ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE

May 31, 2023

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TAB 1

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING
May 31, 2023

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
Telephone 977-853-5247 ID 817 3076 3835
Zoom Conference https://us02web.zoom.us/j/81730763835

AGENDA

May 31, 2022

1:00 pm Call to order
- Roll call - establishment of quorum
- Approval of Agenda
- Issues from AWCB, DWC staff or MSRC

1:50 pm Break

2:00 pm Public Comment Period

3:00 pm Break

3:10 pm Overview/Discussion of MSRC Fee Schedule Issues
- Approval of meeting dates
- Effects of recent Legislation (if any)
- Changes in CMS that effect Alaska
- National Council on Compensation Insurance: Analysis of Alaska Medical Fee Schedule Changes, Effective January 29, 2023
- Consider details of cost and reimbursement of Ambulatory Surgery Center fees and compare to Hospital Outpatient
- Possible language changes to clarify DME
- Clarification of language for Chiropractic billing and reimbursement
- Discussion of regulation 8 AAC 45.086 language on treatment plans
- Treatment guidelines and drug formularies

5:00 pm Adjournment

TAB 2

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 25, 2022

Seat	**Last Name**	**First Name**	**Affiliation**
Chairperson	Collins	Charles	Director, Division of Workers' Compensation
Alaska State Medical Association	Moore, MD	Jeffery	Orthopedic Physicians Anchorage, Inc.
Alaska Chiropractic Society	McCloskey, DC	Mason	Kanady Chiropractic Center
Alaska State Hospital & Nursing Home Association	Gilbert	Jeff	St. Elias Specialty Hospital
Medical Care Provider	Foland, MD	Mary Ann	Primary Care Associates
Lay Member – Industry	Steed	Misty	PACBLU
Lay Member – Industry	Scott	Pam	Northern Adjusters, Inc.
Lay Member – Labor	Mittelstead	Valerie	IBEW
Lay Member – Industry	Kosinski	Susan	ARECA Insurance Exchange

TAB 3

ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE JANUARY 29, 2023

NCCI estimates that the changes to the medical fee schedule in Alaska, effective January 29, 2023[1], will result in an impact of +0.5% on overall workers compensation system costs.

SUMMARY OF CHANGES

The Alaska medical fee schedule (MFS), effective January 29, 2023, is based on 2023 Medicare values with state-specific conversion factors (CFs) established by the Department of Labor and Workforce Development (DLWD).

The changes to the Alaska MFS, effective January 29, 2023, include the following:

Provider Schedule

- Update the maximum allowable reimbursements (MARs) to be based on 2023 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT[2] code and published by the Centers for Medicare and Medicaid Services (CMS). The prior MARs were based on the 2022 Medicare RBRVUs.

- All physician services' CFs remain unchanged.

Hospital Outpatient and Ambulatory Surgical Center (ASC)

- Update the MARs to be based on 2023 Medicare Outpatient Prospective Payment System (OPPS) relative weights. The prior MARs were based on 2022 OPPS relative weights.

- The CFs for Hospital Outpatient and ASC services remain unchanged.

Hospital Inpatient

- Update the MARs to be based on 2023 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior MARs were based on 2022 MS-DRG weights. The DLWD establishes multipliers for each hospital to be applied to the Medicare MAR. There is no change to the multipliers.

[1] Per Alaska DLWD Bulletin 23-01: "Due to unanticipated delays, the Alaska Workers' Compensation Medical Fee Schedule published January 1, 2023, will not take effect until January 29, 2023."
[2] Current Procedural Terminology maintained by the American Medical Association.

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Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

- Update the MARs to be based on the 2023 Medicare DMEPOS Fee Schedule. The prior MARs were based on the 2022 DMEPOS Fee Schedule.

- There is no change to the multiplier established by the DLWD.

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
    - 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, observed payments are aggregated according to 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.
    - Any potential impact from the share of costs not subject to the fee schedule will be realized in future claim experience and reflected in subsequent NCCI loss cost filings, as appropriate.

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 and durable medical equipment, prosthetics, orthotics, and supplies fee schedule changes, a price realization factor of 80% is assumed.

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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 2021. Due to low data volume, the hospital inpatient impact analysis is based on NCCI's Medical Data Call for Alaska for Service Years 2020 and 2021. Reported medical experience for COVID-19 claims as reported in NCCI Call 31 for Large Loss and Catastrophe have been excluded from the data on which this analysis is based.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from Policy Years 2017, 2018, 2019, and 2020 projected to the effective date of the benefit changes.

