

ALASKA WORKERS' COMPENSATION MEDICAL SERVICES REVIEW COMMITTEE MEETING



May 20, 2020

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TAB 1

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING

May 20, 2020

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION

AGENDA

May 20, 2020

10:00 am Call to order

- Roll call - establishment of quorum
- Approval of Agenda
- Reading of minutes from August 23, 2019 meeting

10:15 am Public Comment Period

11:15 am Break

11:30 am Overview/Discussion of 2021 MSRC Fee Schedule Issues

- COVID-19 Potential Impacts
- Lawsuit RE: 2020 fee schedule reimbursement limitations for off-label treatment

1:00 pm Lunch Break

2:00 pm 2021 Fee Schedule Issues Development

- Narrative updates to account for CMS adjustments.
 - CMS changes to E&M category
 - Cosmetic narrative adjustments to add clarity
 - Expand telemedicine descriptions and clarify any limitations
 - Clarify scenario in which relative weight is non-existent, but a payment rate exists in Addendum B (OPPS file) – (e.g. for CPT® 09375, pay at ASP value/multiplier)
- Review access to medical care for injured workers based on 2020 adjustments
- Review each conversion factor/multiplier category (compare to national & regional charges)
- Consolidation toward a single conversion factor?
- Inpatient Hospital conversion factors – evaluate methodology and consider conversion factor adjustments/consolidation.
- Evaluate any available data related to adjustments made in 2020:
 - Impact on utilization associated with work hardening and functional capacity exam increases;
 - Impact of hearing aids/parts limitation of mfr invoice + 30% for fitting and dispensing (HCPCS V5011& V5160) and “gap-fill” relative values;
 - Impact of scope of practice and off label use limitations.
- Recommendations for adoption of evidence-based treatment guidelines and/or evidence based drug formulary.
- Other issues

3:00 pm Break

3:15 pm 2021 Fee Schedule Guidelines Development (cont.)

5:00 pm Adjournment

TAB 2

*Medical Services Review Committee /
Workers' Compensation Board
Special Joint Meeting
Meeting Minutes*

August 23, 2019

I. Call to order

Workers' Compensation Director Grey Mitchell called the MSRC and Board to order at 10:01 am on Friday, August 23, 2019, in Anchorage, Alaska.

II. Roll call

Director Mitchell conducted roll call of the Board. The following Board members were present, constituting a quorum:

Bradley Austin	Randy Beltz	Pamela Cline	Chuck Collins
Bob Doyle	Sara Faulkner	Bronson Frye	Jacob Howdeshell
Sarah Lefebvre	Justin Mack	Donna Phillips	Diane Thompson
Robert Weel	Lake Williams		

Director Mitchell noted that members Bob Doyle, Julie Duquette, and Kimberly Ziegler were excused. Members Nancy Shaw and Rick Traini were absent.

Director Mitchell conducted a roll call of the MSRC. The following Committee members were present, constituting a quorum:

Dr. Mary Ann Foland	Dr. Robert Hall	Jennifer House	Timothy Kanady
Susan Kosinski	Tammi Lindsey	Pamla Scott	

Members Vince Beltrami and Misty Steed were excused.

III. Agenda Approval

A motion to approve the agenda was made by member Austin, and seconded by member Lefebvre. The agenda was approved by unanimous vote.

IV. Approval of MSRC August 9, 2019 Meeting Minutes

A motion to adopt the minutes from August 9, 2019 meeting was made by member Foland and seconded by member Kosinski. Member Kosinski noted that member Tami Lindsey was not present. The motion to approve the minutes as amended passed unanimously.

V. Approval of joint Board/MSRC August 10, 2018 Meeting Minutes

A motion to adopt the minutes from the August 10, 2018 special joint meeting of the Board and MSRC was made by member Lefebvre and seconded by member Collins. The motion passed unanimously.

VI. Public Comment Period 10:15am- 11:15am

Sandy Travis – representing self

- Alleged that doctors are not following the Alaska Fee Schedule, and are charging Medicare and Medicaid instead.
- Alleged that Alaska is behind the times in regards to medical care and believes doctors should not prescribe opioids.
- Accused the MSRC of making deals with pharmaceutical providers.
- Alleged that medical clinics in Alaska are closing because they don't want to deal with the fee schedule.

Greg Weaver – representing self

- Alleged that the Board is biased towards the employer.

Eric McDonald – representing self

- Requests written instruction on how to comply with the medical fee schedule.
- Alleges that he has been instructed he must pay portions of the medical bills associated with his Workers' Compensation claim.

Barbara Williams – representing Injured Workers' Alliance

- Alleged that the Division does not have staff who are able to answer questions regarding the fee schedule.
- Asked that the Division either host a class or designate a staff member who can answer questions regarding the fee schedule.

Cindy Franklin – representing Dr. John Shannon (written comment)

- Opposes fee schedule recommendations which would restrict payments to Alaska Chiropractic Physicians for injections administered per ancillary methodology.

Sue Sumpter – representing Creekside Surgery Center (written comment)

- Opposes proposed 20% reduction to Ambulatory Surgery Center conversion factor.

VII. MSRC's Presentation of Recommendations to Board

The MSRC presented its recommendation to the Board. Director Mitchell provided the history of Alaska Workers' Compensation medical costs and the Alaska Medical Fee Schedule. He explained that despite the MSRC's efforts in recent years, Alaska's medical costs continue to rank among the highest in the nation. Director Mitchell explained the reasoning behind the recommended conversion factor reductions for surgery, radiology, pathology and laboratory, anesthesiology, ambulatory surgery center, and clinical lab.

VIII. Reed Group Presentation

The members of Reed Group introduced themselves and presented on the American College of Occupational and Environmental Medicine Practice Guidelines, and the

State of California's experience adopting evidence-based treatment guidelines. The MSRC and Board members discussed the pros and cons of treatment based guidelines.

Lunch Break 12:45pm – 2:05pm

IX. MSRC's Presentation of Recommendations to Board Cont.

The MSRC continued to present the recommendation to the Board.

The members discussed the new language regarding off-label use of medical services. MSRC Member Foland made a motion to amend the section, by adding additional language about the appropriateness of the medical service. The motion was seconded by MSRC member House. The motion passed unanimously.

Member Austin moved to approve the proposed 2020 Medical Fee Schedule, as amended. Member Lefebvre seconded the motion. The motion passed unanimously.

X. Proposed Regulation Changes

Amend 8 AAC 45.083(a), relating to fees for medical treatment and services. Member Lefebvre moved to approve the amendment of 8 AAC 45.083(a). Member Austin seconded the motion. The motion passed unanimously.

A motion to adjourn was made by member Lefebvre, and seconded by member Austin. The motion passed unanimously.

Meeting Adjourned 4:10pm

TAB 3

Alaska Workers' Compensation Medical Services Review Committee, AS 23.30.095(j)

The commissioner shall appoint a medical services review committee to assist and advise the department and the board in matters involving the appropriateness, necessity, and cost of medical and related services provided under this chapter. The medical services review committee shall consist of nine members to be appointed by the commissioner as follows:

- (1) one member who is a member of the Alaska State Medical Association;
- (2) one member who is a member of the Alaska Chiropractic Society;
- (3) one member who is a member of the Alaska State Hospital and Nursing Home Association;
- (4) one member who is a health care provider, as defined in AS 09.55.560;
- (5) four public members who are not within the definition of "health care provider" in AS 09.55.560; and
- (6) one member who is the designee of the commissioner and who shall serve as chair.

Committee Membership as of May 20, 2020

Seat	Last Name	First Name	Affiliation
Chairperson	Mitchell	Grey	Director, Division of Workers' Compensation
Alaska State Medical Association	Hall, MD	Robert J.	Orthopedic Physicians Anchorage, Inc.
Alaska Chiropractic Society	Kanady, DC	Timothy	Kanady Chiropractic Center
Alaska State Hospital & Nursing Home Association	House	Jennifer	Foundation Health
Medical Care Provider	Foland, MD	Mary Ann	Primary Care Associates
Lay Member	Steed	Misty	PACBLU
Lay Member	Scott	Pam	Northern Adjusters, Inc.
Lay Member	Beltrami	Vince	AFL-CIO
Lay Member	Kosinski	Susan	ARECA Insurance Exchange

TAB 4



THE STATE
of **ALASKA**
GOVERNOR MICHAEL J. DUNLEAVY

Department of Labor and Workforce Development

Office of the Commissioner

PO Box 111149
Juneau, Alaska 99811
Main: 907.465.2700

August 20, 2019

Alaska Workers' Compensation Board
P.O. Box 115512
Juneau, AK 99811-5512

Dear Alaska Workers' Compensation Board,

As required by AS 23.30.097(r), I formally approve the conversion factor adjustment recommendations contained in the Medical Services Review Committee (MSRC) Report dated August 16, 2019. I believe that the report recommendations will maintain employee access to medical care provided through workers' compensation insurance, while improving workers' compensation medical cost stability and predictability to employers operating in Alaska. Thank you for taking up this important matter at your August 23, 2019, joint Board meeting with the MSRC.

Sincerely,

A handwritten signature in black ink that reads "Tamika L. Ledbetter".

Dr. Tamika L. Ledbetter
Commissioner

cc: Director Grey Mitchell



Workers' Compensation Medical Fee Schedule Recommendations

August 16, 2019

Medical Services Review Committee

Grey Mitchell, Chair
Robert Hall, MD
Timothy Kanady, DC
Mary Ann Foland, MD
Jennifer House
Misty Steed
Pamla Scott
Vince Beltrami
Susan Kosinski



THE STATE
of **ALASKA**

GOVERNOR MICHAEL J. DUNLEAVY

**Department of Labor and
Workforce Development**

DIVISION OF WORKERS' COMPENSATION

P.O. Box 115512
Juneau, Alaska 99811-5512
Mail: 907.465.2790
Fax: 907.465.2797

August 16, 2019

To: Dr. Tamika L. Ledbetter,
Commissioner, Department of Labor and Workforce Development

The Medical Services Review Committee (MSRC) is pleased to present the following report outlining workers' compensation medical fee schedule recommendations. The Committee is an advisory body established by the Alaska Legislature in 2005 to assist and advise the Department of Labor and Workforce Development and the Alaska Workers' Compensation Board (Board) in matters involving the appropriateness, necessity, and cost of medical and related services provided under the Alaska Workers' Compensation Act.

In this report, the committee presents its recommendations for your review. It is the committee's belief that these recommendations will maintain employee access to medical care while improving medical cost stability and predictability to the employers who are required by law to pay for workers' compensation medical benefits.

Sincerely,

A handwritten signature in blue ink, appearing to read "Grey Mitchell".

Grey Mitchell
Chair, Medical Services Review Committee
Director, Division of Workers' Compensation

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ACKNOWLEDGEMENTS

As Chair of the Medical Services Review Committee (MSRC), I would like to acknowledge the tremendous amount of time the committee members have dedicated to this task. In 2019, the MSRC held three meetings: June 21, 2019; July 26, 2019; and August 9, 2019. As full-time professionals, the time these committee members took away from their practices and professions is deeply appreciated.

At these meetings, the MSRC analyzed data, reviewed reports, listened to testimony, and learned the complex rules of medical billing and payment formulas. All of these meetings were open to the public, and public comment was taken at each meeting. Stakeholders were encouraged to provide insights and comments throughout the meeting process. The agenda and minutes of those meetings are posted online at <http://labor.alaska.gov/wc/med-serv-comm.htm>.

Carla Gee with Optum, provided valuable input and subject matter expertise to assist the committee's work.

EXECUTIVE SUMMARY

PURPOSE OF THIS REPORT

The purpose of this report is to convey the recommendations of the MSRC for the 2020 Workers' Compensation Medical Fee Schedule.

AS 23.30.095(j) establishes that the MSRC will "assist and advise the department and the board in matters involving the appropriateness, necessity, and cost of medical and related services provided under this chapter."

BACKGROUND

The MSRC is composed of

- one member who is a member of the Alaska State Medical Association;
- one member who is a member of the Alaska Chiropractic Society;
- one member who is a member of the Alaska State Hospital and Nursing Home Association;
- one member who is a health care provider, as defined in AS 09.55.560;
- four public members who are not within the definition of "health care provider" in AS 09.55.560; and
- one member who is the designee of the commissioner and who shall serve as chair.

The members are appointed by the Commissioner of Labor and Workforce Development. No terms for the members are set out in statute or regulation - they serve at the will of the Commissioner.

Seat	Last Name	First Name	Affiliation
Chairperson	Mitchell	Grey	Director, Division of Workers' Compensation
Alaska State Medical Association	Hall, MD	Robert J.	Orthopedic Physicians Anchorage, Inc.
Alaska Chiropractic Society	Kanady, DC	Timothy	Kanady Chiropractic Center, Inc.
Alaska State Hospital & Nursing Home Association	House	Jennifer	Foundation Health
Medical Care Provider	Foland, MD	Mary Ann	Primary Care Associates
Lay Member	Steed	Misty	PACBLU
Lay Member	Scott	Pam	Alaska Timber Insurance Exchange
Lay Member	Beltrami	Vince	AFL-CIO
Lay Member	Kosinski	Susan	ARECA Insurance Exchange

RECOMMENDATIONS OF THE MSRC

Alaska Workers' Compensation Medical Fee Schedule Guidelines

The committee finds that incorporating its recommendations into guidelines would best serve the public. The committee's full recommendations may be found in the attached Alaska Medical Fee Schedule Guidelines (Guidelines). For convenience, significant new recommendations are set forth below.

Medical Fee Schedule

The committee considered the following current medical fee schedule conversion factors/multipliers:

1. Evaluation & Management \$80.00
2. Medicine \$80.00
3. Surgery \$165.00
4. Radiology \$196.00
5. Pathology and Laboratory \$135.00
6. Anesthesiology \$121.82
7. Medicare Part B Drugs 3.375
8. Clinical Lab 6.33
9. Durable Medical Equipment 1.84
10. Ambulatory Surgical Centers \$221.79
11. Outpatient Hospital \$221.79
12. Inpatient Hospitals
 - a. Providence Alaska Medical Center 2.38
 - b. Mat-Su Regional Medical Center 1.84
 - c. Bartlett Regional Hospital 1.79
 - d. Fairbanks Memorial Hospital 1.48
 - e. Alaska Regional Hospital 2.32
 - f. Yukon Kuskokwim Delta Regional Hospital 2.63
 - g. Central Peninsula General Hospital 1.38
 - h. Alaska Native Medical Center 2.53
 - i. Other 2.02

The MSRC recommends the following conversion factor/multiplier changes rounded to the nearest dollar:

1. Surgery \$132.00 (20% reduction)
2. Radiology \$141.00 (28% reduction)
3. Pathology and Laboratory \$122.00 (10% reduction)
4. Anesthesiology \$110.00 (10% reduction)
5. Ambulatory Surgery Center \$177.00 (20% reduction)
6. Clinical Lab 4.43 (30% reduction)

Hearing Aids

The MSRC recommends the dispensing of hearing aids be reported with the appropriate HCPCS Level II codes and a copy of the invoice. It also recommends the MAR be the lower of billed charges or manufacturer's invoice for the hearing aids and parts plus 30 percent which includes charges for fitting and dispensing the hearing aids under Health Care Procedure Code System

(HCPCS) codes V5011 and V5160. In addition, the committee recommends establishing maximum reimbursement levels based on values established by Optum using “gap-fill” relative values for audiology and hearing services and products to avoid cost shifting in the following CPT® and HCPCS codes: 92591, 92593, 92594, 92595, , V5014, and V5020 ,^[cg1].

Clinical Diagnostic Laboratory

The MSRC recommends laboratory services not found in the *Resource-Based Relative Value Scale* (RBRVS) but found in the Centers for Medicare and Medicaid Services (CMS) Clinical Diagnostic Laboratory Fee Schedule (CLAB) file use a multiplier of 4.43 (20% reduction) for the values in the payment rate column in effect at the time of treatment or service. For example, if CPT code 81001 has a payment rate of \$3.92 in the CLAB file, this is multiplied by 4.43 for a MAR of \$17.37. The committee recommended a very significant reduction, as this multiplier is currently set at 6.33 or 633% of Medicare, which is a significant premium over the reimbursement limits in a significant majority of other states, and it has not been subjected to reduction in the previous fee schedules adopted under 8 AAC 45.083.

Treatments outside Scope of Practice

The MSRC recommends prohibiting reimbursement for treatments performed outside the medical provider’s scope of practice as determined by law and the applicable regulatory board for a licensed medical provider.

Experimental Treatments

The MSRC recommends limiting reimbursement for medications, treatments, and experimental procedures that are not consistent with the approval of the U.S. Food and Drug Administration and clarifying documentation necessary to demonstrate the quality and medical necessity of the service.

Ambulatory Surgical Centers

Ambulatory Surgical Centers are currently reimbursed at the same conversion factor (\$221.79) as outpatient hospital reimbursements using the payment determination, packaging, and discounting methodology established in the CMS Outpatient Prospective Payment System (OPPS) methodology. Based on data presented during the MSRC meetings, the current conversion factor for ASC’s is 477% of Medicare, while the same conversion factor for outpatient hospitals is 279% of Medicare. Based on this and comparisons with ASC reimbursement levels for the region and nation, which demonstrated that Alaska ASCs are being reimbursed at disproportionately higher rates, the committee recommended a 20% reduction to Alaska’s ASC conversion factor. Rounded to the nearest dollar, this recommendation results in a conversion factor of \$177.00.

Work Hardening and Functional Capacity Exam (physical therapy)

The functional capacity exam and work hardening services are designed to prepare an injured worker to return to work in the most effective way. Based on input from physical therapy provider stakeholders, the MSRC reviewed existing limits on work hardening and the functional capacity exam and recommends the following increases.

- Increase the functional capacity exam reimbursement limit from 8 units/day to 16 units/day.

- Increase the work hardening services reimbursement limit under CPT® code 97546 from two hours to six hours, while maintaining the reimbursement limit under CPT® code 97545 at two hours.

2020 Objectives

In 2020, the MSRC intends to continue analyzing all fee schedule categories, and make adjustments to move Alaska toward national and regional comparative reimbursement levels as a percentage of Medicare. The committee will take note of data that indicates Workers' Compensation Insurance claimants are having difficulties accessing medical services and take action to adjust reimbursement rates accordingly to ensure adequate access to medical providers. The committee plans to consider developing guidance for evidence-based treatment guidelines. This may include making recommendations for the adoption of evidence-based treatment guidelines to address particular areas of concern or for the adoption of a comprehensive treatment and utilization guideline. Significant changes to the Evaluation and Management category are expected from the Centers for Medicare and Medicaid Services in 2021 and the committee will need to address the adjustments.

The MSRC set the following meeting dates in 2020: May 20, June 19, July 10, and August 7. The committee proposed an August 28, 2020, meeting date for the joint meeting with the Workers' Compensation, subject to approval by the Board.

TAB 5

Introduction

The Alaska Division of Workers' Compensation (ADWC) is pleased to announce the implementation of the *Official Alaska Workers' Compensation Medical Fee Schedule*, which provides guidelines and the methodology for calculating rates for provider and non-provider services.

Fees and charges for medical services are subject to Alaska Statute 23.30.097(a).

Insurance carriers, self-insured employers, bill review organizations, and other payer organizations shall use these guidelines for approving and paying medical charges of physicians and surgeons and other health care providers for services rendered under the Alaska Workers' Compensation Act. In the event of a discrepancy or conflict between the Alaska Workers' Compensation Act (the Act) and these guidelines, the Act governs.

For medical treatment or services provided by a physician, providers and payers shall follow the Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA) billing and coding rules, including the use of modifiers. If there is a billing rule discrepancy between CMS's National Correct Coding Initiative edits and the AMA's *CPT Assistant*, the *CPT Assistant* guidance governs.

Reimbursement is based upon the CMS relative value units found in the Resource-Based Relative Value Scale (RBRVS) and other CMS data (e.g., lab, ambulatory surgical centers, inpatient, etc.). The relative value units and Alaska specific conversion factors represent the maximum level of medical and surgical reimbursement for the treatment of employment related injuries and/or illnesses that the Alaska Workers' Compensation Board deems to be reasonable and necessary. Providers should bill their normal charges for services.

~~For medical treatment or services rendered by other providers, the maximum allowable reimbursement (MAR) for medical services performed by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers, is the lowest of 85 percent of the MAR, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.~~

The **maximum allowable reimbursement (MAR)** is the maximum allowed amount for a procedure established by these rules, or the provider's usual and customary or billed charge, whichever is less, and except as otherwise specified. The following rules apply for reimbursement of fees for medical services:

- 100 percent of the MAR for medical services performed by physicians, hospitals, outpatient clinics, and ambulatory surgical centers
- 85 percent of the MAR for medical services performed by "other providers" (i.e., other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers)

The MAR for medical services that do not have valid Current Procedural Terminology (CPT[®],[®]) or Healthcare Common Procedure Coding System (HCPCS) codes, a currently assigned CMS relative value, or an established conversion factor is the ~~lesser of lowest of: 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.~~

- 85 percent of billed charges.
- The charge for the treatment or service when provided to the general public, or
- The charge for the treatment or service negotiated by the provider and the employer

SCOPE OF PRACTICE LIMITS

Fees for services performed outside a licensed medical provider's scope of practice as defined by Alaska's professional licensing laws and associated regulatory boards will not be reimbursable.

ORGANIZATION OF THE FEE SCHEDULE

The *Official Alaska Workers' Compensation Medical Fee Schedule* is comprised of the following sections and subsections:

- Introduction
- General Information and Guidelines
- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine
 - Physical Medicine
- Category II
- Category III
- HCPCS Level II
- Outpatient Facility
- Inpatient Hospital

Each of these sections includes pertinent general guidelines. The schedule is divided into these sections for structural purposes only. Providers are to use the sections applicable to the procedures they perform or the services they render. Services should be reported using CPT codes and HCPCS Level II codes.

Familiarity with the Introduction and General Information and Guidelines sections as well as general guidelines within each subsequent section is necessary for all who use the schedule. It is extremely important that these be read before the schedule is used.

PROVIDER SCHEDULE

The amounts allowed in the Provider Schedule represent the physician portion of a service or procedure and are to be used by physicians or other certified or licensed providers that do not meet the definition of an outpatient facility.

Some surgical, radiology, laboratory, and medicine services and procedures can be divided into two components—the professional and the technical. A professional service is one that must be rendered by a physician or other certified or licensed provider as defined by the State of Alaska working within the scope of their licensure. The total, professional component (modifier 26) and technical component (modifier TC) are included in the Provider Schedule as contained in the Resource-Based Relative Value Scale (RBRVS).

Note: If a physician has performed both the professional and the technical component of a procedure (both the reading and interpretation of the service, which includes a report, and the technical portion of the procedure), then that physician is entitled to the total value of the procedure. When billing for the total service only, the procedure code should be billed with no modifier. When billing for the professional component only, modifier 26 should be appended. When billing for the technical component only, modifier TC should be appended.

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total fees are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total fees are used for services performed in a practitioner's office, patient's home, or other non-hospital settings such as a residential care facility. For these services, the practitioner typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the practitioner's service. Where the fee is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

DRUGS AND PHARMACEUTICALS

Drugs and pharmaceuticals are considered an integral portion of the comprehensive surgical outpatient fee allowance. This category includes drugs administered immediately prior to or during an outpatient facility procedure and administered in the recovery room or other designated area of the outpatient facility.

The maximum allowable reimbursement for prescription drugs is as follows:

1. Brand name drugs shall be reimbursed at the manufacturer's average wholesale price plus a \$5 dispensing fee;
2. Generic drugs shall be reimbursed at the manufacturer's average wholesale price plus a \$10 dispensing fee;
3. Reimbursement for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's average wholesale price for each drug included in the compound, listed separately by National Drug Code, plus a \$10 compounding fee.

HCPCS LEVEL II

Durable Medical Equipment

The sale, lease, or rental of durable medical equipment for use in a patient's home is not included in the provider's fee or the comprehensive surgical outpatient facility fee allowance.

HCPCS services are reported using the appropriate HCPCS codes as identified in the HCPCS Level II section. Examples include:

- ~~Una~~Surgical boot for a postoperative podiatry patient
- Crutches for a patient with a fractured tibia

Ambulance Services

Ambulance services are reported using HCPCS Level II codes. Guidelines for ambulance services are separate from other services provided within the boundaries of the State of Alaska. See the HCPCS section for more information.

OUTPATIENT FACILITY

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. This includes, but is not limited to, ambulatory surgical centers (ASC), hospitals, and freestanding clinics within hospital property. Only the types of facilities described above will be reimbursed using outpatient facility fees. Only those charges that apply to the facility services—not the professional—are included in the Outpatient Facility section.

INPATIENT HOSPITAL

The Inpatient Hospital section represents services performed in an inpatient setting and billed on a UB-04 (CMS 1450) or 837i electronic claim form. Base rates and amounts to be applied to the Medicare Severity Diagnosis Related Groups (MS-DRG) are explained in more detail in the Inpatient Hospital section.

DEFINITIONS

Act — the Alaska Workers' Compensation Act; Alaska Statutes, Title 23, Chapter 30.

Bill — a request submitted by a provider to an insurer for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment — a reduction of a fee on a provider's bill.

Board — the Alaska Workers' Compensation Board.

Case — a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

Consultation — a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

Covered injury — accidental injury, an occupational disease or infection, or death arising out of and in the course of employment or which unavoidably results from an accidental injury. Injury includes one that is caused by the willful act of a third person directed against an employee because of the employment. Injury further includes breakage or damage to eyeglasses, hearing aids, dentures, or any prosthetic devices which function as part of the body. Injury does not include mental injury caused by stress unless it is established that the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, or the work stress was the predominant cause of the mental injury. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

Critical care — care rendered in a medical emergency that requires the constant attention of the provider, such as cardiac arrest, shock, bleeding, respiratory failure, and postoperative complications, and is usually provided in a critical care unit or an emergency care department.

Day — a continuous 24-hour period.

Diagnostic procedure — a service that helps determine the nature and causes of a disease or injury.

Drugs — a controlled substance as defined by law.

Durable medical equipment (DME) — specialized equipment that is designed to stand repeated use, is appropriate for home use, and is used solely for medical purposes.

Employer — the state or its political subdivision or a person or entity employing one or more persons in connection with a business or industry carried on within the state.

Expendable medical supply — a disposable article that is needed in quantity on a daily or monthly basis.

Follow-up care — care related to recovery from a specific procedure that is considered part of the procedure's maximum allowable fee, but does not include care for complications.

Follow-up days — the days of care following a surgical procedure that are included in the procedure's maximum allowable fee, but does not include care for complications. Follow-up days for Alaska include the day of surgery through termination of the postoperative period.

Incidental surgery — a surgery performed through the same incision, on the same day and by the same physician, that does not increase the difficulty or follow-up of the main procedure, or is not related to the diagnosis (e.g., appendectomy during hernia surgery).

Independent procedure — a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

Insurer — an entity authorized to insure under Alaska Statute 23.30.030 and includes self-insured employers.

Maximum allowable reimbursement (MAR) — the maximum amount for a procedure established by these rules, or the provider's usual and customary or billed charge, whichever is less, and except as otherwise specified.

Medical record — an electronic or paper record in which the medical service provider records the subjective and objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and improvement rating as applicable.

Medical supply — either a piece of durable medical equipment or an expendable medical supply.

Modifier — a two-digit number used in conjunction with the procedure code to describe any unusual circumstances arising in the treatment of an injured or ill employee.

Operative report — the provider's written or dictated description of the surgery and includes all of the following:

- Preoperative diagnosis
- Postoperative diagnosis
- A step-by-step description of the surgery
- Identification of problems that occurred during surgery

- Condition of the patient when leaving the operating room, the provider's office, or the health care organization.

Optometrist — an individual licensed to practice optometry.

Orthotic equipment — orthopedic apparatus designed to support, align, prevent or correct deformities, or improve the function of a moveable body part.

Orthotist — a person skilled and certified in the construction and application of orthotic equipment.

Outpatient service — services provided to patients who do not require hospitalization as inpatients. This includes outpatient ambulatory services, hospital-based emergency room services, or outpatient ancillary services that are based on the hospital premises. Refer to the Inpatient Hospital section of this fee schedule for reimbursement of hospital services.

Payer — the employer/insurer or self-insured employer, or third-party administrator (TPA) who pays the provider billings.

Pharmacy — the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Physician — under AS 23.30.395(32) and *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1258 (Alaska 2007), “physician” includes doctors of medicine, surgeons, chiropractors, osteopaths, dentists, optometrists, and psychologists.

Primary procedure — the therapeutic procedure most closely related to the principal diagnosis and, for billing purposes, the highest valued procedure.

Procedure — a unit of health service.

Procedure code — a five-digit numerical or alpha-numerical sequence that identifies the service performed and billed.

Properly submitted bill — a request by a provider for payment of health care services submitted to an insurer on the appropriate forms, with appropriate documentation, and within the time frame established in Alaska Statute 23.30.097.

Prosthetic devices — include, but are not limited to, eye glasses, hearing aids, dentures, and such other devices and appliances, and the repair or replacement of the devices necessitated by ordinary wear and arising out of an injury.

Prosthesis — an artificial substitute for a missing body part.

Prosthetist — a person skilled and certified in the construction and application of a prosthesis.

Provider — any person or facility as defined in 8 AAC 45.900(a)(15) and licensed under AS 08 to furnish medical or dental services, and includes an out-of-state person or facility that meets the requirements of 8 AAC 45.900(a)(15) and is otherwise qualified to be licensed under AS 08.

Second opinion — when a physician consultation is requested or required for the purpose of substantiating the necessity or appropriateness of a previously recommended medical treatment or surgical opinion. A physician providing a second opinion shall provide a written opinion of the findings.

Secondary procedure — a surgical procedure performed during the same operative session as the primary and, for billing purposes, is valued less than the first billed procedure.

Special report — a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

General Information and Guidelines

This section contains information that applies to all providers' billing independently, regardless of site of service. The guidelines listed herein apply only to providers' services, evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, medicine, and durable medical equipment.

Insurers and payers are required to use the *Official Alaska Workers' Compensation Medical Fee Schedule* for payment of workers' compensation claims.

BILLING AND PAYMENT GUIDELINES

Fees for Medical Treatment

The fee may not exceed the physician's actual fee or the maximum allowable reimbursement (MAR), whichever is lower. The MAR for physician services except anesthesia is calculated using the Resourced-Based Relative Value Scale (RBRVS) relative value units (RVU) produced by the Centers for Medicare and Medicaid Services (CMS) and the Geographic Practice Cost Index (GPCI) for Alaska, based on the following formula:

$(\text{Work RVUs} \times \text{Work GPCI}) + (\text{Practice Expense RVUs} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVUs} \times \text{Malpractice GPCI}) = \text{Total RVU}$

The Alaska MAR payment is determined by multiplying the total RVU by the applicable Alaska conversion factor ~~to obtain the Alaska MAR payment~~, which is rounded to two decimals after the conversion factor is applied.

Example data for CPT code 10021 with the Alaska GPCI using the non-facility RVUs:

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1. 2703	1.500	1. 905545
Practice Expense RVU x Practice Expense GPCI	2.031.61	1.117	2.267541.79837
Malpractice RVU x Malpractice GPCI	0. 4714	0.708	0. 4203609912
Total RVU			4.202873.44249

Data for the purpose of example only

Calculation using example data:

$$1.\underline{2703} \times 1.500 = 1.\underline{905-545}$$

$$+ 2.031.61 \times 1.117 = 2.267541.79837$$

$$+ 0.4714 \times 0.708 = 0.4203609912$$

$$= 4.292873.44249$$

$$4.292873.44249 \times \$165132.00 \text{ (CF)} = 708.32355454.40868$$

Payment is rounded to \$708.32454.41

The Alaska MAR for anesthesia is calculated as explained in the Anesthesia section. The Alaska MAR for laboratory, durable medical equipment (DME), drugs, and facility services is calculated separately, see the appropriate sections for more information.

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total fees are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total fees are used for services performed in a practitioner's office, patient's home, or other non-hospital settings such as a residential care facility. For these services, the practitioner typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the practitioner's service. Where the fee is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

The conversion factors are listed here with their applicable *Current Procedural Terminology* (CPT®) code ranges.

MEDICAL SERVICE	CPT CODE RANGE	CONVERSION FACTOR
Surgery	100 2404 –69990	\$465132.0 0
Radiology	70010–79999	\$496141.0 0
Pathology and Lab	80047–89398	\$435122.0 0
Medicine (excluding anesthesia)	90281–990 9482 and 99151–99199 and 99500–99607	\$80.00
Evaluation and Management	99091 , 99201– 99499	\$80.00
Anesthesia	00100–01999 and 99100–99140	\$121.8211 0.00

An employer or group of employers may negotiate and establish a list of preferred providers for the treatment of its employees under the Act; however, the employees' right to choose their own attending physician is not impaired.

All providers may report and be reimbursed for codes 97014 and 97810–97814.

An employee may not be required to pay a fee or charge for medical treatment or service. For more information, refer to AS 23.30.097(f).

RBRVS Status Codes

The Centers for Medicare and Medicaid Services (CMS) RBRVS Status Codes are listed below. The CMS guidelines apply except where superseded by Alaska guidelines.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
A	<u>Active Code.</u> These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status.	The maximum fee for this service is calculated as described in Fees for Medical Treatment.
B	<u>Bundled Code.</u> Payment for covered services is are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.	No separate payment is made for these services even if an RVU is listed.
C	<u>Contractors price the code.</u> Contractors will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
D	<u>Deleted Codes.</u> These codes are deleted effective with the beginning of the applicable year.	Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .
E	<u>Excluded from Physician Fee Schedule by regulation.</u> These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
F	<u>Deleted/Discontinued Codes.</u> (Code not subject to a 90 day grace period).	Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .

G	<p><u>Not valid for Medicare purposes.</u> Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.</p>	<p>Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>.</p>
H	<p><u>Deleted Modifier.</u> This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H."</p>	<p>Not in current RBRVS. Not payable with modifiers TC and/or 26 under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>.</p>
I	<p><u>Not valid for Medicare purposes.</u> Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>
J	<p><u>Anesthesia Services.</u> There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.</p>	<p>Alaska recognizes the anesthesia base units in the <i>Relative Value Guide</i> published by the American Society of Anesthesiologists. See the <i>Relative Value Guide</i> or Anesthesia Section.</p>
M	<p><u>Measurement Codes.</u> Used for reporting purposes only.</p>	<p>These codes are supplemental to other covered services and for informational purposes only.</p>
N	<p><u>Non-covered Services.</u> These services are not covered by Medicare.</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>

P	<p><u>Bundled/Excluded Codes.</u> There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.</p> <ul style="list-style-type: none"> • If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) • If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act. 	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>
Q	<p><u>Therapy functional information code</u> (used for required reporting purposes only).</p>	<p>These codes are supplemental to other covered services and for informational purposes only.</p>
R	<p><u>Restricted Coverage.</u> Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned is <u>are</u> the alpha-numeric dental codes, which begin with "D." We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>

T	<p><u>Injections</u>. There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into <u>any</u> other services billed on the same date.)</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. For drugs and injections coded under the Healthcare Common Procedure Coding System (HCPCS) the payment allowance limits for drugs is the lower of average sale price multiplied by 3.375 or billed charges. See HCPCS Level II section of these guidelines.</p>
X	<p><u>Statutory Exclusion</u>. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider. For ambulance services see HCPCS Level II section of this guideline.</p>

Add-on Procedures

The CPT book identifies procedures that are always performed in addition to the primary procedure and designates them with a + symbol. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. Specific language is used to identify add-on procedures such as "each additional" or "(List separately in addition to primary procedure)."

