the bill be properly coded.
3. Bills for insured employers must be submitted directly to the insurer of record on the date of injury/~~illness~~ occurrence. Health care providers shall attempt to verify the name of the insurer that wrote the workers' compensation policy for the specific employer on the date of injury/illness prior to the submission of a bill to an insurer.
4. 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.
5. A bill must be accompanied by health care records to substantiate the services rendered. Fees for copies of health care records are outlined below.

1.07

REIMBURSEMENT

1. The injured employee is not liable for payment of any medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206. Except as provided by 39-A M.R.S.A. § 206(2)(B), health care providers may charge the patient directly only for the treatment of conditions that are unrelated to the compensable injury or disease. See 39-A M.R.S.A. § 206(13).
2. Changes to bills by employers/insurers are not allowed. 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~~ that complies with subsection 1.06 unless the bill or previous bills from the same health care provider or the underlying injury has been controverted or denied. If a procedure code currently in use is not included in Appendix II, III or IV, the employer/insurer must pay the health care provider's usual and customary charge.

- A. 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 shall pay the undisputed amounts, if any, and file a notice of controversy within 30 days of receipt. A copy of the notice of controversy must be sent to the health care provider from whom the bill originated in accordance with Chapter 3.
 - B. 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.
 - C. 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~~ medical, surgical and hospital services, nursing, medicines, and mechanical surgical aids.
3. When there is a dispute whether a request for future 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 within 30 days of receipt of the request. 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.
4. Payment of a medical bill is not an admission by the employer/insurer as to the reasonableness of subsequent medical bills.
5. Nothing in this chapter precludes payment agreements to promote the quality of care and/or the reduction of health care costs.
- A. A written payment agreement directly between a health care provider and an employer/insurer supersedes the maximum allowable payment otherwise available under this chapter.
 - B. A written payment agreement between a health care provider and an entity other than the employer/insurer seeking to invoke its terms supersedes the maximum allowable payment otherwise available under this chapter only if the employer/insurer is a contractual beneficiary of the payment agreement on the date of service.
 - C. 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 agreement.

- D. An employer/insurer that invokes a payment agreement to pay an amount that is different from the maximum allowable payment otherwise available under this chapter shall ~~reference that~~ specifically identify the payment agreement in the employer/insurer's explanation of payment or benefit.
- E. In the event of a dispute as to whether there is a payment agreement that supersedes the maximum allowable payment otherwise payable, the burden is on the party invoking the payment agreement to provide a written contract between the provider and the ~~network entity other than the employer/insurer~~ within 30 days of a provider's request. This contract must establish the party's right to pay an amount different than provided in this chapter. Failure to produce the contract within 30 days of a request will result in the bill being subject to the maximum allowable payment established in this chapter.
6. 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.
7. Modifiers which affect reimbursement are as follows:
- 22 Increased Procedural Services: pay 150% of the maximum allowable payment under this chapter.
 - 50 Bilateral Procedure: pay 150% of the maximum allowable payment under this chapter for both procedures combined.
 - 51 Multiple Procedures: pay the highest weighted procedure at 100% of the maximum allowable payment under this chapter and all additional procedures at 50% of the maximum allowable payment under this chapter. Add-on codes are not subject to discounting.
 - 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.

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

-AS Assistant Surgeon (physician assistant, nurse practitioner, or clinical nurse specialist): 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.

-XE Separate Encounter: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-XP Separate Practitioner: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-XS Separate Structure: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

-XU Unusual Non-Overlapping Service: pay 100% of the maximum allowable payment under this chapter (not subject to multiple procedure discounting).

1.08 FEES FOR REPORTS/COPIES

1. Health care providers may charge for completing an 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 an initial M-1 form or other supplemental report is: Each 10 minutes: \$30.00
3. Health care providers may charge for copies of the health care records required to accompany the bill. The charge ~~is to~~ must be identified on the bill using 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. For copies of health care records or other written information, including, but not limited to, billing records furnished in paper form, the maximum fee 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 requesting party. Health care providers shall not require payment prior to responding to the request unless the requesting party has an unpaid balance for previously requested information from the health care provider. In this event, a health care provider may require payment of the past due balance in addition to pre-payment of the current request prior to responding to the request. Health care providers shall not charge a fee for postage/shipping, sales tax, or a fee for researching a request that results in no records.
5. If the requested information exists in a digital or electronic format, the health care provider shall provide an electronic copy of the requested information, if an electronic copy is requested and it is reasonably possible to provide it. The health care provider may charge reasonable actual costs of staff time to create the electronic information and the costs of necessary supplies, up to a maximum of \$150.00. The copying charge must be paid by the requesting party. Health care

