1. **An Administrative Law Judge may order all of the following benefits except:**
2. Weekly incapacity benefits
3. Compensation for pain and suffering
4. Payment of medical bills pursuant to the MFS
5. Interest
6. All of the above
7. None of the above
8. **The Medical Fee Schedule incorporates which of the following by reference:**
9. Medicare’s RBRVS payment system, MS-DRG system, and APC system
10. Medicare’s NCCI Edits
11. AMA’s Current Procedural Terminology
12. State Treasurer's Unclaimed Property Law
13. All of the above
14. None of the above
15. **Which of the following can be reported as medical treatment on form WCB-11:**
16. Nurse case management services
17. Medical bill review services
18. Utilization review services
19. A Section 207 examination
20. All of the above
21. None of the above
22. **Health care providers have how long to appeal a WC payment for medical goods and services:**
23. 30 days from receipt of payment
24. 60 days from receipt of payment
25. 90 days from receipt of payment
26. As outlined in Section 306 of the WC Act
27. Providers may appeal a WC payment at any time
28. Providers may not appeal a WC payment
29. **Which of the following elements, when missing, constitutes an uncoded bill:**
30. The National Provider Identifier of the health care provider
31. The patient/employee’s date of birth
32. The insured/employer’s address
33. The applicable diagnosis codes
34. All of the above
35. None of the above
36. **The Explanation of Benefits/Explanation of Review form must contain:**
37. The billed procedure code and the paid procedure code
38. The amount paid
39. The identity of any managed care network discount applied
40. The provider’s appeal rights
41. All of the above
42. None of the above
43. **To determine the maximum allowable payment per the MFS you must have which of the following:**
44. The provider’s tax identification number
45. Date of injury/occurrence
46. Type of service
47. The patient’s diagnosis
48. The assistance of the Board’s Office of Medical/Rehabilitation Services
49. All of the above
50. **Claim administrators may recoup provider overpayments:**
51. With approval from the provider
52. With approval from the employee
53. With approval from a WCB administrative law judge
54. With approval from the Maine Supreme Judicial Court
55. With approval from all of the above
56. Without approval
57. **Claim administrators are allowed to pay a usual and customary fee for the following:**
58. A valid procedure code without a max fee
59. Physician-dispensed pharmaceuticals
60. Compound drugs
61. For services provided in accordance with a written payment agreement
62. All of the above
63. None of the above
64. **A bill for services received via regular mail may simply be returned to the provider and no denial is necessary when:**
65. A bill is received without accompanying medical records
66. A bill for inpatient services is received without the MS-DRG code
67. A bill is received for an injury and no claim is on file
68. A bill for professional services is not on the required billing form
69. All of the above
70. None of the above
71. **Which of the following statements regarding prior approval/pre-authorization is true:**
72. Pre-authorization is required for treatment by a specialist
73. Pre-authorization is required for treatment by prayer or spiritual means
74. Pre-authorized services must be paid by the claim administrator
75. A NOC must be filed if requested treatment is not reasonable/proper
76. All of the above
77. None of the above
78. **A Notice of Controversy must be filed with the Board when:**
79. A bill for an office visit is received during the surgical follow-up period via regular mail
80. A bill for an office visit is received during the surgical follow-up period via certified mail
81. To dispute the level of service provided
82. Both B and C
83. All of the above
84. None of the above
85. **A line by line determination of the maximum allowable payment is not appropriate for:**
86. A bill for the services of a certified registered nurse anesthesiologist
87. A bill for the services of an assistant surgeon
88. A bill for surgery at an ambulatory surgical center
89. A bill for an artificial leg and related equipment
90. All of the above
91. None of the above
92. **Changes to medical bills are not allowed except when:**
93. The provider has billed a higher level of service than what the medical records support
94. The provider has billed with a deleted procedure code
95. The provider has billed the incorrect number of units
96. The provider has billed amounts greater than the maximum allowed per the fee schedule
97. All of the above
98. None of the above