The same physician or other health service worker that performed the primary service/procedure must perform the add-on service/procedure. Add-on codes describe additional intra-service work associated with the primary service/procedure (e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)). Add-on codes are not subject to reduction and should be reimbursed at the lower of the billed charges or 100 percent of MAR. Do not append modifier 51 to a code identified as an add-on procedure. Designated add-on codes are identified in Appendix D of the CPT book. Please reference the CPT book for the most current list of add-on codes.

Exempt from Modifier 51 Codes

The * symbol is used in the CPT book to identify codes that are exempt from the use of modifier 51, but have not been designated as CPT add-on procedures/services.

As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and as such modifier 51 does not apply. Modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lower of the billed charge or 100 percent of the MAR. Modifier 51 exempt services and procedures can be found in Appendix E of the CPT book.

Professional and Technical Components

Where there is an identifiable professional and technical component, modifiers 26 and TC are identified in the RBRVS. The relative value units (RVUs) for the professional component is found on the line with modifier 26. The RVUs for the technical component is found on the RBRVS line with modifier TC. The total procedure RVUs (a combination of the professional and technical components) is found on the RBRVS line without a modifier.

Global Days

This column in the RBRVS lists the follow-up days, sometimes referred to as the global period, of a service or procedure. In Alaska, it includes the day of the surgery through termination of the postoperative period.

Postoperative periods of 0, 10, and 90 days are designated in the RBRVS as 000, 010, and 090 respectively. Use the values in the RBRVS fee schedule for determining postoperative days. The following special circumstances are also listed in the postoperative period:

- MMM Designates services furnished in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care.
- XXX Designates services where the global concept does not apply.
- YYY Designates services where the payer must assign a follow-up period based on documentation submitted with the claim. Procedures designated as YYY include unlisted procedure codes.
- ZZZ Designates services that are add-on procedures and as such have a global period that is determined by the primary procedure.

Supplies and Materials

Supplies and materials provided by the physician (e.g., sterile trays, supplies, drugs, etc.) over and above those usually included with the office visit may be charged separately.

Medical Reports

A medical provider may not charge any fee for completing a medical report form required by the Workers' Compensation Division. A medical provider may not charge a separate fee for medical reports that are required to substantiate the medical necessity of a service. CPT code 99080 is not to be used to complete required workers' compensation insurance forms or to complete required documentation to substantiate medical necessity. CPT code 99080 is not to be used for signing affidavits or certifying medical records forms. CPT code 99080 is appropriate for billing only after receiving a request for a special report from the employer or payer.

In all cases of accepted compensable injury or illness, the injured worker is not liable for payment for any services for the injury or illness.

Off-label Use of Medical Services

All medications, treatments, experimental procedures, devices, or other medical services should be medically necessary, having a reasonable expectation of cure or significant relief of a covered condition and supported by medical record documentation, and, where appropriate, should be provided consistent with the approval of the Food and Drug Administration (FDA). Off-label medical services must include submission of medical record documentation and comprehensive medical literature review including at least two reliable prospective, randomized, placebo-controlled, or double-blind trials. The Alaska Division of Workers' Compensation (ADWC) will consider the quality of the submitted documents and determine medical necessity for off-label medical services. Off-label use of medical services will be reviewed annually by the Alaska Workers' Compensation Medical Services Review Committee (MSRC).

Payment of Medical Bills

Medical bills for treatment are due and payable within 30 days of receipt of the medical provider's bill, or a completed medical report, as prescribed by the Board under Alaska Statute 23.30.097. Unless the treatment, prescription charges, and/or transportation expenses are disputed, the employer shall reimburse the employee for such expenses within 30 days after receipt of the bill, chart notes, and medical report, itemization of prescription numbers, and/or the dates of travel and transportation expenses for each date of travel. A provider of medical treatment or services may receive payment for medical treatment and services under this chapter only if the bill for services is received by the employer or appropriate payer within 180 days after the later of: (1) the date of service; or (2) the date that the provider knew of the claim and knew that the claim related to employment.

A provider whose bill has been denied or reduced by the employer or appropriate payer may file an appeal with the Board within 60 days after receiving notice of the denial or reduction. A provider who fails to file an appeal of a denial or reduction of a bill within the 60-day period waives the right to contest the denial or reduction.

Scope of Practice Limits

Fees for services performed outside a licensed medical provider's scope of practice as defined by Alaska's professional licensing laws and associated regulatory boards will not be reimbursable.

Board Forms

All board bulletins and forms can be downloaded from the Alaska Workers' Compensation Division website: www.labor.state.ak.us/wc.

MODIFIERS

Modifiers augment CPT and HCPCS codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

Modifier 26—Reimbursement is calculated according to the RVU amount for the appropriate code and modifier 26.

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued, then both sides are reported with modifiers 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

Modifier 51—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure.

Consistent with the Centers for Medicare and Medicaid Services (CMS) guidelines, code-specific multiple procedure reduction guidelines apply to endoscopic procedures, and certain other procedures including radiology, diagnostic cardiology, diagnostic ophthalmology, and therapy services.

Modifiers 80, 81, and 82— Reimbursement is the lower of the billed charge or 20 percent of the MAR for the surgical procedure.

Applicable HCPCS Modifiers

Modifier TC—Technical Component

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number. Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure code with modifier TC.

Modifier QZ—CRNA without medical direction by a physician

Reimbursement is the lower of the billed charge or 85 percent of the MAR for the anesthesia procedure. Modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.

State-Specific Modifiers

Modifier AS—Physician Assistant or Nurse Practitioner Assistant at Surgery Services

When assistant at surgery services are performed by a physician assistant or nurse practitioner, the service is reported by appending modifier AS.

Reimbursement is the lower of the billed charge or 15 percent of the MAR for the procedure. Modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.

Modifier AS is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

If two procedures are performed by the PA or NP, see the example below:

Procedure 1 (Modifier AS)	\$1,350.00
Procedure 2 (Modifier AS, 51)	\$1,100.00
Reimbursement	\$285.00 [(\$1,350.00 x .15) + ((1,100.00 x .15) x .50)]

Data for the purpose of example only

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

Physician assistant and advanced practice registered nurse services are identified by adding modifier PE to the usual procedure number. A physician assistant must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided. An advanced practice registered nurse (APRN) must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

Reimbursement is the lower of the billed charge or 85 percent of the MAR for the procedure; modifier PE shall be used when services and procedures are provided by a physician assistant or an advanced practice registered nurse.

Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

If two procedures are performed by the PA or APRN, see the example below:

Procedure 1 (Modifier PE)	\$150.00
Procedure 2 (Modifier PE, 51)	\$130.00
Reimbursement	\$182.75 [(\$150.00 x .85) + ((130.00 x .85) x .50)]

Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

This brief overview of the current guidelines should not be the provider's or payer's only experience with this section of the CPT® book. Carefully read the complete guidelines in the CPT book; much information is presented regarding aspects of a family history, the body areas and organ systems associated with examinations, and so forth.

The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Consultation codes are linked to location.

Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.

When exact text of the AMA 2018⁹⁹ CPT® guidelines is used, the text is either in quotations or is preceded by a reference to the CPT book, CPT instructional notes, or CPT guidelines.

BILLING AND PAYMENT GUIDELINES

New and Established Patient Service

Several code subcategories in the Evaluation and Management (E/M) section are based on the patient's status as being either new or established. CPT guidelines clarify this distinction by providing the following time references:

“A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

“An established patient is one who has received professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

The new versus established patient guidelines also clarify the situation in which one physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

E/M Service Components

The first three components (history, examination, and medical decision making) are the keys to selecting the correct level of E/M codes, and all three components must be addressed in the documentation. However, in established, subsequent, and followup categories, only two of the three must be met or exceeded for a given code. CPT guidelines define the following:

1. The history component is categorized by four levels:

Problem Focused — chief complaint; brief history of present illness or problem.

Expanded Problem Focused — chief complaint; brief history of present illness; problem-pertinent system review.

Detailed — chief complaint; extended history of present illness; problem-pertinent system review extended to indicate a review of a limited number of additional systems; pertinent past, family medical, and/or social history directly related to the patient's problems.

Comprehensive — chief complaint; extended history of present illness; review of systems that is directly related to the problems identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

2. The physical exam component is similarly divided into four levels of complexity:

Problem Focused — an exam limited to the affected body area or organ system.

Expanded Problem Focused — a limited examination of the affected body area or organ system and of other symptomatic or related organ system(s).

Detailed — an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive — A general multisystem examination or a complete examination of a single organ system.

The CPT book identifies the following body areas:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

The CPT book identifies the following organ systems:

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory

- Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Hematologic/Lymphatic/Immunologic
3. Medical decision making is the final piece of the E/M coding process, and is somewhat more complicated to determine than are the history and exam components. Three subcomponents must be evaluated to determine the overall complexity level of the medical decision.
- a. The number of possible diagnoses and/or the number of management options to be considered.
 - b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed.
 - c. The risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

Contributory Components

Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than 50 percent of the time spent). In these cases, time determines the proper code. Document the exact amount of time spent to substantiate the selected code. Also, set forth clearly what was discussed during the encounter. If a physician coordinates care with an interdisciplinary team of physicians or health professionals/agencies without a patient encounter, report it as a case management service.

Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. Per CPT guidelines for office encounters, count only the time spent face-to-face with the patient and/or family; for hospital or other inpatient encounters, count the time spent in the patient's unit or on the patient's floor. The time assigned to each code is an average and varies by physician. **Note:** Time is not a factor when reporting emergency room visits (99281–99285) like it is with other E/M services.

According to the CPT book, “a presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason” for the patient encounter. The CPT book defines five types of presenting problems. These definitions should be reviewed frequently, but remember, this information merely contributes to code selection—the presenting problem is not a key factor. For a complete explanation of evaluation and management services refer to the CPT book.

Subcategories of Evaluation and Management

The E/M section is broken down into subcategories by type of service. The following is an overview of these codes.

Office or Other Outpatient Services (99201–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary. Support the claim with documentation.

Hospital Observation Services (99217–99226)

CPT codes 99217 through 99226 report E/M services provided to patients designated or admitted as “observation status” in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The CPT instructional notes for Initial Hospital Observation Care include the following instructions:

- Use these codes to report the encounter(s) by the supervising physician or other qualified health care professional when the patient is designated as outpatient hospital “observation status.”
- These codes include initiation of observation status, supervision of the health care plan for observation, and performance of periodic reassessments. To report observation encounters by other physicians, see Office or Other Outpatient Consultation codes (99241–99245) or subsequent observation care (99224–99226).

When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician’s office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for postrecovery of a procedure that is considered a global surgical service.

Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving observation services, is admitted to the hospital on the same date—the observation service is not reported separately.

Observation Care Discharge Services (99217)

This code reports observation care discharge services. Use this code only if discharge from observation status occurs on a date other than the initial date of observation status. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. If a patient is admitted to, and subsequently discharged from, observation status on the same date, see codes 99234–99236.

Hospital Inpatient Services (99221–99239)

The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge-day management. Per CPT guidelines for inpatient care, the time component includes not only face-to-face time with the patient but also the physician’s time spent in the patient’s unit or on the patient’s floor. This time may include family counseling or discussing the patient’s

condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals such as other physicians, nursing staff, respiratory therapists, and so on.

If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.

Codes 99238 and 99239 report hospital discharge day management, but excludes discharge of a patient from observation status (see 99217). When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital Care codes.

Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular provider. Hospital visit codes shall be combined into the single code that best describes the service rendered where appropriate.

Consultations (99241–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations. For Follow-up Inpatient Consultations, see Subsequent Hospital Care codes 99231–99233 and Subsequent Nursing Facility Care codes 99307–99310. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (99201–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both subcategories. The general rules and requirements of a consultation are defined by the CPT book as follows:

- A consultation is a “a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem.”
- Most requests for consultation come from an attending physician or other appropriate source, and the necessity for this service must be documented in the patient’s record. Include the name of the requesting physician on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (99201–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both consultation subcategories.
- The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.
- The opinion rendered and services ordered or performed must be documented in the patient’s medical record and a report of this information communicated to the requesting entity.
- Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

- When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consultation codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

Emergency Department Services (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The CPT guidelines clearly define an emergency department as “an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.” Care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Critical Care Services (99291–99292)

The CPT book clarifies critical services providing additional detail about these services. Critical care is defined as “the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.” Carefully read the guidelines in the CPT book for detailed information about the reporting of critical care services. Critical care is usually, but not always, given in a critical care area such as a coronary care unit (CCU), intensive care unit (ICU), pediatric intensive care unit (PICU), respiratory care unit (RCU), or the emergency care facility.

Note the following instructional guidelines for the Critical Care Service codes:

- Critical care codes include evaluation and management of the critically ill or injured patient, requiring constant attendance of the physician.
- Care provided to a patient who is not critically ill but happens to be in a critical care unit should be identified using Subsequent Hospital Care codes or Inpatient Consultation codes as appropriate.
- Critical care of less than 30 minutes should be reported using an appropriate E/M code.
- Critical care codes identify the total duration of time spent by a physician on a given date, even if the time is not continuous. Code 99291 reports the first 30-74 minutes of critical care and is used only once per date. Code 99292 reports each additional 30 minutes of critical care per date.
- Critical care of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes should not be reported.

Nursing Facility Services (99304–99318)

Nursing facility E/M services have been grouped into three subcategories: Comprehensive Nursing Facility Assessments, Subsequent Nursing Facility Care, and Nursing Facility Discharge Services. Included in these codes are E/M services provided to patients in psychiatric residential treatment centers. These facilities must provide a “24-hour therapeutically planned and professionally staffed group living and learning environment.” Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (99324–99337)

These codes report care given to patients residing in a long-term care facility that provides room and board, as well as other personal assistance services. The facility's services do not include a medical component.

Home Services (99341–99350)

Services and care provided at the patient's home are coded from this subcategory.

Prolonged Services (99354–99360, 99415–99416)

This section of E/M codes includes three service categories:

Prolonged Physician Service with Direct (Face-to-Face) Patient Contact

These codes report services involving direct (face-to-face) patient contact beyond the usual service, with separate codes for office and outpatient encounters (99354 and 99355) and for inpatient encounters (99356 and 99357). Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

Code 99354 or 99356 reports the first hour of prolonged service on a given date, depending on the place of service, with 99355 or 99357 used to report each additional 30 minutes for that date. Services lasting less than 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by 99354 or 99356 alone. Services lasting one hour and seventeen minutes are reported by the code for the first hour plus the code for an additional 30 minutes.

Prolonged Physician Service without Direct (Face-to-Face) Patient Contact

These prolonged physician services without direct (face-to-face) patient contact may include review of extensive records and tests, and communication (other than telephone calls) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service. Use 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

Physician Standby Services

Code 99360 reports the circumstances of a physician who is requested by another physician to be on standby, and the standby physician has no direct patient contact. The standby physician may not provide services to other patients or be proctoring another physician for the time to be reportable. Also, if the standby physician ultimately provides services subject to a surgical package, the standby is not separately reportable.

This code reports cumulative standby time by date of service. Less than 30 minutes is not reportable, and a full 30 minutes must be spent for each unit of service reported. For example, 25 minutes is not reportable, and 50 minutes is reported as one unit (99360 x 1).

Case Management Services (99366–99368)

Physician case management is the process of physician-directed care. This includes coordinating and controlling access to the patient or initiating and/or supervising other necessary health care services.

Care Plan Oversight Services (99374–99380)

These codes report the services of a physician providing ongoing review and revision of a patient's care plan involving complex or multidisciplinary care modalities. Only one physician may report this code per patient per 30-day period, and only if more than 30 minutes is spent during the 30 days. Do not use this code for supervision of patients in nursing facilities or under the care of home health agencies unless the patient requires recurrent supervision of therapy. Also, low intensity and infrequent supervision services are not reported separately.

Special Evaluation and Management Services (99450–99456)

This series of codes reports physician evaluations in order to establish baseline information for insurance certification and/or work related or medical disability.

Evaluation services for work related or disability evaluation is covered at the following total RVU values:

99455	10.63
99456	21.25

Other Evaluation and Management Services (99499)

This is an unlisted code to report services not specifically defined in the CPT book.

MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

State-Specific Modifier**Modifier PE: Physician Assistants and Advanced Practice Registered Nurses**

Physician assistant and advanced practice registered nurse services are identified by adding modifier PE to the usual procedure number. A physician assistant must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided. An advanced practice registered nurse (APRN) must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

Reimbursement is the lower of the billed charges or 85 percent of the MAR for the procedure; modifier PE shall be used when services and procedures are provided by a physician assistant or an advanced practice registered nurse.

Anesthesia

GENERAL INFORMATION AND GUIDELINES

This schedule utilizes the relative values for anesthesia services from the current *Relative Value Guide*® published by the American Society of Anesthesiologists (ASA). No relative values are published in this schedule—only the conversion factors and rules for anesthesia reimbursement.

Report services involving administration of anesthesia by the surgeon, the anesthesiologist, or other authorized provider by using the CPT® five-digit anesthesia procedure code(s) (00100–01999), physical status modifier codes, qualifying circumstances codes (99100–99140), and modifier codes (defined under Anesthesia Modifiers later in these ground rules).

BILLING AND PAYMENT GUIDELINES

Anesthesia services include the usual preoperative and postoperative visits, the administration of the anesthetic, and the administration of fluids and/or blood incident to the anesthesia or surgery. Local infiltration, digital block, topical, or Bier block anesthesia administered by the operating surgeon are included in the surgical services as listed.

When multiple operative procedures are performed on the same patient at the same operative session, the anesthesia value is that of the major procedure only (e.g., anesthesia base of the major procedure plus total time).

Anesthesia values consist of the sum of anesthesia base units, time units, physical status modifiers, and the value of qualifying circumstances multiplied by the specific anesthesia conversion factor ~~\$121.82~~110.00. Relative values for anesthesia procedures (00100–01999, 99100–99140) are as specified in the current *Relative Value Guide* published by the American Society of Anesthesiologists.

Time for Anesthesia Procedures

Time for anesthesia procedures is calculated in 15-minute units. Anesthesia time starts when the anesthesiologist begins constant attendance on the patient for the induction of anesthesia in the operating room or in an equivalent area. Anesthesia time ends when the anesthesiologist is no longer in personal attendance and the patient may be safely placed under postoperative supervision.

Calculating Anesthesia Charges

The following scenario is for the purpose of example only:

01382 Anesthesia for arthroscopic procedure of knee joint

Dollar Conversion Unit = ~~\$121.82~~110.00

Base Unit Value = 3

Time Unit Value = 8 (4 units per hr x 2 hrs)

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

Anesthesia Fee = ~~\$121,821.00~~ x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = ~~\$1,340,021.00~~

Physical status modifiers and qualifying circumstances, are discussed below. Assigned unit values are added to the base unit for calculation of the total maximum allowable reimbursement (MAR).

Anesthesia Supervision

Reimbursement for the combined charges of the nurse anesthetist and the supervising physician shall not exceed the scheduled value for the anesthesia services if rendered solely by a physician.

Anesthesia Monitoring

When an anesthesiologist is required to participate in and be responsible for monitoring the general care of the patient during a surgical procedure but does not administer anesthesia, charges for these services are based on the extent of the services rendered.

Other Anesthesia

Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the unit value for the surgical procedure.

If the attending surgeon administers the regional anesthesia, the value shall be the lower of the "basic" anesthesia value only, with no added value for time, or billed charge (see Anesthesia by Surgeon in the Surgery guidelines). Surgeons are to use surgical codes billed with modifier 47 for anesthesia services that are performed. No additional time units are allowed.

Adjunctive services provided during anesthesia and certain other circumstances may warrant an additional charge. Identify by using the appropriate modifier.

ANESTHESIA MODIFIERS

All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) plus the addition of a physical status modifier. The use of other optional modifiers may be appropriate.

Physical Status Modifiers

Physical status modifiers are represented by the initial letter 'P' followed by a single digit from 1 to 6 defined below. See the *ASA Relative Value Guide* for units allowed for each modifier.

MODIFIER	DESCRIPTION
P1	A normal healthy patient
P2	A patient with mild systemic disease

P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

These physical status modifiers are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

Qualifying Circumstances

Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly impact the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedures to qualify an anesthesia procedure or service. More than one qualifying circumstance may apply to a procedure or service. See the ASA *Relative Value Guide*® for units allowed for each code.

CODE	DESCRIPTION
99100	Anesthesia for patient of extreme age: younger than 1 and older than 70
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency conditions (specify)

Note: An emergency exists when a delay in patient treatment would significantly increase the threat to life or body part.

Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

Applicable HCPCS Modifiers

Modifier AA Anesthesia services performed personally by anesthesiologist—This modifier indicates that the anesthesiologist personally performed the service. When this modifier is used, no reduction in physician payment is made. Payment is the lower of billed charges or the MAR.

Modifier AD Medical supervision by a physician: more than four concurrent anesthesia procedures— Modifier AD is appended to physician claims when a physician supervised four or more concurrent procedures. In these instances, payment is made on a 3 base unit amount. Base units are assigned by CMS or payers, and the lowest unit value is 3.

Modifier G8 Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure— Modifier G8 is appended only to anesthesia service codes to identify those circumstances in which monitored anesthesia care (MAC) is provided and the service is a deeply complex, complicated, or markedly invasive surgical procedure.

Modifier G9 Monitored anesthesia care for patient who has history of severe cardiopulmonary condition— Modifier G9 is appended only to anesthesia service codes to identify those circumstances in which a patient with a history of severe cardio-pulmonary conditions has a surgical procedure with monitored anesthesia care (MAC).

Modifier QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals— This modifier is used on physician claims to indicate that the physician provided medical direction of two to four concurrent anesthesia services. Physician payment is reduced to the lower of billed charges or 50 percent of the MAR.

Modifier QS Monitored anesthesia care service— This modifier should be used by either the anesthesiologist or the CRNA to indicate that the type of anesthesia performed was monitored anesthesiology care (MAC). Payment is the lower of billed charges or the MAR. No payment reductions are made for MAC; this modifier is for information purposes only.

Modifier QX CRNA service: with medical direction by a physician— This modifier is appended to CRNA or anesthesiologist assistant (AA) claims. This informs a payer that a CRNA or AA provided the service with direction by an anesthesiologist. Payment is the lower of billed charges or 50 percent of the MAR.

Modifier QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist— This modifier is used by the anesthesiologist when directing a CRNA in a single case.

Modifier QZ CRNA without medical direction by a physician— Reimbursement is the lower of the billed charge or 85 percent of the MAR for the anesthesia procedure. Modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist. When a CRNA performs the anesthesia procedure without any direction by a physician, modifier QZ should be appended to the code for the anesthesia service. ~~In these instances, CRNA or AA payment is based on the lower of billed charges or 100 percent of the MAR.~~

Surgery

GENERAL INFORMATION AND GUIDELINES

Definitions of Surgical Repair

The definition of surgical repair of simple, intermediate, and complex wounds is defined in the CPT® book and applies to codes used to report these services.

BILLING AND PAYMENT GUIDELINES

Global Reimbursement

The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care. Normal range of care includes day of surgery through termination of postoperative period.

In addition to the surgical procedure, global reimbursement includes:

- Topical anesthesia, local infiltration, or a nerve block (metacarpal, metatarsal, or digital)
- Subsequent to the decision for surgery, one related E/M encounter may be on the date immediately prior to or on the date of the procedure and includes history and physical
- Routine postoperative care including recovery room evaluation, written orders, discussion with other providers as necessary, dictating operative notes, progress notes orders, and discussion with the patient's family and/or care givers
- Normal, uncomplicated follow-up care for the time periods indicated as global days. The number establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances
- The allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. The day of surgery is day one when counting follow-up days

Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only the care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be charged for in accordance with the services rendered.

Follow-up Care for Therapeutic Surgical Procedures

Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges. The workers' compensation carrier is responsible only for charges related to the compensable injury or illness.

Additional Surgical Procedure(s)

When additional surgical procedures are carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

Incidental Procedure(s)

When additional surgical procedures are carried out within the listed period of follow-up care, an additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

Suture Removal

Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

Aspirations and Injections

Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

Surgical Assistants

For the purpose of reimbursement, physicians who assist at surgery may be reimbursed as a surgical assistant. The surgical assistant must bill separately from the primary physician. Assistant surgeons should use modifier 80, 81, or 82 and are allowed the lower of the billed charge or 20 percent of the MAR.

When a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon, the reimbursement will be the lower of the billed charge or 15 percent of the MAR. The physician assistant or nurse practitioner billing as an assistant surgeon must add modifier AS to the line of service on the bill in addition to modifier 80, 81, or 82 for correct reimbursement.

Modifier AS is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

If two procedures are performed by the PA or NP, see the example below:

Procedure 1 (Modifier AS)	\$1,350.00
Procedure 2 (Modifier AS, 51)	\$1,100.00
Reimbursement	\$285.00 [(\$1,350.00 x .15) + ((1,100.00 x .15) x .50)]

Data for the purpose of example only

Payment will be made to the physician assistant or nurse practitioner's employer (the physician).

Note: If the physician assistant or nurse practitioner is acting as the surgeon or sole provider of a procedure, he or she will be paid at a maximum of the lower of the billed charge or 85 percent of the MAR.

Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

If two procedures are performed by the PA or APRN, see the example below:

Procedure 1	\$150.00
Procedure 2	\$130.00
Reimbursement	\$182.75 [(\$150.00 x .85) + ((130.00 x .85) x .50)]

Data for the purpose of example only

Anesthesia by Surgeon

Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Reimbursement is the lower of the billed charge or the anesthesia base unit amount multiplied by the anesthesia conversion factor. No additional time is allowed.

Multiple or Bilateral Procedures

It is appropriate to designate multiple procedures that are rendered at the same session by separate billing entries. To report, use modifier 51. When bilateral or multiple surgical procedures which add significant time or complexity to patient care are performed at the same operative session and are not separately identified in the schedule, use modifier 50 or 51 respectively to report. Reimbursement for multiple surgical procedures performed at the same session is calculated as follows:

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued then both sides are reported with modifier 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

Modifier 51—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure.

- Major (highest valued) procedure: maximum reimbursement is the lower of the billed charge or 100 percent of the MAR
- Second and all subsequent procedure(s): maximum reimbursement is the lower of the billed charge or 50 percent of the MAR

Note: CPT codes listed in Appendix D of the CPT book and designated as add-on codes have already been reduced in RBRVS and are not subject to the 50 percent reimbursement reductions listed above. CPT codes

listed in Appendix E of the CPT book and designated as exempt from modifier 51 are also not subject to the above multiple procedure reduction rule. They are reimbursed at the lower of the billed charge or MAR.

Example:

Procedure 1	\$1000	
Procedure 2	\$600	
Total Payment	\$1300	\$1300 (\$1000 + (.50 x \$600))

Data for the purpose of example only

Endoscopic Procedures

Certain endoscopic procedures are subject to multiple procedure reductions. They are identified in the RBRVS with a multiple procedure value of "3" and identification of an endoscopic base code in the column "endo base." The second and subsequent codes are reduced by the MAR of the endoscopic base code. For example, if a rotator cuff repair and a distal claviclectomy were both performed arthroscopically, the value for code 29824, the second procedure, would be reduced by the amount of code 29805.

Example:

Code	MAR	Adjusted amount
29827	\$6,412.49	\$6,412.49 (100%)
29824	\$4,004.43	\$1,200.32 (the value of 29824 minus the value of 29805)
29805	\$2,804.11	
	Total	\$7,612.81

Data for the purpose of example only

Arthroscopy

Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued then both sides are reported with modifier 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

Modifier 51—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure. For multiple endoscopic procedures please see the Endoscopic Procedures section above.

Modifiers 80, 81, and 82— Reimbursement is the lower of the billed charge or 20 percent of the MAR for the surgical procedure when performed by a physician. See modifier AS for physician assistant or nurse practitioner.

State-Specific Modifiers

Modifier AS—Physician Assistant or Nurse Practitioner Assistant at Surgery Services

When assistant at surgery services are performed by a physician assistant or nurse practitioner, the service is reported by appending modifier AS.

Reimbursement is the lower of the billed charge or 15 percent of the MAR for the procedure. Modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.

Modifier AS is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

If two procedures are performed by the PA or NP, see the example below:

Procedure 1 (Modifier AS)	\$1,350.00
Procedure 2 (Modifier AS, 51)	\$1,100.00
Reimbursement	$\$285.00 [(\$1,350.00 \times .15) + ((1,100.00 \times .15) \times .50)]$

Data for the purpose of example only

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

Physician assistant and advanced practice registered nurse services are identified by adding modifier PE to the usual procedure number. A physician assistant must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided. An advanced practice registered nurse (APRN) must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

Reimbursement is the lower of the billed charge or 85 percent of the MAR for the procedure; modifier PE shall be used when services and procedures are provided by a physician assistant or an advanced practice registered nurse.

Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

If two procedures are performed by the PA or APRN, see the example below:

Procedure 1	\$150.00
Procedure 2	\$130.00
Reimbursement	\$182.75 [(\$150.00 x .85) + ((130.00 x .85) x .50)]

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

This section refers to radiology services, which includes nuclear medicine and diagnostic ultrasound. These rules apply when radiological services are performed by or under the responsible supervision of a physician.

RVUs without modifiers are for the technical component plus the professional component (total fee). Reimbursement for the professional and technical components shall not exceed the fee for the total procedure. The number of views, slices, or planes/sequences shall be specified on billings for complete examinations, CT scans, MRAs, or MRIs.

BILLING AND PAYMENT GUIDELINES

Professional Component

The professional component represents the value of the professional radiological services of the physician. This includes performance and/or supervision of the procedure interpretation and written report of the examination and consultation with the referring physician. (Report using modifier 26.)

Technical Component

The technical component includes the charges for personnel, materials (including usual contrast media and drugs), film or xerography, space, equipment and other facilities, but excludes the cost of radioisotopes and non-ionic contrast media such as the use of gadolinium in MRI procedures. (Report using modifier TC.)

Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical provider or other medical personnel. Neither the professional component value (modifier 26) nor the radiologic consultation code (76140) is reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

Written Reports

A written report, signed by the interpreting physician, should be considered an integral part of a radiologic procedure or interpretation.

Multiple Radiology Procedures

CMS multiple procedure payment reduction (MPPR) guidelines for the professional component (PC) and technical component (TC) of diagnostic imaging procedures apply if a procedure is billed with a subsequent

diagnostic imaging procedure performed by the same physician (including physicians in a group practice) to the same patient in the same session on the same day.

The MPPR on diagnostic imaging services applies to the TC services. It applies to both TC-only services and to the TC portion of global services. The service with the highest TC payment under the MAR is paid at the lower of billed charges or the MAR, subsequent services are paid at the lower of billed amount or 50 percent of the TC MAR when furnished by the same physician (including physicians in a group practice) to the same patient in the same session on the same day.

The MPPR also applies to the PC services. Full payment is the lower of billed charges or the MAR for each PC and TC service with the highest MAR. For subsequent procedures furnished by the same physician (including physicians in a group practice) to the same patient in the same session on the same day payment is made at the lower of billed charges or 95 percent of the MAR. See example below under Reimbursement Guidelines for CPT Modifiers.

MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

Reimbursement Guidelines for CPT Modifiers

Specific CPT modifiers shall be reimbursed as follows:

Modifier 26—Reimbursement is the lower of the billed charge or the MAR for the code with modifier 26.

Modifier 51—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure.

For specific procedures of the same radiological family, the second and subsequent procedures would be reimbursed at 50 percent of the TC (technical component). The PC (professional component) of the second and subsequent procedures is subject to a 5 percent reduction. The reduction applies even if the global (combined TC and PC) amount is reported. These services are identified in the RBRVS with a value of “4” in the multiple procedure column.

Alaska MAR:

72142	\$2,440.12 <u>1,510.83</u>
72142-TC	\$1,465.24 <u>19.43</u>
72142-26	\$683.88 <u>491.40</u>
72147	\$2,133.80 <u>1,503.53</u>
72147-TC	\$1,452.44 <u>13.13</u>

72147-26	\$681.69 <u>490.40</u>
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Data for the purpose of example only

If codes 72142 and 72147 were reported on the same date for the same patient:

Technical Component:

72142-TC	\$1,465.24 <u>019.43</u>	100% of the TC
72147-TC	\$726.06 <u>506.57</u>	(50% of the TC for the second procedure)
Total	\$2,191.30 <u>1,526.00</u>	

Professional Component:

72142-26	\$683.88 <u>491.40</u>	100% of the 26
72147-26	\$647.64 <u>465.88</u>	(95% of the 26 for the second procedure)
Total	\$1,331.40 <u>957.28</u>	

Global Reimbursement:

72142	\$2,149.12 <u>1,510.83</u>	100% of the global
72147-51	\$1,373.67 <u>972.45</u>	(\$726.06 + \$647.64 <u>506.57 + \$465.88</u> TC and 26 above)
Total	\$3,522.79 <u>2,483.28</u>	

Applicable HCPCS Modifiers

TC Technical Component—

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Reimbursement is the lower of the billed charge or the MAR for the code with modifier TC.

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

Pathology and laboratory services are provided by the pathologist, or by the technologist, under responsible supervision of a physician.

The MAR for codes in this section include the recording of the specimen, performance of the test, and reporting of the result. Specimen collection, transfer, or individual patient administrative services are not included. (For reporting, collection, and handling, see the 99000 series of CPT® codes.)

The fees listed in the Resource-Based Relative Value Scale (RBRVS) without a modifier include both the professional and technical components. Utilization of the listed code without modifier 26 or TC implies that there will be only one charge, inclusive of the professional and technical components. The values apply to physicians, physician-owned laboratories, commercial laboratories, and hospital laboratories.

The conversion factor for Pathology and Laboratory codes (80047–89398) is \$~~135~~122.00 for codes listed in the RBRVS.