providers shall not require payment prior to responding to the request unless the requesting party has an unpaid balance for previously requested information from the health care provider. In this event, a health care provider may require payment of the past due balance in addition to pre-payment of the current request prior to responding to the request. Health care providers shall not charge a fee for postage/shipping, sales tax, or a fee for researching a request that results in no 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: \$250.00
Each additional 15 minutes: \$125.00
3. The maximum fee for attendance at depositions and hearings for the purpose of giving testimony is:
First hour or any fraction thereof: \$500.00
Each subsequent 15 minutes: \$125.00
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: \$400.00
5. Health care providers may request advance payment of not more than \$400.00 in order to schedule attendance at depositions and hearings. The advance payment will be applied against the total fees for medical testimony (preparation, travel, and attendance).
6. Health care providers will receive a maximum of \$350.00 per canceled deposition when the cancellation occurs less than 24 hours prior to the scheduled start of the deposition. Health care providers will receive a maximum of \$300.00 per canceled deposition when the cancellation takes place less than 48 but more than 24 hours

prior to the scheduled start of the deposition. The party canceling the deposition is responsible for the fee.

1.10 EXPENSES

1. The employer/insurer must pay the employee's travel-related expenses incurred for treatment (includes travel to the pharmacy) related to the claimed injury in accordance with Board Rules and Regulations Chapter 17.
2. The employer/insurer must pay the employee's travel-related expenses within 30 days of receipt of a request for reimbursement.
3. The employer/insurer must reimburse the employee's out-of-pocket costs for medicines and other non-travel-related expenses within 30 days of a request for reimbursement accompanied by receipts.

1.11 MEDICAL INFORMATION

1. A. Pursuant to 39-A M.R.S.A. § 208(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.

B. Pursuant to 39-A M.R.S.A. § 208(1), health care providers must, at the written request of the employer/insurer representative, furnish copies of health care records or other written information, including, but not limited to, billing records to the employer/insurer representative and to the employee representative (if none, to the employee) pertaining to a claimed workers' compensation injury or disease, regardless of whether the claimed injury or disease is denied by the employer/insurer. Written requests must be on company letterhead, must clearly state the information being requested, and must include the following: (1) the requestor's full name; (2) the requestor's mailing address, telephone number, and e-mail address; (3) the first and last name of the employee; (4) the requestor's relationship to the employee whose records are sought; (5) the date of injury; (6) the body part(s) or conditions pertaining to the date of injury; and, (7) either the specific date(s) of service or the date range within which the requested services were provided. Copies must be furnished within 10 business days from receipt of the written request. An itemized invoice must accompany the copies sent to the requestor.

C. Pursuant to 39-A M.R.S.A. § 208(1), health care providers must, at the written request of the employee or the employee's representative, furnish copies of health care records or other written information, including, but not limited to, billing records to the employee or the employee's representative pertaining to a claimed workers' compensation injury or disease, regardless of whether the claimed injury or disease is denied by the employer/insurer. Written requests must be on company letterhead (if applicable), must clearly state the information being requested, and must include the following: (1) the requestor's full name; (2) the requestor's mailing address, telephone number, and e-mail address; (3) the first and last name of the employee; (4) the requestor's relationship to the employee whose records are sought; (5) the date of injury; (6) the body part(s) or conditions pertaining to the date of injury; and, (7) either the specific date(s) of service or the date range within which the requested services were provided. Copies must be furnished within 10 business days from receipt of the written request. An itemized invoice must accompany the copies sent to the requestor.

2. A. Except as provided in subsection 3 of this section, if the employer/insurer or employee representative contends that medical information pre-existing and subsequent to the workplace injury for which claim is being made is relevant to issues in the workers' compensation case, it shall use Form WCB-220, set forth in Appendix V. Within 14 calendar days the employee or the employee's authorized representative, as defined in paragraph C of this section, shall sign the release and return it to the requesting party.

B. ~~All~~ Except as provided in this paragraph, all parties, including health care providers, shall only use Form WCB-220 set forth in Appendix V. The use of forms other than the ones set forth in Appendix V and/or requiring additional forms is prohibited except that the employee may also sign a medical authorization form acceptable to the health care provider whose records are sought subject to the following requirements:

- i. the health care provider is responsible for obtaining the employee's signature on the form;
- ii. the completed release must be sent to the requesting party with the copies of the health care records; and
- iii. the requested records must be furnished within the 30-day time period set forth in paragraph D of this subsection.
- iv. Within 14 calendar days of receiving the form release set forth in Appendix V from the employer or insurer, the employee or the employee's authorized representative as defined in paragraph C of this section shall sign the health

care provider's release and return it to the requesting party.

C. For purposes of this section, "authorized representative" has the same definition as set forth in 22 M.R.S.A § 1711-C(1)(A).

