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| **Number** | **True or False** | **Question** |
| 1 | F | The patient is the best source of WC billing/insurance information? Unless the patient is receiving ongoing treatment for an established work injury, the patient is not likely to have any information regarding WC billing/insurance information. |
| 2 | T | A patient hurt on the job has the right to refuse to make a WC claim? A patient injured at work always retains the right not to file a claim with his/her employer. In such cases, the M-1 form is not required and the patient is 100% responsible for the payment. The bill may not be submitted to the patient’s health insurer (if any).  |
| 3 | F | Certain treatments such as acupuncture and massage therapy require pre-authorization? There are no pre-authorization requirements and the ER/IR may not require pre-authorization as a condition of payment. |
| 4 | F | Physical therapists may not complete the diagnostic medical report? Health care providers must complete the M-1 form in accordance with 39­A M.R.S.A. §208.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; this definition includes physical therapists and all other providers that meet the definition.  |
| 5 | T | Providers may be subject to fines up to $10,000 if they are not utilizing the prescribed M-1 Form? Providers may be subject to fines under 39-A §§ 208 and 360. This includes fines up to $10,000 for willful violations of the Act. |
| 6 | F | There is a 120 day timely filing limit for workers’ compensation claims? An employer/insurer cannot put a time limit on the submission of workers’ compensation bills. The time for filing petitions is governed by Act § 306. |
| 7 | F | Professional fees must be billed on CMS Form-1500? There is no prescribed billing form for professional fees. In addition, for dates of service after 10/1/15, there is no requirement for professional fees to be billed separately from facility fees. Professional fees are reimbursed in accordance with Section 2/Appendix II regardless of what form they are billed on. |
| 8 | F | Providers must supply invoices for implantables that exceed the amount of the applicable threshold? Providers may seek additional reimbursement for implantables that exceed the amount of the applicable threshold by submitting a copy of the invoice(s) along with the bill, however, it is not always advantageous to seek additional reimbursement for implantables as it may actually reduce payment to the provider. |
| 9 | T | Critical access hospitals are paid by DRG for inpatient facility charges? Both critical access and acute care hospitals are reimbursed by DRG for inpatient facility charges. Hospitals are not required to supply the DRG code; the DRG code is not a required billing element. |
| 10 | F | Insured employers are permitted to pay medical bills up to the amount of their deductible? All claims must be reported by the employer to the insurer. The carrier that wrote the policy is responsible from the first dollar regardless of any deductibles on the policy. |
| 11 | T and F | The Board’s website provides the mailing address for each of the claim administrators? The Board’s website contains a list of self-insured employers along with the name and address of the claim administrator. The website also contains a link to NCCI’s insurance coverage verification site. Unfortunately, the insurance coverage verification site results only provide the name of the insurance coverage provider and the policy number. The site does not contain any claim administrator information. Claim administrator information must be obtained from the employer, insurer, or the Board.  |
| 12 | T and F | Payment of medical bills is due within 30 days if bills are sent via certified mail? Per Chapter 5, § 1.07(2), medical bills must be paid or denied within 30 day of a properly submitted bill. When medical bills are sent via certified mail and not paid or denied within 30 days receipt, the provider may receive accrued penalties up to $50/day for each day over 30 days up to a maximum of $1,500 per Act § 205(4). |
| 13 | F | Claim jurisdiction is determined in part by the provider’s location? The provider’s location has no bearing on the jurisdiction of the claim. |
| 14 | F | The Explanation of Benefits/Review must clearly identify which charges are not being paid and why? EOBs/EORs are not required. Assuming there is not a valid payment agreement to pay something other than the amount due per the fee schedule, the employer/insurer must pay the bill in accordance with the fee schedule. If anything less than the amount due under the fee schedule is paid, a partial denial must be filed electronically with the Board contemporaneous with the payment. A copy of the denial/notice of controversy form must be sent to the employee, the employer and the health care provider from whom the bill originated within 24 hours after the Notice of Controversy is transmitted to the Board. |
| 15 | F | Overpayments must be returned to the payor within 90 days? Per Workers’ Compensation Board Decision No. 96-0: Donald C. Pritchard, Jr. V. S.D. Warren Company And Sedgwick James Of Northern New England, “The present Act provides this employer with no mechanism to recover what the employer regards as an overpayment of compensation.” A payor may request a voluntary repayment. |