Example data for CPT code 80500 in the RBRVS with the Alaska GPCI using the non-facility RVUs:

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	0.37	1.500	0.555
Practice Expense RVU x Practice Expense GPCI	0. 2726	1.117	0. 3045929042
Malpractice RVU x Malpractice GPCI	0.02	0.708	0.01416
Total RVU			0. 8707585958

Data for the purpose of example only

Calculation using example data:

$$0.37 \times 1.500 = 0.555$$

$$+ 0.~~2726~~ \times 1.117 = 0.~~3045929042~~$$

$$+ 0.02 \times 0.708 = 0.01416$$

$$= 0.~~8707585958~~$$

$$0.~~8707585958~~ \times \$~~135~~122.00 (CF) = ~~117.55125104.86876~~$$

Payment is rounded to ~~\$117.55~~104.87

Laboratory services not ~~found~~valued in the RBRVS but ~~found~~valued in the Centers for Medicare and Medicaid Services (CMS) Clinical Diagnostic Laboratory Fee Schedule (CLAB) file use a multiplier of ~~6.334.43~~ for the values in the payment rate column in effect at the time of treatment or service. The CLAB may also be referred to as the Clinical Laboratory Fee Schedule (CLFS) by CMS.

For example, if CPT code 81001 has a payment rate of \$3.~~9252~~ in the CLAB file, this is multiplied by ~~6.334.43~~ for a MAR of ~~\$24.84~~15.59.

Reimbursement is the lower of the billed charge or the MAR (RBRVS or CLAB) for the pathology or laboratory service provided. Laboratory and pathology services ordered by physician assistants and advanced practice registered nurses are reimbursed according to the guidelines in this section.

BILLING AND PAYMENT GUIDELINES

Professional Component

The professional component represents the value of the professional pathology services of the physician. This includes performance and/or supervision of the procedure, interpretation and written report of the laboratory procedure, and consultation with the referring physician. (Report using modifier 26.)

Technical Component

The technical component includes the charges for personnel, materials, space, equipment, and other facilities. (Report using modifier TC.) The total value of a procedure should not exceed the value of the professional component and the technical component combined.

Organ or Disease Oriented Panels

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (CPT codes 80047–80081), use the code number corresponding to the appropriate panel test. The individual tests performed should not be reimbursed separately. Refer to the CPT book for information about which tests are included in each panel test.

Drug Screening

Drug screening is reported with CPT codes 80305–80307. These services are reported once per patient encounter. These codes are used to report urine, blood, serum, or other appropriate specimen. Drug confirmation is reported with codes G0480–G0483 dependent upon the number of drug tests performed. These codes are valued in the CLAB schedule and the multiplier is ~~6.334.43~~.

MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

Specific CPT modifiers shall be reimbursed as follows:

Modifier 26—Reimbursement is the lower of the billed charge or the MAR for the code with modifier 26.

Applicable HCPCS Modifiers

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.

Reimbursement is the lower of the billed charge or the MAR for the code with modifier TC.

Medicine

GENERAL INFORMATION AND GUIDELINES

Visits, examinations, consultations, and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or in health supervision. The maximum allowable fees apply only when a licensed health care provider is performing those services within the scope of practice for which the provider is licensed; or when performed by a non-licensed individual rendering care under the direct supervision of a physician.

BILLING AND PAYMENT GUIDELINES

All providers may report and be reimbursed for codes 97014 and 97810–97814.

Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries. See modifier section below for examples of the reduction calculations.

Separate Procedures

Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate reimbursement. When, however, such a procedure is performed independently of, and is not immediately related to the other services, it may be listed as a separate procedure. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

Materials Supplied by Physician

Supplies and materials provided by the physician (e.g., sterile trays, supplies, drugs, etc.), over and above those usually included with the office visit or other services rendered, may be charged for separately. List drugs, trays, supplies, and materials provided and identify using the CPT or HCPCS Level II codes with a copy of the [manufacturer/supplier's](#) invoice for supplies.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes and the Alaska value in effect at the time of treatment in the Medicare DMEPOS fee schedule multiplied by 1.84.

Physical Medicine

Physical medicine is an integral part of the healing process for a variety of injured workers. Recognizing this, the schedule includes codes for physical medicine, i.e., those modalities, procedures, tests, and measurements in the Medicine section, 97010–97799, representing specific therapeutic procedures performed by or under the direction of physicians and providers as defined under the Alaska Workers' Compensation Act and Regulations.

The initial evaluation of a patient is reimbursable when performed with physical medicine services. Follow-up evaluations for physical medicine are covered based on the conditions listed below. Physicians should use the appropriate code for the evaluation and management section, other providers should use the appropriate physical medicine codes for initial and subsequent evaluation of the patient. Physical medicine procedures include setting up the patient for any and all therapy services and an E/M service is not warranted unless reassessment of the treatment program is necessary or another physician in the same office where the physical therapy services are being rendered is seeing the patient.

A physician or provider of physical medicine may charge for and be reimbursed for a follow-up evaluation for physical therapy only if new symptoms present the need for re-evaluation as follows:

- There is a definitive change in the patient's condition
- The patient fails to respond to treatment and there is a need to change the treatment plan
- The patient has completed the therapy regime and is ready to receive discharge instructions
- The employer or carrier requests a follow-up examination

TENS Units

TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription.

CPT code 64550 has been deleted. There is no replacement other than physical therapy codes.

Publications, Books, and Videos

Charges will not be reimbursed for publications, books, or videos unless by prior approval of the payer.

Functional Capacity Evaluation

Functional capacity evaluations (FCE) are reported using code 97750 for each 15 minutes. A maximum of 16 units or four hours may be reported per day.

Work Hardening

Work hardening codes are a covered service. Report 97545 for the initial two hours of work hardening and 97546 for each additional hour of work hardening. Treatment is limited to a maximum of eight hours per day (97545 x 1 and 97546 x 6). They are valued with the following total RVUs:

97545	3.41
97546	1.36

Osteopathic Manipulative Treatment

The following guidelines pertain to osteopathic manipulative treatment (codes 98925–98929):

- Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.
- Evaluation and management services may be reported separately if, the patient's condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the OMT. Different diagnoses are not required for the reporting of the OMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.

- Recognized body regions are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

Chiropractic Manipulative Treatment

The following guidelines pertain to chiropractic manipulative treatment (codes 98940–98943):

- Chiropractic manipulative treatment (CMT) is a form of manual treatment using a variety of techniques for treatment of joint and neurophysiological function. The chiropractic manipulative treatment codes include a premanipulation patient assessment.
- Evaluation and management services may be reported separately if, the patient's condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the CMT. Different diagnoses are not required for the reporting of the CMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.
- There are five spinal regions recognized in the CPT book for CMT: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacroiliac joint) region. There are also five recognized extraspinal regions: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.
- Chiropractors may report codes 97014, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943.

MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code appended in the appropriate field for electronic or paper submission of the billing.

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.

Reimbursement Guidelines for CPT Modifiers

Modifier 26—Reimbursement is the lower of the billed charge or the MAR for the code with modifier 26.

Specific modifiers shall be reimbursed as follows:

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued then both sides are reported with modifier 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

Modifier 51—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure.

The multiple procedure payment reduction (MPPR) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient on the same day. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services and to the TC of global services. The MPPRs are as follows:

Cardiovascular services—Full payment is made for the TC service with the highest MAR. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a “6” in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

93303	\$649.66 <u>631.79</u>
93303-TC	\$449.72 <u>431.85</u>
93303-26	\$199.94
93351	\$644.03 <u>638.10</u>
93351-TC	\$376.12 <u>370.19</u>
93351-26	\$267.91

Data for the purpose of example only

Technical Component:

93303-TC	\$449.72 <u>431.85</u>	100% of the TC
93351-TC	\$282.09 <u>277.64</u>	(75% of the TC for the second procedure)
Total	\$731.84 <u>709.49</u>	

Global Reimbursement:

93303	\$649.66 <u>631.79</u>	100%
93351	\$550.00 <u>545.55</u>	(75% of the TC for the second procedure + 100% of the 26) (\$282.09 <u>277.64</u> + \$267.91 = \$550.00 <u>545.55</u>)
Total	\$1,199.66 <u>1177.34</u>	

Ophthalmology services—Full payment is made for the TC service with the highest MAR. Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a “7” in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

92060	\$484.94 <u>183.12</u>
92060-TC	\$66.69 <u>65.80</u>
92060-26	\$418.22 <u>117.32</u>

92132	\$88.07
92132-TC	\$37.20
92132-26	\$50.86

Data for the purpose of example only

Technical Component:

92060-TC	\$66.69 <u>65.80</u>	100% of the TC
92132-TC	\$29.76	(80% of the TC for the second procedure)
Total	\$96.45 <u>95.56</u>	

Global Reimbursement:

92060	\$184.94 <u>183.12</u>	100% of the global
92132	\$80.62	(80% of the TC for the second procedure + 100% of the 26) (\$29.76 + \$50.86 = \$80.62)
Total	\$265.53 <u>263.74</u>	

Therapy services—For the practitioner and the office or institutional setting, all therapy services are subject to MPPR. These services are identified with a “5” in the multiple procedure column of the RBRVS. The Practice Expense (PE) portion of the service is reduced by 50 percent for the second and subsequent services provided on a date of service.

Alaska MAR:

97016	\$45.40 <u>37.36</u>
$[(.18 \times 1.5) + (.2617 \times 1.117) + (0.01 \times .708)] \times 80$	
97024	\$19.38
$[(.06 \times 1.5) + (.13 \times 1.117) + (0.01 \times .708)] \times 80$	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	\$33.78 <u>29.76</u>
$[(.18 \times 1.5) + ((.2617 \times 1.117) \times .5) + (0.01 \times .708)] \times 80$	
97024	\$13.57
$[(.06 \times 1.5) + ((.13 \times 1.117) \times .5) + (0.01 \times .708)] \times 80$	

Example:

97016	\$45.40 37.36
97016 (2nd unit same date)	\$33.78 29.76
97024 (additional therapy same date)	\$13.57

Applicable HCPCS Modifiers

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are facility charges and not billed separately by the physician.

Reimbursement is the lower of the billed charge or the MAR for the code with modifier TC.

Category II

Category II codes are supplemental tracking codes for performance measurement. These codes are not assigned a value. Reporting category II codes is part of the Quality Payment Program (QPP). Quality measures were developed by the Centers for Medicare and Medicaid Services (CMS) in cooperation with consensus organizations including the AQA Alliance and the National Quality Forum (NQF). Many of the quality measures are tied directly to CPT codes with the diagnoses for the conditions being monitored. The reporting of quality measures is voluntary but will affect reimbursement in future years for Medicare.

The services are reported with alphanumeric CPT codes with an ending value of “F” or HCPCS codes in the “G” section.

Category II modifiers are used to report special circumstances such as Merit-based Incentive Payment System (MIPS) coding including why a quality measure was not completed.

Category III

Category III codes are temporary codes identifying emerging technology and should be reported when available. These codes are alphanumeric with an ending value of "T" for temporary.

The use of these codes supersedes reporting the service with an unlisted code. It should be noted that the codes in this section may be retired if not converted to a Category I, or standard CPT code. Category III codes are updated semiannually by the American Medical Association (AMA).

Category III codes are listed numerically as adopted by the AMA and are not divided into service type or specialty.

CATEGORY III MODIFIERS

As the codes in category III span all of the types of CPT codes all of the modifiers are applicable. Please see a list of CPT modifiers in the General Information and Guidelines section.

HCPCS Level II

GENERAL INFORMATION AND GUIDELINES

The CPT® coding system was designed by the American Medical Association to report physician services and is, therefore, lacking when it comes to reporting durable medical equipment (DME) and medical supplies. In response, the Centers for Medicare and Medicaid Services (CMS) developed a secondary coding system, HCPCS Level II, to meet the reporting needs of the Medicare program and other sectors of the health care industry.

HCPCS (pronounced “hick-picks”) is an acronym for Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book.

MEDICARE PART B DRUGS

For drugs and injections coded under the Healthcare Common Procedure Coding System (HCPCS) the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges. **Note:** The corresponding National Drug Code (NDC) number should be included in the records for the submitted HCPCS codes.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value in effect at the time of treatment or service multiplied by 1.84 or billed charges. If no CPT code identifies the supply, bill using the appropriate HCPCS code with a copy of the manufacturer/supplier's invoice for supplies.

Hearing Aids

The dispensing of hearing aids is reported with the appropriate HCPCS Level II codes and a copy of the manufacturer/supplier's invoice. Reimbursement is the lower of the manufacturer/supplier's invoice cost plus 30 percent or billed charges including dispensing and fitting cost. HCPCS codes V5011 and V5160 are not separately reimbursed services.

Hearing Aid Services

The codes below are reimbursed according to the listed maximum allowable reimbursement (MAR) or the actual fee, whichever is less.

<u>CODE</u>	<u>MAR</u>
<u>92591</u>	<u>\$193.62</u>
<u>92593</u>	<u>\$99.64</u>
<u>92594</u>	<u>\$57.89</u>
<u>92595</u>	<u>\$124.11</u>
<u>V5014</u>	<u>\$249.31</u>
<u>V5020</u>	<u>\$116.17</u>

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

- NU New equipment
- RR Rental (use the RR modifier when DME is to be rented)
- UE Used durable medical equipment

AMBULANCE SERVICES

The maximum allowable reimbursement (MAR) for lift off fees and air mile rates for air ambulance services rendered under AS 23.30 (Alaska Workers' Compensation Act), is as follows:

- (1) for air ambulance services provided **entirely in this state** that are not provided under a certificate issued under 49 U.S.C. 41102 or that are provided under a certificate issued under 49 U.S.C. 41102 for charter air transportation by a charter air carrier, the maximum allowable reimbursements are as follows:
 - (A) a fixed wing lift off fee may not exceed \$11,500;
 - (B) a fixed wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;
 - (C) a rotary wing lift off fee may not exceed \$13,500;
 - (D) a rotary wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;
- (2) for air ambulance services in circumstances not covered under (1) of this subsection, the maximum allowable reimbursement is 100 percent of billed charges.

Charter Air Carrier Note: The limitations on allowable reimbursements apply to air carriers who have on-demand, emergent, and unscheduled flights, including, but not limited to, intra-state air services responding to "911" emergency calls. The employer may require the air carrier to provide the carrier's operating certificate along with the initial billing for services under this section.

Ground ambulance services are reported using the appropriate HCPCS codes. The maximum allowable reimbursement (MAR) for medical services that do not have valid Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) codes, a currently assigned CMS relative value, or

an established conversion factor is the lowest of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers' Compensation Act), ~~an outpatient~~ conversion factor of ~~\$221.79~~ shall be applied to the hospital outpatient relative weights established for each *Current Procedural Terminology* (CPT®) or *Ambulatory Payment Classifications* (APC) code adopted by reference in 8 AAC 45.083(m). ~~Outpatient hospital and ambulatory surgical center reimbursement used a single conversion factor and hospital relative weights. The outpatient facility conversion factor will be \$221.79 and the ambulatory surgical center (ASC) conversion factor will be \$177.00.~~ Payment determination, packaging, and discounting methodology shall follow the CMS OPPS methodology for hospital outpatient and ambulatory surgical centers (ASCs). For procedures performed in an outpatient setting, implants shall be paid at manufacturer/supplier's invoice plus 10 percent.

The maximum allowable reimbursement (MAR) for medical services that do not have valid Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) codes, currently assigned Centers for Medicare and Medicaid Services (CMS) relative value, or an established conversion factor is the lowest of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

A revenue code is defined by CMS as a code that identifies a specific accommodation, ancillary service or billing calculation. Revenue codes are used by outpatient facilities to specify the type and place of service being billed and to reflect charges for items and services provided. A substantial number of outpatient facilities use both CPT codes and revenue codes to bill private payers for outpatient facility services. The outpatient facility fees are driven by CPT code rather than revenue code. Common revenue codes are reported for components of the comprehensive surgical outpatient facility charge, as well as pathology and laboratory services, radiology services, and medicine services. The CMS guidelines applicable to status indicators are followed unless otherwise superseded by Alaska state guidelines. The following billing and payment rules apply for medical treatment or services provided by hospital outpatient clinics, and ambulatory surgical centers:

- (1) medical services for which there is no *Ambulatory Payment Classifications* weight listed are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (2) status indicator codes C, E, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (3) two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;

(4) a payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.

Status indicators determine how payments are calculated, whether items are paid, and which reimbursement methodology is used. The *Official Alaska Workers' Compensation Medical Fee Schedule* guidelines supersede the CMS guidelines as described below.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPSS, for example: <ul style="list-style-type: none"> • Ambulance services • Separately payable clinical diagnostic laboratory services • Separately payable non-implantable prosthetic and orthotic devices • Physical, occupational, and speech therapy • Diagnostic mammography • Screening mammography 	Not paid under OPSS. See the appropriate section under the provider fee schedule.
B	Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPSS. An alternate code that is recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPSS. <i>Alaska Specific Guideline: May be performed in the outpatient or ASC setting if beneficial to the patient and as negotiated by the payer and providers. Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i>
D	Discontinued codes	Not paid under OPSS.

E1	<p>Items, codes and services:</p> <ul style="list-style-type: none"> • Not covered by any Medicare outpatient benefit category • That are not covered by Medicare based on statutory exclusion <u>Statutorily excluded by Medicare</u> • Not reasonable and necessary 	<p>Not paid under OPPS.</p> <p><i>Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i></p>
E2	<p>Items and services for which pricing information and claims data are not available</p>	<p>Not paid under OPPS. Status may change as data is received by CMS.</p> <p><i>Alaska specific guideline: payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i></p>
F	<p>Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines</p>	<p>Not paid under OPPS. Paid at reasonable cost.</p>
G	<p>Pass-through drugs and biologicals</p>	<p>Paid under OPPS; separate APC payment includes pass-through amount.</p>
H	<p>Pass-through device categories</p>	<p>Separate cost-based pass-through payment.</p> <p><i>Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.</i></p>

J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
J2	Hospital Part B services that may be paid through a comprehensive APC	<p>Paid under OPPS; addendum B displays APC assignments when services are separately payable.</p> <p>(1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.</p> <p>(2) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1.</p> <p>(3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.</p>
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine	Not paid under OPPS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS.
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

		<p><i>Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.</i></p>
P	Partial hospitalization	<p>Paid under OPPS: <u>per diem APC payment.</u></p> <p><i>Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i></p>
Q1	STV packaged codes	<p>Paid under OPPS: <u>addendum B displays APC assignments when services are separately payable.</u></p> <p>(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI of S, T, or V.</p> <p><u>(2) Composite APC payment if billed with specific combinations of services based on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.</u></p> <p>(3) In other circumstances, payment is made through a separate APC payment.</p>
Q2	T packaged codes	<p>Paid under OPPS: <u>addendum B displays APC assignments when services are separately payable.</u></p> <p>(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI T.</p> <p>(2) In other circumstances, payment is made through a separate APC payment</p>
Q3	Codes that may be paid through a composite APC	<p>Paid under OPPS: <u>addendum B displays APC assignments when services are separately payable.</u></p> <p>1. Composite APC payment on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.</p>

		(2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	<u>Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS).</u> 2. Packaged APC payment if billed on the same claim as a HCPCS code assigned published OPSI J1, J2, S, T, V, Q1, Q2, or Q3. (2) In other circumstances, laboratory tests should have an SI = A and payment is made under the Clinical Laboratory Fee Schedule (CLFS) <u>CLFS.</u>
R	Blood and blood products	(2) Paid under OPPS; <u>separate APC payment.</u>
S	Significant procedure <u>Procedure or service</u> , not discounted when multiple	Paid under OPPS; <u>separate APC payment.</u>
T	Significant procedure <u>Procedure or service</u> , multiple reduction applies	Paid under OPPS; <u>separate APC payment.</u> <i>Alaska Specific Guideline: Two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classification's calculated amount and all other status indicator code T items paid at 50 percent.</i>
U	Brachytherapy sources	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPPS; <u>separate APC payment.</u>
Y	Non-implantable durable medical equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC.

SURGICAL SERVICES

Outpatient facility services directly related to the procedure on the day of an outpatient surgery comprise the comprehensive, or all-inclusive, surgical outpatient facility charge. The comprehensive outpatient surgical facility charge usually includes the following services:

- Anesthesia administration materials and supplies

- Blood, blood plasma, platelets, etc.
- Drugs and biologicals
- Equipment, devices, appliances, and supplies
- Use of the outpatient facility
- Nursing and related technical personnel services
- Surgical dressings, splinting, and casting materials

An outpatient is defined as a person who presents to a medical facility for services and is released on the same day. Observation patients are considered outpatients because they are not admitted to the hospital.

DRUGS AND BIOLOGICALS

Drugs and biologicals are considered an integral portion of the comprehensive surgical outpatient fee allowance. This category includes drugs administered immediately prior to or during an outpatient facility procedure and administered in the recovery room or other designated area of the outpatient facility.

Intravenous (IV) solutions, narcotics, antibiotics, and steroid drugs and biologicals for take-home use (self-administration) by the patient are not included in the outpatient facility fee allowance.

EQUIPMENT, DEVICES, APPLIANCES, AND SUPPLIES

All equipment, devices, appliances, and general supplies commonly furnished by an outpatient facility for a surgical procedure are incorporated into the comprehensive outpatient facility fee allowance.

Example:

- Syringe for drug administration
- Patient gown
- IV pump

SPECIALTY AND LIMITED-SUPPLY ITEMS

Particular surgical techniques or procedures performed in an outpatient facility require certain specialty and limited-supply items that may or may not be included in the comprehensive outpatient facility fee allowance. This is because the billing patterns vary for different outpatient facilities.

These items should be supported by the appropriate HCPCS codes listed on the billing and ~~an~~ manufacturer/supplier's invoice ~~from the supplier~~ showing the actual cost incurred by the outpatient facility for the purchase of the supply items or devices.

DURABLE MEDICAL EQUIPMENT (DME)

The sale, lease, or rental of durable medical equipment for use in a patient's home is not included in the comprehensive surgical outpatient facility fee allowance.

Example:

- ~~Una~~Surgical boot for a postoperative podiatry patient
- Crutches for a patient with a fractured tibia

USE OF OUTPATIENT FACILITY AND ANCILLARY SERVICES

The comprehensive surgical outpatient fee allowance includes outpatient facility patient preparation areas, the operating room, recovery room, and any ancillary areas of the outpatient facility such as a waiting room or other area used for patient care. Specialized treatment areas, such as a GI (gastrointestinal) lab, cast room, freestanding clinic, treatment or observation room, or other facility areas used for outpatient care are also included. Other outpatient facility and ancillary service areas included as an integral portion of the comprehensive surgical outpatient facility fee allowance are all general administrative functions necessary to run and maintain the outpatient facility. These functions include, but are not limited to, administration and record keeping, security, housekeeping, and plant operations.

NURSING AND RELATED TECHNICAL PERSONNEL SERVICES

Patient care provided by nurses and other related technical personnel is included in the comprehensive surgical outpatient facility fee allowance. This category includes services performed by licensed nurses, nurses' aides, orderlies, technologists, and other related technical personnel employed by the outpatient facility.

SURGICAL DRESSINGS, SPLINTING, AND CASTING MATERIALS

Certain outpatient facility procedures involve the application of a surgical dressing, splint, or cast in the operating room or similar area by the physician. The types of surgical dressings, splinting, and casting materials commonly furnished by an outpatient facility are considered part of the comprehensive surgical outpatient facility fee allowance.

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

For medical services provided by inpatient acute care hospitals under AS 23.30 (Alaska Workers' Compensation Act), the Centers for Medicare and Medicaid Services (CMS) Inpatient PC Pricer Software shall be applied to the *Medicare Severity Diagnosis Related Groups* (MS-DRG) weight adopted by reference in 8 AAC 45.083(m). The MAR is determined by multiplying the CMS Inpatient PC Pricer amount by the applicable multiplier to obtain the Alaska MAR payment. *Software solutions other than the CMS PC Pricer are acceptable as long as they produce the same results.*

- (1) the PC Pricer amount for Providence Alaska Medical Center is multiplied by 2.38;
- (2) the PC Pricer amount for Mat-Su Regional Medical Center is multiplied by 1.84;
- (3) the PC Pricer amount for Bartlett Regional Hospital is multiplied by 1.79;
- (4) the PC Pricer amount for Fairbanks Memorial Hospital is multiplied by 1.48;
- (5) the PC Pricer amount for Alaska Regional Hospital is multiplied by 2.32;
- (6) the PC Pricer amount for Yukon Kuskokwim Delta Regional Hospital is multiplied by 2.63;
- (7) the PC Pricer amount for Central Peninsula General Hospital is multiplied by 1.38;
- (8) the PC Pricer amount for Alaska Native Medical Center is multiplied by 2.53;
- (9) except as otherwise provided by Alaska law, the PC Pricer amount for all other inpatient acute care hospitals is multiplied by 2.02;

Note: Mt. Edgecumbe is now a critical access hospital.

- (10) hospitals may seek additional payment for unusually expensive implantable devices if the manufacturer/supplier's invoice cost of the device or devices was more than \$25,000. ~~Invoices~~Manufacturer/supplier's invoices are required to be submitted for payment. Payment will be the manufacturer/supplier's invoice cost minus \$25,000 plus 10 percent of the difference.

Example of Implant Outlier:

If the implant was \$28,000 the calculation would be:

Implant invoice	\$28,000
Less threshold	(\$25,000)
Outlier amount	= \$ 3,000
	<u>x 110%</u>
Implant reimbursement	= \$ 3,300

In possible outlier cases, implantable device charges should be subtracted from the total charge amount before the outlier calculation, and implantable devices should be reimbursed separately using the above methodology.

Any additional payments for high-cost acute care inpatient admissions are to be made following the methodology described in the Centers for Medicare and Medicaid Services (CMS) final rule CMS-1243-F published in the *Federal Register* Vol. 68, No. 110 and updated with federal fiscal year values current at the time of the patient discharge.

EXEMPT FROM THE MS-DRG

Charges for a physician's surgical services are exempt. These charges should be billed separately on a CMS-1500 or 837p electronic form with the appropriate CPT procedure codes for surgical services performed.

SERVICES AND SUPPLIES IN THE FACILITY SETTING

The MAR includes all professional services, equipment, supplies, and other services that may be billed in conjunction with providing inpatient care. These services include but are not limited to:

- Nursing staff
- Technical personnel providing general care or in ancillary services
- Administrative, security, or facility services
- Record keeping and administration
- Equipment, devices, appliances, oxygen, pharmaceuticals, and general supplies
- Surgery, special procedures, or special treatment room services

PREPARING TO DETERMINE A PAYMENT

The CMS Inpatient PC Pricer is normally posted by CMS one to two months after the Inpatient Prospective Payment System rule goes into effect each October 1. The version that is available on January 1, 20~~19~~20 remains in effect, unless the Alaska Workers' Compensation Division publishes notice a new version is in effect. Besides the PC Pricer software, two additional elements are required to determine a payment:

1. The hospital's provider certification number (often called the CCN or OSCAR number): Below is a current list of Alaska hospital provider numbers:

Providence Alaska Medical Center	020001
Mat-Su Regional Medical Center	020006
Bartlett Regional Hospital	020008
Fairbanks Memorial Hospital	020012
Alaska Regional Hospital	020017
Yukon Kuskokwim Delta Regional Hospital	020018
Central Peninsula General Hospital	020024
Alaska Native Medical Center	020026

Note: Mt. Edgecumbe is now a critical access hospital.

2. The claim's MS-DRG assignment: Billing systems in many hospitals will provide the MS-DRG assignment as part of the UB-04 claim. It is typically located in FL 71 (PPS Code) on the UB-04 claim.

Payers (and others) who wish to verify the MS-DRG assignment for the claim will need an appropriate grouping software package. The current URL for the Medicare grouper software is:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY20189-IPPS-Final-Rule-Home-Page.html>

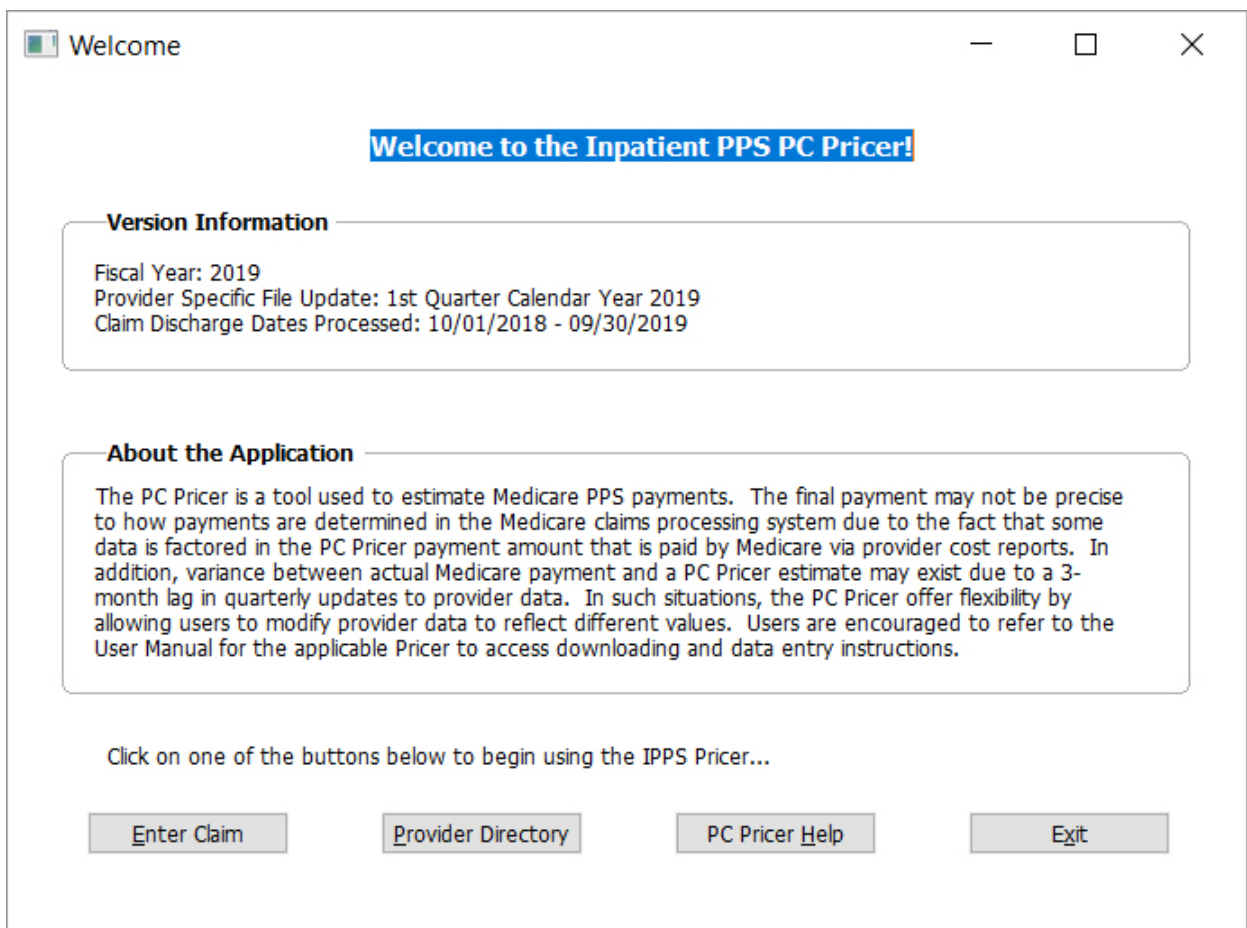
Third-party vendors such as Optum, 3M, and others also have software available which will assign the MS-DRG to the claim.

The current version of the PC Pricer tool may be downloaded here:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html>

Guidelines for downloading and executing the PC Pricer can be downloaded here:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/Guidelines.html>

The following illustration is a sample of the PC Pricer as found on the CMS website.

NOTE: These illustrations and calculations are for example purposes only and do not reflect current reimbursement.



Claim Entry

IPSS Claim Entry Form

Enter all claim information requested below.
Press Submit Claim when complete to calculate the prospective payment.

Provider Number: Patient ID:

Admit Date: Discharge Date:

DRG Code: Charges Claimed:

Short-Term Acute Transfer? HMO Paid Claim?

Post-Acute Transfer? Cost Outlier Threshold?

Enter procedure and diagnosis codes for new technology and islet cell transplantation if applicable.

Procedure Codes:

Diagnosis Codes:

The PC Pricer instructions are included below:

Data Entry and Calculation Steps for the Inpatient PPS PC Pricer—From the welcome screen above (top image), select Enter Claim. The IPSS Claim Entry Form will appear.

PROVIDER NUMBER—Enter the six-digit OSCAR (also called CCN) number present on the claim.

Note: The National Provider Number (NPI) on the claim (if submitted by the hospital) is not entered in this field. Please note that depending on NPI billing rules, a hospital may only submit their NPI number without their OSCAR number. Should this occur, contact the billing hospital to obtain their OSCAR number as the PC Pricer software cannot process using an NPI.

PATIENT ID—Not required, but the patient’s ID number on the claim can be entered.

ADMIT DATE—Enter the admission date on the claim FL 12 (the FROM date in Form Locator (FL) 6 of the UB-04).

DISCHARGE DATE—Enter the discharge date on the claim (the THROUGH date in FL 6 of the UB-04).

DRG—Enter the DRG for the claim. The DRG is determined by the Grouper software or may be on the UB-04 claim form in FL 71.

CHARGES CLAIMED—Enter the total covered charges on the claim.

SHORT TERM ACUTE CARE TRANSFER—Enter 'Y' if there is a Patient Status Code 02 on the claim. Otherwise, enter 'N' (or tab). Pricer will apply a transfer payment if the length of stay is less than the average length of stay for this DRG.

HMO PAID CLAIM—N/A for IHS/CHS. Enter 'N' (or tab). HMOs must enter 'Y.'

POST ACUTE TRANSFER—Enter 'Y' if one of the following Patient Status Codes is present on the claim: 03, 05, 06, 62, 63, or 65. Pricer will determine if the postacute care transfer payment will apply depending on the length of stay and the DRG.

COST OUTLIER THRESHOLD—Enter 'N' (or tab) if the cost outlier threshold is not applicable for the claim. For the cost outlier threshold, enter 'Y.' For all of the remaining new technology fields, enter the procedure and diagnosis code if there is a procedure code on the claim that is defined within the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Otherwise, enter 'N' (or tab). Certain new technologies provide for an additional payment.

The following screen is an example of what will appear. Note that some fields may have 0 values depending on the inputs entered in the prior screen.

IPPS Payment Results

FY 2019 Inpatient Prospective Payment (IPPS) Payment Results

Calculator Version: C19.0

Claim Return Code: 14 - Paid normal DRG payment with per diem days = or > GM ALOS.