SUMMARY OF IMPACTS

The impacts from the fee schedule changes in Alaska, effective January 29, 2023, 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	+0.2%	46.1%	+0.1%
Hospital Inpatient	+1.7%	10.7%	+0.2%
Hospital Outpatient	+0.5%	15.1%	+0.1%
ASC	+2.6%	10.7%	+0.3%
DMEPOS	+1.8%	6.4%	+0.1%
Combined Impact on Medical Costs (D) = Total of (C)			**+0.8%**
Medical Costs as a Share of Overall Costs (E)			66%
Combined Impact on Overall Costs (F) = (D) x (E)			**+0.5%**

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.

NON-QUANTIFIED CHANGES

- Maximum reimbursement for dental services and ambulance services are also governed by the fee schedule in Alaska. The share of these payments with a MAR makes up a small portion of medical costs. Therefore, the impact on overall costs due to updating the fee schedule for these services is not anticipated to be material. As such, any potential impact from this change will be realized in future claim experience and reflected in subsequent NCCI loss cost filings in Alaska, as appropriate.

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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	3.5%	0.0%
Surgery	25.1%	+0.4%
Radiology	9.4%	-1.3%
Pathology & Laboratory	0.8%	0.0%
Evaluation & Management	21.1%	+0.3%
Medicine	36.3%	+0.5%
Other HCPCS*	0.0%	0.0%
Payments with no MAR	3.8%	–
Total	**100.0%**	**+0.2%**

*Healthcare Common Procedure Coding System

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	96.2%	+0.2%	+0.2%
Hospital Inpatient	79.2%	+2.1%	+1.7%
Hospital Outpatient	91.0%	+0.6%	+0.5%
ASC	92.9%	+3.3%	+2.6%
DMEPOS	27.6%	+2.3%	+1.8%

THIS DOCUMENT AND ANY ANALYSIS, ASSUMPTIONS, AND PROJECTIONS CONTAINED HEREIN PROVIDE AN ESTIMATE OF THE POTENTIAL PROSPECTIVE SYSTEM 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, JON SINCLAIR, FCAS, MAAA, AM A DIRECTOR AND 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.

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TAB 4

ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

Workers' Compensation Medical Services Review Committee

Medical Services Review Committee Members

Charles Collins, Chair
Jeff Moore, MD
Mason McCloskey, DC
Mary Ann Foland, MD
Jeff Gilbert
Misty Steed
Pam Scott
Valerie Mittelstead
Susan Kosinski

Contents

Foundation

Establishment under Alaska Statute 23.30.095:

Medical treatments, services, and examinations.

(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.

In accordance with Alaska Statute 23.30.097:

Fees for medical treatment and services.

(a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section. A fee or other charge for medical treatment or service

(1) rendered in the state may not exceed the lowest of

(A) the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, for treatment or service provided on or after December 31, 2010, not to exceed the fees or other charges as specified in the fee schedules established by the medical services review committee and adopted by the board in regulation; the fee schedules must include

(i) a physician fee schedule based on the federal Centers for Medicare and Medicaid Services' resource-based relative value scale;

(ii) an outpatient and ambulatory surgical center fee schedule based on the federal Centers for Medicare and Medicaid Services' ambulatory payment classification; and

(iii) an inpatient hospital fee schedule based on the federal Centers for Medicare and Medicaid Services' Medicare severity diagnosis related group;

(B) the fee or charge for the treatment or service when provided to the general public; or

(C) the fee or charge for the treatment or service negotiated by the provider and the employer under (c) of this section;

(2) rendered in another state may not exceed the fee or charge for a treatment or service set by the workers' compensation statutes of the state where the services are rendered.

Committee

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.

Chairperson	Charles Collins	**Director, Division of Workers' Compensation**
Alaska State Medical Association	Jeff Moore, MD	**Orthopedic Physicians Anchorage, Inc.**
Alaska Chiropractic Society	Mason McCloskey, DC	**Kanady Chiropractic Center**
Alaska State Hospital & Nursing Home Association	Jeff Gilbert	**Providence – St. Elias Specialty Hospital**
Medical Care Provider	Mary Ann Foland, MD	**Primary Care Associates**
Lay Member – Industry	Misty Steed	**PACBLU**
Lay Member – Industry	Pam Scott	**Northern Adjusters, Inc.**
Lay Member – Labor	Valerie Mittelstead	**IBEW**
Lay Member – Industry	Susan Kosinski	**ARECA Insurance Exchange**

The committee is assisted by Carla Gee and Nannette Orme from Optum.

