INTRODUCTION

The Maryland Workers' Compensation Commission (Commission) amended COMAR 14.09.03.01 (Guide of Medical and Surgical Fees) on February 12, 2004.

AUTHORITY

The Workers' Compensation Act provides in part as follows:

In addition to the compensation provided under this subtitle, if a covered employee has suffered an accidental personal injury, compensable hernia, or occupational disease the employer or its insurer promptly shall provide to the covered employee, as the Commission may require:

(1) medical, surgical, or other attendance or treatment;
(2) hospital and nursing services;
(3) medicine;
(4) artificial arms, feet, hands, and legs and other prosthetic appliances.

Labor and Employment Article, § 9-660

The Commission may regulate fees and other charges for medical services or treatment under this subtitle.

Labor and Employment Article, § 9-663(b)(1)

The Commission may adopt regulations about:

(i) the provision of medicine and medical, nursing, and hospital services to a covered employee;
(ii) payment for medicine and services.

Labor and Employment Article, § 9-663(a)(2)

ADOPTION OF CENTERS FOR MEDICARE AND MEDICAID (CMS) REIMBURSEMENT

To achieve standardization, the Commission amended COMAR 14.09.03.01, hereinafter referred to as Medical Fee Guide (MFG), which, with some exceptions, uses the 2004 reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid (CMS), including applicable payment policies relating to coding, billing, and reporting.

PRECEDENCE OF WORKERS' COMPENSATION ACT AND COMMISSION REGULATIONS

Specific provisions contained in the Maryland Annotated Code, Labor and Employment, Title 9 (The Act) and Maryland Workers' Compensation Commission regulations (COMAR), shall take precedence over any conflicting provisions adopted by or utilized by CMS in administering the Medicare program. Exceptions to Medicare payment policies for medical necessity may be provided by Commission regulation and/or Commission decision. It is intended that this MFG be flexible. Adjudication of any variation is the responsibility of the Commission under the laws of Maryland.

APPLICATION OF THE MEDICAL FEE GUIDE

(1) Authorized Providers:

The following health care providers are recognized by the Commission and must comply with the billing and reimbursement policies and Maximum Reimbursement Allowable (MRAs):

Licensed Acupuncturist
Medical Doctor (M.D.)
Doctor of Osteopathy (D.O.)
Doctor of Chiropractic (D.C.)
Podiatrist (D.P.M.)
Optometrist (O.D.)

Certified Registered Nurse Anesthetist (C.R.N.A.)
Occupational Therapist (O.T.)
Pharmacist (R.Ph.)
Licensed Physical Therapist (P.T.)
Psychologist (Ph.D.)
Licensed Clinical Social Worker (L.C.S.W.)
Dentist (D.D.S./D.M.D.)
Licensed Audiologist
Licensed Speech-language Pathologist

(2) This section shall be applicable for professional medical services provided on or after September 1, 2004. For professional medical services provided prior to September 1, 2004, Maryland Annotated Code, Labor and Employment §9-663 and 9-731 and COMAR 14.09.03 (relating to Medical Fee Guide) shall be applicable.

(3) Notwithstanding CMS payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(4) Specific provisions contained in the Act, or COMAR regulations, including this regulation, shall take precedence over any conflicting provision adopted by or utilized by CMS in administering the Medicare program. Exceptions to Medicare payment policies for medical necessity may be provided by Commission regulation and/or decision.

(5) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Commission rules, decisions and orders for services rendered on or after the effective date of the revised component.

(6) For coding, billing, reporting, and reimbursement of professional medical services, compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a treatment is provided with any additions or exceptions in this section.

(7) To determine the MRA for professional services and treatment, system participants shall apply the CMS payment policies with the following minimal modifications:

(a) for all service categories, the conversion factor to be used for determining reimbursement in the Maryland workers' compensation system is the effective conversion factor adopted by CMS for 2004 multiplied by 109%. For Anesthesiology services, the same conversion factor shall be used.
(b) The multiple procedure discount for physical medicine and rehabilitation (CPT codes 97010-97799) be eliminated to be consistent with CMS.
(c) For CPT codes 97012-97039, only one code per session will be reimbursed per visit.
(d) For services rendered at Ambulatory Surgical Centers, as defined in Maryland Annotated Code, Health General §19-3B-01, ASC, the conversion factor to be used when determining reimbursement in the Maryland Workers' Compensation System is the effective conversion factor adopted by CMS multiplied by 109%.
(e) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate American Medical Association (AMA) Physician's Current Procedural Terminology (CPT) code. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed.

(8) For products and services for which CMS or the Commission does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value which may be based on nationally recognized published relative value studies, or values assigned for services involving similar work and resource commitments. Upon application of either party, the amount of reimbursement is subject to review by the Commission, pursuant to Maryland Annotated Code, Labor and Employment § 9–663, 664.

(9) Except as provided in subsection (c), reimbursement shall be the lesser of the:

(a) MRA amount as established by this rule; or
(b) Health care providers usual and customary charge.
(c) If, in the opinion of a health care provider it is medically necessary to exceed the MRA under the MFG, substantiating documentation must be submitted by the provider to the payor with the Form CMS-1500 or C-51.