PROVIDER DETAILS	CLAIM DETAILS	PPS FACTORS & ADJUSTMENTS
Provider #: 020001 PSF Record Eff Date: 10/01/2018 Provider Type: 00 GEO/STD CBSA: 11260 / <input type="text"/> Reclass CBSA: <input type="text"/>	Patient Id: 1111111 DRG: 460 Discharge Date: 10/22/2018 Length of Stay: 12 Days Charges: \$75,000.00	OP/CAP CCR: 0.2050 / 0.0160 OP/CAP DSH: 0.3077 / 0.1074 Operating IME: 000000.028533292 Capital IME: 000000.021967351 Nat Labor/Non-Labor %: 0.6830 / 0.3170 Nat Labor: 03856.27 Nat Non-Labor: 01789.81 Inp Wage Index: 01.2130 Inp PR Wage Index: 00.0000 Inp DRG Weight: 04.0375 Inp DRG GM ALOS: 02.9 Transfer Adj. Factor: 0.0000 Readmissions Adj. Factor: 1.0000 VBP Adj. Factor: 1.00322832430 Bundle %: 0.000 EHR Reduction Indicator: <input type="checkbox"/> HAC Reduction Indicator: N Cost Outlier Threshold: \$0.00
CAPITAL AMOUNTS C-FSP: \$2,284.40 C-Outlier: \$0.00 C-DSH: \$245.34 C-IME: \$50.18	OPERATING AMOUNTS O-FSP: \$27,918.98 O-HSP: \$0.00 O-Outlier: \$0.00 O-DSH: \$2,147.67 O-IME: \$796.62 Uncomp Care: \$2,327.43 Readmissions Adj.: \$0.00 VBP Adjustment: \$90.13 New Tech: \$0.00	
OTHER PPS AMOUNTS HAC Adj.: \$0.00 Low Volume: \$0.00 Pass Thru + Misc: \$404.16 Islet Add-on: \$0.00 EHR Adj.: \$0.00 Bundle Adj.: \$0.00 MA-HSP: \$0.00	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <p>* TOTAL PAYMENT *</p> <p>\$36,264.91</p> </div>	

A Note on Pass-through Payments in the PC Pricer

There are certain hospital costs that are excluded from the IPPS payment and are paid on a reasonable cost basis. Pass-through payments under Medicare FFS are usually paid on a bi-weekly interim basis based upon cost determined via the cost report (or data received prior to cost report filing). It is computed on the cost report based upon Medicare utilization (per diem cost for the routine and ancillary cost/charge ratios). In order for the PC Pricer user to estimate what the pass-through payments are, it uses the pass-through per diem fields that are outlined in the provider specific file.

Pass-through estimates should be included when determining the Alaska workers' compensation payment.

Determining the Final Maximum Allowable Reimbursement (MAR)

To determine the Alaska workers' compensation MAR, multiply the TOTAL PAYMENT field result above by the hospital specific multiplier listed above to calculate the payment. In the above example, the TOTAL PAYMENT is reported as:

CMS Inpatient PC Pricer Total Payment amount	\$36,601.81 <u>\$36,264.91</u>	
Multiplied by Providence Alaska Medical Center multiplier	x <u>2.38</u>	
Alaska Workers' Compensation Payment	\$87,112.31 <u>\$86,310.49</u>	

Critical Access Hospital, Rehabilitation Hospital, Long-term Acute Care Hospital

GENERAL INFORMATION AND GUIDELINES

The maximum allowable reimbursement (MAR) for medical services provided by a critical access hospital, rehabilitation hospital, or long-term acute care hospital is the lowest of 100 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

For a list of critical access hospitals in Alaska, please contact the Alaska Department of Health and Social Services, Division of Health Care Services.

TAB 6



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE JANUARY 1, 2020**

Based on NCCI’s analysis, the below changes to the fee schedule in Alaska, to become effective January 1, 2020, will result in an impact of -3.7% on overall workers compensation system costs.

SUMMARY OF CHANGES

The following changes to the Alaska medical fee schedule (MFS) are to become effective for medical services provided on or after 1/1/2020:

Provider Schedule

- Decrease the following conversion factors (CF) established by the Department of Labor and Workforce Development (DLWD):

Physician Practice Category	Current CF	Proposed CF
Anesthesia	\$121.82	\$110.00
Surgery	\$165.00	\$132.00
Radiology	\$196.00	\$141.00
Pathology & Laboratory	\$135.00	\$122.00

- Decrease the multiplier established by the DLWD, which gets applied to the Clinical Laboratory Fee Schedule by the Centers for Medicare and Medicaid Services (CMS), from 6.33 to 4.43.

All other physician services’ conversion factors remain unchanged. This pricing assumes no change to the 2019 Medicare Resource-Based Relative Value Units¹ established for each CPT² code and published by the CMS.

Ambulatory Surgical Center (ASC)

- Decrease the conversion factor established by the DLWD from \$221.79 to \$177.00. This pricing assumes no change to the 2019 Outpatient Prospective Payment System (OPPS) relative weights¹.

ACTUARIAL ANALYSIS

NCCI’s methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements

¹ The Alaska MFS, effective January 1, 2020, is based on 2020 Medicare values which are not currently available in their entirety. The impact, if any, due to changes in Medicare relative value units and/or weights will be analyzed separately once fully available and reflected in a future NCCI loss cost filing in Alaska.

² Current Procedural Terminology maintained by the American Medical Association.



ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2020

- Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code.
 - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the revised fee schedule
 - NCCI research by David Colón and Paul Hendrick, “The Impact of Fee Schedule Updates on Physician Payments” (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.
 3. Determine the share of costs that are subject to the fee schedule
 - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.
 - The share is calculated as the greater of the percent of observed payments with a maximum allowable reimbursement (MAR) or 75%. NCCI assumes no change for the share of costs not subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI’s Medical Data Call for Alaska for Service Year 2018.
- The share of benefit costs attributed to medical benefits is based on NCCI’s Financial Call data for Alaska from Policy Years 2014, 2015, and 2016 projected to the effective date of the benefit changes.

Provider Fee Schedule

In Alaska, payments for physician services represent 47.6% of total medical costs. The overall change in maximums for physician services is a weighted average of the percentage change in MAR by procedure code (Revised MAR/Prior MAR). The weights are based on Service Year 2018 observed payments by procedure code for Alaska, as reported on NCCI’s Medical Data Call. The overall weighted-average percentage change in maximums for physician services is -9.1%. The impact by category is shown in the following table.



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE JANUARY 1, 2020**

Physician Practice Category	Share of Physician Costs	Percentage Change in MAR
Anesthesia	3.8%	-9.7%
Surgery	25.6%	-20.0%
Radiology	12.2%	-28.1%
Pathology & Laboratory	0.9%	-28.9%
Evaluation & Management	20.1%	-
Medicine	33.5%	-
Other HCPCS*	0.3%	-
Physician Payments with no specific MAR	3.6%	-
Total Physician Costs	100.0%	-9.1%

*Healthcare Common Procedure Coding System

A price realization factor of 80% was applied. The impact on physician payments after applying the price realization factor is -7.3% (= -9.1% x 0.80).

The above impact of -7.3% is then multiplied by the percentage of medical costs attributed to physician payments in Alaska (47.6%) to arrive at an impact of -3.5% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact of -2.5% on overall workers compensation costs.

Ambulatory Surgical Centers Fee Schedule

In Alaska, payments for ASC services represent 11.9% of total medical costs. Of these payments, 93.1% have a MAR. The impact on ASC services, which is calculated in an analogous manner to the physician fee schedule change, is -18.8%. A price realization factor of 80% was applied. The impact on ASC payments after applying the price realization factor is -15.0% (= -18.8% x 0.80).

The above impact of -15.0% is then multiplied by the percentage of medical costs attributed to ASC payments in Alaska (11.9%) to arrive at an impact of -1.8% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact of -1.3% on overall workers compensation costs.

ASC payments in Alaska follow the Medicare rules for outpatient services. Note that these rules contain a comprehensive payment policy that packages payment for adjunctive and secondary items, services, and procedures into the primary procedure under certain circumstances. For this analysis, the experience is aggregated according to the packaging rules reflected under Medicare, where applicable.



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE JANUARY 1, 2020**

SUMMARY OF IMPACTS

The impacts from the fee schedule change in Alaska, effective January 1, 2020, are summarized in the following table:

Type of Service	(A) Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Impact on Medical Costs
Physician	-7.3%	47.6%	-3.5%
ASC	-15.0%	11.9%	-1.8%
Combined Impact on Medical Costs (D) = Total of (C)			-5.3%
Medical Costs as a Share of Overall Costs (E)			70%
Combined Impact on Overall Costs (F) = (D) x (E)			-3.7%

THIS DOCUMENT AND ANY ANALYSIS, ASSUMPTIONS, AND PROJECTIONS CONTAINED HEREIN PROVIDE AN ESTIMATE OF THE POTENTIAL PROSPECTIVE COST IMPACT(S) OF PROPOSED/ENACTED SYSTEM CHANGE(S) AND IS PROVIDED SOLELY AS A REFERENCE TOOL TO BE USED FOR INFORMATIONAL PURPOSES ONLY. THIS DOCUMENT SHALL NOT BE CONSTRUED OR INTERPRETED AS PERTAINING TO THE NECESSITY FOR OR A REQUEST FOR A LOSS COST/RATE INCREASE OR DECREASE, THE DETERMINATION OF LOSS COSTS/RATES, OR LOSS COSTS/RATES TO BE REQUESTED. THE ANALYSIS CONTAINED HEREIN EVALUATES THE DESCRIBED CHANGES IN ISOLATION UNLESS OTHERWISE INDICATED; ANY OTHER CHANGES NOT INCLUDED IN THIS ANALYSIS THAT ARE ULTIMATELY ENACTED MAY RESULT IN A DIFFERENT ESTIMATED IMPACT. I, CAROLYN WISE, ACAS, MAAA, AM AN ASSOCIATE ACTUARY FOR THE NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC. AND THE ACTUARY RESPONSIBLE FOR THE PREPARATION OF THIS DOCUMENT. THIS DOCUMENT IS PROVIDED "AS IS" ON THE DATE SET FORTH HEREIN AND INCLUDES INFORMATION AND EVENTS AVAILABLE AT THE TIME OF PUBLICATION ONLY.



ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2020

NCCI estimates that the below changes to the medical fee schedule in Alaska¹, effective January 1, 2020, will result in an impact of +0.6% on overall workers compensation system costs.

SUMMARY OF CHANGES

The Alaska MFS, effective January 1, 2020 is based on 2020 Medicare values with state-specific conversion factors established by the Department of Labor and Workforce Development. The impact due to the conversion factor changes for the provider schedule and ASC services was priced previously and included in the January 1, 2020 Alaska voluntary loss costs and assigned risk rates filing.

The following changes to the Alaska medical fee schedule (MFS) are to become effective for medical services provided on or after 1/1/2020:

Provider Schedule

- Update the maximum allowable reimbursements (MARs) to be based on 2020 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT² code and published by the Centers for Medicare and Medicaid Services (CMS). The prior MARs were based on 2019 Medicare RBRVUs.

Hospital Outpatient and Ambulatory Surgical Center (ASC)

- Update the MARs to be based on 2020 Medicare Outpatient Prospective Payment System (OPPS) relative weights. The prior MARs were based on 2019 OPPS relative weights.

Hospital Inpatient

- Update the MARs to be based on 2020 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior MARs were based on 2019 MS-DRG weights. The Department of Labor and Workforce Development (DLWD) establishes multipliers for each hospital to be applied to the Medicare MAR. There is no change to the multipliers.

ACTUARIAL ANALYSIS

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

¹ The Alaska MFS, effective January 1, 2020 is based on 2020 Medicare values with state-specific conversion factors established by the Department of Labor and Workforce Development. The impact due to the conversion factor changes for the provider schedule and ASC services was priced previously and included in the January 1, 2020 Alaska voluntary loss costs and assigned risk rates filing.

² Current Procedural Terminology maintained by the American Medical Association.



ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2020

1. Calculate the percentage change in maximum reimbursements
 - Compare the prior and revised maximum reimbursements by procedure code to determine the percentage change by procedure code. For hospital inpatient services, the prior and revised maximum reimbursements are compared by episode.
 - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights. For hospital inpatient services, the observed payments by episode are used as weights. For hospital outpatient and ASC services, Alaska's fee schedule follows Medicare rules which contain a comprehensive payment policy that packages payment for adjunctive and secondary items, services, and procedures into the primary procedure under certain circumstances. For this analysis, the hospital outpatient and ASC experience are aggregated according to the packaging rules, where applicable.
2. Determine the share of costs that are subject to the fee schedule
 - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.
 - The share is calculated as the greater of the percent of observed payments with a maximum allowable reimbursement (MAR) or 75%. NCCI assumes no change for the share of costs not subject to the fee schedule.
3. Estimate the price level change as a result of the revised fee schedule
 - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change.
 - For facility fee schedule changes, a price realization factor of 80% is assumed.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Alaska for Service Year 2018.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from Policy Years 2015, 2016, and 2017 projected to the effective date of the benefit changes.



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE JANUARY 1, 2020**

SUMMARY OF IMPACTS

The impacts from the fee schedule changes in Alaska, effective January 1, 2020, are summarized below.

Type of Service	(A) Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Impact on Medical Costs
Physician	+0.1%	47.6%	0.0%
Hospital Inpatient	+1.4%	9.9%	+0.1%
Hospital Outpatient	+1.3%	13.7%	+0.2%
ASC	+3.8%	11.9%	+0.5%
Combined Impact on Medical Costs (D) = Total of (C)			+0.8%
Medical Costs as a Share of Overall Costs (E)			70%
Combined Impact on Overall Costs (F) = (D) x (E)			+0.6%

Refer to the appendix for the weighted-average changes in MARs by physician practice category, the share of costs subject to the fee schedule by type of service, and the weighted-average change in MAR by type of service.

APPENDIX

Weighted-Average Percentage Change in MARs Prior to Price Realization by Physician Practice Category

Physician Practice Category	Share of Physician Costs	Percentage Change in MARs
Anesthesia	3.8%	--
Surgery	25.5%	0.0%
Radiology	12.2%	0.0%
Pathology & Laboratory	0.7%	-5.1%
Evaluation & Management	20.1%	+0.2%
Medicine	33.4%	+0.4%
Other HCPCS*	0.3%	-1.5%
Payments with no MAR	4.0%	—
Total	100.0%	+0.1%

*Healthcare Common Procedure Coding System



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE JANUARY 1, 2020**

Share of Costs Subject to the Fee Schedule and Weighted-Average Percentage Change in MARs by Type of Service

Type of Service	Share of Costs Subject to the Fee Schedule	Percentage Change in MARs	Impact after 80% Price Realization
Physician	96.0%	+0.1%	+0.1%
Hospital Inpatient	71.2%	+1.8%	+1.4%
Hospital Outpatient	91.4%	+1.6%	+1.3%
ASC	90.7%	+4.7%	+3.8%

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From: [Todd Johnson](#)
To: [Mitchell, Grey R \(DOL\)](#)
Subject: RE: NCCI Analysis of AK Medical Fee Schedule Changes eff 1/1/2020
Date: Monday, February 24, 2020 3:18:41 PM
Attachments: [image001.png](#)
[image003.png](#)
[image005.png](#)

Director Mitchell –

I've addressed your questions below by **answering in red text**.

Kindly advise if you need any further information.

Todd Johnson, CPCU

State Relations Executive, External & Government Affairs

National Council on Compensation Insurance

The Source You Trust

901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362

561-893-3814 (W) 971-288-6876 (M)

Todd_Johnson@NCCI.com | [NCCI.com](#)

From: Mitchell, Grey R (DOL) <grey.mitchell@alaska.gov>
Sent: Friday, February 21, 2020 5:44 PM
To: Todd Johnson <Todd_Johnson@ncci.com>
Subject: RE: NCCI Analysis of AK Medical Fee Schedule Changes eff 1/1/2020

CAUTION: This email originated from outside of the organization and the identity of the sender could not be validated. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Thanks Todd.

If I'm tracking this analysis correctly, it does not include the impacts of the conversion factor adjustments in the 2020 WC Fee Schedule, as these were previously accounted for in NCCI's estimate dated October 18, 2019 (see attached). **Correct. The February 2020 analysis (+0.6%) only includes the items listed in the Summary of Changes.**

NCCI estimated a -3.7% impact on WC system costs. Is it correct to read this current analysis to say that the overall impact of the 2020 WC Fee schedule would be estimated at -3.1% after adding the .6% increase associated with the Medicare adjustments for 2020? Or is the analysis saying that Medicare changes had a +4.2% effect, but after reducing that by 3.7% (due to fee schedule conversion factor reductions) the overall result is a .6% increase on WC system costs for 2020? **The combined impact from conversion factors (CF; -3.7%) and maximum allowable reimbursements (MARs; +0.6%), would be approximately -3.1%, where both are effective 1/1/2020.**

DOI disagreed with NCCI's assessment of the 2020 WC Fee Schedule conversion factor adjustments and substituted a -1.9% fee schedule impact in its Regulator Order R19-04. Will DOI also weigh in on the latest NCCI analysis or does that only happen during the rate filing approval process? **NCCI would intend to file the +0.6% MAR impact within the 1/1/2021 loss cost filing, and the DOI would have an opportunity to ask interrogatories and make a final decision on the loss cost impact during the filing approval process in the fall of 2020.**

I appreciate your assistance. Thanks again.
Grey

Grey Mitchell
Director
(907)465-2790

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From: Todd Johnson <Todd_Johnson@ncci.com>
Sent: Friday, February 21, 2020 2:00 PM
To: Mitchell, Grey R (DOL) <grey.mitchell@alaska.gov>
Subject: NCCI Analysis of AK Medical Fee Schedule Changes eff 1/1/2020

Hello Director Mitchell –

Attached please find NCCI [Analysis of Alaska Medical Fee Schedule Changes Effective January 1, 2020](#). NCCI estimates that the medical fee schedule changes in Alaska, effective 1/1/2020, will result in an impact of +0.6% on overall workers compensation system costs. Please see the attached analysis for specific and important information.

Additionally, I will be providing a copy of this analysis to the Alaska Division of Insurance.

I hope all is well. Please advise if I can offer any additional support or services to the Division of Workers Compensation.

Todd Johnson, CPCU

State Relations Executive, External & Government Affairs

National Council on Compensation Insurance

The Source You Trust

901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362

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TAB 7



COVID-19 and Workers Compensation: Modeling Potential Impacts

The novel coronavirus (COVID-19) was declared a public health emergency in the United States in late January 2020, followed by the World Health Organization’s pandemic designation on March 11, 2020. As the crisis began to unfold, policymakers and the insurance industry began to question the impact COVID-19 would have on the workers compensation (WC) system. Relying on its expertise as a sector thought leader, the National Council on Compensation Insurance (NCCI) has crafted a white paper to assist in understanding the potential cost impact on WC losses due to COVID-19.

While there are many unknowns regarding COVID-19 and its ultimate impact on the US population, the following serves to provide an estimate of potential WC system cost¹ impacts under various hypothetical scenarios detailed in the white paper. This document is being provided as a tool which may be used to gain insight into the potential implications of a state enacting legislation related to the compensability of COVID-19-related claims in certain occupations.

ASSUMPTIONS USED IN THE MODEL

There are many COVID-19-related factors, and the white paper provides a thorough discussion of the many assumptions that must be considered. Data reported to NCCI has been leveraged where possible to estimate various factors such as average weekly indemnity benefits, fatal benefits, and medical severities. Assumptions for infection rates, hospitalization rates, compensability rates, and fatal rates all necessarily come into play when assessing COVID-19’s potential impact range on the WC system. Some assumptions have a more pronounced impact than others and some contain a significant amount of variability. While each of these factors is discussed at length in the white paper, the table below summarizes a few of the key assumptions used in the model. Quoted research² on the assumptions is shown where applicable.

Category	Assumptions	Ranges Referenced in White Paper	Description
Frequency	Infection rate	From < 10%, up to 81%	Percentage of workers who contract COVID-19
	Report Rate	20% to 95%	One minus the asymptomatic rate
	Compensability Rate	0% to 100%	Percentage of symptomatic cases entitled to WC benefits
Severity	Fatal rate	0.19% to 1.97%	Percentage of claims that result in death benefits
	Hospitalization rate	1% to 31%	Impacts distribution of claims categorized with mild, moderate, or severe symptoms
	Critical Care Rate	5% to 27%	

¹ In this document, the use of the terms “WC system costs” and “WC losses” are considered synonymous

² Sources for values used in this white paper and displayed in this table of assumptions include: Institute of Health Metrics and Evaluation; Marc Lipsitch, professor of epidemiology at Harvard T.H. Chan School of Public Health; Imperial College COVID-19 Response Team; Sergio Romagnani, professor of clinical immunology at the University of Florence; Centre for Evidence-Based Medicine; FAIR Health; *The New England Journal of Medicine*; and the Centers for Disease Control and Prevention

Potential Impacts of COVID-19

The following table summarizes a broad range of estimated impacts³ using the various scenarios displayed in the white paper (Tables 11–13) for all states where NCCI provides ratemaking services⁴:

	First Responders	First Responders and Healthcare Workers	All Workers
# of Workers (BLS)	1,176,110	9,666,420	86,351,950
Potential Range of Impacts on Worker Segment	+10% to +170%	+33% to +550%	+8% to +254%
Estimated Annual Losses Without COVID-19	\$1.1B	\$3.0B	\$32.1B
Potential Range of Impacts From COVID-19	+\$0.1B to +\$1.9B	+\$1.0B to +\$16.2B	+\$2.7B to +\$81.5B

	Assumptions ⁵		
Infection Rate	5% to 50%	5% to 50%	5% to 50%
Compensability Rate	60% to 100%	60% to 100%	20% to 60%
Fatal Rate	0.5%	0.5%	0.5%

Note: Dollar impacts shown above are provided for illustrative purposes only.^{6,7}

The analytical approach referenced in this document and employed in the white paper all operate under the same framework, with the white paper providing a larger set of assumptions and state- or occupation-specific data in its tables and appendices. The white paper provides four detailed scenarios to demonstrate how one may use specific assumptions and the appendices to produce an estimate of the impact of COVID-19 on the WC system. Users can apply this framework to develop their own scenarios by selecting from a range of variables—including those based on their individual jurisdiction(s).

The white paper illustrates the impact of COVID-19 on first responders using one potential set of assumptions for all NCCI states combined. In addition, the white paper contains tables that display the impact for each individual jurisdiction under the same set of assumptions. Hence, the first column of impacts shown in the table above is an example of an application of the white paper. That is, the infection and compensability rates were varied, from that contained in Scenario 3 of the white paper, to produce a potential range of impacts on first responders.

³ Displayed values are not shown to full precision.

⁴ Includes: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV; subsequent references to this group of jurisdictions have been shortened to “NCCI states.”

⁵ The impacts displayed in the Executive Summary are for a narrower set of assumptions than shown in the white paper; this should not be interpreted to suggest that selections of assumptions outside of the above ranges are not appropriate.

⁶ The dollar impacts are determined by multiplying estimated losses by the percentage impacts displayed. For the specified segment of workers, estimated losses are calculated as the product of US Bureau of Labor Statistics (BLS) annual wages and the weighted average of the latest approved pure premium factors for all states for which NCCI provides ratemaking services. The pure premium factor represents the expected losses as a percentage of payroll in hundreds. Values used to derive the figures shown are included in the white paper’s appendices.

⁷ The use of BLS wages provides an estimate of the impact on all private and public employers regardless of how work-related injury costs are funded (e.g., privately insured, self-insured, policyholder retained portion of deductible policies, or employees exempted from WC requirements).

Scenario #4 of the white paper provides similar information, but for healthcare workers. Again, an application of the framework in the white paper was used to produce estimates of the potential impacts, utilizing a range of assumptions for infection and compensability rates. The resulting impacts for healthcare workers were combined with the impacts for first responders to produce the second column of data displayed in the table above.

This framework can be further leveraged to develop potential system impacts across a broader set of occupations. In particular, the white paper highlights examples of the impact of COVID-19 across all occupations for individual jurisdictions (Scenario #2) or for all NCCI states combined (Scenario #1). A similar application of the framework for Scenario #1 of the white paper was used to populate the impacts shown in the last column of data in the table above.

An initial look at a broader group of occupations that may be considered essential during the initial wave of infection suggests that between 49 million and 62 million individuals in the workforce (33% to 42%) could potentially qualify as essential workers⁸. To the extent that the essential workers' share of the workforce is comparable to their share of statewide WC losses, the corresponding scenario estimate of WC losses related to COVID-19 for these occupations is between 33% and 42% of the "ALL Workers" estimate for the applicable jurisdiction, as displayed in the white paper.

CONCLUSION

NCCI has provided a framework to estimate the potential magnitude of the impact of COVID-19 on WC losses under various scenarios. The white paper presents a qualitative discussion concerning the challenges in estimating key assumptions and outlines the potential directional impact of variables not contemplated in the model. The framework may also be used to evaluate the potential impact on losses to the system of additional user-defined hypothetical scenarios, as needed. NCCI believes this is a valuable analytical tool that will assist in understanding the potential COVID-19 impact as individual state proposals continue to emerge relating to WC coverage.

⁸ Adie Tomer and Joseph Kane. *How to protect essential workers during COVID-19*. Brookings (3/31/2020). www.brookings.edu/research/how-to-protect-essential-workers-during-covid-19/



COVID-19 AND WORKERS COMPENSATION: MODELING POTENTIAL IMPACTS

Introduction

During December 2019, a new infectious disease appeared in China and has since spread around the world. In late January 2020, the novel coronavirus (COVID-19) was declared a public health emergency in the United States and was officially declared a pandemic by the World Health Organization (WHO) on March 11, 2020.

While there are many unknowns regarding COVID-19 and its ultimate impact on the US population, the following serves to provide an estimate of potential workers compensation (WC) system impacts under various hypothetical scenarios. In addition, this document may be used as a tool to gain insight into the potential implications of a state enacting legislation related to the compensability of COVID-19-related claims in certain occupations.

Incidence of COVID-19

The infection rate of COVID-19 is widely speculated. Depending on the model used, up to 80% of the US population is expected to ultimately be infected (see Table 1). Estimates may vary drastically due to many levels of uncertainty, including:

- The limited time to collect data,
- Incomplete data due to a lack of testing capacity, and
- A changing environment (e.g., social distancing and isolation).

Additionally, any estimate that narrows the focus to a single jurisdiction or occupation further exacerbates the uncertainty surrounding such a projection.

Because of this and uncertainty related to compensability of COVID-19-related claims under WC statutes, NCCI has limited its analysis to quantifying the impact of hypothetical scenarios across a very broad range of assumptions.

Table 1: Projected Infection Rates by Source

Rate	Source (Date of Estimate)	Comments
Less than 10%	Institute of Health Metrics and Evaluation (4/8/20) ^{1,2}	US Rate, assumes strict infection controls
20% - 60%	Marc Lipsitch, professor of epidemiology at Harvard T.H. Chan School of Public Health (3/4/20) ³	Global Adult Population Rate
40% - 80%	NY Gov. Andrew Cuomo (3/21/20)	New York Rate
56%	CA Gov. Gavin Newsom (3/18/20)	California Rate
81%	Imperial College COVID-19 Response Team (3/16/20) ⁴	Assumes no infection controls

After assuming less than 80% of the population will become infected by COVID-19, it is then important to determine what subset of the infected are asymptomatic (i.e., will not develop symptoms) or experience mild enough symptoms that they are unaware they have the disease. Similar to the infection rate, the percentage of infected people who develop few to no symptoms is unknown. Those that are asymptomatic are much less likely to be tested for COVID-19 relative to those who show symptoms—resulting in the existence of only limited data for this subset of the infected population. This is especially true when the ability to test for COVID-19 is currently limited, and random sampling of the population cannot be consistently performed. Although some have cited that 40% to 50% of the ultimate number of infected persons will be asymptomatic or have such mild symptoms that they do not seek out medical services, there is not a clear consensus among studies where total populations have been tested (see Table 2).

Table 2: Asymptomatic Rates by Source

Rate	Source (Date of Estimate)	Comments
18%	Centers for Disease Control and Prevention (3/26/20) ⁵	Based on 712 infected persons aboard the Diamond Princess cruise ship
40% - 50%	Imperial College COVID-19 Response Team (3/16/20) ⁴	Unidentified cases, not just asymptomatic. Based on data from China

¹ Institute for Health Metrics and Evaluation (IHME). *United States COVID-19 Hospital Needs and Death Projections*. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), University of Washington, 2020. (4/11/2020), <https://covid19.healthdata.org/united-states-of-america>

² Less than 10% infection rate is not explicitly stated in the projection of bed usage in the United States¹, but was confirmed via correspondence regarding the underlying assumptions on the first wave of infection of COVID-19 in the United States

³ Jonathan Shaw, "Cooperating to Combat Coronavirus." *Harvard Magazine* (2/23/20), <https://harvardmagazine.com/2020/02/fighting-sars-2>

⁴ Neil M. Ferguson, Daniel Laydon, Gemma Nedjati-Gilani, et al. *Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand*. Imperial College London (3/16/2020), <https://doi.org/10.25561/77482>

⁵ Moriarty LF, Plucinski MM, Marston BJ, et al. *Public Health Responses to COVID-19 Outbreaks on Cruise Ships — Worldwide, February–March 2020*. *Morbidity and Mortality Weekly Report* 2020 (3/26/20), doi: <http://dx.doi.org/10.15585/mmwr.mm6912e3>

Rate	Source (Date of Estimate)	Comments
50% - 75%	Sergio Romagnani, professor of clinical immunology at the University of Florence (3/23/20) ⁶	3,000 tested in Vo'Euganeo, Italy
5% - 80%	Centre of Evidence-Based Medicine (4/6/20) ⁷	Compilation of 21 distinct sources in review

For purposes of our scenario testing, we made a simplified assumption that 50% of the ultimate number of COVID-19 cases will be asymptomatic or have mild and unnoticed symptoms.⁸ Applying these rates to the working population, our impact scenarios will focus on 40% (= 50% x 80%) or less of the US working population having notable COVID-19 symptoms and thereby not being able to work to some extent during their illness. Ultimately, the development of symptoms is expected to be heavily influenced by the age⁹ and any associated health conditions¹⁰ of the population. Therefore, caution should be applied when assessing the applicability and reasonability of hypothetical scenarios to specific jurisdictions or occupations.

Severity of COVID-19 Symptoms

To better determine the estimated average cost of wage replacement and medical services for COVID-19 claims, we separate the population of cases with notable symptoms into three distinct symptom groups. The determination of expected fatal benefits will be calculated separately (discussed later).

Symptom Group	Description
Mild	Requires some medical treatment but no hospitalization
Moderate	Requires a hospital stay without the intensive care unit (ICU) or ventilation
Severe	Requires a hospital stay involving the ICU and/or ventilation

Most sources we initially reviewed have cited an overall average hospitalization rate (percentage of infected that require hospitalization) of between 15% and 20% (see Table 3). This initial rate may be biased high, relative to the total infected population, due to an underreporting of less severe cases. However, this is mitigated to the extent that we are focused on cases with notable symptoms in the above scenario range for frequency (infection rate x report rate) of 40% or less. If a 15% hospitalization rate was used, this would imply that up to 6% (=15% x 40%) of the US working population will be hospitalized in part due to COVID-19.

⁶ Day M. Covid-19: identifying and isolating asymptomatic people helped eliminate virus in Italian village. *BMJ* 2020 (3/23/20), <https://www.bmj.com/content/368/bmj.m1165>

⁷ Heneghan C, Brassey J, Jefferson T. *COVID-19: What proportion are asymptomatic*, The Centre for Evidence-Based Medicine. (4/6/2020), <https://www.cebm.net/covid-19/covid-19-what-proportion-are-asymptomatic/>

⁸ This assumption is reflected in the scenario calculations as the Report Rate which equals the complement of those that are symptomatic or have mild and unnoticed symptoms (= 1.0 – 50%)

⁹ *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020*. Morbidity and Mortality Weekly Report. (3/26/2020) doi: <http://dx.doi.org/10.15585/mmwr.mm6912e2>

¹⁰ *Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 — United States, February 12–March 28, 2020*. Morbidity and Mortality Weekly Report. (4/2/2020) doi: <http://dx.doi.org/10.15585/mmwr.mm6913e2>

Table 3: Hospitalization Rates by Source

Rate	Source (Date of Estimate)	Comments
11% or lower	Institute of Health Metrics and Evaluation (4/10/20) ^{1,2}	Implied hospitalization rate based on a less than 10% infection rate and projected hospital admissions in the United States
1% - 17%	Imperial College COVID-19 Response Team (3/16/20) ⁴	Stratified by age based on data from China. Overall weighted average of 7% expected for US age distribution
15% - 20%	FAIR Health (3/25/20) ¹¹	Based on a review of multiple interviews on COVID-19
21% - 31%	Centers for Disease Control and Prevention (3/18/20) ¹²	Based on 4,226 cases in the United States

It should also be noted that the correlation between the severity of symptoms and age could result in a material difference if applied to a population with a different age distribution. Using hospitalization rates by age from the Centers for Disease Control and Prevention (CDC),¹³ weighted together using employee counts by age for 2019 from the US Bureau of Labor Statistics (BLS), we observed only a slight difference in the hospitalization rate (99.6% relativity = adjusted/overall hospitalization rate). However, if the BLS employee counts are further restricted to those 65 years of age or younger, the adjustment begins to show more material differences (84.5% relativity). **In view of differences in age distribution and the lower estimates from more recent studies, we assumed a hospitalization rate of 10% in our scenario testing. It should be noted that this assumption can vary materially when applied to a specific occupation or state due to factors such as different age distributions, prevalence of pre-existing health conditions, or intensity of exposure to the virus.**

To distinguish infected persons who are hospitalized with and without the need for ICU or ventilation, a critical care rate that represents the percentage of admitted hospital cases which will require the use of ICU or ventilation was selected. Most sources we reviewed imply a range of between 10% and 20% (see Table 4). **For the purposes of scenario testing, we assumed an average 15% critical care rate.**

Table 4: Critical Care Rates by Source

Rate	Source (Date of Estimate)	Comments
16%	<i>The New England Journal of Medicine</i> (2/28/20) ¹⁴	Early estimate of severe illness in China
5% – 27%	Imperial College COVID-19 Response Team (3/16/20) ⁴	Stratified by age based on data from China. Overall weighted average of 10% expected for US employee age distribution

¹¹ *The Projected Economic Impact of the COVID-19 Pandemic on the US Healthcare System*. A FAIR Health Brief (3/25/2020), <https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/COVID-19%20-%20The%20Projected%20Economic%20Impact%20of%20the%20COVID-19%20Pandemic%20on%20the%20US%20Healthcare%20System.pdf>

¹² *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020*. Morbidity and mortality Weekly Report (3/18/2020), doi: <http://dx.doi.org/10.15585/mmwr.mm6912e2>

¹³ *Laboratory-Confirmed COVID-19-Associated Hospitalizations Preliminary cumulative rates as of 4/4/2020*. COVID-NET (4/12/2020), https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html

¹⁴ Wei-jie Guan, Ph.D., Zheng-yi Ni, M.D., Yu Hu, M.D., et al. "Clinical Characteristics of Coronavirus Disease 2019 in China." *The New England Journal of Medicine* (2/28/2020), doi: <https://www.nejm.org/doi/full/10.1056/NEJMoa2002032>

Rate	Source (Date of Estimate)	Comments
20%	Institute for Health Metrics and Evaluation (4/10/20) ^{1,2}	Implied based on projected mean of US new ICU/hospital admission projections
20%	Centers for Disease Control and Prevention (3/28/20) ¹⁵	Based on 6,354 cases in the United States

Based on the hospitalization and critical care rates, our scenarios assume the infected population with notable symptoms is comprised as follows:

- 90% (= 1.0 – Hospitalization Rate) with mild symptoms,
- 8.5% (= Hospitalization Rate x [1.0 – Critical Care Rate]) with moderate symptoms, and
- 1.5% (= Hospitalization Rate x Critical Care Rate) with severe symptoms.