D. Health care providers must furnish copies of the health care records within 30 calendar days from receipt of a properly completed Form WCB-220.

E. Form WCB-220 may be revoked using Form WCB-220R.

3. A. In the event that the employer/insurer or employee representative contends that testing, treatment or counseling records related to psychological matters, HIV/AIDS, substance ~~abuse~~ use disorder, or sexually transmitted diseases ~~matters~~ are relevant to issues in the workers' compensation case, it may obtain such specific information as agreed upon by the ~~represented~~ parties. If the ~~represented~~ parties agree, the parties shall use Form WCB-220A, WCB-220B, or WCB-220C, set forth in Appendix V, as appropriate. Within 14 calendar days after agreement the employee or the employee's authorized representative, as defined in paragraph D of this section, shall sign the release and return it to the requesting party

B. ~~All~~ Except as provided in this paragraph, all parties, including health care providers parties, including health care providers, shall only use Form WCB-220A, WCB-220B, or WCB-220C set forth in Appendix V. The use of forms other than the ones set forth in Appendix V ~~and/or requiring additional forms~~ is prohibited except that the employee may also sign a medical authorization form acceptable to the health care provider whose records are sought subject to the following requirements:

- i. the health care provider is responsible for obtaining the employee's signature on the form;
- ii. the completed release must be sent to the requesting party with the copies of the health care records; and
- iii. the requested records must be furnished within the time period set forth in paragraph E of this subsection.
- iv. Within 14 calendar days of receiving the form release set forth in Appendix V from the employer or insurer, the employee or the employee's authorized representative as defined in paragraph E of this section shall sign the health care provider's release and return it to the requesting party.

C. In all other cases such information shall be requested on written motion to the Administrative Law Judge showing the need for the information. The Administrative Law Judge may authorize the release of this information subject to appropriate terms and conditions as to reasonable protection of confidentiality.

D. For purposes of this section, “authorized representative” has the same definition as set forth in 22 M.R.S.A § 1711-C(1)(A)E.

E. Health care providers must furnish copies of the health care records within 30 calendar days from receipt of a legible and properly completed Form WCB-220A, WCB-220B, or WCB-220C or within 30 calendar days from receipt of an order of an Administrative Law Judge.

F. Form WCB-220A, WCB-220B, or WCB-220C may be revoked using Form WCB-220R.

4. A. If an employee who is being paid pursuant to a compensation payment scheme revokes a medical release using Form WCB-220R, the employer/insurer may file a Motion to Compel with the Administrative Law Judge assigned to the case.

B. The Motion must include, at a minimum:

- (i) A copy of the medical release form that was revoked;
- (ii) The relevant Form WCB-220R;
- (iii) Proof that the revocation was sent to the relevant health care provider(s);
- (iv) An explanation of why continued receipt of the medical records is necessary to adjust the employee’s claim; and
- (v) Notice that the employee has 21 days to respond to the Motion.

C. The employee may reply within 21 days after receipt of the Motion. The reply must explain why continued receipt of the medical records is not necessary to adjust the employee’s claim.

D. The Administrative Law Judge may grant the Motion to Compel if continued receipt of the medical records is necessary to adjust the employee’s claim.

5. 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.
6. Health care providers must complete the M-1 form set forth in Appendix I in accordance with 39-A M.R.S.A. § 208. The use of a form other than the one set forth in Appendix I is prohibited and may subject the health care provider to penalty under 39-A M.R.S.A. § 360.

7. Pursuant to 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.
8. Fees for copies of medical information are as set forth in § 1.08 of this chapter.

1.12 PERMANENT IMPAIRMENT RATINGS

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

SECTION 2. PROFESSIONAL SERVICES

2.01 PAYMENT CALCULATION

1. Pursuant to 39-A M.R.S.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 \$60.00.
3. Fees for all other professional services are calculated for procedure codes by multiplying the applicable conversion factor times the non-facility total RVU. The conversion factor for all other professional services is \$60.00.
4. Fees for professional services (excluding anesthesia) are as outlined in Appendix II. In the event of a dispute regarding the fee listed in Appendix II, the listed relative weight times the base rate controls. For time-based medicine services, one time unit is allowed for each 15 minute interval or significant fraction thereof (7.5 minutes or more) of time. Documentation of actual time spent rendering the service must accompany the bill for services.