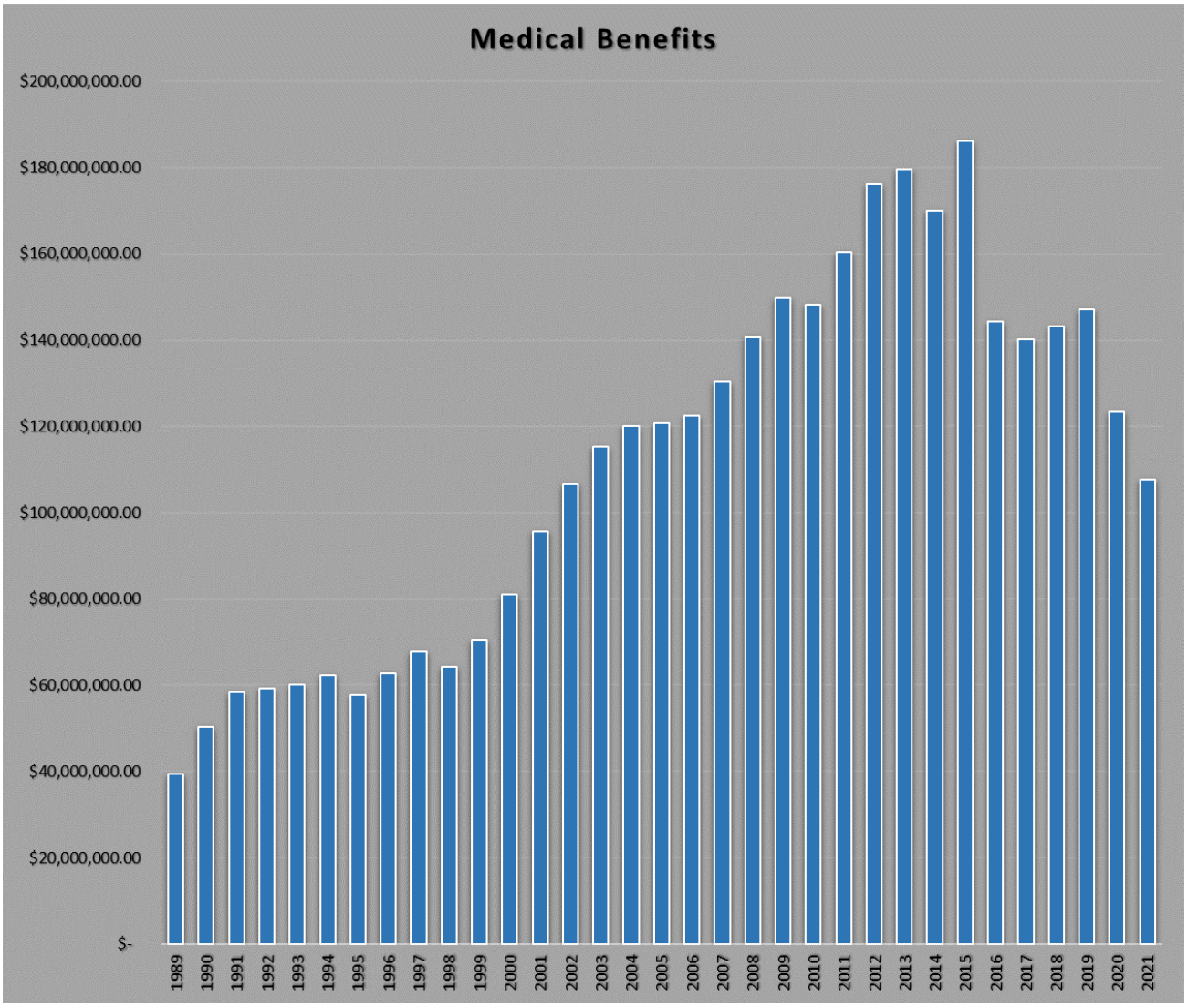
Schedule for 2023

Meeting dates for this year are May 31 at 1pm, June 16, at 9am, July 14 at 9am, and August 4 at 9am. The committee is invited to meet in-person on May 31 and August 4 at the Board room, suite 208 of the Eagle Street building. Address is Department of Labor and Workforce Development 3301 Eagle St., Anchorage, AK 99503. All meetings will also be broadcast with Zoom and the June and July meetings will only be virtual. To conduct business a quorum must be present.

