Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 08 Guide of Medical and Surgical Fees (Effective as of February 24, 2020)

Authority: Labor and Employment Article, §§9-309, 9-663, and 9-731, Annotated Code of Maryland

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Ambulatory surgical center (ASC)" means any center, service, office facility, or other entity that:

(a) Operates primarily for the purpose of providing surgical services to patients requiring a period of postoperative observation but not requiring overnight hospitalization; and

(b) Seeks reimbursement from payers as an ambulatory surgery center.

(2) "Authorized provider" means:

(a) A licensed physician's assistant (P.A.), providing services on or after March 24, 2008;

(b) A licensed acupuncturist;

(c) A medical doctor (M.D.);

(d) A doctor of osteopathy (D.O.);

(e) A doctor of chiropractic (D.C.), for services provided within the scope of Health Occupations Article, Title 3, Annotated Code of Maryland;

(f) Podiatrist (D.P.M.);

(g) An optometrist (O.D.);

(h) A certified registered nurse anesthetist (C.R.N.A.);

(i) An occupational therapist (O.T.);

(j) A pharmacist (R. Ph.);

(k) A licensed physical therapist (P.T.);

(l) A psychologist (Ph.D.);

(m) A licensed clinical social worker (L.C.S.W.);

(n) A licensed audiologist;

(16) "Resource based relative value scale (RBRVS)" means the system by which medical providers are reimbursed based on the resource costs needed to provide a given service. Under the RBRVS, CMS assigns each medical procedure a relative value quantifying the relative work (work), practice expense (PE), and malpractice costs (MP) for each service.

(17) "RBRVS relative value unit (RVU)" means the uniform value assigned by CMS to each medical procedure and service identified by CPT/HCPCS code quantifying the work (work), practice expense (PE), and malpractice costs (MP) for each service.

(18) "Time Unit" means a measure of each 15-minute interval, or fraction thereof, during which anesthesiology services are performed.

.02 Incorporation by Reference.

A. The "Official Maryland Workers' Compensation Medical Fee Guide" (1995) is incorporated by reference.

B. Health Services Cost Review Commission. In accordance with Health-General Article, §19-211, Annotated Code of Maryland, in the case of a discrepancy between a rate for a hospital service set by the Health Services Cost Review Commission and that set by the Workers' Compensation Commission, the rate set by the Health Services Cost Review Commission shall prevail.

(3) The facility MRA shall be calculated by multiplying each RBRVS RVU by each corresponding GPCI, adding those sums, and then multiplying that total by the MSCF as follows: Facility MRA = ((Work RVU × Work GPCI) + (Transitioned Facility PE RVU × PE GPCI) + (MP RVU × MP GPCI)) × MSCF.

(4) For anesthesiology services, the MRA shall be calculated by adding the Time Units and Base Units and multiplying that sum by the MSCF: MRA = (Time Units + Base Units) × MSCF.

(5) In calculating the MRA, the following MSCFs apply:

(a) For anesthesiology services, the MSCF is $19.39;

(b) For orthopedic and neurological surgical procedures, MSCF is $53.77; and

(c) For all other medical services and treatment, except as otherwise provided, the MSCF is $40.70.

F. Ambulatory Surgical Centers.

(1) For medical services and treatment provided at an ASC between September 1, 2004, and January 31, 2006, the MRA is calculated by multiplying the CMS 2004 ASC group payment rate by 109 percent.

(2) For medical services and treatment provided at an ASC between February 1, 2006, and March 24, 2008, the MRA is calculated by multiplying the 2004 CMS ASC group payment rate by 125 percent.

(3) For medical services and treatment provided at an ASC on, or after, March 24, 2008, the MRA is calculated by multiplying the current calendar year ASC MRR by 125 percent.

G. MSCF Annual Adjustment.

(1) Beginning January 1, 2009, an adjustment shall be made to the prior year's MSCFs and percentage multiplier (for ASCs).

(2) The MSCFs for the following year shall be calculated by multiplying the MSCFs in effect on November 1 of the current year by the percentage change in the first quarter MEI of the current year, as published on November 1 of the current year, and adding that amount to the current year's MSCFs.

(3) The percentage multiplier for the following year shall be calculated by multiplying the percentage multiplier in effect on November 1 of the current year by the percentage change in the first quarter MEI of the current year, as published on November 1 of the current year, and adding that amount to the current year's percentage multiplier.

(4) The resulting figures shall be utilized as the new MSCF and percentage multiplier for the following year for the purpose of calculating the MRA under §§E and F of this regulation.

(5) The Commission shall post the new MSCFs and percentage multiplier on its website by December 1.

(6) The resulting new MSCFs and percentage multiplier shall be effective January 1 of the following year.

(7) The Commission shall review the annual adjustment process every 5 years to assure that reimbursement rates are neither inadequate nor excessive.

.06 Reimbursement Procedures.

A. To obtain reimbursement under this chapter, an authorized provider shall:

(1) Complete Form CMS-1500 in accordance with the written instructions posted on the Commission's website; and

(2) Within the time provided in §H of this regulation, submit to the employer or insurer the completed Form CMS-1500, which shall include:

(a) An itemized list of each service;

(b) The diagnosis relative to each service;

(c) The medical records related to the service being billed;

(d) The appropriate CPT/HCPCS code with CPT modifiers, if any, for each service;

(e) The date of each service;

(f) The specific fee charged for each service;

(g) The tax ID number of the provider;

(h) The professional license number of the provider; and

(i) The National Provider Identifier (NPI) of the provider.

B. Modifiers.

(1) Modifying circumstances may be identified by use of the relevant CPT modifier in effect when the medical service or treatment was provided.

(2) The identification of modifying circumstances does not imply or guarantee that a provider will receive reimbursement as billed.

C. 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 §G of this regulation.

D. Untimely Reimbursement. If an employer or insurer does not pay the fee calculated under this chapter or file a notice of denial of reimbursement, within 45 days of receipt of the CMS-1500, the Commission may assess a fine against the employer or its insurer, and award interest to the provider in accordance with Labor and Employment Article, §§9-663 and 9-664, Annotated Code of Maryland, and COMAR 14.09.06.02.

E. Denial of Reimbursement.

(1) If an employer or insurer denies, in full or in part, a claim for treatment or services, the employer or insurer shall:

(a) Notify the provider of the reasons for the denial in writing; and

.07 Medical Records.

A. Medical records are the basis for determining whether a particular treatment or service is medically necessary and, therefore, reimbursable.

B. Each health care provider is responsible for creating and maintaining legible medical records documenting the employee's course of treatment.

C. Employee medical records shall include the:

(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) Any plan or plans of care or recommendations for treatment; and

(e) Updated assessments of patient's medical status and response to 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; and

(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.

D. Writing, Maintaining, and Submitting Medical Records.

(1) Employee medical records shall be submitted to the employer or insurer, or, upon request, to the Commission.

(2) The cost of maintaining medical records is included in the treatment and service fees established by the Official Maryland Workers' Compensation Medical Fee Guide (1995) and this chapter. A provider may not submit a separate fee for writing or maintaining medical records.

(3) Additional Medical Report Fees.