2.02 EVALUATION AND MANAGEMENT GUIDELINES

1. Definition of New Patient
 - A. A new patient is one who has not received any professional services from the health care provider (or another health care provider of the exact same specialty and subspecialty who belongs to the same group practice) within the past three years, or
 - B. A new patient is one who is being evaluated for a new injury/illness to determine work relatedness/causality, or
 - C. A new patient is one who is being seen for a new episode of care for an existing injury/illness.
2. Payments for New Patient Visits

Only one new patient visit is reimbursable to a health care provider (or another health care provider of the exact same specialty and subspecialty who belongs to the same group practice) for the same patient relating to the same episode of care.

3. For purposes of this section, “episode of care” includes all the professional services provided by the health care provider (or another health care provider of the exact same specialty and subspecialty who belongs to the same group practice) for the same patient for the same injury/illness from date of initial examination to date of discharge from care.

2.03 ANESTHESIA GUIDELINES

1. Definition of the Unit Components

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

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

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

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

UNIT VALUE

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

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

2. Calculation Examples

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

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

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

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

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

Total Units X Conversion Factor = Maximum Allowable Payment

~~CONVERSION FACTOR = \$50.00~~

2.04 SURGICAL GUIDELINES

1. For surgical procedures that usually mandate a variety of attendant services, the reimbursement allowances are based on a global reimbursement concept. Global reimbursement covers the performance of the basic service and the normal range of care required before and after surgery. The normal range of post-surgical care is indicated under “Global Days” in Appendix II. The maximum allowable payment for a surgical procedure includes all of the following:
 - A. Any visit that has as its principal function the determination that the surgical procedure is needed.
 - B. All visits which occur after the need for surgery is determined and are related to or preparatory to the surgery.
 - C. Surgery.
 - D. All post-surgical care services, which are routinely performed by the surgeon or by members of the same group within the same specialty as the surgeon, including removal of sutures.
2. The following four exceptions to the global reimbursement policy may warrant additional reimbursement for services provided before surgery:
 - A. When a pre-operative visit is the initial visit and prolonged detention or evaluation is necessary to prepare the patient or to establish the need for a particular type of surgery.
 - B. When the pre-operative visit is a consultation.
 - C. When pre-operative services are provided that are usually not part of the preparation for a particular surgical procedure. For example, bronchoscopy prior to chest surgery.
 - D. When a procedure would normally be performed in the office, but circumstances mandate hospitalization.
3. Additional charges and reimbursement may be warranted for additional services rendered to treat complications, exacerbation, recurrence, or other diseases and injuries. Under such circumstances, additional reimbursement may be requested.
4. An incidental surgery will not be paid under the Workers’ Compensation system.
5. When two or more surgical procedures are performed at the same session by the same individual, the highest weighted surgical code is paid at 100% of the fee listed in Appendix II and additional surgical procedures are paid at 50% of the fee listed in Appendix II. Add-on codes are not subject to discounting.

2.05 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

1. There is no reimbursement for incidental supplies. Supplies and materials that exceed incidental supplies can be billed separately. Code 99070 can only be billed when there is no specific supply code available.
2. The employer/insurer must pay for all durable medical equipment, prosthetics, orthotics, and supplies that are ordered and approved by the treating health care provider.
3. Fees for durable medical equipment, prosthetics, orthotics, and supplies are as outlined in Appendix II. Invoices need not be requested by the employer/insurer.

SECTION 3. INPATIENT FACILITY FEES

3.01 BILLING

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

3.02 ACUTE CARE HOSPITALS

The base rate for inpatient services at acute care hospitals is \$11,121.68.

3.03 CRITICAL ACCESS HOSPITALS

The base rate for inpatient services at critical access hospitals is \$11,788.98.

3.04 *[Reserved]*

3.05 PAYMENT CALCULATION

Pursuant to 39-A M.R.S.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 fees in effect on the discharge date.

3.06 OUTLIER PAYMENTS

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

3.07 IMPLANTABLES

Where an implantable exceeds \$10,000.00 in cost, an acute care or critical access hospital may seek additional reimbursement by submitting a copy of the invoice(s) along with the bill. Invoices need not be requested by the employer/insurer. Reimbursement is set at the actual amount paid plus \$500.00. Handling and freight charges must be included in the hospital's invoiced cost and are not to be reimbursed separately. When a hospital seeks additional reimbursement pursuant to this chapter for an implantable, the implantable charge is excluded from any payment calculation ~~for an outlier payment~~.

3.08 SERVICES INCLUDED

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

3.09 FACILITY TRANSFERS

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

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

3.10 OTHER INPATIENT FACILITY FEES

Inpatient services provided by institutional health care providers other than acute care or critical access hospitals must be paid at 75% of the provider's usual and customary charge.

3.11 PROFESSIONAL SERVICES

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

SECTION 4. OUTPATIENT FACILITY FEES

4.01 BILLING

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.

4.02 ACUTE CARE HOSPITALS

The base rate for outpatient services at acute care hospitals is \$150.05.