Finally, we must consider any additional fatal benefits associated with cases that end in death. Because the fatal rate associated with COVID-19 is usually projected as a percentage of infected, we did not attempt to break this out by symptom group (mild, moderate, and severe). Most sources suggest the fatal rate is less than 2% (see Table 5) despite some initially observed, crude fatal rates that were much higher.¹⁶ This difference is likely due to gaps in reported asymptomatic or very mild symptom cases. **For the purposes of scenario testing, we assumed a fatal rate of 0.5%.**

Table 5: Fatal Rates by Source

Rate	Source (Date of Estimate)	Comments
0.34%	Centers for Disease Control and Prevention (4/10/20) ¹⁷	Empirical cumulative deaths to confirmed and presumptive positive cases
0.37% - 1.97%	Centers for Disease Control and Prevention (3/18/20) ¹²	Weighted age-specific rates using US working population
0.19% - 1.85%	Institute for Health Metrics and Evaluation (4/10/2020) ^{1,2}	Implied based on a less than 10% infection rate (upper bound set at 1%) and mean projected deaths in the United States

Average Indemnity Cost per COVID-19 Claim

Workers who contract COVID-19 are not expected to be able to work due to illness, hospitalization, or self-quarantine, and may be entitled to wage replacement benefits if exposure is determined to be work-related. The average amount of time away from work (i.e., average duration) will depend on the severity of their symptoms. Average durations were assigned to each of our symptom groups (mild, moderate, and severe). These duration estimates were based on figures reported by the WHO,¹⁶ which states that the median time between the onset of COVID-19 symptoms and clinical recovery is approximately two weeks for mild cases and ranges from three to six weeks for severe and critical cases. Accordingly, we have assigned

¹⁵ Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 — United States, February 12–March 28, 2020. Morbidity and Mortality Weekly Report. (4/8/2020) doi: <http://dx.doi.org/10.15585/mmwr.mm6913e2>

¹⁶ WHO-China Joint Mission, Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19), (2/28/20), [https://www.who.int/publications-detail/report-of-the-who-china-joint-mission-on-coronavirus-disease-2019-\(covid-19\)](https://www.who.int/publications-detail/report-of-the-who-china-joint-mission-on-coronavirus-disease-2019-(covid-19))

¹⁷ COVID-19: U.S. At A Glance. CDC Coronavirus 2019 (COVID-19) Cases & Surveillance (4/11/2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html#weekly-surveillance-report>

average durations of two, three, and six weeks for the mild, moderate, and severe symptom groups, respectively. It is important to recognize that the figures reported by the WHO are median durations. To the extent that the mean (average) and median estimates materially differ, which may be more likely for the severe cohort, the resulting scenario impacts would be affected.

It should also be noted that these selections assume that the infected employee is released to work upon reaching clinical recovery. This assumption was made as the criteria that define clinical recovery overlap with the CDC's criteria for discontinuing isolation.¹⁸ While the parallels between the WHO definition of clinical recovery and the CDC isolation guidelines support this assumption, it may understate the actual duration in instances where patients are instructed to self-isolate further after clinical recovery. In addition, certain jobs may lend themselves to a quicker return to work than others (e.g., occupations that allow telecommuting), thereby creating additional differences in the cost of claims across occupations.

For each NCCI state and duration, the expected temporary total disability benefit was estimated to account for each state's unique benefit structure¹⁹ (see Appendix 1 for state-specific information). The expected benefit payments by state were then weighted by reported manual premiums²⁰ and trended to Accident Year 2020 (7/1/2020) to determine an overall estimate (see Table 6). Note that the effect of waiting and retroactive periods results in notably different rates of change between the displayed average durations and wage replacement benefits for the listed cohorts (e.g., moving from two to three weeks more than doubles the average wage replacement benefit).

Table 6: Wage Replacement Benefits per Case

Case	Average Duration	Estimated Average Wage Replacement Benefit
Mild	2 weeks	\$688
Moderate	3 weeks	\$1,403
Severe	6 weeks	\$3,146

In severe cases, COVID-19 may result in permanent impairment (e.g., damage to the lungs, heart, or brain) which may bar workers from returning to their original occupation, particularly in physically demanding jobs. **In these instances, permanent partial or permanent total benefits may apply, but the potential frequency of these scenarios is currently unknown. In addition, the development of a mental illness, either as a direct result of recovering from COVID-19 or solely from exposure to traumatic situations (e.g., healthcare worker or first responder being diagnosed with post-traumatic stress disorder), may lead to an incapacity to work and thereby potentially additional WC benefit costs. Further, any potential liability that may surface related to coverage contained in Part Two-Employers Liability Insurance of the standard WC policy is unknown. Our scenario testing does NOT consider these benefits/costs when estimating the impact to expected losses.**

In addition to wage replacement benefits, some workers may ultimately pass away from COVID-19. To determine the severity of related fatal benefits per claim, we reviewed each state's published ultimate indemnity severity²¹ for fatal claims

¹⁸ *Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings (Interim Guidance)*, CDC Coronavirus Disease 2019 (COVID-19) (4/10/2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>

¹⁹ Differences in benefit structures by state include, but are not limited to, waiting periods, retroactive periods, compensation rates, and average weekly injured worker's wages

²⁰ NCCI Unit Statistical Plan data reported for Policy Year 2017

²¹ Exhibit 11 of NCCI's *Annual Statistical Bulletin*, 2019 Edition, <https://www.ncci.com/ASB#/Year/2019>

and trended these values forward so that they are applicable to claims occurring in Accident Year 2020 (see Appendix 1 for state-specific information). The trended amounts were then weighted by each state’s reported manual premium,²² which produced an overall estimated average indemnity benefit amount of \$344,557 per fatal claim.

It should be noted that claims underlying NCCI’s **Annual Statistical Bulletin (ASB)** may have different characteristics than COVID-19 claims.²³ To the extent that this is true, our estimate could vary. For the purposes of scenario testing, we assumed a benefit amount of \$341,411 (= \$344,557 - \$3,146) was paid in addition to any previously estimated wage replacement benefits for claims that ultimately result in death. Hence, this value assumes all fatal claims are the result of cases with severe symptoms, though this assumption was not material to the analysis.

Average Medical Cost per COVID-19 Claim

The level of medical care and associated costs with treating COVID-19 varies depending on the severity of symptoms. Information from the NCCI Medical Data Call (MDC)²⁴ was used to produce cost estimates for medical services to approximate those costs that may result from treating COVID-19 cases. The following International Classification of Disease Codes were used to identify respiratory distress claims in the MDC:

- J00-J06: Acute upper respiratory infections
- J09-J18: Influenza and pneumonia
- J20-J22: Other acute lower respiratory infections

The applicable respiratory distress claims were then categorized as either with or without hospitalization. Due to the limited number of identified respiratory distress claims requiring hospitalization,²⁵ we did not attempt to develop distinct estimates for the moderate and severe claim symptom groups. The average total medical payment plus case reserve²⁶ for each scenario was trended forward to 2020 using the Chain-Weighted Personal Healthcare Index from the BLS to derive the final medical severity estimates. Based on these calculations, we derived the following severity estimates:

Table 7: MDC Medical Severity Estimate by Case

Case	Level of Medical Care	Estimated Average Medical Benefit Cost
Mild	Medical treatment for respiratory distress, no hospitalization required	\$1,000
Moderate – Severe	Hospital stay for respiratory distress	\$25,500

Because of the limited number of claims underlying the “moderate – severe” medical severity estimate, an alternative calculation was used for comparison based on the average inpatient cost per diem for ALL hospitalized claims from the MDC for Service Year 2018. The average inpatient cost per diem was trended to 2020 and the following assumptions were made by case.

²² NCCI Unit Statistical Plan data reported for Policy Year 2017

²³ For example, a different distribution of dependents or duration of temporary total wage replacement benefits

²⁴ Medical Data Call, all NCCI states, services provided between Calendar Years 2014 and 2018 (i.e., Service Years 2014-2018)

²⁵ Less than 25 respiratory distress claims with associated hospital inpatient costs were reported on the Medical Data Call for Service Years 2014-2018

²⁶ Based on Unit Statistical Plan data for respiratory claims identified in the MDC, to reflect both paid and case reserve amounts

For moderate cases:

- Assume a three-day hospital stay to approximate inpatient costs
- Use the average outpatient emergency room visit cost from the MDC for Service Year 2018, trended to 2020, as a proxy for the nonfacility and outpatient medical costs

For severe cases:

- Assume a seven-day hospital stay to approximate inpatient costs
- Use a multiplicative factor (1.45) to determine total severity from inpatient costs

The 1.45 factor was based on the percentage of inpatient costs-to-total costs for the hospitalized respiratory distress claims previously identified. The derived alternative set of severity estimates for moderate and severe claims is shown in Table 8.

Table 8: Alternative MDC Medical Severity Estimate by Case

Case	Level of Medical Care	Estimated Average Medical Benefit Cost
Moderate	3-day hospital stay with no ICU or ventilation	\$19,000
Severe	7-day hospital stay with ICU or ventilation	\$59,000
Moderate – Severe ²⁷	Hospital stay for respiratory distress	\$25,000

It is important to note that actual COVID-19 medical reimbursements may vary from historical average payments for similar services due to the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which has multiple provisions that differ from the standard Medicare reimbursement rules. In particular, the CARES Act, if applied to WC reimbursement rates, would be expected to increase payments for inpatient facility costs related to COVID-19 by 20%. For this reason, we increased the moderate-to-severe severity estimates by 14% (shown below) based on the share of inpatient costs. Additionally, the severity estimates may vary to the extent that COVID-19 claims result in a different intensity or mix of services, compared with those assumed in these estimates, due to factors such as age, gender, or experimental therapies.

To further validate the reasonableness of the above estimates, we also reviewed those used by FAIR Health,¹¹ which estimated that the average allowed reimbursement amount for commercially-insured patients requiring an inpatient stay was between \$21,936 and \$38,775. **For purposes of scenario testing, we used the MDC estimates (Table 7) and multiplied the moderate-to-severe cases by 1.14, recognizing the CARES Act (mild severity of \$1,000, moderate-to-severe severity of \$29,000).**

²⁷ Based on the weighted average of the moderate and severe estimates using the critical care rate assumption of 15%

Impact to Expected Losses by Scenario

Please note the following when reviewing potential impacts to WC losses for the below specified scenarios:

- Impacts assume **all cases with medical services would result in a compensable WC claim**. The actual percentage of COVID-19 cases that may ultimately be deemed compensable is unknown but is expected to be less than 100%. This parameter is expected to be modified by the user based on their expectations of compensability. **Table 9 highlights the sensitivity of this selection to the resulting scenario impacts.**
- Impacts assume **all cases with mild symptoms receive some medical services**. To the extent that cases with no medical services are found compensable, the illustrated scenario impact may be understated because the report rate assumes these are currently not compensable.
- Impacts assume **no expected losses for permanent partial disability, permanent total disability, or associated mental illnesses**. To the extent that these materially occur, the illustrated scenario impacts may be understated.

The following example calculation, Scenario #1, utilizes a randomly selected infection rate (10%) from the assumed range (less than 80%). A specific infection rate was used to better illustrate the calculation and does not imply that it is more accurate than others in the range. Note that Tables 9 and 10 highlight how the scenario impacts may vary using alternative selections for the infection rate.

Hypothetical Scenario #1—Impact to Expected Losses

Row Description	Scenario Assumption
(1) Infection Rate	10%
(2) Report Rate	50%
(3) Hospitalization Rate	10%
(4) Critical Care Rate	15%
(5) Fatal Rate	0.5%
(6) Average Fatal Indemnity Benefit	\$341,411
(7) Average Salary ¹	\$50,258
(8) Pure Premium Factor ²	0.74

Row Description	Symptom Type			Overall ³
	Mild	Moderate	Severe	
(9) COVID-19 Claim Frequency	4.5%	0.425%	0.075%	5%
(10) Compensability Rate	100%	100%	100%	100%
(11) Wage Replacement Severity	\$688	\$1,403	\$3,146	\$786
(12) Medical Severity	\$1,000	\$29,000	\$29,000	\$3,800
(13) Nonfatal Total Severity = (11) + (12)	\$1,688	\$30,403	\$32,146	\$4,586

Row Description	Estimate	
(14) Sample Workforce Population ⁴	100,000	
(15) Expected Payroll	\$5,026M	= (14) x (7)
(16) COVID-19 Total Severity	\$6,293	= (13) Overall + (6) x (5)
(17) COVID-19 Expected Losses	\$31.5M	= (14) x (9) Overall x (10) x (16)
(18) Current Expected Losses	\$37.2M	= (15) / 100 x (8)
(19) Scenario Expected Losses	\$68.7M	= (17) + (18)
(20) Scenario Impact	85%	= (19) / (18) - 1.0

Displayed values not shown to full precision

¹Annual mean wage through May 2019 from the US Bureau of Labor Statistics for all occupations in NCCI states

²Weighted average of the underlying pure premium factor in each approved loss cost/rate across NCCI states

³Overall (10) – (13) derived as the weighted average of the Mild/Moderate/Severe symptom values

⁴This has no effect on the calculation of the impact (%); it is used only to provide dollar amounts for rows (15), (17) – (19)

As noted in Row (10) of the Scenario #1 calculation, all reported cases were assumed to be compensable under the WC system. This serves as a placeholder estimate because the actual percentage is unknown. The selection of this percentage for a specific jurisdiction or occupation should take into consideration the expected likelihood of compensability under the WC system.

To provide a more complete picture, the assumptions under **Scenario #1** will remain fixed, except that both the infection rate and compensability rate are varied. Doing this results in the following impacts to expected losses:

Table 9: Overall WC Loss Impacts by Infection and Compensability Rate

Impact to Expected Losses	Compensability Rate				
	20%	40%	60%	80%	100%
1%	2%	3%	5%	7%	8%
2%	3%	7%	10%	14%	17%
3%	5%	10%	15%	20%	25%
4%	7%	14%	20%	27%	34%
5%	8%	17%	25%	34%	42%
10%	17%	34%	51%	68%	85%
15%	25%	51%	76%	102%	127%
20%	34%	68%	102%	135%	169%
30%	51%	102%	152%	203%	254%
40%	68%	135%	203%	271%	338%
50%	85%	169%	254%	338%	423%
60%	102%	203%	305%	406%	508%
70%	118%	237%	355%	474%	592%
80%	135%	271%	406%	541%	677%

Another primary source of uncertainty is the assumption of the fatal rate. Varying the infection rate and fatal rate, while maintaining the assumptions in **Scenario #1**, we observe the following impacts to expected losses:

Table 10: Overall WC Loss Impacts by Infection and Fatal Rate

Impact to Expected Losses	Fatal Rate					
	0.25%	0.50%	0.75%	1.00%	1.25%	1.50%
1%	7%	8%	10%	11%	12%	13%
2%	15%	17%	19%	22%	24%	26%
3%	22%	25%	29%	32%	36%	39%
4%	29%	34%	38%	43%	48%	52%
5%	37%	42%	48%	54%	60%	65%
10%	73%	85%	96%	108%	119%	130%
15%	110%	127%	144%	161%	179%	196%
20%	146%	169%	192%	215%	238%	261%
30%	219%	254%	288%	323%	357%	391%
40%	292%	338%	384%	430%	476%	522%
50%	366%	423%	480%	538%	595%	652%
60%	439%	508%	576%	645%	714%	783%
70%	512%	592%	673%	753%	833%	913%
80%	585%	677%	769%	860%	952%	1044%

It should be noted that the percentages shown in both Table 9 and Table 10 reflect the impact to expected losses due to the first wave of COVID-19 in Accident Year 2020. There is currently too much uncertainty to know how subsequent virus seasons could impact the US population due to the potential development of a vaccine or reinfection rates. Hence, the impacts shown here are specific to Accident Year 2020; it is unclear if subsequent years will have similar impacts.

So far, the scenario testing has provided an illustration of the possible impact of COVID-19 on WC losses for the combined 38 states in which NCCI provides ratemaking services. **We now consider applying a similar calculation to a specific state in Scenario #2.** Doing so requires reassessment of the scenario assumptions. Please see Appendix 1 for a list of known parameter differences by state. In addition to those listed in Appendix 1, some other considerations when determining the reasonability of scenario assumptions likely include:

- **Age distribution and frequency of pre-existing health conditions** in the state. This may impact the report, hospitalization, critical care, and fatal rates assumed in the scenario.
- **Population density of the state and implementation of social distancing or isolation** policies. This may impact the infection rate of the disease.
- **Statutes related to compensability** may impact the likelihood of claims being found compensable, particularly in cases where the infected self-isolates with no hospitalization, which is expected to constitute most of infection cases. Again, the below impacts assume all cases with medical services result in a compensable WC claim. This parameter is expected to be modified by the user based on their expectations of compensability for COVID-19 cases in the state being analyzed.

Hypothetical Scenario #2—Alabama—Impact to Expected Losses

Assumption Changes From Scenario #1 Are **Bolded**

Row Description	Scenario Assumption
(1) Infection Rate	10%
(2) Report Rate	50%
(3) Hospitalization Rate	10%
(4) Critical Care Rate	15%
(5) Fatal Rate	0.5%
(6) Average Fatal Indemnity Benefit	\$139,981
(7) Average Salary¹	\$44,930
(8) Pure Premium Factor²	0.88

Row Description	Symptom Type			Overall ³
	Mild	Moderate	Severe	
(9) COVID-19 Claim Frequency	4.5%	0.425%	0.075%	5%
(10) Compensability Rate	100%	100%	100%	100%
(11) Wage Replacement Severity	\$754	\$1,234	\$2,880	\$827
(12) Medical Severity⁴	\$640	\$32,770	\$32,770	\$3,853
(13) Nonfatal Total Severity = (11) + (12)	\$1,394	\$34,004	\$35,650	\$4,680

Row Description	Estimate	
(14) Workforce Population	1,974,170	
(15) Expected Payroll	\$88,699M	= (14) x (7)
(16) COVID-19 Total Severity	\$5,380	= (13) Overall + (6) x (5)
(17) COVID-19 Expected Losses	\$531.0M	= (14) x (9) Overall x (10) x (16)
(18) Current Expected Losses	\$780.6M	= (15) / 100 x (8)
(19) Scenario Expected Losses	\$1311.6M	= (17) + (18)
(20) Scenario Impact	68%	= (19) / (18) - 1.0

Displayed values not shown to full precision

¹Annual mean wage through May 2019 from the US Bureau of Labor Statistics for all occupations by state

²Underlying pure premium factor from latest approved NCCI loss cost/rate filing

³Overall (10) – (13) derived as the weighted average of the Mild/Moderate/Severe symptom values

⁴(Scenario #1 severity estimate) x (Appendix A-I medical relativity)

Extending the **Scenario #2** calculation, NCCI used the values found in Appendix 1 to determine the impact by state and infection rate. This results in the following impacts to expected losses:

**Table 11: WC Loss Impact by State and Infection Rate
Where Compensability Rate = 100%**

Impact to Expected Losses	Infection Rate										
	1%	2%	3%	4%	5%	10%	15%	20%	30%	40%	50%
Alabama	7%	14%	20%	27%	34%	68%	102%	136%	204%	272%	340%
Alaska	6%	12%	18%	23%	29%	59%	88%	117%	176%	234%	293%
Arizona	13%	25%	38%	50%	63%	126%	189%	252%	378%	505%	631%
Arkansas	8%	17%	25%	34%	42%	85%	127%	170%	255%	340%	425%
Colorado	8%	16%	24%	32%	40%	80%	120%	160%	240%	320%	400%
Connecticut	7%	14%	21%	29%	36%	72%	107%	143%	215%	286%	358%
District of Columbia	15%	31%	46%	62%	77%	154%	231%	308%	462%	617%	771%
Florida	7%	14%	21%	28%	35%	69%	104%	138%	208%	277%	346%
Georgia	6%	12%	18%	24%	30%	59%	89%	119%	178%	237%	297%
Hawaii	4%	8%	12%	16%	20%	39%	59%	78%	118%	157%	196%
Idaho	5%	11%	16%	22%	27%	54%	81%	108%	161%	215%	269%
Illinois	7%	14%	21%	28%	34%	69%	103%	138%	207%	276%	345%
Indiana	9%	18%	26%	35%	44%	88%	132%	176%	264%	352%	440%
Iowa	8%	16%	24%	32%	40%	80%	120%	160%	240%	320%	400%
Kansas	9%	17%	26%	35%	43%	87%	130%	173%	260%	347%	433%
Kentucky	6%	12%	18%	24%	31%	61%	92%	122%	183%	244%	306%
Louisiana	4%	8%	12%	16%	20%	40%	59%	79%	119%	159%	198%
Maine	5%	10%	15%	20%	25%	50%	76%	101%	151%	202%	252%
Maryland	7%	13%	20%	26%	33%	66%	99%	132%	197%	263%	329%
Mississippi	6%	12%	17%	23%	29%	58%	87%	116%	174%	232%	290%
Missouri	7%	15%	22%	30%	37%	74%	111%	148%	222%	295%	369%
Montana	4%	9%	13%	18%	22%	45%	67%	90%	135%	180%	225%
Nebraska	7%	15%	22%	30%	37%	75%	112%	149%	224%	299%	373%
Nevada	8%	15%	23%	30%	38%	75%	113%	151%	226%	302%	377%
New Hampshire	14%	28%	42%	56%	70%	139%	209%	279%	418%	558%	697%
New Mexico	5%	10%	15%	20%	26%	51%	77%	102%	154%	205%	256%
North Carolina	8%	16%	24%	32%	40%	80%	120%	161%	241%	321%	401%
Oklahoma	7%	14%	21%	28%	35%	70%	106%	141%	211%	282%	352%
Oregon	9%	19%	28%	37%	46%	93%	139%	186%	278%	371%	464%
Rhode Island	6%	12%	18%	23%	29%	59%	88%	117%	176%	235%	293%
South Carolina	5%	10%	15%	20%	25%	50%	76%	101%	151%	202%	252%
South Dakota	7%	14%	21%	28%	35%	71%	106%	142%	213%	284%	355%
Tennessee	9%	18%	27%	36%	45%	90%	134%	179%	269%	359%	448%
Texas	25%	49%	74%	98%	123%	245%	368%	491%	736%	981%	1227%

Impact to Expected Losses	Infection Rate										
	1%	2%	3%	4%	5%	10%	15%	20%	30%	40%	50%
Utah	14%	27%	41%	54%	68%	136%	203%	271%	407%	543%	678%
Vermont	5%	10%	16%	21%	26%	52%	78%	104%	156%	209%	261%
Virginia	8%	17%	25%	33%	41%	83%	124%	166%	249%	332%	415%
West Virginia	12%	25%	37%	49%	62%	124%	185%	247%	371%	495%	618%
Overall	8%	17%	25%	34%	42%	85%	127%	169%	254%	338%	423%

The impacts shown by state in Table 11 serve only as a baseline scenario estimate, as it assumes all COVID-19 cases will result in a compensable WC claim and ignores any differences in scenario assumptions not otherwise listed in Appendix 1. It is expected that further refinement of assumptions would be required to get a true picture of the impact when focused on a specific state. For example, a compensability rate of less than 100% can be incorporated by multiplying the impact(s) shown in Table 11 by the selected compensability rate. Similar adjustments to alter the compensability rate can be used for all the baseline scenario estimates (Tables 10 to 13).

In Scenarios #3 and #4, we begin to focus on first responders²⁸ and healthcare workers²⁹ since some states have looked to broaden compensability standards for these occupations amid the COVID-19 crisis. A new set of scenario assumptions can be found in Appendix 2 (first responders) and Appendix 3 (healthcare workers). These assumptions only adjust for some of the many differences between all occupations combined and these specific occupations. It should be noted that our adjustment to calculate fatal and wage replacement benefits used the relative average wages as a multiplicative factor. To the extent that first responders or healthcare workers reach the maximum/minimum benefits in place for various states, adjustments to the resulting scenario impacts may be warranted. Additionally, other considerations when applying this calculation to specific occupations likely include:

- **Age distribution or frequency of pre-existing health conditions** in the occupation. These factors would be expected to impact the severity of symptoms.
- **Amount of exposure to the public.** This may impact the infection rate of the disease. Additionally, some published literature has suggested that the potential for extended exposure to COVID-19 also impacts the severity of symptoms.
- **Nonstandard self-isolation guidelines.** This could vary the expected time for return to work.
- **Statutes related to compensability** for specific occupations, if they exist, such as first responders or healthcare workers. This may impact the likelihood of claims being found compensable.

Please note that the calculated impacts are specific to the expected losses for the associated occupations and NOT overall state expected losses.

²⁸ For the purposes of scenario testing, we assumed this group was made up of firefighter (7704, 7710, 7711) and police (7720) classifications

²⁹ For the purposes of scenario testing, we assumed this group was made up of the three largest healthcare-related (8832, 8833, 8835) classifications

Hypothetical Scenario #3—Alabama—First Responders Impact to Expected Losses

Assumption Changes From Scenario #2 Are **Bolded**

Row Description	Scenario Assumption
(1) Infection Rate	10%
(2) Report Rate	50%
(3) Hospitalization Rate	10%
(4) Critical Care Rate	15%
(5) Fatal Rate	0.5%
(6) Average Fatal Indemnity Benefit	\$146,980
(7) Average Salary¹	\$47,175
(8) Pure Premium Factor²	1.93

Row Description	Symptom Type			Overall ³
	Mild	Moderate	Severe	
(9) COVID-19 Claim Frequency	4.5%	0.425%	0.075%	5%
	$= (1) \times (2) \times [1.0 - (3)]$	$= (1) \times (2) \times (3) \times [1.0 - (4)]$	$= (1) \times (2) \times (3) \times (4)$	$= (1) \times (2)$
(10) Compensability Rate	100%	100%	100%	100%
(11) Wage Replacement Severity	\$792	\$1,296	\$3,024	\$868
(12) Medical Severity	\$640	\$32,770	\$32,770	\$3,853
(13) Nonfatal Total Severity	\$1,432	\$34,066	\$35,794	\$4,721
	$= (11) + (12)$			

Row Description	Estimate	
(14) Workforce Population	27,070	
(15) Expected Payroll	\$1,277M	$= (14) \times (7)$
(16) COVID-19 Total Severity	\$5,456	$= (13) \text{ Overall} + (6) \times (5)$
(17) COVID-19 Expected Losses ⁴	\$7.4M	$= (14) \times (9) \text{ Overall} \times (10) \times (16)$
(18) Current Expected Losses ⁴	\$24.6M	$= (15) / 100 \times (8)$
(19) Scenario Expected Losses ⁴	\$32.0M	$= (17) + (18)$
(20) Scenario Impact ⁴	30%	$= (19) / (18) - 1.0$

Displayed values not shown to full precision

¹Annual mean wage through May 2019 from the US Bureau of Labor Statistics for a subset of "Protective Service Occupations" by state (occupation codes 33-1011, 33-1012, 33-1021, 33-1090, 33-2011, 33-2021, 33-2022, 33-3011, 33-3012, 33-3021, 33-3031, 33-3051, 33-9021, 33-3052)

²Weighted average pure premium factor in each approved loss cost/rate filing as of 4/10/2020 for the firefighter (7704, 7710, 7711) and police (7720) classifications

³Overall (10) – (13) derived as the weighted average of the Mild/Moderate/Severe symptom values

⁴Estimate for associated occupations, NOT the overall state

Hypothetical Scenario #4—Alabama—Healthcare Workers Impact to Expected Losses

Assumption Changes From Scenario #2 Are **Bolded**

Row Description	Scenario Assumption
(1) Infection Rate	10%
(2) Report Rate	50%
(3) Hospitalization Rate	10%
(4) Critical Care Rate	15%
(5) Fatal Rate	0.5%
(6) Average Fatal Indemnity Benefit	\$166,577
(7) Average Salary¹	\$53,602
(8) Pure Premium Factor²	0.52

Row Description	Symptom Type			Overall ³
	Mild	Moderate	Severe	
(9) COVID-19 Claim Frequency	4.5%	0.425%	0.075%	5%
	= (1) x (2) x [1.0 - (3)]	= (1) x (2) x (3) x [1.0 - (4)]	= (1) x (2) x (3) x (4)	= (1) x (2)
(10) Compensability Rate	100%	100%	100%	100%
(11) Wage Replacement Severity	\$897	\$1,468	\$3,427	\$983
(12) Medical Severity	\$640	\$32,770	\$32,770	\$3,853
(13) Nonfatal Total Severity	\$1,537	\$34,238	\$36,197	\$4,836
	= (11) + (12)			

Row Description	Estimate	
(14) Workforce Population	197,750	
(15) Expected Payroll	\$10,600M	= (14) x (7)
(16) COVID-19 Total Severity	\$5,669	= (13) Overall + (6) x (5)
(17) COVID-19 Expected Losses ⁴	\$56.1M	= (14) x (9) Overall x (10) x (16)
(18) Current Expected Losses ⁴	\$55.1M	= (15) / 100 x (8)
(19) Scenario Expected Losses ⁴	\$111.2M	= (17) + (18)
(20) Scenario Impact ⁴	102%	= (19) / (18) - 1.0

Displayed values not shown to full precision

¹Annual mean wage through May 2019 from the US Bureau of Labor Statistics for "Healthcare Practitioners and Technical Occupations" and "Healthcare Support Occupations" by state

²Weighted average pure premium factor in each approved loss cost/rate filing as of 4/10/2020 for the largest healthcare-related (8832, 8833, 8835) classifications

³Overall (10) – (13) derived as the weighted average of the Mild/Moderate/Severe symptom values

⁴Estimate for associated occupations, NOT the overall state

The differences in impact between Scenario #2 (68%), Scenario #3 (30%), and Scenario #4 (102%) are not due to significant differences in the COVID-19 expected losses per worker (because we assumed the same infection rates). The primary difference is the current expected losses (determined by the pure premium factor) per worker in each occupation. This means that riskier classifications (relative to their payroll) will observe less of a percentage impact to their expected losses because the base (current expected losses) is larger.