A joint AWCB/MSRC meeting will be held in person on August 26th, 2023, in the same location. The committee recommendations will be presented at this meeting.

Concerns and issues to be addressed at each meeting with the following questions already on the agenda.

Trend Line for Medical Benefits



Medical spend in Alaska has moderated with the implementation of the RBRVU fee schedule effective in 2016. Alaska's spend on medical benefits reached a twenty year low in 2021, this is the most recent data available and reflects both out work on the Fee Schedule but also a slightly diminished workforce.

The effects forecasted by National Council of Compensation Insurance, (NCCI), the state's actuary, were recently shared with the Division. These show a small increase in costs is forecasted for 2023, with an overall impact on workers' compensation system costs of +0.5%.

The impacts from the fee schedule changes in Alaska, effective January 29, 2023, 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
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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.

Comparing medical costs from Alaska with other states is a difficult maneuver. All states have different workers' compensation laws, medical fee schedules, and sometimes more direct state control of reimbursement amounts. For example, Washington is a monopolistic workers' compensation state, this allows for direct control by the state government on insurance coverage, benefit reimbursement, and medical provider referral.

The most common denominator to gauge progress of properly reimbursing for medical providers is to use Medicare as the base line and compare the difference between state fee schedule amounts to Medicare on an annual basis. Included are tables from a study by the Workers' Compensation Research Institute charting costs in comparison to Medicare, in 2019 Alaska had an overall score of 179% above the Medicare fee schedule and the highest among the states with a fee schedule in the nation. In 2022, Alaska has reduced the overall score to 153%, but continues to lead the nation in relation to Medicare.

Table 3b Workers' Compensation Difference from Medicare, February 2019

State	Overall	Emergency Services	Evaluation and Management	Major Radiology		Minor Radiology		Neurological/ Neuromuscular Testing	Physical Medicine	Pain Management Injections	Major Surgery
				Professional Component	Technical Component	Professional Component	Technical Component				
Alabama	80	29	1	312	249	323	151	0	62	32	250
Alaska	179	122	122	444	432	444	444	122	122	358	358
Arizona	101	84	82	132	256	132	137	83	84	132	150
Arkansas	51	29	33	105	123	105	124	35	32	114	121
California[a]	27	27	27	27	27	27	27	27	27	27	27
Colorado	50	51	50	157	103	99	87	97	22	95	98
Connecticut	71	55	54	101	108	110	96	90	25	161	247
Delaware[a]	41	80	-4	25	172	57	58	69	23	145	153
District of Columbia	13	13	13	13	11	13	13	13	13	13	13
Florida[a]	19	9	8	10	143	10	3	7	11	37	41
Georgia	83	50	52	149	168	149	146	71	52	68	224
Hawaii	30	95	37	72	23	54	16	22	22	19	33
Idaho	108	104	108	157	173	157	174	110	44	174	302
Illinois[a]	98	145	8	251	513	277	179	124	45	212	303
Kansas	60	61	62	62	77	63	59	72	36	116	129
Kentucky	98	128	62	102	435	142	127	79	74	143	154
Louisiana[b]	50	60	4	83	285	109	91	12	43	40	105
Maine	73	72	72	71	74	71	75	73	71	73	80
Maryland	33	28	28	28	29	28	29	28	28	49	68
Massachusetts	1	-9	-17	-4	185	-8	18	-36	-31	11	109
Michigan	34	34	33	33	39	33	28	34	34	32	34
Minnesota	78	94	92	94	102	95	82	90	59	93	94
Mississippi	79	36	37	88	109	88	131	77	65	197	217
Montana	73	69	71	72	82	72	66	74	75	71	66
Nebraska	72	84	45	150	152	155	150	57	39	109	204
Nevada	159	158	40	492	936	358	224	62	86	152	414
New Mexico	87	91	56	399	243	176	85	75	66	110	139
New York[a]	16	71	-24	109	226	181	70	-10	-12	-4	107
North Carolina	54	69	40	95	95	95	95	53	43	62	95
North Dakota	108	112	108	109	99	109	106	106	107	108	115
Ohio	51	41	40	41	46	41	34	41	42	62	118
Oklahoma	41	43	40	103	305	74	46	-1	3	51	90
Oregon	95	98	95	110	258	110	98	87	67	160	135
Pennsylvania[a]	58	44	10	142	416	137	90	16	39	39	119
Rhode Island[d]	96	27	29	192	179	177	123	34	n/c	204	215
South Carolina	38	39	38	39	44	39	44	39	39	37	35
South Dakota	42	88	1	163	357	103	44	7	14	7	126
Tennessee[c]	47	89	51	89	89	89	89	51	23	89	89
Texas[a]	69	64	64	64	61	64	64	64	64	64	106
Utah	56	44	58	63	80	63	65	51	44	86	82
Vermont[b]	41	39	-1	164	n/a	146	n/a	7	33	109	91
Virginia[a]	104	336	59	185	386	234	223	160	60	210	195
Washington	78	79	78	79	85	78	70	79	78	76	79
West Virginia	35	35	35	35	32	34	34	35	35	35	35
Wyoming	49	89	3	197	425	130	64	13	9	22	157