4.03 CRITICAL ACCESS HOSPITALS

The base rate for outpatient services at critical access hospitals is \$174.00.

4.04 AMBULATORY SURGICAL CENTERS

The base rate for surgical services at ambulatory surgical centers is \$113.39.

4.05 PAYMENT CALCULATION

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

1. For procedure codes with no CPT[®]/HCPCS code or for procedure codes with a status indicator of N, there is no separate payment.
2. If the ACH Fee, CAH Fee or ASC Fee listed in Appendix IV is \$0.00 for a procedure code with a status indicator other than N, then payment must be calculated at 75% of the health care provider's usual and customary charge.
3. When two or more procedure codes with a status indicator of T are billed on the same date of service, the highest weighted code is paid at 100% of the fee listed in Appendix IV and additional T status code procedures are paid at 50% of the fee listed in Appendix IV. Add-on codes are not subject to discounting.
4. ~~When one or more procedure codes with a status indicator of N are billed without any 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.),~~ If application of this subsection results in

a \$0.00 fee, payment must be calculated at 75% of the provider's usual and customary charge.

4.06 OUTLIER PAYMENTS

The threshold for outlier payments is \$2,500.00 per procedure code plus the fee listed in Appendix IV. If the outlier threshold is met, the outlier payment is the charges above the threshold multiplied by 75%. If a bill has more than one surgical procedure with a status indicator of J, S or T and one or more of those procedures has less than a \$1.01 charge, charges for all status J, S and T lines are summed and the charges are then divided across the J, S and T lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the outlier calculation.

4.07 IMPLANTABLES

Where an implantable exceeds \$250.00 in cost, hospitals or ambulatory surgical centers may seek additional reimbursement (regardless of the status indicator) by submitting a copy of the invoice(s) along with the bill. Invoices need not be requested by the employer/insurer. Reimbursement is set at the actual amount paid plus 20% or the actual amount paid plus \$500.00, whichever is less. Handling and freight charges must be included in the facility's invoiced cost and are not to be reimbursed separately. When a hospital seeks additional reimbursement for an implantable, the implantable charge is excluded from any payment calculation.

4.08 SERVICES INCLUDED

Outpatient services include observation in an outpatient status.

4.09 TRANSFERS

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

1. A hospital or ambulatory surgical center transferring a patient is paid the maximum allowable payment established in this section.
2. A hospital discharging a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons per section 3.
3. Facility transfers do not include costs related to transportation of a patient to obtain medical care. Costs related to transportation are payable separately.

4.10 OTHER OUTPATIENT FACILITY FEES

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

4.11 PROFESSIONAL SERVICES

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

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

EFFECTIVE DATE:

January 15, 1993 (EMERGENCY)

EFFECTIVE DATE OF PERMANENT RULE:

April 17, 1993

REPEALED AND REPLACED:

April 4, 1994

EFFECTIVE DATE (ELECTRONIC CONVERSION):

April 28, 1996

AMENDED:

January 1, 1997 - agency asserts § 16 as effective retroactively to April 4, 1994.

July 1, 1997 - changed address in § 9 (4), replaced Appendix III.

May 1, 1999 - updated CPT® copyright year, replaced Appendices I, II, & III.

NON-SUBSTANTIVE CORRECTIONS:

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

AMENDED:

July 1, 2001

July 1, 2002 - refiled June 13, 2002 to include some codes missing from the previous filing.

September 24, 2002 - filing 2002-349 affecting § 7 sub-§ 2.

NON-SUBSTANTIVE CORRECTIONS:

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

AMENDED:

November 5, 2006 - filing 2006-458

December 11, 2011 - filing 2011 - (repeal Rule and Apps. I-III and replace with new Rule and Apps. I-V)

October 1, 2015 - filing 2015-173

AMENDED:

September 1, 2018 - filing 2018-122 - 136

AMENDED:

January 1, 2019 - filing 2018-268

DRAFT

CHAPTER 5

APPENDIX I

~~MEDICAL FEE SCHEDULE~~

PRACTITIONER'S REPORT (FORM M-1)

DRAFT

**M-1 DIAGNOSTIC MEDICAL REPORT
MAINE WORKERS' COMPENSATION BOARD**

EMPLOYEE NAME:		EMPLOYEE DOB:	EMPLOYEE SSN (last 4 digits only): XXX-XX-	EMPLOYEE EMAIL:
EMPLOYEE PHONE:		EMPLOYEE ADDRESS:		
EMPLOYER NAME:		EMPLOYER ADDRESS:		
EMPLOYER CONTACT NAME:		EMPLOYER CONTACT PHONE:	EMPLOYER FAX/EMAIL:	
DATE OF INJURY:	TIME OF INJURY:	DID INJURY OCCUR ON EMPLOYER PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, LIST PLACE OF INJURY		

CAUSE AND NATURE OF THE INJURY/ILLNESS (EXAMPLE – CUT FINGER; THE KNIFE SLIPPED WHILE CUTTING LEMONS.)