Extending the **Scenario #3** calculation, we use the values found in Appendix 2 to determine the impact by state and infection rate. This results in the following impacts to expected losses for first responders:

Table 12: First Responder WC Loss Impacts by State and Infection Rate

Impact to Expected Losses	Infection Rate										
	1%	2%	3%	4%	5%	10%	15%	20%	30%	40%	50%
Alabama	3%	6%	9%	12%	15%	30%	45%	60%	90%	120%	150%
Alaska	3%	5%	8%	11%	13%	27%	40%	53%	80%	106%	133%
Arizona	4%	9%	13%	18%	22%	44%	67%	89%	133%	177%	222%
Arkansas	6%	11%	17%	22%	28%	56%	84%	112%	168%	224%	280%
Colorado	3%	5%	8%	10%	13%	26%	39%	52%	79%	105%	131%
Connecticut	2%	3%	5%	7%	8%	16%	25%	33%	49%	65%	82%
District of Columbia	4%	8%	12%	16%	20%	40%	60%	80%	119%	159%	199%
Florida	2%	5%	7%	9%	12%	23%	35%	47%	70%	93%	117%
Georgia	3%	6%	9%	12%	14%	29%	43%	58%	87%	116%	145%
Hawaii	2%	4%	6%	8%	10%	19%	29%	38%	57%	77%	96%
Idaho	3%	6%	9%	12%	15%	31%	46%	61%	92%	123%	153%
Illinois	4%	7%	11%	15%	19%	37%	56%	75%	112%	149%	186%
Indiana	4%	9%	13%	17%	22%	43%	65%	87%	130%	174%	217%
Iowa	3%	5%	8%	10%	13%	26%	39%	52%	78%	104%	131%
Kansas	4%	8%	12%	16%	20%	41%	61%	81%	122%	162%	203%
Kentucky	3%	7%	10%	13%	16%	33%	49%	65%	98%	130%	163%
Louisiana	2%	3%	5%	7%	9%	17%	26%	35%	52%	70%	87%
Maine	2%	5%	7%	10%	12%	24%	36%	48%	72%	96%	120%
Maryland	2%	4%	6%	8%	10%	20%	30%	39%	59%	79%	98%
Mississippi	4%	8%	12%	16%	20%	40%	60%	80%	119%	159%	199%
Missouri	3%	6%	8%	11%	14%	28%	41%	55%	83%	111%	138%
Montana	2%	5%	7%	10%	12%	25%	37%	50%	75%	100%	125%
Nebraska	3%	6%	9%	12%	15%	29%	44%	59%	88%	118%	147%
Nevada	2%	4%	7%	9%	11%	22%	33%	44%	66%	87%	109%
New Hampshire	6%	12%	19%	25%	31%	62%	93%	124%	185%	247%	309%
New Mexico	3%	7%	10%	14%	17%	35%	52%	69%	104%	138%	173%
North Carolina	4%	8%	11%	15%	19%	38%	57%	76%	114%	152%	189%
Oklahoma	3%	5%	8%	11%	13%	27%	40%	54%	81%	108%	135%
Oregon	3%	6%	10%	13%	16%	32%	49%	65%	97%	130%	162%
Rhode Island	2%	5%	7%	10%	12%	24%	36%	49%	73%	97%	122%

Impact to Expected Losses	Infection Rate										
	1%	2%	3%	4%	5%	10%	15%	20%	30%	40%	50%
South Carolina	3%	6%	9%	12%	15%	30%	45%	60%	91%	121%	151%
South Dakota	3%	6%	9%	13%	16%	31%	47%	63%	94%	125%	157%
Tennessee	4%	8%	12%	17%	21%	42%	62%	83%	125%	166%	208%
Texas	10%	21%	31%	41%	52%	104%	156%	207%	311%	415%	519%
Utah	6%	11%	17%	22%	28%	56%	84%	111%	167%	223%	278%
Vermont	2%	4%	5%	7%	9%	18%	27%	36%	54%	72%	90%
Virginia	3%	6%	9%	12%	15%	29%	44%	58%	88%	117%	146%
West Virginia	6%	12%	18%	23%	29%	58%	88%	117%	175%	234%	292%
Overall	3%	7%	10%	14%	17%	34%	51%	68%	102%	136%	170%

Extending the **Scenario #4** calculation, we use the values found in Appendix 3 to determine the impact by state and infection rate. This results in the following impacts to expected losses for healthcare workers:

Table 13: Healthcare Workers WC Loss Impacts by State and Infection Rate

Impact to Expected Losses	Infection Rate										
	1%	2%	3%	4%	5%	10%	15%	20%	30%	40%	50%
Alabama	10%	20%	31%	41%	51%	102%	153%	203%	305%	407%	508%
Alaska	10%	20%	30%	40%	50%	100%	150%	200%	300%	401%	501%
Arizona	22%	45%	67%	90%	112%	224%	336%	448%	672%	895%	1119%
Arkansas	17%	34%	51%	69%	86%	171%	257%	343%	514%	686%	857%
Colorado	11%	23%	34%	45%	57%	113%	170%	226%	339%	452%	565%
Connecticut	10%	20%	30%	40%	50%	100%	150%	201%	301%	401%	501%
District of Columbia	12%	23%	35%	47%	59%	117%	176%	235%	352%	470%	587%
Florida	12%	25%	37%	50%	62%	124%	187%	249%	373%	498%	622%
Georgia	11%	21%	32%	43%	53%	106%	160%	213%	319%	426%	532%
Hawaii	7%	15%	22%	30%	37%	74%	111%	148%	221%	295%	369%
Idaho	11%	21%	32%	42%	53%	106%	158%	211%	317%	422%	528%
Illinois	15%	31%	46%	61%	77%	153%	230%	307%	460%	613%	766%
Indiana	18%	36%	54%	72%	90%	179%	269%	358%	537%	716%	895%
Iowa	19%	39%	58%	78%	97%	194%	291%	388%	582%	776%	970%
Kansas	21%	42%	63%	84%	105%	209%	314%	419%	628%	838%	1047%
Kentucky	14%	27%	41%	55%	68%	137%	205%	273%	410%	547%	683%
Louisiana	8%	16%	24%	32%	41%	81%	122%	162%	244%	325%	406%
Maine	8%	16%	25%	33%	41%	82%	123%	164%	245%	327%	409%
Maryland	15%	30%	45%	60%	75%	151%	226%	301%	452%	602%	753%
Mississippi	12%	24%	36%	48%	60%	120%	180%	240%	360%	480%	600%
Missouri	13%	26%	39%	52%	65%	129%	194%	258%	387%	516%	645%
Montana	8%	16%	24%	32%	40%	80%	121%	161%	241%	322%	402%
Nebraska	16%	32%	49%	65%	81%	162%	243%	323%	485%	647%	809%

Impact to Expected Losses	Infection Rate										
	1%	2%	3%	4%	5%	10%	15%	20%	30%	40%	50%
Nevada	17%	33%	50%	66%	83%	165%	248%	330%	496%	661%	826%
New Hampshire	18%	36%	54%	72%	90%	181%	271%	361%	542%	722%	903%
New Mexico	11%	22%	32%	43%	54%	108%	162%	216%	324%	432%	540%
North Carolina	14%	28%	42%	56%	69%	139%	208%	278%	417%	555%	694%
Oklahoma	13%	26%	39%	52%	65%	130%	195%	260%	389%	519%	649%
Oregon	18%	36%	53%	71%	89%	178%	267%	356%	533%	711%	889%
Rhode Island	9%	17%	26%	34%	43%	86%	128%	171%	257%	342%	428%
South Carolina	10%	20%	30%	40%	50%	100%	150%	200%	300%	400%	500%
South Dakota	19%	38%	57%	76%	95%	189%	284%	379%	568%	758%	947%
Tennessee	17%	34%	50%	67%	84%	168%	251%	335%	503%	670%	838%
Texas	65%	129%	194%	259%	324%	647%	971%	1295%	1942%	2590%	3237%
Utah	28%	57%	85%	114%	142%	284%	426%	569%	853%	1137%	1421%
Vermont	8%	15%	23%	31%	38%	76%	114%	153%	229%	305%	381%
Virginia	13%	27%	40%	54%	67%	134%	201%	268%	402%	535%	669%
West Virginia	29%	57%	86%	115%	144%	287%	431%	574%	862%	1149%	1436%
Overall	16%	32%	47%	63%	79%	158%	237%	316%	473%	631%	789%

The impacts shown above by state (Tables 12 and 13) serve as a baseline-scenario estimate for first responders and healthcare workers, as they assume all symptomatic COVID-19 cases for these occupations will result in a compensable WC claim.

An initial look at a broader group of occupations that may be considered essential during the initial wave of infection suggests between 49 million and 62 million individuals in the workforce (33% to 42%) could potentially qualify.³⁰ To the extent that the essential workers’ share of the workforce is comparable to their share of statewide expected losses, the corresponding scenario estimate of expected losses related to COVID-19 for these occupations would be between 33% and 42% of the estimate for all workers in the applicable jurisdiction.

³⁰ Adie Tomer and Joseph Kane. *How to protect essential workers during COVID-19*. Brookings (3/31/2020). <https://www.brookings.edu/research/how-to-protect-essential-workers-during-covid-19/>

Summary

There is a substantial amount of uncertainty when determining the ultimate impact of COVID-19 on WC expected losses either on a national, state, or occupation-specific level. Depending on the number of infected workers, severity of symptoms, and compensability standards, the degree of variation in estimated impacts may be extreme. However, there is a reasonable likelihood for COVID-19 to result in significant WC claim costs during Accident Year 2020.

Additional Considerations

As it relates to loss costs/rates, ratemaking itself is prospective in nature. If a vaccine becomes available or negligible cases of reinfection occur, it may be more predictive to use historical premium and loss experience not impacted by COVID-19 in the prospective ratemaking process. However, if such exposures persist going forward, as well as occupation-specific presumptions regarding compensability, then COVID-19-related experience would need to be reflected accordingly in future loss costs and/or rate filings. It is therefore extremely important to continue monitoring this exposure to determine how best to estimate future losses. At the same time, other factors resulting from the COVID-19 crisis, such as the increased usage of telecommuting and longer-term effects to the economy, may also have significant, potentially offsetting, impacts to the WC system.

As it relates to proposed COVID-19 legislation, the ultimate impact of any legislation will depend not only on the various assumptions discussed here but also on differences between current and proposed handling of COVID-19 claims in the associated context. The scenario testing included in this document serves to provide insight into the potential impact to expected losses for such claims.

Appendix 1: Scenario Inputs by State

State	Employee Count ¹	Average Salary ¹	Pure Premium Factor ²	Fatal Claim Severity ³	Wage Replacement Benefits			Medical Severity Relativity	
					Mild 2 Weeks	Moderate 3 Weeks	Severe 6 Weeks	Mild ⁴	Moderate to Severe ⁵
Alabama	1,974,170	44,930	0.88	139,981	754	1,234	2,880	0.64	1.13
Alaska	317,090	59,290	1.22	388,774	899	1,472	3,434	1.72	1.38
Arizona	2,866,820	50,930	0.62	551,071	511	1,533	3,067	1.12	1.23
Arkansas	1,217,420	42,690	0.51	132,643	412	1,442	2,884	0.81	0.61
Colorado	2,678,490	57,690	0.66	362,848	827	1,578	3,157	1.01	0.84
Connecticut	1,665,100	62,350	0.77	285,089	1,014	1,521	3,042	1.07	1.17
District of Columbia	723,510	89,800	0.28	716,315	1,074	2,051	4,101	0.88	0.75
Florida	8,794,050	47,750	0.90	121,118	505	1,010	3,030	0.74	1.41
Georgia	4,471,860	49,620	0.89	183,836	451	902	2,706	1.00	1.00
Hawaii	635,500	54,930	1.28	130,646	775	1,268	2,748	0.98	1.08
Idaho	727,160	44,890	1.35	163,026	624	1,456	2,912	1.31	1.31
Illinois	6,025,790	55,130	0.88	349,445	884	1,688	3,375	0.75	1.13
Indiana	3,073,680	46,770	0.61	150,992	516	1,032	3,096	1.11	0.92
Iowa	1,549,460	47,330	1.16	718,363	856	1,634	3,268	1.12	1.11
Kansas	1,392,480	46,520	0.68	212,639	449	898	2,694	0.98	1.04
Kentucky	1,896,900	44,020	0.77	274,346	525	1,575	3,150	0.87	0.46
Louisiana	1,921,950	44,170	1.15	230,650	930	1,395	2,790	0.67	0.44
Maine	611,170	48,470	1.09	138,702	518	1,554	3,109	1.15	1.02
Maryland	2,701,010	60,230	0.64	228,517	942	1,799	3,597	0.94	0.70
Mississippi	1,128,280	40,090	0.89	93,024	767	1,151	2,301	0.82	0.73
Missouri	2,820,610	47,820	0.97	335,058	796	1,521	3,041	1.12	1.13
Montana	468,000	45,370	1.33	248,142	674	1,146	2,831	1.24	0.80
Nebraska	982,040	48,250	0.88	372,394	511	1,023	3,068	0.90	1.06
Nevada	1,392,680	47,210	1.24	1,090,762	990	1,485	2,969	0.84	0.54
New Hampshire	660,480	53,950	0.64	502,557	1,124	1,686	3,372	1.48	1.58
New Mexico	823,570	47,040	1.01	306,413	500	1,001	3,002	1.00	0.64
North Carolina	4,462,800	48,550	0.61	256,392	519	1,038	3,114	0.87	0.72
Oklahoma	1,617,390	45,620	1.10	520,865	851	1,393	3,019	0.83	0.96
Oregon	1,905,860	53,890	0.77	675,823	858	1,639	3,278	1.38	0.73
Rhode Island	483,580	57,220	0.78	368,738	816	1,336	2,895	0.88	0.59
South Carolina	2,107,760	44,380	1.06	195,312	494	1,482	2,963	0.83	0.83
South Dakota	425,140	42,920	1.04	330,753	1,044	1,565	3,131	0.70	1.01
Tennessee	3,007,710	45,650	0.60	205,003	519	1,557	3,113	0.86	0.85
Texas	12,431,200	50,490	0.33	723,912	607	1,820	3,639	1.00	1.00
Utah	1,504,070	49,420	0.53	275,278	898	1,715	3,429	0.90	1.35
Vermont	306,300	51,120	1.24	393,207	1,183	1,775	3,550	0.66	0.96
Virginia	3,878,770	56,740	0.62	196,532	532	1,064	3,192	1.00	1.15
West Virginia	702,100	43,420	0.58	508,291	1,098	1,646	3,293	0.79	0.62
Countrywide ⁶	86,351,950	50,258	0.74	341,411	688	1,403	3,146	1.00	1.00

¹ US Bureau of Labor Statistics for all occupations by state

² Underlying pure premium factor in each approved loss cost/rate filing as of 4/10/2020

³ NCCI's Exhibit 11, *Annual Statistical Bulletin*, 2019 Edition. Average of 1st through 3rd reports, trended to 2020, less the severe case duration wage replacement benefit

⁴ State to Countrywide average amount paid per transaction for physician's CPT Code 99213 from NCCI's Medical Data Call, Service Year 2018 (Not Available for Texas)

⁵ State to Countrywide average amount paid per day for hospital inpatient services from NCCI's Medical Data Call, Service Year 2018 (Not Available for Texas)

⁶ Countrywide estimate for all figures, except medical relativities, reflect a weighted average of NCCI states shown on this exhibit

Appendix 2: Scenario Inputs by State for First Responders

State	Employee Count ¹	% of Total Employees	Average Salary ¹	Pure Premium Factor ²	Fatal Claim Severity ³	Wage Replacement Benefits ³		
						Mild 2 Weeks	Moderate 3 Weeks	Severe 6 Weeks
Alabama	27,070	1.4%	47,175	1.93	146,980	792	1,296	3,024
Alaska	4,420	1.4%	75,346	2.32	493,743	1,142	1,869	4,361
Arizona	46,550	1.6%	60,072	1.61	650,264	603	1,809	3,619
Arkansas	18,970	1.6%	41,990	0.78	129,990	404	1,413	2,826
Colorado	30,840	1.2%	68,465	1.84	431,789	984	1,878	3,757
Connecticut	19,280	1.2%	72,149	3.08	330,703	1,176	1,764	3,529
District of Columbia	7,940	1.1%	81,355	1.13	651,847	977	1,866	3,732
Florida	129,190	1.5%	56,690	2.33	144,130	601	1,202	3,606
Georgia	70,410	1.6%	46,287	1.92	170,967	419	839	2,517
Hawaii	8,010	1.3%	75,418	2.10	178,985	1,062	1,737	3,765
Idaho	8,630	1.2%	50,750	2.16	184,219	705	1,645	3,291
Illinois	82,270	1.4%	72,200	1.40	457,773	1,158	2,211	4,421
Indiana	35,500	1.2%	51,725	1.15	167,601	573	1,146	3,437
Iowa	13,490	0.9%	58,058	3.24	883,586	1,053	2,010	4,020
Kansas	18,560	1.3%	49,112	1.40	225,397	476	952	2,856
Kentucky	23,310	1.2%	43,370	1.46	271,603	520	1,559	3,119
Louisiana	35,290	1.8%	42,920	2.65	223,731	902	1,353	2,706
Maine	7,400	1.2%	51,300	2.20	147,024	549	1,647	3,296
Maryland	35,880	1.3%	69,658	1.98	265,080	1,093	2,087	4,173
Mississippi	20,330	1.8%	38,002	1.35	88,373	729	1,093	2,186
Missouri	37,470	1.3%	51,496	2.48	361,863	860	1,643	3,284
Montana	5,170	1.1%	56,309	2.10	307,696	836	1,421	3,510
Nebraska	9,500	1.0%	55,470	2.05	428,253	588	1,176	3,528
Nevada	15,260	1.1%	71,757	3.90	1,657,958	1,505	2,257	4,513
New Hampshire	8,510	1.3%	57,378	1.39	532,710	1,191	1,787	3,574
New Mexico	15,480	1.9%	50,680	1.44	330,926	540	1,081	3,242
North Carolina	67,340	1.5%	45,731	1.34	241,008	488	976	2,927
Oklahoma	21,010	1.3%	49,798	2.75	567,743	928	1,518	3,291
Oregon	18,280	1.0%	71,145	1.97	892,086	1,133	2,163	4,327
Rhode Island	6,700	1.4%	68,050	1.74	438,798	971	1,590	3,445
South Carolina	29,090	1.4%	43,730	1.79	193,359	489	1,467	2,933
South Dakota	4,490	1.1%	48,942	2.19	377,058	1,190	1,784	3,569
Tennessee	39,230	1.3%	48,009	1.25	215,253	545	1,635	3,269
Texas	174,320	1.4%	58,617	0.73	839,738	704	2,111	4,221
Utah	12,110	0.8%	55,305	1.20	308,311	1,006	1,921	3,840
Vermont	2,340	0.8%	58,033	3.37	448,256	1,349	2,024	4,047
Virginia	57,940	1.5%	58,503	1.72	202,428	548	1,096	3,288
West Virginia	8,530	1.2%	43,110	1.23	503,208	1,087	1,630	3,260
Countrywide ⁴	1,176,110	1.4%	55,929	1.73	378,966	764	1,557	3,492

¹US Bureau of Labor Statistics for a subset of "Protective Service Occupations" by state (occupation codes 33-1011, 33-1012, 33-1021, 33-1090, 33-2011, 33-2021, 33-2022, 33-3011, 33-3012, 33-3021, 33-3031, 33-3051, 33-9021, 33-3052)

²Weighted average pure premium factor in each approved loss cost/rate filing as of 4/10/2020 for the firefigther (7704, 7710, 7711) and police (7720) classifications

³Derived as Appendix-I value multiplied by a salary relativity (occupation-specific salary / overall state salary)

⁴Countrywide estimate for all figures reflect a weighted average of NCCI states shown on this exhibit

Appendix 3: Scenario Inputs by State for Healthcare Workers

State	Employee Count ¹	% of Total Employees	Average Salary ¹	Pure Premium Factor ²	Fatal Claim Severity ³	Wage Replacement Benefits ³		
						Mild 2 Weeks	Moderate 3 Weeks	Severe 6 Weeks
Alabama	197,750	10.0%	53,602	0.52	166,577	897	1,468	3,427
Alaska	31,960	10.1%	74,428	0.62	489,855	1,133	1,855	4,327
Arizona	291,960	10.2%	63,268	0.31	683,328	634	1,901	3,803
Arkansas	132,390	10.9%	52,680	0.22	163,151	507	1,774	3,547
Colorado	240,240	9.0%	64,484	0.44	406,390	926	1,767	3,536
Connecticut	183,730	11.0%	68,044	0.52	310,747	1,105	1,658	3,316
District of Columbia	49,140	6.8%	76,757	0.39	608,868	913	1,743	3,486
Florida	842,460	9.6%	61,685	0.41	156,242	651	1,303	3,909
Georgia	381,060	8.5%	60,920	0.43	226,118	555	1,109	3,328
Hawaii	54,200	8.5%	74,597	0.55	177,679	1,054	1,724	3,737
Idaho	75,050	10.3%	56,509	0.58	205,413	786	1,835	3,669
Illinois	571,580	9.5%	61,859	0.37	391,378	990	1,891	3,780
Indiana	307,970	10.0%	60,456	0.25	194,780	666	1,331	3,994
Iowa	145,360	9.4%	56,763	0.44	862,036	1,027	1,961	3,922
Kansas	149,860	10.8%	52,076	0.26	238,156	503	1,006	3,017
Kentucky	193,660	10.2%	54,875	0.31	342,933	656	1,969	3,938
Louisiana	219,210	11.4%	50,060	0.53	260,635	1,051	1,576	3,153
Maine	77,990	12.8%	60,769	0.57	173,378	648	1,943	3,886
Maryland	266,950	9.9%	69,002	0.26	262,795	1,083	2,069	4,137
Mississippi	124,240	11.0%	50,459	0.37	117,210	966	1,450	2,899
Missouri	327,050	11.6%	53,349	0.52	375,265	892	1,704	3,406
Montana	48,330	10.3%	61,348	0.62	334,992	910	1,547	3,822
Nebraska	99,990	10.2%	59,288	0.36	458,045	629	1,258	3,774
Nevada	105,620	7.6%	68,505	0.52	1,581,605	1,436	2,153	4,305
New Hampshire	64,610	9.8%	68,515	0.43	638,247	1,427	2,141	4,282
New Mexico	97,520	11.8%	54,795	0.44	355,439	580	1,161	3,482
North Carolina	453,770	10.2%	57,543	0.32	305,106	618	1,235	3,706
Oklahoma	159,240	9.8%	56,218	0.54	640,664	1,047	1,713	3,713
Oregon	177,060	9.3%	70,300	0.36	878,570	1,115	2,131	4,261
Rhode Island	58,180	12.0%	69,350	0.49	446,173	987	1,617	3,503
South Carolina	204,150	9.7%	56,261	0.46	248,046	627	1,882	3,763
South Dakota	45,100	10.6%	58,855	0.33	453,132	1,430	2,144	4,289
Tennessee	299,640	10.0%	56,603	0.28	254,204	644	1,931	3,860
Texas	1,220,290	9.8%	55,429	0.12	796,303	668	2,002	4,003
Utah	115,100	7.7%	57,260	0.23	319,322	1,042	1,989	3,978
Vermont	33,320	10.9%	62,097	0.77	475,780	1,431	2,148	4,296
Virginia	352,130	9.1%	62,209	0.36	216,185	585	1,170	3,511
West Virginia	92,450	13.2%	53,899	0.23	630,281	1,362	2,041	4,083
Countrywide ⁴	8,490,310	9.8%	59,350	0.36	402,865	812	1,656	3,712

¹US Bureau of Labor Statistics for all "Healthcare Practitioners and Technical Occupations" and "Healthcare Support Occupations" by state

²Weighted average pure premium factor in each approved loss cost/rate filing as of 4/10/2020 for the largest healthcare-related (8832, 8833, 8835) classifications

³Derived as Appendix-I value multiplied by a salary relativity (occupation-specific salary / overall state salary)

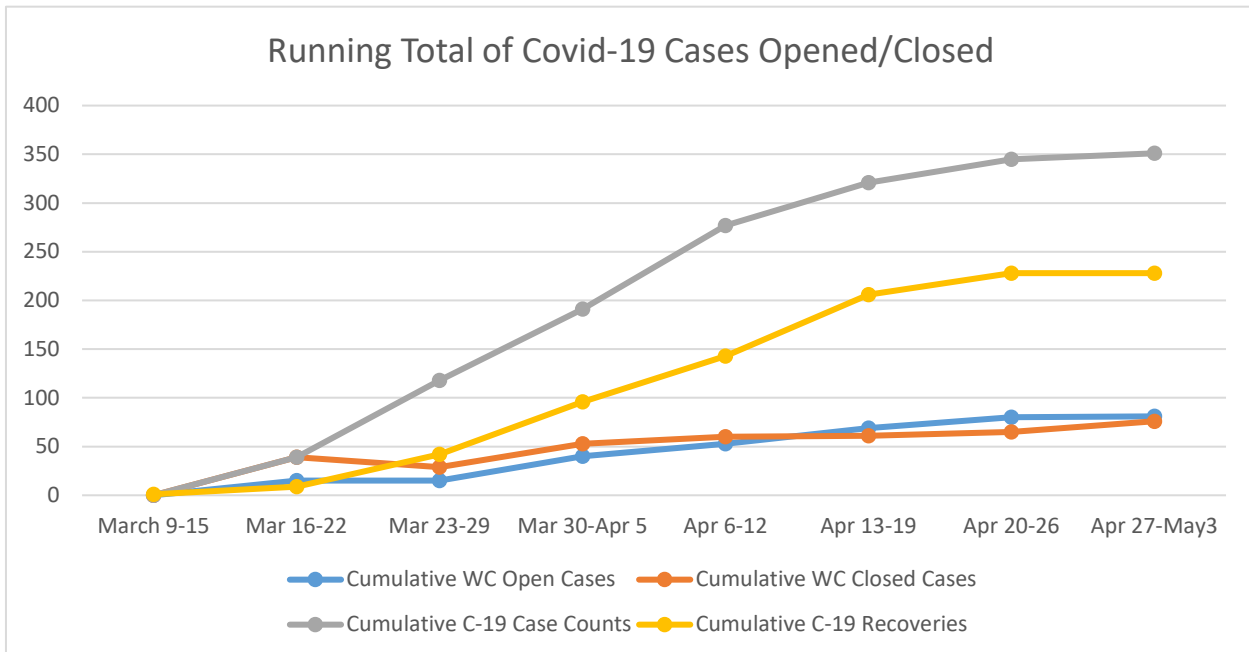
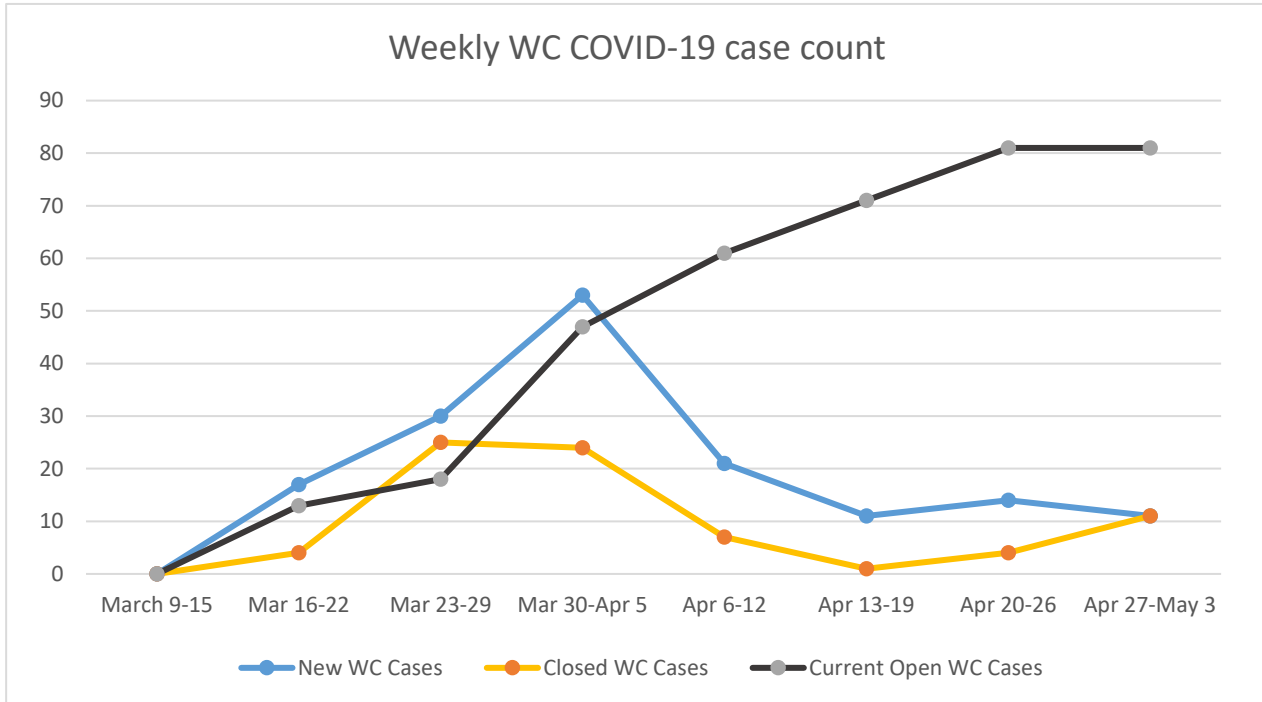
⁴Countrywide estimate for all figures reflect a weighted average of NCCI states shown on this exhibit

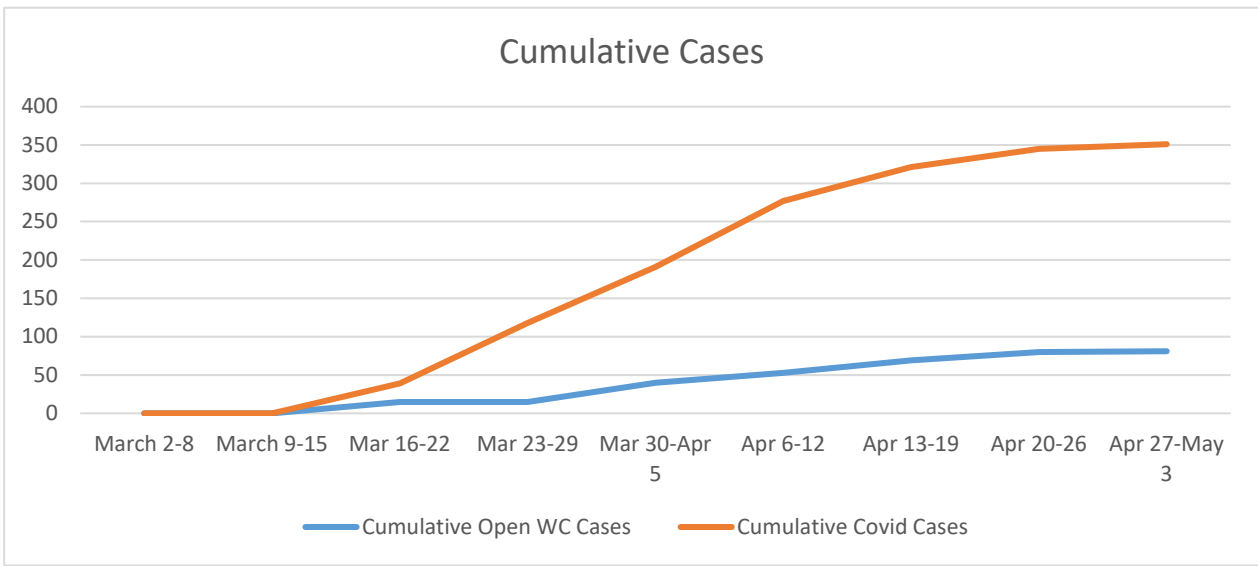
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TAB 8

Opened	Closed	Current	Paid	Amount to date
157	76	81	8	\$8,686.03

As of 4/28





TAB 9



Viral pandemic management (COVID-19)

Published April 3, 2020

Body system:

Infectious Diseases

The following recommendations should be followed and supplemented by adherence to the most current [Centers for Disease Control and Prevention \(CDC\)](#) and the [Occupational Safety and Health Administration \(OSHA\)](#) guidance references, which have evolved rapidly and continue to be subject to change.

ODG Criteria

Criteria for employees and employers ([CDC, 2020](#)):

Please check primary sources since federal, state, and local guidance changes may be frequently updated

- Employees should notify their supervisor and stay home if they have symptoms (ie, fever, cough, shortness of breath)
- Sick employees should follow CDC recommended steps; Employees should not return to work until criteria to discontinue home isolation are met, in consultation with healthcare providers and state and local health departments
- Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and follow CDC recommended precautions
- Employees who appear to have symptoms upon arrival to work or who become sick during the day should immediately be separated from other employees, customers, and visitors, and be promptly sent home
- Older adults and higher risk employees with chronic conditions should minimize face-to-face contact, maintaining a distance of 6 feet from others, and doing telework if possible
- If an employee is confirmed to have COVID-19 infection, employers should inform fellow employees of possible exposure to COVID-19 in the workplace, but maintain confidentiality as required by the Americans with Disabilities Act (ADA); Fellow employees should then self-monitor for symptoms
- Employers should not require a positive COVID-19 test result or a healthcare provider's note for employees who are sick to validate their illness, qualify for sick leave, or to return to work

Isolation Recommendations:

CDC COVID-19 recommendations include several options regarding discontinuance of home isolation: (1) Time-since-illness-onset and time-since-recovery (non-test-based) strategy, and (2) Test-based strategy; Time since recovery is defined as resolution of fever without use of fever-reducing medications and improvement of respiratory symptoms (cough and shortness of breath)

- **Non-test based strategy for employees with symptoms:** For symptoms of acute respiratory illness it is recommended to stay home and not come to work until at least 7 days have passed since symptoms first appeared, and at least 72 hours have followed recovery

- **Test-based strategy for test-positive employees with symptoms:** Contingent on availability of ample testing supplies and laboratory capacity, and convenient access to testing; Protocols have been simplified to require only one nasopharyngeal swab for sampling; Requires resolution of fever and symptoms as described for non-test-based strategy, and negative re-test results from at least two consecutive swab specimens collected at least 24-hours apart

- **Test-based strategy in test-positive employees with no symptoms:** May discontinue home isolation when at least 7 days have passed since first positive diagnostic test and without subsequent illness

Additional Recommendations:

- Posters that encourage staying home when sick, cough and sneeze etiquette, and hand hygiene should be placed at the workplace entrance and other visible areas
- Tissues, no-touch disposal receptacles, soap and water, and alcohol-based hand rubs should be readily available; practice social distancing and avoid large gatherings (per local standards)

Criteria for health care personnel evaluating Patients Under Investigation (PUI):

- Make every effort to interview PUI by telephone, text monitoring system, or video conferencing
- If health personnel must interview PUI face-to-face, they should wear recommended personal protective equipment (PPE) that completely covers clothing, skin, and mucous membranes, such as gown, gloves, face mask, and eye protection, following standard and airborne precautions
- More stringent criteria and additional recommendations are available for health care workers treating patients, depending on local jurisdictions and supply availability

Criteria (general) from the Occupational Safety and Health Administration (OSHA, 2020):

- Frequently wash hands with soap and water for at least 20 seconds; If soap and water are unavailable, use an alcohol-based hand rub with at least 60% alcohol
- Avoid touching face, eyes, nose, or mouth with unwashed hands
- Avoid close contact with people who are sick

Emerging Treatment:

Treatment options have consisted primarily of conventional care, with most antiviral regimens remaining largely experimental, pending quality trials

- Supportive care, including fluid and respiratory management (eg, oxygen, ventilation)
- Antibiotics may be prescribed empirically for secondary bacterial pneumonia, but continued use should be based on subsequent bacterial culture and sensitivity
- Corticosteroids are only recommended if there is evidence of refractory septic shock; Routine use is not recommended ([Russell, 2020](#))
- Hydroxychloroquine is under investigation in clinical trials for pre-exposure or post-exposure prophylaxis and treatment of mild, moderate, and severe cases, with few randomized controlled trials providing clinical guidance on use, dosing, or duration for prophylaxis ([CDC, 2020](#))
- Remdesivir is an investigational drug, now allowed in the U.S. on an uncontrolled compassionate basis, with an expanded access program by the manufacturer ([Gilead, 2020](#)) ([CDC, 2020](#))
- Antiviral treatment with lopinavir, ritonavir, and/or ribavirin treatment is highly experimental, with ongoing research pending
- Antivirals targeted at influenza virus are not recommended unless there is evidence of positive rapid influenza molecular assay testing ([He, 2020](#)) ([Smith, 2020](#))

Evidence Summary

Background: A worldwide outbreak of respiratory disease caused by a novel (new) coronavirus was first detected in Wuhan, China, with the virus initially being named “SARS-CoV-2” or “2019-nCoV, and the disease named “coronavirus disease 2019” (abbreviated “COVID-19”), although COVID-19 has since also been applied to the virus. Coronaviruses are a large family of viruses that are common in humans and many different species of animals, although animal coronaviruses can rarely cross-infect people with subsequent spread, as has previously occurred with Severe Acute Respiratory Syndrome (SARS-CoV) and Middle East Respiratory Syndrome (MERS-CoV). While early data suggested that most COVID-19 illness is mild, reports from China have indicated that serious illness may occur in up to 16% of cases, with older people and/or those with severe underlying health conditions being at significantly higher risk. The CDC stated, as of Mar 7, 2020: “The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend not only on the clinical presentation, but also on the patient’s ability to engage in monitoring, home isolation, and the risk of transmission in the patient’s home environment.” Protocols for release from isolation now involve “non-test-based” and “test-based” strategies, requiring only a single nasopharyngeal swab per test. Either strategy requires resolution of fever without use of fever-reducing medications, improvement in respiratory symptoms, and passage of at least 7 days since onset of symptoms. ([CDC, 2020](#))

Epidemiology: COVID-19 has been associated with much more rapid and wider spread than SARS or MERS, although it appears to be considerably less virulent. The fatality rate from COVID-19 has been reported to be as high as 3% and low as 1%, which compares favorably to fatality rates of 11% and 35% for SARS and MERS, respectively. Best estimates from China have indicated mean incubation periods for both COVID-19 and SARS of 5 days (range 2-14 days), with 97.5% developing symptoms within 11.5 days. ([Lauer, 2020](#)) Death rates have been higher in males (ratio of male to female deaths 3.25:1), while the disease may progress faster in the elderly (age 60 and older). ([Sun, 2020](#)) Recommendations for the length of quarantine or active monitoring of persons potentially exposed to SARS-CoV-2 has been largely on a case-by-case basis worldwide, while longer monitoring periods may be justified in some cases. Among infected individuals who will eventually develop symptoms, it is expected that only 1% will do so after the end of a 14-day monitoring period. ([Meo, 2020](#))

Transmission and diagnosis: SARS-CoV-2 (COVID-19) usually spreads from close person-to-person contact through respiratory droplets from coughing and sneezing, although tiny droplets can remain airborne after the viral carrier has left. Recommended precautions include (1) frequent hand washing with soap and water for at least 20 seconds, or alcohol-based hand sanitizer when washing is unavailable; (2) coughing or sneezing into a tissue or flexed elbow; (3) not touching the face with unwashed hands; (4) avoiding contact with others showing symptoms; (5) staying home when ill; (6) cleaning and disinfecting high-touch surfaces; and (7) using a face mask only when respiratory symptoms are present or when caring for someone with symptoms. COVID-19 can only be diagnosed with a laboratory test. ([Johns Hopkins, 2020](#)) Human coronaviruses, including SARS, MERS, or endemic human coronaviruses (HCoV) can persist on inanimate surfaces like metal, glass, or plastic for up to 9 days, but can be efficiently inactivated by surface disinfection with 62-71% ethanol, 0.5% hydrogen peroxide, or 0.1% sodium hypochlorite within 1 minute. Other biocidal agents such as 0.05-0.2% benzalkonium chloride or 0.02% chlorhexidine digluconate have been less effective. ([Kampf, 2020](#))



Clinical manifestations: In symptomatic individuals, clinical signs usually begin within a week. The major clinical findings in coronavirus infections SARS-CoV-2, MERS-CoV, and SARS-CoV are fever (90% to 95%), cough (70%), shortness of breath (55%), and fatigue and muscle pain (44%). Sore throat, sputum production, headaches, diarrhea, and confusion occur in smaller percentages. Chest computed tomography (CT) abnormalities have been reported in 75% to 100% of patients, consisting of bilateral areas of “grinding-glass” and consolidation. Mild disease, with no or mild pneumonia, has been reported in approximately 80% of patients, while asymptomatic infection of unknown frequency may also be associated with lung CT changes. Pneumonia may develop during the second to the third week of symptomatic infection, being severe (> 50% lung involvement over 24-48 hours) in about 15% of patients and critical in another 5%. The most common complications include acute respiratory distress syndrome, followed by anemia, acute heart injury, and secondary infections. ([Velavan, 2020](#)) ([Sun, 2020](#)) ([Hu, 2020](#)) The American College of Radiology, noting that the findings on chest imaging are not specific, has recommended that “CT should not be used to screen for or as a first-line test to diagnose COVID-19” and “CT should be used sparingly and reserved for hospitalized, symptomatic patients with specific clinical indications for CT.” ([ACR, 2020](#))

Coding: New ICD-10 emergency codes have been added through an emergency session of the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC), creating a new chapter, XXII (U00-U99), including U07.1 (COVID-19, virus identified, CDC adopted) and U07.2 (COVID-19, virus not identified-probable or suspected, not CDC adopted); new codes replace code B97.29 (other coronavirus as the cause of diseases classified elsewhere). ([WHO, 2020](#)) Supplement codes have been created by CDC (effective April 1, 2020) related to COVID-19 for pneumonia (J12.89), acute bronchitis (J20.8), lower respiratory infection (J22), ARDS (J80), and other related conditions. ([CDC, 2020](#)) The American Medical Association provides additional coding guidance surrounding COVID-19 care, accounting for different circumstances. ([AMA, 2020](#))

Last review/update date: Apr 3, 2020 (use online version for updates)

ODG provides unbiased, evidence-based guidelines that unite payers, providers, and employers in the effort to confidently and effectively return employees to health.