(10) Submission of bills by provider to employer or insurer:

(a) All bills for treatment or services shall be made on Form CMS-1500 or an equivalent form, and shall include:
1) an itemized list of each service;
2) the diagnosis relative to each service;
3) the medical records related to the service being billed;
4) the appropriate CPT code with modifiers, if any, for each service;
5) the date of each service;
6) the specific fee charged for each service;
7) the tax ID number of the provider; and
8) the professional license number of the provider.

(b) Time for reimbursement – Reimbursement by the employer or insurer shall be made within 45 days of the date on which the Form CMS-1500 was received by the employer or insurer, unless the claim for treatment or services is denied in full or in part under paragraph (d) of this section.

(c) Penalty for untimely reimbursement – If an employer or insurer does not pay the fee pursuant to the MFG in the time prescribed in paragraph (b) of this section, or file a notice of denial of reimbursement within 45 days, the Commission may assess a fine against the employer or its insurer, and award interest to the provider in accordance with Maryland Annotated Code, Labor and Employment §9-663 and 9-664, and COMAR 14.09.01.22.

(d) Denial of reimbursement – If an employer or insurer denies, in full or in part, a claim for treatment or services, then the employer or insurer shall:

1. Notify the provider of the reasons for the denial in writing;
2. Mail the notice of denial of reimbursement with 45 days of the date on which Form CMS-1500 was received.

(e) Waiver of right to deny reimbursement – an employer or insurer who fails to file a notice of denial of reimbursement within 45 days thereby waives its right to deny reimbursement and is subject to the provisions of Maryland Annotated Code, Labor and Employment § 9-663 and 9-664, and COMAR 14.09.01.22.

(f) Objection to Denial of Reimbursement

1. A provider may contest an employer's or insurer's partial or total denial of reimbursement, by submitting to the Commission the following items:
   a. WCC Form C-51 "Claim for Medical Services;"
   b. the Form CMS-1500 which relates to the unpaid claims; and
   c. all correspondence relating to the unpaid claim.
2. The Commission shall review the items submitted, without hearing, and issue its decision in an Order Nisi.

(g) Hearing on Objection to Commission's Order Nisi

1. The provider, employer or insurer may contest the Commission's Order Nisi by filing a Controversion of Medical Claim (Form H-24M) with the Commission within 30 days of the date of the Order Nisi.
2. The Commission will schedule a hearing on the matter and render its decision.

(11) Medical Records

(a) Maintaining Medical Records – Medical records are the basis for determining whether a particular treatment or service is medically necessary and therefore reimbursable, and, thus, each health care provider is responsible for creating and keeping a legible medical record documenting the employee's course of treatment.

(b) Contents – Medical records shall include:

1. History of the patient;

2. Results of a physical examination performed in conformity with the standard of practice of similar health care providers, with similar training, in the same or similar communities;
3. Progress, clinical, or office notes that reflect:
    a. subjective patient complaints;
    b. objective findings of the provider;
    c. assessment of the presenting problem;
    d. plan(s) of care or recommendation(s) for treatment; and
    e. updated assessments of patient's
        1. medical status; and
        2. response to treatment or therapy.
4. Copies of lab, x-ray, or other diagnostic tests, if any, that reflect the current progress of the patient and response to therapy
5. Hospital inpatient and outpatient records, if any, including:
    a. operation reports;
    b. test results;
    c. consultation reports;
    d. discharge summaries; and
    e. other dictated reports.

(c) Submission

1. The medical record shall be submitted to the payor, or, upon request, to the Commission.

2. Prompt submission of medical records will expedite the payment of claims.

(d) Cost of writing and maintaining medical records - The cost of maintaining medical records is included in the fee for the service set by the MFG, thus, no separate fee should be submitted for writing or maintaining medical records.

1. Additional Medical Reports
    a. Submission – Additional medical reports shall be written and submitted promptly upon the

request of any party or upon request, to the Commission.

b. Cost of writing additional medical reports

1) The bill for writing the additional medical report shall identify the appropriate CPT code.

2) There shall be no fee for writing additional medical reports requested by the Commission to substantiate medical necessity.

2. Copies of Medical Records and Additional Medical Reports.

a. Requests for Copies

1) Requests for copies shall be reasonable and specific.

2) Health care providers shall respond promptly to requests for medical records and additional medical reports.

3) To avoid undue time demands, health care providers may request clarification regarding which medical records and additional medical reports are requested.

4) Copies submitted by the provider, but not specifically requested by the payor, will not be subject to reimbursement.

b. Fees for Copying

1) Copies of medical records and additional medical reports requested by the injured employee, injured employee's attorney, employer, and/or insurer will be reimbursed pursuant to Maryland Annotated Code, Health General §4-304(c) and all other applicable law.

2) Medical record requests by the Commission will be furnished by the provider without charge.

(12) Deposition Witness Fee Limitation

(a) A health care provider who gives a deposition shall be allowed a witness fee.

(b) Reimbursement

1. The health care provider shall submit a bill for the witness fee using the CPT code for the service.
2. Reimbursement for a deposition is limited to the amount published in the MFG for the appropriate CPT code.