DATE OF THIS EXAMINATION: _____ ☐ INITIAL ☐ PROGRESS ☐ FINAL

DIAGNOSIS: _____

IN MY OPINION, THE INJURY DESCRIBED ABOVE IS A CAUSE OF THE DIAGNOSIS? ☐ YES ☐ NO ☐ UNCLEAR

TREATMENT: IS TREATMENT TO CONTINUE: ☐ NO ☐ YES

IF YES, DATE OF NEXT APPOINTMENT: _____ IF YES, EST. LENGTH OF TREATMENT: _____

TREATMENT PLAN:

WORK CAPACITY:

☐ REGULAR DUTY ☐ NO WORK CAPACITY IF CHECKED, ESTIMATED RETURN TO WORK DATE: _____

☐ MODIFIED WORK (LIST BELOW OR DETAIL ON REVERSE) IF CHECKED, EST. LENGTH OF RESTRICTIONS: _____

BODY REGION(S) THAT RESTRICTIONS APPLY TO: _____

RESTRICTIONS RECOMMENDED*: **List Below (PLEASE BE AS SPECIFIC AS POSSIBLE)**

*Restrictions are provided at the professional recommendation of the provider; actual functional testing may not have been performed.

SIGNATURE OF HEALTH CARE PROVIDER: _____ DATE: _____

PRINT NAME: _____ PHONE: _____

PROVIDER ADDRESS: _____

DUTIES OF HEALTH CARE PROVIDERS

Pursuant to 39-A M.R.S.A. § 208(2), duties of health care providers are as follows:

- 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, the health care provider treating the employee shall forward to the employer and the employee a diagnostic medical report, on forms prescribed by the board, for the injury for which compensation is being claimed. The report must include the employee's work capacity, likely duration of incapacity, return to work suitability and treatment required. The board may assess penalties up to \$500 per violation on health care providers who fail to comply with the 5-day requirement of this subsection.
- If ongoing medical treatment is being provided, every 30 days the employee's health care provider shall forward to the employer and the employee a diagnostic medical report on forms prescribed by the board. An employer may request, at any time, medical information concerning the condition of the employee for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request.
- A health care provider shall submit to the employer and the employee a final report of treatment within 5 working days of the termination of treatment, except that only an initial report must be submitted if the provider treated the employee on a single occasion.
- Upon the request of the employee and 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 medical records regarding the employee, including x rays, shall forward all medical 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 shall request to have the records transferred.
- A health care provider may not charge the insurer or self-insurer an amount in excess of the fees prescribed in §209-A for the submission of reports prescribed by this section and for the submission of any additional records.
- An insurer or self-insurer may withhold payment of fees for the submission of any required reports of treatment to any provider who fails to submit the reports on the forms prescribed by the board and within the time limits provided. The insurer or self-insurer is not required to file a notice of controversy under these circumstances, but must notify the provider that payment is being withheld due to the failure to use prescribed forms or to submit the reports in a timely fashion. In the case of dispute, any interested party may petition the board to resolve the dispute.

Other reminders:

- Except for the header information, the remainder of the M-1 form must be completed by the health care provider. This information is vital to the administration of the claim and the employee's return to work.
- The M-1 form is not submitted to the board.
- Pursuant to Board Rules Chapter 5, a health care provider may charge a fee for completing the initial M-1.
- ~~The~~ Except as set forth in § 1.06(5) of this rule, the attachment of narratives is optional; however, an employer/insurer may request, at any time (for a fee), medical information concerning the condition of the employee for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request. Pursuant to 39-A M.R.S.A. § 208(1) a medical release is not necessary if the information pertains to an injury claimed to be compensable under the Act (whether or not the claim is controverted/denied).