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FOR IMMEDIATE RELEASE: April 13, 2020

Contact: jguerriero@mdguidelines.com

ACOEM and MDGuidelines® Release First Evidence-Based COVID-19 Guideline for Occupational Health

Free Access Provided to COVID-19 Workplace Safety and Treatment Recommendations

The American College of Occupational and Environmental Medicine (ACOEM) and MDGuidelines today released a new clinical practice guideline focusing on novel coronavirus 2019 (COVID-19). Because of the need to provide clinicians with the most up-to-date information possible, the COVID-19 guideline is available free of charge at <https://info.mdguidelines.com/covid-19>. The ACOEM *Practice Guidelines* in MDGuidelines are widely used by clinicians in the care and treatment of working-age individuals.

COVID-19, the acute respiratory infection caused by a new strain of coronavirus (SARSCoV-2), has disrupted the normal course of business worldwide. The COVID-19 guideline provides recommendations for employer considerations, a discussion of disability considerations, and diagnostic approach, as well as treatment recommendations.

“The urgency of the COVID-19 pandemic necessitates the quick development and delivery of guidelines for use by health care systems, physicians, governmental agencies, and organizations managing worker safety and health,” said Kurt T. Hegmann, MD, editor-in-chief of the ACOEM *Practice Guidelines*. “Using the best-quality evidence available, we are able to offer guidance today for workplace safety, observations on possible impact on disability, and treatment recommendations for patients who are moderately to severely affected by COVID-19.”

Workplace Safety

Among the evidence-based guidance for workplace safety, the COVID-19 guideline outlines the following for employers:

- Ensure the ability for affected workers to sufficiently observe a quarantine period which may include examining paid leave policies.
- If affected workers are in fact sick, examine provisions to allow employees to stay at home
- If workers are not sick but need to care for the sick, examine provisions to allow for these circumstances.
- Stop all non-essential travel to any cities/countries with outbreaks or community spread in family members.

Treatment Recommendations

Based on review of the preliminary data available, and determinations by the U.S. Food and Drug Administration, the COVID-19 guideline includes the following treatment recommendations:

Recommended:

- Hydroxychloroquine or chloroquine as possible treatments for patients who are **moderately to severely affected by COVID-19**; azithromycin may be added for severely affected patients
- Convalescent plasma antibodies from survivors of COVID-19 as possible treatment for patients who are severely affected by COVID-19
- Interleukin-6 (IL-6) receptor anatagonists (tocilizumab and sarilumab) as possible treatments for patients who are severely affected by COVID-19

Not recommended:

- Hydroxychloroquine and chloroquine are not recommended for widespread prophylactic use
- Lopinavir/ritonavir are not recommended

No recommendation:

- Favipiravir

Recognizing the urgent need for workplace recommendations related to COVID-19, ACOEM however cautions that quality literature is quite limited for treatment of COVID-19, [therefore] aspects of this guideline could rapidly become out of date. “We intend to monitor the literature frequently and update the COVID-19 guideline as needed,” noted Stephen Frangos, MD, ACOEM President.

All ACOEM *Practice Guidelines* are developed using a state-of-the-art methodology which incorporates the highest scientific standards for reviewing evidence-based literature to ensure the most rigorous, reproducible, and transparent guidelines available. All recommendations are labeled as: strongly recommended, moderately recommended, recommended, consensus-recommended, consensus-no recommendation, consensus—not recommended, not recommended, moderately not recommended, or strongly not recommended based on the strength of the scientific evidence. The strength of evidence ratings included with the recommendations are used to designate the quality and amount of evidence that supports the recommendation. All guidelines are reviewed periodically to identify any major changes in the evidence.

Development of the COVID-19 guideline was overseen by Kurt Hegmann, MD, and the Evidence-Based Practice COVID-19 Panel. Physician panelists represent expertise in occupational medicine, internal medicine, pulmonary medicine, and infectious disease.

For more information about or to access the COVID-19 guideline, visit <https://info.mdguidelines.com/covid-19>, or contact Joe Guerriero at jguerriero@mdguidelines.com.

About ACOEM and Practice Guidelines

The American College of Occupational and Environmental Medicine (www.acoem.org) is an international society of 4,000 occupational physicians and other health care professionals. The College provides leadership to promote optimal health and safety of workers, workplaces, and environments. The College is located in Elk Grove Village, Ill.

ACOEM’s *Occupational Medicine Practice Guidelines* define best practices for key areas of occupational medical care and disability management. They are intended to improve the efficiency and accuracy of the diagnostic process as well as identify the effectiveness and risks of individual treatments in resolving an illness or injury—helping workers return to normal activities as quickly and safely as possible.

About MDGuidelines

MDGuidelines, is the industry’s leading solution for total health management and workplace productivity. MDGuidelines features the world’s most trusted disability durations, predictive modeling, analytic services, drug formulary, and evidence-based clinical practice guidelines from ACOEM.

###

Introduction

These Treatment Guidelines have been developed to inform clinicians how to care for patients with COVID-19. Because clinical information about the optimal management of COVID-19 is evolving quickly, these Guidelines will be updated frequently as published data and other authoritative information becomes available.

The recommendations in these Guidelines are based on scientific evidence and expert opinion. Each recommendation includes two ratings: a letter (**A**, **B**, or **C**) that indicates the strength of the recommendation and a Roman numeral (**I**, **II**, or **III**) that indicates the quality of the evidence that supports the recommendation (see Table 1).

Panel Composition

Members of the COVID-19 Treatment Guidelines Panel (the Panel) were appointed by the Panel co-chairs and chosen based on their clinical experience and expertise in patient management, translational and clinical science, and/or development of treatment Guidelines. Panel members include representatives from federal agencies, health care and academic organizations, and professional societies. **Federal agencies and professional societies represented on the Panel include:**

- American College of Chest Physicians
- American College of Emergency Physicians
- American Thoracic Society
- Biomedical Advanced Research and Development Authority
- Centers for Disease Control and Prevention
- Department of Defense
- Department of Veterans Affairs
- Food and Drug Administration
- Infectious Diseases Society of America
- National Institutes of Health
- Pediatric Infectious Diseases Society
- Society of Critical Care Medicine
- Society of Infectious Diseases Pharmacists.

The inclusion of representatives from professional societies does not imply that their societies have endorsed all elements of this document.

The names, affiliations, and conflict of interest disclosures of the Panel members, ex-officio members, and support staff are provided in the [Panel Roster](#) and [Financial Disclosures](#).

Development of the Guidelines

Each section of the Guidelines was developed by a working group of Panel members with expertise in the section's area of interest. Each working group was responsible for identifying relevant information and published scientific literature, and conducting a systematic, comprehensive review of that information and literature. The working groups will propose updates to the Guidelines based on the latest published research findings and evolving clinical information.

Each guideline section has been reviewed, modified as necessary, and voted on by the entire Panel. A majority vote was required for a recommendation to be included in the posted Guidelines. Panel members are required to keep all Panel deliberations and unpublished data considered during the development of the guidelines confidential.

Method of Synthesizing Data and Formulating Recommendations

The working groups critically review and synthesize the available data to develop recommendations. Aspects of the data that are considered include, but are not limited to, the type of study (e.g., case series, prospective cohort, randomized controlled trial), the quality and suitability of the methods, the number of participants, and the effect sizes observed. Each recommendation is assigned two ratings according to the scheme presented in Table 1.

Table 1. Recommendation Rating Scheme

Strength of Recommendation	Quality of Evidence for Recommendation
A: Strong recommendation for the statement	I: One or more randomized trials with clinical outcomes and/or validated laboratory endpoints
B: Moderate recommendation for the statement	II: One or more well-designed, nonrandomized trials or observational cohort studies
C: Optional recommendation for the statement	III: Expert opinion

It is important to note that at present, to develop the recommendations in these Guidelines, the Panel relied heavily on experience with other diseases, supplemented with evolving personal clinical experience with COVID-19, and incorporated the rapidly growing published scientific literature on COVID-19. When information existed in other published Guidelines that the Panel felt important to include in these Guidelines, the information was included with permission from the original sources.

Evolving Knowledge on Treatment for COVID-19

Currently there are no Food and Drug Administration (FDA)-approved drugs for COVID-19. However, an array of drugs approved for other indications, as well as multiple investigational agents, are being studied for the treatment of COVID-19 in several hundred clinical trials around the globe. These trials can be accessed at [ClinicalTrials.gov](#). In addition, providers can access and prescribe investigational drugs or agents approved

or licensed for other indications through various mechanisms, including Emergency Use Authorizations (EUA), Emergency Investigational New Drug (EIND) applications, compassionate use or expanded access programs with drug manufacturers, and/or off-label use.

For this reason, whenever possible, the Panel recommends that promising, unapproved or unlicensed treatments for COVID-19 be studied in well-designed controlled clinical trials. This includes drugs that have been approved or licensed for other indications. The Panel recognizes the critical importance of clinical research in generating evidence to address unanswered questions regarding the safety and efficacy of potential treatments for COVID-19. However, the Panel also realizes that many patients and providers who cannot access such trials are still seeking guidance about whether to use these agents.

Finally, it is important to stress that the rated treatment recommendations in these Guidelines should not be considered mandates. The choice of what to do or not to do for an individual patient is ultimately decided by the patient together with their provider.

Therapeutic Options for COVID-19 Currently Under Investigation

Summary Recommendations

At present, no drug has been proven to be safe and effective for treating COVID-19. There are no Food and Drug Administration (FDA)-approved drugs specifically to treat patients with COVID-19. Although reports have appeared in the medical literature and the lay press claiming successful treatment of patients with COVID-19 with a variety of agents, definitive clinical trial data are needed to identify optimal treatments for this disease. Recommended clinical management of patients with COVID-19 includes infection prevention and control measures and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated. As in the management of any disease, treatment decisions ultimately reside with the patient and their health care provider.

Antivirals:

- There are insufficient clinical data to recommend either for or against using **chloroquine** or **hydroxychloroquine** for the treatment of COVID-19 **(AIII)**.
 - If chloroquine or hydroxychloroquine is used, clinicians should monitor the patient for adverse effects, especially prolonged QTc interval **(AIII)**.
- There are insufficient clinical data to recommend either for or against using the investigational antiviral drug **remdesivir** for the treatment of COVID-19 **(AIII)**.
 - Remdesivir as a treatment for COVID-19 is currently being investigated in clinical trials and is also available through expanded access and compassionate use mechanisms for certain patient populations.
- Except in the context of a clinical trial, the COVID-19 Treatment Guidelines Panel (the Panel) **recommends against** the use of the following drugs for the treatment of COVID-19:
 - The combination of **hydroxychloroquine plus azithromycin (AIII)** because of the potential for toxicities.
 - **Lopinavir/ritonavir (AI)** or other **HIV protease inhibitors (AIII)** because of unfavorable pharmacodynamics and negative clinical trial data.

Host Modifiers/Immune-Based Therapy:

- There are insufficient clinical data to recommend either for or against the use of **convalescent plasma** or **hyperimmune immunoglobulin** for the treatment of COVID-19 **(AIII)**.
- There are insufficient clinical data to recommend either for or against the use of the following agents for the treatment of COVID-19 **(AIII)**:
 - **Interleukin-6 inhibitors** (e.g., sarilumab, siltuximab, tocilizumab)
 - **Interleukin-1 inhibitors** (e.g., anakinra)
- Except in the context of a clinical trial, the Panel **recommends against** the use of other immunomodulators, such as:
 - **Interferons (AIII)**, because of lack of efficacy in treatment of severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) and toxicity.
 - **Janus kinase inhibitors** (e.g., baricitinib) **(AIII)**, because of their broad immunosuppressive effect.

TAB 10



ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION PROPOSED TO BE EFFECTIVE JANUARY 1, 2020

NCCI estimates that the implementation of the Official Disability Guidelines Workers' Compensation Drug Formulary Appendix A (the ODG drug formulary) would result in an estimated impact of -0.1% to -0.6% (\$-0.3M to \$-1.5M¹) on overall workers compensation system costs in Alaska. An effective date of January 1, 2020 is assumed for purposes of this proposal.

The impact of the implementation of the American College of Occupational and Environmental Medicine's (ACOEM) treatment guidelines, ODG treatment guidelines, or other evidence-based drug formularies may reduce overall workers compensation system costs in Alaska; however, the magnitude of any potential savings cannot be quantified.

BACKGROUND AND SUMMARY OF PROPOSED CHANGES

The Alaska Division of Workers' Compensation has requested an estimate of the potential savings associated with the adoption of the ODG drug formulary.

The ODG drug formulary is a detailed list of prescription drugs that are frequently used in the treatment of injured workers. Within this list, there is a status indicator that identifies whether each drug requires prior authorization. Drugs with a status indicator of "N" (N-drugs) require prior authorization by the employer or workers compensation insurer, while drugs with a status indicator of "Y" (Y-drugs²) do not require prior authorization.

ACTUARIAL ANALYSIS

In this analysis, NCCI relies primarily on the following data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call (MDC) for Alaska for Service Year 2018.
- The share of benefit costs attributed to medical benefits based on NCCI's Financial Call data for Alaska from Policy Years 2015, 2016, and 2017, projected to January 1, 2020.

In some components of the analysis, NCCI may rely on other data sources, which are referenced where applicable.

¹ The estimated dollar impacts are the percentage impacts displayed multiplied by 2017 written premium of \$251M from NAIC Annual Statement data for Alaska. These figures do not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impacts assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impacts on overall system costs inclusive of self-insurance are estimated to be between \$-0.3M to \$-2.0M, where data on self-insurance is approximated using the National Academy of Social Insurance's October 2018 publication "Workers' Compensation Benefits, Costs, and Coverage, 2016."

² In this analysis, drugs whose status may vary based on intended use are assumed to be treated as Y-drugs.



ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION PROPOSED TO BE EFFECTIVE JANUARY 1, 2020

To evaluate the cost impact of the ODG drug formulary implementation, NCCI identified drugs dispensed for workers compensation claims in Alaska classified by the formulary as N-drugs or NA-drugs (i.e., drugs not listed on the formulary). Based on MDC data for Service Year 2018, N-drugs represent 22.1% of all Alaska drug payments, while NA-drugs represent 23.4% of all Alaska drug payments.

There are several factors that affect the estimated cost impact of implementing a formulary, including:

- The degree to which Y-drugs or other non-drug treatments would be substituted for N-drugs
- The degree of elimination of N-drugs
- The degree of authorization of N-drugs

To estimate a cost impact of the implementation on N-drugs, NCCI considered several potential cost impact estimates:

ODG Drug Formulary in Texas

The ODG drug formulary was implemented in Texas on September 1, 2011 for new claims (and applied to legacy claims as of September 1, 2013). The Texas Department of Insurance has calculated a 78% reduction in the total N-drug costs from Fiscal-Accident Year 2011 (ending August 31, 2011) to Fiscal-Accident Year 2012³. NCCI's own analysis has shown a 75% decrease in average N drug costs per claim in Texas between Service Year 2010 and Service Year 2014, and a 92% decrease in N-drug average cost per claim for Accident Year (AY) 2014 relative to AY 2010 at 12-month maturity.

NCCI Research

NCCI research on recent ODG drug formulary implementations⁴ in Tennessee and Arizona has suggested a more muted initial impact when compared to that observed in Texas. In these states, utilization of N-drugs after formulary adoption decreased by approximately 7% to 14% beyond the utilization decreases observed in nonformulary states. Post-reform experience in Texas may have differed from experience in Arizona and Tennessee for several reasons, including:

- Texas law does not permit the settlement of future medical benefits.
- Texas began implementation of its drug formulary in 2011. Since that time, increased awareness of the opioid epidemic along with rising drug prices have prompted workers compensation insurers to pay greater attention to pharmaceutical experience.

³ *Impact of the Texas Pharmacy Closed Formulary*, Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, July 2016.

⁴ Hendrick, Paul "Formulary Implementations and Initial Impacts on Workers Compensation" National Council on Compensation Insurance, Inc., June 2019, available at <https://www.ncci.com/Articles/Documents/Insights-Research-Brief-Formulary-Post-Reform-june2019.pdf>



ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION
PROPOSED TO BE EFFECTIVE JANUARY 1, 2020

Other Considerations

As an alternative estimate, NCCI also compared the average cost per script by reimbursement status (“Y” and “N”) for Service Year 2018 for Alaska. The average cost per script for Y-drugs (\$127.68) was 45.6% of the average cost per script for N-drugs (\$279.70). This relativity implies a -54.4% ($= \$127.68/\$279.70 - 1.0$) impact on N-drug costs, assuming substitution of each N-drug script for a Y-drug script at the average Y-drug cost per script.

In addition to these estimates, NCCI also considered that other factors could affect the impact of the proposed ODG drug formulary in Alaska:

- In the aforementioned NCCI research, other recent prescription drug cost containment efforts, such as increased use of pharmacy benefit managers and restrictions on drug repackaging and physician dispensing, may already be causing shifts in workers compensation drug utilization patterns.
- The proposal does not explicitly state if NA-drugs would require preauthorization. NCCI expects that the degree of substitution, elimination, and authorization would differ between N-drugs and NA-drugs for several reasons, including:
 - NA-drugs may be relatively new to the market with no alternative Y-drugs currently available for substitution
 - Insurers may have less familiarity with NA-drugs than more commonly used N-drugs and may thus grant prior authorization at different rates than more common N-drugs.

COST IMPACT

Based on the cost impact considerations above, NCCI estimates that the impact on drug costs in Alaska due to the proposed implementation of the ODG drug formulary would be between -3.3% and -16.6%. These estimated impacts are then multiplied by the percentage of medical costs attributed to drug costs in Alaska (5.4%) to arrive at an estimated impact on medical costs between -0.2% and -0.9%. These estimated impacts are then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an estimated impact of -0.1% to -0.6% on overall workers compensation system costs.

The above estimates only consider the cost impact of the proposed formulary implementation on N-drugs. The cost impact may differ substantially between N-drugs and NA-drugs. Any cost impact of the ODG drug formulary implementation on NA-drugs, if adopted, would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings in Alaska.



**ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION
PROPOSED TO BE EFFECTIVE JANUARY 1, 2020**

SUMMARY OF ESTIMATED IMPACTS

Based on impact on N-drugs from the proposed ODG drug formulary in Alaska, assumed to be effective January 1, 2020, is summarized in the following table. Any cost impact on NA-drugs of the ODG drug formulary implementation cannot be reasonably quantified and if adopted, would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings in Alaska.

	(A)	(B)	(C) = (A) x (B)	(D)	(E) = (C) x (D)
Type of Service	Estimated Impact on Type of Service	Share of Medical Costs	Estimated Impact on Medical Costs	Medical Costs as a Share of Overall Costs	Estimated Impact on Overall Costs
Drugs	-3.3% to -16.6%	5.4%	-0.2% to -0.9%	70%	-0.1% to -0.6%

THIS DOCUMENT AND ANY ANALYSIS, ASSUMPTIONS, AND PROJECTIONS CONTAINED HEREIN PROVIDE AN ESTIMATE OF THE POTENTIAL PROSPECTIVE COST IMPACT(S) OF PROPOSED/ENACTED SYSTEM CHANGE(S) AND IS PROVIDED SOLELY AS A REFERENCE TOOL TO BE USED FOR INFORMATIONAL PURPOSES ONLY. THIS DOCUMENT SHALL NOT BE CONSTRUED OR INTERPRETED AS PERTAINING TO THE NECESSITY FOR OR A REQUEST FOR A LOSS COST/RATE INCREASE OR DECREASE, THE DETERMINATION OF LOSS COSTS/RATES, OR LOSS COSTS/RATES TO BE REQUESTED. THE ANALYSIS CONTAINED HEREIN EVALUATES THE DESCRIBED CHANGES IN ISOLATION UNLESS OTHERWISE INDICATED; ANY OTHER CHANGES NOT INCLUDED IN THIS ANALYSIS THAT ARE ULTIMATELY ENACTED MAY RESULT IN A DIFFERENT ESTIMATED IMPACT. I, CAROLYN WISE, ACAS, MAAA, AM AN ASSOCIATE ACTUARY FOR THE NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC. AND THE ACTUARY RESPONSIBLE FOR THE PREPARATION OF THIS DOCUMENT. THIS DOCUMENT IS PROVIDED "AS IS" ON THE DATE SET FORTH HEREIN AND INCLUDES INFORMATION AND EVENTS AVAILABLE AT THE TIME OF PUBLICATION ONLY. NCCI'S FINAL ESTIMATED IMPACT MAY DIFFER FROM WHAT IS PROVIDED IN THIS ANALYSIS IF ADDITIONAL INFORMATION BECOMES AVAILABLE OR IF DATA NECESSARY TO ANALYZE PROVISIONS THAT WERE NOT EXPLICITLY QUANTIFIED PREVIOUSLY BECOMES AVAILABLE.

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National Council of Insurance Legislators (NCOIL)

Model Workers' Compensation Drug Formulary Act

**Sponsored by Rep. Matt Lehman (IN)*

**Adopted by the Workers' Compensation Insurance Committee on December 12th, 2019 and the Executive Committee on December 13th, 2019.*

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Section 1. Short Title

This Act shall be known as the "Model Workers' Compensation Drug Formulary Act"

Section 2. Purpose

The purpose of this Act shall be to require the establishment of a drug formulary for use in a state's workers' compensation system in order to facilitate the safe and appropriate use of prescription drugs in the treatment of work-related injury and occupational disease.

Section 3. Selection or Development of Drug Formulary

(A) It is the intent of the Legislature that the [insert appropriate state agency/department] select a nationally recognized, evidence-based drug formulary, for use in the workers' compensation system, or to develop such a formulary, by rule. Such formulary shall apply to prescription drugs that are prescribed and dispensed for outpatient use in

connection with workers' compensation claims with a date of injury on or after [insert date]. The drug formulary shall not apply to care provided in an emergency department or inpatient setting.

(B) In developing by rule or selecting a nationally recognized, evidence-based drug formulary for adoption, the [department] shall consider the following factors:

- (1) Whether the formulary focuses on medical treatment specific to workers' compensation.
- (2) Whether the basis for the formulary is readily apparent and publicly available.
- (3) Whether the formulary includes measures to aid in management of opioid medications.
- (4) The cost of implementation and post-implementation associated costs of the formulary.
- (5) Evidence-based guidelines for the treatment of workplace injury and disease.

(C) Within [thirty (30)] days of the effective date of this Act, the [department] shall solicit public comments regarding the selection of a nationally recognized, evidence-based prescription drug formulary under this section. The public comment period shall be [ninety (90) days]. During the public comment period, the [department] shall conduct at least one public hearing on the selection of a drug formulary. The [department] shall publish notice of the public comment period and public hearings on its website. The public hearing shall include, but not be limited to, employers, insurers, private sector employee representatives, public sector employee representatives, treating physicians actively practicing medicine, pharmacists, pharmacy benefit managers, attorneys who represent applicants, and injured workers.

(D) Commencing [insert date], and concluding with the implementation of the formulary, the [administrative director] shall publish at least two interim reports on the internet web site of the [division of workers' compensation] describing the status of the selection of the formulary.

(E) The [department] shall [annually] review updates issued by the formulary publisher to the selected formulary.

(F) The [department] shall ensure that the current nationally recognized, evidence-based prescription drug formulary is available through its publicly accessible Internet website for reference by physicians and the general public.

Section 4. Operation of Formulary

(A) Beginning [insert date] reimbursement is not permitted for a claim for payment of a drug that:

(1) is prescribed for use by an employee who files a notice of injury under this Act; and

(2) is listed but not approved in the formulary, or omitted from the formulary, unless the employee begins use of such drug after [insert date], and the use continues after [insert date].

(3) if the employee begins use of the such drug before [insert date], and the use continues after [insert date], reimbursement is permitted for such drug until [insert date].

(B) If a prescribing physician submits to an employer a request to permit use of a drug that is listed but not approved in the formulary, or omitted from the formulary, including the prescribing physician's reason for requesting use of such drug and the employer approves the request, the prescribing physician may prescribe such drug for use by the injured employee.

(C) If the employer does not approve the prescribing physician's request under subsection (B) to permit use of a drug that is listed but not approved in the formulary, or omitted from the formulary, the employer shall:

(1) send the request to a third party that is certified by the [Utilization Review Accreditation Commission (URAC) or another Accreditation Organization] to make a determination concerning the request. The use by the employer of an independent review organization selected by the [department] shall also satisfy this subsection; and

(2) notify the prescribing physician and the injured employee of the third party's determination not more than [three (3)] business days after receiving the request.

(D) If an employer fails to provide the notice required by subsection (C)(2), the prescribing physician's request under subsection (B) is considered approved, and reimbursement of the drug that is listed but not approved in the formulary, or omitted from the formulary, and prescribed for use by the injured employee is authorized.

(E) If the third party's determination under subsection (C) is to deny the prescribing physician's request to permit the use of the drug that is listed but not approved on the formulary, or omitted from the formulary:

(1) the employer shall notify the prescribing physician and the injured employee; and

(2) the injured employee may apply to [workers' compensation board] for a final determination concerning the third party's determination under subsection (C)

(F) Notwithstanding subsections (A) through (E), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is a drug that is listed but not approved on the formulary, or omitted from the formulary.

Section 5. Third Party Conflict of Interest

(A) The URAC certified third party identified in Section 4(C)(1) shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state.

(B) No URAC certified third party identified in Section 4(C)(1) shall have any material professional, material familial, or material financial affiliation with any of the following:

- (1) The employer, insurer or claims administrator.
- (2) Any officer, director, employee of the employer, or insurer or claims administrator.
- (3) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.
- (4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.
- (5) The development or manufacture of the drug proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.
- (6) The injured employee or the employee's immediate family, or the employee's attorney.

Section 6. Rules

The [state department] shall promulgate rules necessary for the implementation of the formulary.

Section 7. Effective Date

This Act shall take effect [xxx days] following enactment.

TAB 11

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION

2021 Fee Schedule Issues

- Narrative updates to account for CMS adjustments.
 - CMS changes to E&M category
 - Cosmetic narrative adjustments to add clarity
 - Expand telemedicine descriptions and clarify any limitations
 - Clarify scenario in which relative weight is non-existent, but a payment rate exists in Addendum B (OPPS file) – e.g. for CPT® 09375, pay at ASP value/multiplier
 - Clarify that reimbursement for critical access hospital (CAH) implant procedures is the lowest of 100% of billed charge, the charge for the treatment when provided to the general public, or the charge for the treatment negotiated by the provider and employer.
- Review access to medical care for injured workers
- Review each conversion factor/multiplier category (compare to national & regional charges)
- Consolidation toward a single conversion factor?
- Inpatient Hospital conversion factors – evaluate methodology and consider conversion factor adjustments/consolidation.
- Critical Access Hospitals – Should implant reimbursement be limited based on invoice cost? Current fee schedule allows lowest of 100% of billed charge, charge to general public, or negotiated price between provider and employer.
- Evaluate any available data related to adjustments made in 2020:
 - Impact on utilization associated with work hardening and functional capacity exam increases;
 - Impact of hearing aids/parts limitation of mfr invoice + 30% for fitting and dispensing (HCPCS V5011& V5160) and “gap-fill” relative values;
 - Impact of scope of practice and off label use limitations.
- Recommendations for adoption of evidence-based treatment guidelines and/or evidence based drug formulary.
- Other issues

TAB 12

Hospital Free Profile Data from American Hospital Directory (ahd.com)
 Financial Date for hospital cost report period ending 9/30/2018

Facility	PC Pricer Mult.	Beds	Type	Profit/NP	TTL Patient \$	TTL Patient Days	TTL Discharges	Other \$	Ttl Rev. \$	Net Income/Loss	Rev./Patient Day	Income/P Day
Providence AK Med. Center	2.38	401	ST Acute Care	NP	\$ 2,440,247,354	109,991	15,660	\$(1,809,950)	\$ 2,438,437,404	\$ 109,915,625	\$ 22,169	\$ 999
Mat-Su Regional Med. Center	1.84	74	ST Acute Care	Corp.	\$ 744,061,843	19471	4324	\$ 844,216	\$ 744,906,059	\$ 56,890,637	\$ 38,257	\$ 2,922
Bartlett Regional Hospital	1.79	57	ST Acute Care	Govt	\$ 1,750,075,666	6733	1647	\$ 9,565,651	\$ 184,573,217	\$ 5,512,697	\$ 27,413	\$ 819
Foundation Health - FBKS Mem Hosp	1.48	212	ST Acute Care	NP	\$ 501,562,381	20829	4467	\$ 5,055,831	\$ 506,618,212	\$ 19,012,586	\$ 24,323	\$ 913
Alaska Regional Hospital	2.32	174	ST Acute Care	Corp.	\$ 1,135,761,469	34726	6388	\$ 530,506	\$ 1,136,291,975	\$ 62,828,656	\$ 32,722	\$ 1,809
Yukon-Kuskokwim Delta Reg. Hosp	2.63	34	ST Acute Care	Govt	\$ -	4963	1822	\$ -	\$ -	\$ (187,756,831)	\$ -	\$ (37,831)
Central Peninsula Gen Hosp	1.38	109	ST Acute Care	NP	\$ 377,679,563	11969	2525	\$ 5,354,675	\$ 383,034,238	\$ 8,132,565	\$ 32,002	\$ 679
AK Native Medical Center	2.53	174	ST Acute Care	Govt	\$ -	38396	8376	\$ -	\$ -	\$ (556,553,788)	\$ -	\$ (14,495)

Alaska Workers' Compensation Analysis

The goal of this project was to build an Alaska workers' compensation benchmark, providing guidance in developing a Medicare-derived payment system.

We had two different datasets available, one from FAIR Health and the other from NCCI. We used the NCCI data for this analysis based on several factors including:

- NCCI data had Alaska utilization (volume) information, FAIR Health did not.
- NCCI provided two years of data allowing a comparison for year over year.

Using the NCCI data, we did the following:

Hospital Inpatient

- We used the appropriate relative weights (i.e., FFY 2012 for 2012 data, FFY 2013 for 2013 data). It's worth noting that Medicare inpatient is based on the federal fiscal year while outpatient is on a calendar year.
- We summed the relative weights and total payments for each year's inpatient claims. For 2013 data this was 357.72 and \$8,719,881.99. Dividing the total payments by the total relative weights produces an effective Medicare base rate of \$21,449.74. (Cells D2, G2, H2 in spreadsheet IP2013.)
- As a cross-check, this produced a workers' compensation case mix index of 1.873 which is in line with Optum's national calculations and what we have seen in other states.
- The 2015 total "all in" base rates range from \$7,498.69 for Central Peninsula General Hospital to \$12,991.50 for Yukon Kuskokwim Delta Regional Hospital. (See spreadsheet labeled Hospital IP Rates.) The average rate was \$8,944.40. Because we did not have volumes by hospital, we could not adjust the rate to reflect different utilization patterns. The committee may wish to consider whether the average rate is appropriate or some other rate would be more reflective. We also used the 2015 average rate for the 2012 analysis in order to keep relativity between the 2012/2013 data.
- We did not include the disproportionate (DSH) per claim amount in the calculation. Some Alaska hospitals qualify for DSH per claim payments; some do not. The average DSH per claim amount in Alaska is \$973.25. (Including the DSH per claim payment would increase the total payments by \$185,891 for 2013 data.)
- Based on this, we estimate the current payments as 239.8% compared with Medicare. For 2012, the percentage to Medicare was 255.7%.