CHAPTER 5

APPENDIX II

**NOTE: FOR A COMPLETE COPY OF THE MEDICAL FEE SCHEDULE,
INCLUDING THE APPENDICES, PLEASE SEE THE SEPARATE PUBLICATION ENTITLED:
"MEDICAL FEE SCHEDULE" LOCATED ON THE BOARD'S
WEBSITE HERE: <http://www.maine.gov/wcb/departments/omrs/medfeesched.html>**

CHAPTER 5

APPENDIX III

**NOTE: FOR A COMPLETE COPY OF THE MEDICAL FEE SCHEDULE,
INCLUDING THE APPENDICES, PLEASE SEE THE SEPARATE PUBLICATION ENTITLED:
"MEDICAL FEE SCHEDULE" LOCATED ON THE BOARD'S
WEBSITE HERE: <http://www.maine.gov/wcb/departments/omrs/medfeesched.html>**

CHAPTER 5

APPENDIX IV

**NOTE: FOR A COMPLETE COPY OF THE MEDICAL FEE SCHEDULE,
INCLUDING THE APPENDICES, PLEASE SEE THE SEPARATE PUBLICATION ENTITLED:
"MEDICAL FEE SCHEDULE" LOCATED ON THE BOARD'S
WEBSITE HERE: <http://www.maine.gov/wcb/departments/omrs/medfeesched.html>**

CHAPTER 5 APPENDIX V

MEDICAL RELEASE FORMS

**(FORMS WCB-220, WCB-220A, WCB-220B,
WCB-220C, AND WCB- 220R)**



State of Maine Workers' Compensation Board General Release of Medical/Health Care Information

Name:

SSN (last 4 digits): XX-XX-

Date of Birth:

Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to employee: The employer/insurer contends your medical records are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable. This means all written records relating to the diagnosis, treatment and care, including but not limited to diagnostic imaging/tests, related to the following body part(s) and/or condition(s):

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

Notice to Health Care Practitioners and Facilities: You are required to provide the records to the recipient indicated below within 30 days of receiving this signed authorization. You may also request that the employee sign a medical release acceptable to you pursuant to W.C.B. Rules, Ch. 5 § 1.11(2)(B)

Employee Authorization to Disclose Protected Health Information ("PHI")/Health Care Information

I hereby authorize my health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including but not limited to diagnostic and imaging tests, of the body part(s) and/or condition(s) listed above subject to the following exclusions:

☐ None

☐ Exclusions: _____

This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance use disorder; HIV/Aids and sexually transmitted diseases.

This authorization is to release written records only. It does not authorize oral communications with anyone other than me or my representative, if I have one.

This release authorizes the release of records dating from _____ until thirty (30) months after the date I

sign this form. This release authorizes the above health care practitioners and/or facilities to release records pursuant to a later request after this release is signed through the termination date of this release.

Acknowledgements:

- **Voluntary:** I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy (“NOC”). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: www.maine.gov/wcb/employees.
- **Redisclosure:** I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers’ Compensation Act (Title 39-A) is compensable.
- **Revocable:** I understand I may revoke this authorization at any time in writing, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation, but doing so may result in a loss of, or reduction in, entitlement to workers’ compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. The WCB form 220-R is effective only after it is received and does not apply to information that was already disclosed.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder.
- A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.

I authorize release of my medical records to: _____
(Name of recipient/recipient’s employer)

Address of recipient/recipient’s employer:

Format Requested (circle one): Electronically (if available): _____ **Fax to:** _____

Mail to : _____

Employee or Authorized Representative Signature _____ **Date:** _____

For purposes of this release, “authorized representative” has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers’ Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711. WCB-220 (effective XX/XX/2023)



**State of Maine Workers' Compensation Board
Limited Release of Protected Medical/Health Care
Information Related to Psychological Matters**

Name of Employee:

Date of Injury:

SSN (last 4 digits): XXX-XX-

Date of Birth:

Description of Injury:

Notice to employer/insurer/employee: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected health care information to an employer or its insurer. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to health care providers: You are required to provide the records identified below to the recipient listed below within 30 days of receiving this signed authorization. You may also request that the employee sign a medical release acceptable to you pursuant to W.C.B. Rules Ch. 5 § 1.11 (2)(B).

This release permits the release of psychological treatment records by the following provider:

Name(s):

Address(es):

Insurer must choose one: ☐ We request only treatment records related to the date and description of injury listed above

☐ We request all treatment records from this health care provider

Employee must choose one: ☐ I consent only to the release of treatment records related to the date and description of injury listed above

☐ I consent to the release of all treatment records from this health care provider

Limited scope of treatment records: I understand this form authorizes the healthcare provider to release only written records. This form does NOT authorize oral communications with anyone other than me or my representative if I have one.

Timeframe: This release authorizes the disclosure of psychological treatment records dating from _____ until twelve (12) months after the date I sign this form.

Voluntary: I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy ("NOC"). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: <https://www.maine.gov/wcb/employees.html>

Redisclosure: I understand the records provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, my entitlement to workers' compensation benefits. Revocation of this authorization may only be accomplished by completing and sending WCB Form 220-R to the recipient listed below. This authorization may not be cancelled as to records already provided.

RIGHT TO REVIEW: You have the right to review your psychological counseling records prior to the authorized release of the records. You may add material to your record in order to clarify information you believe is false, inaccurate, or incomplete.

I DO / DO NOT (circle one) want to review my records before they are released. By selecting I DO and signing below, I understand the review will be supervised and my review of the records prior to their release may delay the consideration of my claim.

I authorize the health care provider to release records to:
Name of Recipient/reipient's employer:

Address of Recipient of records:

Format Requested (circle one):

Electronically (if available): _____

Fax to: _____

Mail to : _____

I hereby authorize the above named recipient to obtain records from my health care provider(s) subject to the terms of this release.

Employee signature _____

Date signed: _____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A)

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220-A (effective XX/XX/2023)



State of Maine Workers' Compensation Board Limited
Release of Protected Medical/Health Care Information
Related to Substance Use Disorder

Name:

Date Birth:

SSN (last 4 digits): XXX-XX-

Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to health care providers: You are required to provide the records to the recipient indicated below within 30 days of receiving this signed authorization. You may also request that the employee sign a medical release acceptable to you pursuant to W.C.B. Rules Ch. 5 § 1.11(2)(B).

Notice to employee: The employer/insurer/employee representative contends your health care providers' records related to the identity, diagnosis, prognosis, or treatment of substance use disorder, regardless of the date of injury, are relevant to whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers, including 42 CFR Part 2
Program(s) _____ to release the records
(name of facility/provider/program)

they have related to the identity, diagnosis, prognosis, or treatment of substance use disorder.

This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy ("NOC"). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: <https://www.maine.gov/wcb/employees.html>

Limited: I understand this form gives my health care providers permission to release only those health records related to the condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release may be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers'

Compensation Act (Title 39-A) is compensable. Please note: Redisclosure of information subject to 42 CFR Part 2 can only be redisclosed as provided by 42 CFR Part 2.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below.

Note: You may not cancel this release with respect to medical records already provided.

I authorize release of my medical records to:

Name of Recipient/Recipient's Employer

Address of Recipient:

Format Requested (circle one):

Electronically (if available): _____

Fax to: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature: _____

Date: _____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220-B (effective XX/XX/2023)



**State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information
Related to HIV/AIDS and Sexually Transmitted Diseases**

Name:

Date of Birth:

SSN (last 4 digits): XXX-XX-

Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to employee: The employer/insurer/employee representative contends your health care providers' medical records related to:

- ☐ Your HIV infection status, including the results of an HIV test
- ☐ The diagnosis, treatment and care of sexually transmitted diseases

are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records they have related to the diagnosis, treatment and care of the condition(s) listed above, regardless of the date of injury. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care practitioner(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy ("NOC"). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: <https://www.maine.gov/wcb/employees.html>.

Limited: I understand this form gives my health care providers permission to release only the medical records related to the condition(s) indicated above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

Potential Implications of Release: Releasing this information may have implications. Positive implications may include giving you more complete care. Negative implications may include discrimination if the data is misused.

IMPORTANT NOTICE: By signing this form I understand that I am authorizing the release of my medical records related to my HIV infection status and/or my medical records regarding diagnosis, treatment and care of sexually transmitted diseases.

I authorize release of my medical records to: (Name of Recipient/Recipient's Employer)

Address of Recipient:

Format Requested (circle one): **Electronically (if available):** _____

Fax to: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature _____

Date: _____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-220-C (effective XX/XX/2023)



State of Maine Workers' Compensation Board

Revocation of Release of Protected Medical/Health Care Information

Name:

SSN (last 4 digits): XXX-XX-

Date of Birth:

Date of Injury/Illness:

Notice to employee: This revocation must be sent to the recipient who is named on your release. You should provide a copy of this revocation to your health care providers as soon as possible. You should keep a copy of the signed form for your records. Your health care provider may not receive your revocation immediately and will continue to release your records until they receive a copy of this revocation.

I _____ am revoking the release of protected
(Name)

medical/health care information signed by me on _____ and provided to
(Date)

_____. This release revokes authorization for all health care providers,
(Recipient)

unless specified below:

☐

Only the following health care providers: _____

I understand this revocation may result in a loss of or reduction in entitlement to workers' compensation benefits. I also understand this release does not apply to medical records already provided pursuant to the release.

I have read and understood this form.

I hereby revoke the release of my medical records:

Employee or Authorized Representative Signature _____

Date: _____

For purposes of this revocation, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

Notice to employer/insurer/employee representative: Within 14 days after receipt of this form you must forward a copy to all health care providers to whom you provided the release signed by the employee on the date listed above.

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~~ \$.46 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~~ \$.46 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~~ \$.46 per mile.

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

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

1. ~~\$.44~~ \$.46 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 - Section 3

February 11, 1992 - Section 3

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

AMENDED:

October 1, 2015 – filing 2015-1