Hospital Outpatient

- Hospital Outpatient followed a similar process except that we used the 2015 Medicare weights for both the 2012 and 2013 data. This is because Medicare has been moving various CPT/HCPCS codes into differing APCs and changing their weight, sometimes substantially. We wanted to keep relativity between the data years for accurate comparison.
- We summed the relative weights and total payments for each year's outpatient claims. For 2013 data this was 31,750.6 and \$7,042,049.83. Dividing the total payments by the total relative weights produces an effective Medicare base rate of \$221.79. (Cells D2, F2, G2 in spreadsheet OP2013.)
- It's useful to note that this weight calculation leaves out a number of services that Medicare pays under a differing payment methodology and not on an APC system. Such items include some laboratory, DME and therapy codes.
- Under the Ambulatory Payment Calculation (APC) system, Medicare bundles some items together and only establishes a payment for the primary service. We used all payments reported so bundled items are included in the calculation where they exist. However, because NCCI data only consisted of a data sample (66%) the calculation presumes a 1:1 correlation between bundled items and primary items that may not exist. The result may somewhat over- or under-state the payments because of this. Typically, bundled payment items represent relatively small amounts. Based on an analysis of national Medicare data, we estimate the margin of error is likely to be within 1-3% either way.
- Hospital outpatient only has a single adjustment between hospitals, by wage index. The formula is
$$\text{Hospital rate} = \begin{array}{l} (\text{national rate}) * 60\% * (\text{hospital wage index}) \\ + (\text{national rate}) * 40\% \end{array}$$
- There are two 2015 wage indexes in Alaska (1.3042 and 1.9343) with a substantial difference between them. As with inpatient, because we did not have volumes by hospital, we used an average to determine the comparison base rate of \$101.72. The panel may wish to consider whether this is an appropriate approach.
- Although the volumes differed between 2012 and 2013, the comparison to Medicare produced almost the same results for each year. The 2013 calculation estimated the percentage to Medicare as 218.0%.

TAB 13

cindy@bcarlsonlaw.com

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

JOHN SHANNON, JR. D.C.)
Plaintiff,)
)
vs.)
)
STATE OF ALASKA DEP'T OF LABOR AND)
WORKFORCE DEVELOPMENT, ALASKA)
DIVISION OF WORKERS COMPENSATION,)
and ALASKA MEDICAL SERVICES)
REVIEW COMMITTEE)
)
Defendants.)
)

Case No: ___ - ___ - _____

COMPLAINT

COMES NOW, Plaintiff, John Shannon, D.C., P.C. (“Plaintiff”), by and through his counsel, Cynthia A. Franklin, with The Law Office of Bradly A. Carlson, L.L.C., and for its Complaint against Defendants, the State of Alaska Department of Labor and Workforce Development, the Alaska Worker’s Compensation Board and the Medical Services Review Committee (“Defendants”) alleges as follows:

THE PARTIES

1. Plaintiff is a Chiropractic Physician, the owner of a U-MED Pain Management, chiropractic clinic located in Anchorage, a resident of the State of Alaska, and lives in Anchorage, Alaska.

2. Defendant State of Alaska Department of Labor and Workforce Development (“DOLWD”) is a department of the state under whose auspices the Alaska Worker’s Compensation

Board is formed. DOLWD sponsors regulations promulgated by the Alaska Worker's Compensation Board within the Division of Worker's Compensation.

3. Defendant Alaska Division of Workers' Compensation ("ADWC") is the agency charged with the administration of the Alaska Workers' Compensation Act (Act). The Act provides for the payment by employers or their insurance carriers of medical, disability and reemployment benefits to injured workers. The Division is required to administer the Act in a manner that is both fair and efficient to all parties. In addition to its administrative function, the Division also houses the Alaska Workers' Compensation Board ("Board") which hears disputes arising between employees and employers or their insurance carriers regarding the payment of benefits under the Act.

4. Defendant Medical Services Review Committee ("MSRC") is a committee appointed by the commissioner of the DOWLD to assist and advise the DOWLD and the Board in matters involving the appropriateness, necessity, and cost of medical and related services provided under AS 23.30.095.

5. This is an action for injunctive relief and for a declaratory judgment relating to a regulation recently recommended by the Medical Services Review Committee and approved by the Worker's Compensation Board, and moved forward to the Alaska Lieutenant Governor for his signature by the Alaska Department of Labor and Workforce Development.

JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction pursuant to AS 22.10.020.

7. This Court has personal jurisdiction pursuant to AS 09.05.015.

8. Venue is not improper because the disputed regulation was finally approved in the Third Judicial District and Anchorage is the city where the main office of the Board is housed.

FACTUAL ALLEGATIONS

9. Plaintiff is a Doctor of Chiropractic licensed in Alaska. He owns U-MED Pain Management, which operates three chiropractic clinics located in Anchorage, Alaska. Plaintiff has conducted an active chiropractic practice on all dates relevant to this matter.

10. As a regular part of his practice in conjunction with chiropractic ancillary methodology, Plaintiff uses injection procedures as part of his practice. This treatment has been proven effective for lessening or eliminating pain in repairing joints, tendons, and ligaments. This procedure is administered and billed under seven CPT codes which have been approved by the Board. Plaintiff has billed under these codes and has been paid by employers for these procedures since 2005.

11. Some of Plaintiff's patients are suffering from injuries they sustained at work. Dr. Shannon is paid for his treatment of these patients through their worker's compensation claims.

12. The State of Alaska (SOA) and Municipality of Anchorage (MOA) are self-insured governmental entities and two of Alaska's largest employers. They are represented in worker's compensation claims by an Assistant Attorney General and an Assistant City Attorney, respectively. These attorneys function as insurance defense attorneys.

13. Since 2005 in multiple claims, the SOA and MOA attorneys have attempted to deny Dr. Shannon's fee claims for the injectable treatment described in paragraph 10 above.

14. On August 8, 2019, the Board affirmed in for the fourth time in AWCB 19-00084 that Dr. Shannon's treatment fees must be paid by any insurer of the patient receiving the treatment.

15. Per AS 23.30.097, Defendant Medical Services Review Committee (MSRC) provides an annual Fee Schedule which is adopted via a regulation by the Board.

16. In its adoption of the Fee Schedule at its October 3-4, 2019 meeting, the Board added a paragraph titled "OFF LABEL USE". It is the unlawful addition of this paragraph that is the subject of this action for injunctive relief and for a declaratory judgment.

17. Assistant Attorney General Adam Franklin has taken a particularly aggressive approach in seeking to deny payment to Dr. Shannon for his treatment of worker's compensation patients for procedures billed under approved CPT codes 64450, 20550, 20600, 20605, 20610, 20552, and 20553.

18. AAG Franklin is one of the State of Alaska's worker's compensation attorneys, functionally acting as an insurance defense attorney for the self-insured government entity.

19. AAG Franklin has teamed with Assistant City Attorney Martha Tansik who has been equally aggressive in seeking to deny Plaintiff's fees with regard to MOA worker's compensation claims.

20. In *Sereyko and Shannon v. Municipality of Anchorage*, AWCB Case No. 201802897, the Board filed a Final Decision and Order on August 9, 2019. The Decision (AWCB Decision No.19-00084) concludes that the issue of whether the injections are within a Chiropractic Physician's scope of practice can only be determined by the Board of Chiropractic Examiners, and that the injections were reasonably and medically necessary. The Board pointed out that the MOA attorney stated that the injections would be appropriate if performed by an MD rather than a DC. The Board stated that all of the MOA's objections to paying the claims were scope of practice. The Board ordered MOA to pay the claims.

21. Upon information and belief, Defendant MSRC actively discussed Plaintiff and his fees for treatment in adding the "OFF LABEL USE" paragraph to the 2020 Fee Schedule.

22. Upon information and belief, AAG Franklin has utilized his position in the Attorney General's Office to actively promote the addition of the "OFF LABEL USE" paragraph to the 2020 fee schedule in order to set up denial of payment of Plaintiff's treatments administered to his worker's compensation clients.

23. AAG Franklin has recently indicated that he is not only aware of the unlawful addition of the “OFF LABEL USE” paragraph in the 2020 Fee Schedule, he intends to rely upon the not-yet-enacted regulation to deny payment to Plaintiff in a pending worker’s compensation claim.

24. The Attorney General’s Office not only represents the State of Alaska as insurer and employer in worker’s compensation claims, it represents the Defendants in various capacities including advising the Board on draft regulations and approving of regulations adopted by the Board, as well as advising the Department generally on regulation projects and forwarding adopted regulations to the Lieutenant Governor for his signature and enactment.

25. Upon information and belief, AAG Franklin and his colleagues encouraged Defendant MSRC add the “OFF LABEL USE” paragraph to the 2020 Fee Schedule in order to give the SOA, MOA and any other insurer a means to deny Plaintiff’s treatment fees given the Board of Chiropractic Examiners conclusion that the procedures in question are within Plaintiff’s scope of practice and given the Boards opinion in *Sereyko* that the treatment fees are valid and reimbursable.

26. Now that the unlawful paragraph has been adopted by reference by the Board and Department, other AAG’s will bear the responsibility of approving the regulations project by determining whether or not it was adopted in comportment with the Alaska Administrative Procedure Act (APA) and forwarding it to the Lieutenant Governor for his signature and enactment. This triple representation, the results of which bring direct financial benefit to the SOA, constitutes impermissible and unlawful conflicts of interest that violate multiple provisions of the Alaska Administrative Procedure Act and common law.

27. The “OFF-LABEL USE paragraph reads as follows:

“Off-label Use of Medical Services All medications, treatments, experimental procedures, devices, or other medical services should be medically necessary, having a reasonable expectation of cure or significant relief of a covered condition and supported by medical record documentation, and, where appropriate, should be provided consistent with the approval of the Food and Drug Administration (FDA).

Off-label medical services must include submission of medical record documentation and comprehensive medical literature review including at least two reliable prospective, randomized, placebo-controlled, or double-blind trials. The Alaska Division of Workers' Compensation (ADWC) will consider the quality of the submitted documents and determine medical necessity for off-label medical services. Off-label use of medical services will be reviewed annually by the Alaska Workers' Compensation Medical Services Review Committee (MSRC).”

COUNT I
(Alaska Statute 44.62.060(1))

28. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

29. AS 44.62.060(1) requires that before a regulation can take effect, the Department of Law must have certified that the regulation is legal, constitutional and consistent with other regulations. For the reasons set forth in this count and in related common law counts below, with regard to the OFF-LABEL USE paragraph of Defendant MSRC’s 2020 Fee schedule, the paragraph cannot be so certified by the Department of Law.

30. The OFF-LABEL USE paragraph is illegal because it was inserted to restrain trade. Plaintiff is lawfully engaging in medical procedures as a Chiropractic Physician which are reasonable and medically necessary. The insurance attorneys and medical doctors responsible for inserting this paragraph into Defendant MSRC’s 2020 Fee Schedule have stated in open court that were the injections administered by an M.D. rather than a D.C., they would have no objections to reimbursing an M.D. for the treatments. This paragraph is designed to curb the D.C. practices so that patients are forced to seek out pain treatment from M.D.s. This regulation is designed to shut down Plaintiff’s businesses and funnel those who have sought chiropractic care from Plaintiff to medical doctors for the treatment of their pain.

31. The OFF-LABEL USE is unconstitutional because it is vague and overbroad. Although the paragraph purports to apply to “off-label medical services” which is not defined, but may or may not be the “medications, treatments, experimental procedures, devices, or other medical services” referred to in the first section of the regulation. Because “treatments”, “devices”, “procedures” and “other medical services” may or may not even have labels, determining what is an “off-label use” of such treatments is an impossible guessing game. There are no definitions or any guidance whatsoever offered to medical providers treating injured workers who are bound by the regulation. Because the language of the regulation is so broad and vague, it is susceptible to inconsistent application resulting in denial of reimbursement to only those providers that Defendant AWCD chooses to apply the regulation. This is unconstitutional.

COUNT II
(Alaska Statute 44.62.060(3))

32. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

33. AS 44.62.060(3) encompasses an underlying certification by the Department of Law that any regulation passed under the Alaska Administrative Procedure Act be clear, simple in its expression, and possess the absence of a possibility of misapplication.

34. The “OFF-LABEL USE regulation cannot meet the requirements of AS 44.62.060(3) because it is undefined in all aspects, requires two impossibilities, and is facially prone to misapplication.

35. The OFF-LABEL USE paragraph has three components, all based on requiring all providers to submit extensive documentation of impossible to meet requirements when the bill for providers services is submitted for payment.

36. The first component of the illegal regulation is a general statement that all medications, treatments, experimental procedures, devices or other medical services should be medically necessary, having a reasonable expectation of cure or significant relief of a covered condition and supported by medical record documentation. This component requires the approval of the FDA. This portion of the regulation fails to address that the FDA only approves prescription drugs, which may or may not be the “medications” to which the regulation refers.

37. No additional definitions were provided with the proposed regulation, so providers have no guidance as to what constitutes whether services are “consistent” “where appropriate” with the FDA. “Medically necessary” and “reasonable expectation of cure or significant relief of a covered condition” are not defined.

38. In the *Sereyko* matter, the Board indicated that all medical services are required to be “reasonable and necessary medical treatment” to be reimbursable in worker’s compensation cases. This standard is derived from caselaw.

39. It is unclear whether the first section of the proposed illegal regulation is intended to replace the standard the Board has previously used in this key factor as to whether an injured worker’s medical services will be covered. This is only one of the many aspects of the proposed regulation that are unclear and which possess a tremendous potential of misapplication.

40. The second section of the proposed regulation is even more unclear. It requires, with the use of the word “shall” that any medical provider engaging in an “Off Label Use” of the foregoing “medications, treatments, experimental procedures, devices or other medical services shall submit extensive documentation to qualify for reimbursement.

41. The term “Off Label Use” is undefined. The other terms are undefined as well. Is the injection of an epidural before labor a “medication”, a “treatment” or an “experimental procedure.?”

Use”? What standard will be applied to make the determination? These remain open ended questions, rendering the regulation unusable. Yet, the Attorney General representing the State of Alaska has already declared his intention to rely on the regulation to deny previously submitted claims for reimbursement.

42. Finally, the proposed regulation states that “The Alaska Division of Workers’ Compensation (ADWC) will consider the quality of the submitted documents and determine medical necessity for off-label medical services. Off-label use of medical services will be reviewed annually by the Alaska Workers’ Compensation Medical Services Review Committee (MSRC)”.

43. The regulation does not define with what standard the Defendant ADWC will consider the quality of double blind medical studies, for instance. What employee or employees of the ADWC would have the knowledge to read peer reviewed medical articles in order to determine that the treatment was medically necessary? To what standard of “quality” must the submitted documents meet? There are no definitions or procedures that clarify what this qualitative review of the documents looks like, who performs the review, how long they have to review the documents, and what happens if they determine the documents are not of sufficient “quality”.

44. The last sentence of the regulation is very unclear. An annual review of the off-label medical services by the Defendant MSRC for what? For how many of the claims were paid v. not paid? For how the regulation was administered.

45. The proposed regulation is unclear, is not simple in its expression and is extremely prone to unfair application by the Board. It would be impossible for the Department of Law to find that it is the opposite and meets the requirements in the statute for the Department of Law’s review.

COUNT II
(Alaska Statue 44.62.040(3))

42. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

43. AS 44.62.040(3) provides that every state agency that by statute possesses regulation-making authority shall submit to the lieutenant governor for filing a certified original and one duplicate copy of every regulation or order of repeal adopted by it, except one that is directed to a specifically named person or to a group of persons and does not apply generally throughout the state.

44. Although the regulation in question does not name Plaintiff in its text, the Intent to Rely filed by AAG Alexander, coupled by evidence that the Defendant MSRC specifically discussed Plaintiff as the target of the regulation makes the regulation a violation of the Alaska Administrative Procedure Act.

45. The timing of the regulation is also indicative that it is specifically adopted in order to deny Plaintiff's treatment fees for reimbursement in worker's compensation cases. Defendant Board has just ruled that it could not legally deny Plaintiff's claims when the paragraph was inserted into a fee schedule which is annually adopted by reference. By nesting the paragraph deep in a complex and routinely adopted document, the insurers and medical doctors attempted to insert an alternate mechanism to denying Plaintiff and his patient this form of treatment.

COUNT III
(Alaska Statue 44.62.240)

46. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

47. AS 44.62.240 provides that if a regulation adopted by an agency under this chapter is primarily legislative, the regulation has prospective effect only. A regulation adopted under this chapter that is primarily an "interpretative regulation" has retroactive effect only if the agency

adopting it has adopted no earlier inconsistent regulation and has followed no earlier course of conduct inconsistent with the regulation. Silence or failure to follow any course of conduct is considered earlier inconsistent conduct.

48. The agency has followed a course of conduct with regard to reimbursing plaintiff for the treatments described in this complaint for fourteen years. Although challenged again and again by the insurance companies and the attorneys for the self-insured government entities, the reasonableness and medical necessity of the treatments have been affirmed. The regulation cannot be applied retroactively, although AAG Franklin, by his Notice to Rely, has clearly indicated that is exactly why the regulation was added to the fee schedule.

**COUNT IV
(Direct Financial Benefit)**

49. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

50. This regulation was added by the Administration of the State of Alaska, through Defendant DOLWD for the direct financial benefit of the State of Alaska as a self-insured governmental entity. It is illegal for the state to write laws to financially benefit itself as an insurance company at the expense of its employees.

**COUNT V
(Conflict of Interest)**

52. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

53. The regulation must be voided because of the conflict of interest created between the statutory role of the Department of Law in approving and certifying the advisability of the adoption of regulations to the Lieutenant Governor, its role in advising the Defendants DOLWD, ADWC, and

MSRC as to the legality of the regulation, and its role occupied by AAG Franklin as the attorney

attempting to save the state costs and treatment fees in its worker's compensation claims. Because there is no internal wall between these attorneys and collaboration flows fluidly among the three types of representation, it creates the situation at hand. The insurance defense AAG, frustrated with the court's continued orders to pay the claims, influences the agency AAG to get its division, board, and commission to bury the regulation that will change its fortune in a routine fee schedule annually adopted by reference. The "gatekeeper" guarding the regulatory process works for the exact same AG and chain of command as the attorneys who came up with the plan for the claims to be denied.

**COUNT VI
(Unconstitutionally Vague and Overbroad)**

54. Plaintiffs hereby re-allege and incorporate herein the allegations contained in paragraphs 1–27.

55. Laws, including regulations, must be written in such a manner that those subject to the laws can easily determine what conduct is subject to a requirement and what conduct is not. In addition to the APA requiring constitutionality, the regulation in question is subject to a more general test of vagueness and overbreadth under but the Alaska Constitution and that of the United States of America.

**COUNT VII
(Unenforceability)**

56. Plaintiffs hereby re-allege and incorporate herein the allegations contained in paragraphs 1–27.

57. The regulation cannot be consistently enforced because the language of the regulation raises questions and challenges complying with it that cannot be overcome. Because compliance is impossible, enforcement of the regulation is equally impossible.

**COUNT VIII
(Estoppel and Due Process)**

58. Plaintiff hereby re-alleges and incorporates herein the allegations contained in paragraphs 1–27.

59. The Board has been reimbursing Plaintiff for the questioned services for fourteen years, through many legal challenges. The state must be estopped from attempting to use an end-run around the courts and Plaintiff’s due process to get to a result it could not achieve without making up a law intended to end reimbursement for the treatment.

PRAYER FOR RELIEF

96. An injunction preventing the Alaska Workers Compensation Board from denying claims or requiring documentation as set forth in the paragraph entitled OFF-LABEL USE.

97. A declaratory judgment severing the unlawful paragraph from the 2020 Fee Schedule adopted by Defendant Alaska Worker’s Compensation Board at its October 3-4, 2019 meeting.

98. An award of Alaska R. Civ. P. 79 costs, and the full amount of Alaska R. Civ. P. 82 attorney’s fees incurred in bringing this action; and

99. For such other relief as this Court deems just and proper.

DATED this ____ day of November 2019, at Anchorage, Alaska.

The Law Office of Bradly A. Carlson, L.L.C.
Counsel for Plaintiff John Shannon, Jr., D.C.

Cynthia A. Franklin, ABA #0710057

jnu.law.ecf@alaska.gov

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

JOHN SHANNON, JR., D.C.,)

Plaintiff,)

v.)

STATE OF ALASKA,)

DEPARTMENT OF LABOR AND)

WORKFORCE DEVELOPMENT,)

ALASKA DIVISION OF WORKERS')

COMPENSATION, ALASKA)

WORKERS' COMPENSATION)

BOARD, ALASKA MEDICAL)

SERVICES REVIEW COMMITTEE,)

and ALASKA OFFICE OF THE)

ATTORNEY GENERAL,)

Defendants.)

Case No. 3AN-20-04694 CI

COPY
Original Received
MAR 16 2020
Clerk of the Trial Courts

ANSWER

The Defendants, State of Alaska, Department of Labor and Workforce Development, Alaska Division of Workers' Compensation, Alaska Workers' Compensation Board, Alaska Medical Services Review Committee, and the Alaska Office of the Attorney General (collectively, "the State"), answer the complaint in this action as follows:

THE PARTIES

1. Admitted upon information and belief.
2. Alaska statutes and regulations speak for themselves. This paragraph states legal conclusions to which no response is required. Admitted that the Defendant

1 State of Alaska Department of Labor and Workforce Development (“DOLWD”) is a
2 department of the state under whose auspices the Alaska Workers’ Compensation Board
3 (“the Board”) is formed. Admitted that the DOLWD is tasked with adopting regulations
4 to carry out the provisions of the Alaska Workers’ Compensation Act (“the Act”) and
5 may adopt regulations concerning the medical care provided for under the Act.
6

7 Admitted that regulations adopted by the DOLWD under AS 23.30.005 (h) and (i)
8 become effective only after approval by a majority of the full board.

9 3. Admitted that the Alaska Division of Workers’ Compensation (“the
10 Division”) is a division established in the DOLWD to administer the Act. With respect
11 to the second sentence of this paragraph, Alaska statutes and regulations speak for
12 themselves. The third sentence of this paragraph states legal conclusions to which no
13 response is required. Admitted that the Board is housed in the Division and hears
14 disputes about the payment of benefits under the Act.
15

16 4. Alaska statutes and regulations speak for themselves. This paragraph
17 states legal conclusions to which no response is required. Admitted that the
18 commissioner of the DOLWD appoints a medical services review committee (“the
19 Committee”) to assist and advise the DOLWD and the Board in matters involving the
20 appropriateness, necessity, and cost of medical and related services provided under the
21 Act. Admitted that the Committee establishes fee schedules, which are adopted by the
22 Board in regulation.
23

24 5. Admitted that the Attorney General of the State of Alaska is appointed by
25 and serves at the pleasure of the Governor of the State of Alaska, and that the Attorney
26

1 General is the principal executive officer of the Department of Law. Further admitted
2 that the Department of Law employs hundreds of attorneys, some of whom are Assistant
3 Attorneys General, to carry out the Department's statutory duties. Further admitted that
4 the State of Alaska is a self-insured entity. The balance of this paragraph is denied.
5

6 6. This paragraph states a description of the plaintiff's case to which no
7 response is required.

8 **JURISDICTION AND VENUE**

- 9 7. This paragraph states a legal conclusion to which no response is required.
- 10 8. This paragraph states a legal conclusion to which no response is required.
- 11 9. This paragraph states a legal conclusion to which no response is required.
- 12

13 **FACTUAL ALLEGATIONS**

14 10. Admitted that Plaintiff is a Doctor of Chiropractic licensed in Alaska.
15 Admitted, on information and belief, that Plaintiff owns and operates chiropractic
16 clinics in Alaska. The balance of this paragraph is denied for lack of knowledge.

- 17 11. Denied for lack of knowledge.
- 18 12. Denied for lack of knowledge.
- 19

20 13. Admitted that the State of Alaska is a self-insured governmental entity,
21 that the Department of Law—acting through an Assistant Attorney General—represents
22 the State of Alaska in disputed workers' compensation claims. The remainder of
23 allegations in this paragraph are denied for lack of knowledge.

24
25 14. Admitted that in the course of litigating workers' compensation cases, the
26 State of Alaska has disputed payment for certain treatments, including but not limited to

1 some treatments provided by the Defendant. The second sentence of this paragraph
2 attempts to characterize the import of Alaska Workers' Compensation Board decisions,
3 which speak for themselves, and states a legal conclusion to which no response is
4 required. The balance of this paragraph is denied for lack of knowledge.

6 15. The language of Alaska Workers' Compensation Board Decision
7 19-00084 speaks for itself. This paragraph further states a legal conclusion to which no
8 response is required.

9 16. Alaska statutes and regulations speak for themselves. This paragraph
10 states a legal conclusion to which no response is required.

11 17. Admitted that the Alaska Workers' Compensation Fee Schedule, effective
12 January 1, 2020, contains a paragraph titled "Off-Label Use of Medical Services." This
13 paragraph states a description of the plaintiff's case to which no response is required.
14 The remainder of this paragraph is denied.

15 18. This paragraph states an opinion for which no response is required. This
16 paragraph is also denied for lack of knowledge.

17 19. Admitted that Adam Franklin is employed by the State of Alaska,
18 Department of Law, and that in the course of his employment he represents the State of
19 Alaska, a self-insured employer, in disputed workers' compensation claims. The
20 balance of this paragraph is denied.

21 20. This paragraph states an opinion for which no response is required.
22 Denied that Martha Tansik is an Assistant City Attorney. The remainder of this
23 paragraph is denied for lack of knowledge.

1 21. Alaska Workers' Compensation Board Decision in *Sereyko and Shannon*
2 *v. Municipality of Anchorage*, AWCB Case No. 201802897, speaks for itself. This
3 paragraph states legal conclusions to which no response is required.

4 22. On information and belief, admitted that Plaintiff's treatments were a
5 topic of discussion during a medical services review committee meeting. To the extent
6 that this paragraph suggests the Defendants engaged in any improper or unlawful
7 conduct, those allegations are denied.

8 23. Denied.

9 24. Admitted that in the course of carrying out his official duties on behalf of
10 the State of Alaska Department of Law, AAG Franklin provided notice to the Alaska
11 Workers' Compensation Board that the State, as a self-insured employer, would rely on
12 the regulation adopted by the department. To the extent that this paragraph alleges
13 unlawful conduct, the allegations are denied.

14 25. Admitted that attorneys in the Torts and Workers' Compensation section
15 of the Attorney General's Office represent the State of Alaska, as a self-insured
16 employer, in disputed workers' compensation claims. Further admitted that attorneys
17 employed in other sections of the Department of Law represent the State of Alaska in
18 various other capacities as required by law, including advising the Alaska Workers'
19 Compensation Board on draft regulations, advising State of Alaska agencies and
20 officials on regulations projects, and forwarding adopted regulations to the Lieutenant
21 Governor for his signature and enactment. To the extent that this paragraph alleges
22 unlawful conduct, the allegations are denied.

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26. Denied.

27. Admitted that consistent with their legal authority and obligations, an attorney in the Department of Law reviewed the regulations project for compliance with the Alaska Administrative Procedures Act and that a different attorney in the Department of Law forwarded the regulations packet to the Lieutenant Governor's office. The remainder of this paragraph is denied.

28. The text of the "Off-label Use of Medical Services" provision of the regulation speaks for itself, and thus, requires no response.

COUNT I
THE REGULATION IS NOT LEGAL, CONSTITUTIONAL, OR CONSISTENT
(Alaska Statute 44.62.060(1))

29. Defendants hereby incorporate their responses to paragraphs 1-28.

30. The first paragraph of this allegation states a legal conclusion to which no response is required. To the extent this paragraph contains factual allegations to which a response is required, the allegations are denied.

31. Denied.

32. Denied.

COUNT II
THE REGULATION IS NOT CLEAR OR SIMPLE AND WILL BE
MISAPPLIED AND THE REGULATION IS UNCONSTITUTIONALLY
VAGUE AND OVERBROAD
(Alaska Statute 44.62.060(3))

33. Defendants hereby incorporate their responses to paragraphs 1-32.

34. This paragraph states legal conclusions to which no response is required. The language of AS 44.62.030 speaks for itself.

1 35. The text of the “Off-label Use of Medical Services” provision of the
2 regulation speaks for itself. This paragraph states legal conclusions to which no response
3 is required. To the extent a response is required, this paragraph is denied.

4 36. The text of the “Off-label Use of Medical Services” provision of the
5 regulation speaks for itself. To the extent a response is deemed necessary, this paragraph
6 is denied.

7 37. The text of the “Off-label Use of Medical Services” provision of the
8 regulation speaks for itself. The defendants deny that the regulation is “illegal.” To the
9 extent a response is deemed necessary, this paragraph is denied.
10

11 38. The text of the “Off-label Use of Medical Services” provision of the
12 regulation speaks for itself. This paragraph states legal conclusions to which no response
13 is required. To the extent a response is deemed necessary, this paragraph is denied.
14

15 39. Alaska Workers’ Compensation Board Decision in *Sereyko and Shannon*
16 *v. Municipality of Anchorage*, AWCB Case No. 201802897, speaks for itself. This
17 paragraph states legal conclusions to which no response is required.
18

19 40. This paragraph states legal conclusions to which no response is required.
20 To the extent a response is deemed necessary, this paragraph is denied.

21 41. This paragraph states legal conclusions to which no response is required.
22 To the extent this paragraph contains factual allegations for which a response is
23 required, the allegations are denied.
24

25 42. Defendants deny that the Department of Law acted with an “impermissible
26 motive” and further deny this allegation to the extent it suggests Defendants acted

1 unlawfully. This paragraph states legal argument and poses a series of questions to
2 which no response is required. To the extent this paragraph contains factual allegations
3 for which a response is required, the allegations are denied.

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5 43. The text of the “Off-label Use of Medical Services” provision of the
6 regulation speaks for itself. This paragraph states legal conclusions to which no response
7 is required.

8 44. The text of the “Off-label Use of Medical Services” provision of the
9 regulation speaks for itself. This paragraph states legal arguments and hypothetical
10 questions to which no response is required. To the extent this paragraph contains factual
11 allegations for which a response is required, the allegations are denied.

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13 45. This paragraph states legal arguments to which no response is required. To
14 the extent this paragraph contains factual allegations for which a response is required,
15 the allegations are denied.

16 46. This paragraph states legal arguments to which no response is required. To
17 the extent this paragraph contains factual allegations for which a response is required,
18 the allegations are denied.

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20 47. This paragraph states legal conclusions to which no response is required.
21 To the extent this paragraph contains factual allegations for which a response is
22 required, the allegations are denied.

23 48. Denied.
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COUNT III
THE REGULATION TARGETS SPECIFIC PRACTICES
OF CHIROPRACTIC PHYSICIANS
(Alaska Statute 44.62.040(3))

49. Defendants hereby incorporate their responses to paragraphs 1-48.

50. The language of AS 44.62.040 speaks for itself. This paragraph states legal conclusions to which no response is required. To the extent a response is required, this paragraph is denied.

51. This paragraph states legal conclusions to which no response is required. To the extent this paragraph contains factual allegations for which a response is required, the allegations are denied.

52. Denied.

COUNT IV
THE REGULATION IS INTENDED TO BE APPLIED RETROSPECTIVELY IN
VIOLATION OF THE ALASKA ADMINISTRATIVE PROCEDURE ACT
(Alaska Statute 44.62.240)

53. Defendants hereby incorporate their responses to paragraphs 1-52.

54. The text of AS 44.62.240 speaks for itself. This paragraph states legal conclusions to which no response is required. To the extent a response is required, this paragraph is denied.

55. This paragraph states legal conclusions to which no response is required. To the extent this paragraph alleges unlawful conduct, it is denied.

56. This paragraph states legal conclusions, argument, or demands for relief to which no response is required. To the extent a response is required and to the extent it alleges the Defendants violated the law in some manner, this paragraph is denied.

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COUNT V
JUSTIFICATION FOR THE REGULATION IS SUBTERFUGE FOR
IMPERMISSIBLE MOTIVE OF ATTORNEY GENERAL AND BOARD

57. Defendants hereby incorporate their responses to paragraphs 1-56.

58. This paragraph states legal arguments to which no response is required. To the extent this paragraph states factual allegations for which a response is required, this paragraph is denied.

59. This paragraph states legal arguments to which no response is required. To the extent this paragraph states factual allegations for which a response is required, this paragraph is denied.

60. Denied.

61. Denied.

COUNT VI
THE REGULATION GRANTS POWERS TO THE BOARD
WITHOUT LEGISLATIVE AUTHORITY
(Alaska Statute 44.62.020)

62. Defendants hereby incorporate their responses to paragraphs 1-61.

63. Alaska Workers' Compensation Board Decision in *Sereyko and Shannon v. Municipality of Anchorage*, AWCBC Case No. 201802897, speaks for itself. This paragraph states legal conclusions to which no response is required. To the extent this paragraph state factual allegations for which a response is required, this paragraph is denied.

64. Alaska Workers' Compensation Board Decision in *Sereyko and Shannon v. Municipality of Anchorage*, AWCBC Case No. 201802897, speaks for itself. This

1 paragraph states legal conclusions to which no response is required. To the extent this
2 paragraph states factual allegations for which a response is required, this paragraph is
3 denied.

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5 65. This paragraph states legal arguments to which no response is required. To
6 the extent this paragraph states factual allegations for which a response is required, this
7 paragraph is denied.

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9 66. This paragraph states legal arguments to which no response is required. To
10 the extent this paragraph states factual allegations for which a response is required, this
11 paragraph is denied.

12 67. Denied.

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14 68. The text of the “Off-label Use of Medical Services” provision of the
15 regulation speaks for itself. This paragraph states legal arguments to which no response
16 is required. To the extent this paragraph contains factual allegations for which a
17 response is deemed necessary, this paragraph is denied.

18
19 69. The text of the “Off-label Use of Medical Services” provision of the
20 regulation speaks for itself. This balance of this paragraph is denied.

21 **AFFIRMATIVE DEFENSES**

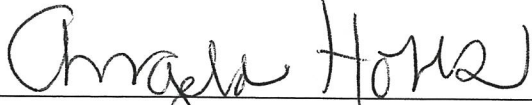
- 22 1. Some or all of the plaintiff’s claims are nonjusticiable.
23 2. The plaintiff has failed to state a claim on which relief can be granted.
24 3. Some or all of the relief requested by the plaintiff is not within the court’s
25 power to grant.
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CERTIFICATE OF SERVICE

The undersigned certifies that on March 16, 2020, a copy of the foregoing document, **STATE'S ANSWER**, was mailed via USPS, first class postage prepaid, addressed to:

Cynthia A. Franklin
Law Office of Bradly A. Carlson, LLC
645 G. Street, Suite 100 #558
Anchorage, AK 99501



Angela Hobbs, Law Office Assistant II