Notes: Positive numbers in this table, from Fomenko and Liu (2019), reflect a percentage above the Medicare fee schedule levels for a state, and negative numbers in this table reflect a percentage below the Medicare fee schedule levels for a state. The 30 fee schedule states that are included in this MPI-WC report are in bold typeface.

Table 3a Workers' Compensation Difference from Medicare, March 2022

State	Overall	Emergency Services	Evaluation and Management	Major Radiology		Minor Radiology		Neurological/ Neuromuscular Testing	Physical Medicine	Pain Management Injections	Major Surgery
				Professional Component	Technical Component	Professional Component	Technical Component				
Alabama	88	29	-4	375	329	385	140	9	80	40	267
Alaska	153	131	131	250	247	250	250	131	131	244	244
Arizona	97	91	93	105	123	106	106	98	94	108	108
Arkansas	59	37	41	115	139	116	140	44	40	130	138
California[a]	34	34	34	34	34	34	34	34	34	34	34
Colorado	54	58	54	95	97	96	82	94	36	90	96
Connecticut	65	36	36	101	112	110	99	89	30	157	252
Delaware[a]	42	86	-10	43	183	76	48	69	31	148	166
District of Columbia	13	13	13	13	12	13	13	13	13	13	13
Florida[a]	15	2	-5	16	170	16	-10	8	12	33	42
Georgia	95	61	63	169	196	171	172	89	65	85	256
Hawaii	26	83	20	80	37	60	3	24	25	16	32
Idaho	117	117	120	171	192	171	193	123	53	195	329
Illinois[a]	102	148	2	302	631	330	166	145	56	229	337
Kansas	61	60	48	77	103	77	46	83	45	120	142
Kentucky	91	116	42	115	501	158	100	91	76	147	165
Louisiana[b]	45	49	-9	92	340	121	70	15	44	45	105
Maine	82	80	81	79	85	79	85	82	80	83	91
Maryland	46	40	40	40	41	40	41	40	40	64	85
Massachusetts	-5	-13	-27	1	213	-2	4	-37	-31	6	106
Michigan	39	39	39	38	47	39	35	41	40	38	39
Minnesota	78	90	75	109	120	110	70	98	69	92	101
Mississippi	81	27	22	96	132	97	80	85	69	264	277
Montana	77	76	76	76	85	77	70	79	77	75	76
Nebraska	86	102	59	175	176	177	176	73	53	129	237
Nevada	163	153	31	567	1169	410	210	74	100	164	434
New Mexico	95	82	66	433	292	228	86	94	77	120	147
New York[a]	31	112	-11	140	294	219	61	70	6	7	120
North Carolina	52	69	40	95	94	95	95	53	43	62	95
North Dakota	112	117	112	112	106	112	109	109	110	111	120
Ohio	51	42	42	41	49	42	37	44	43	65	118
Oklahoma	41	51	41	124	153	87	25	40	16	73	103
Oregon	97	110	96	108	299	110	101	94	73	167	129
Pennsylvania[a]	75	57	11	194	550	190	91	34	62	53	154
Rhode Island[c]	n/c	28	20	222	225	206	108	38	n/c	211	235
South Carolina	43	45	32	48	56	49	47	50	49	46	44
South Dakota	34	78	-12	178	408	112	25	6	13	4	126
Tennessee[d]	55	100	60	100	100	100	100	60	31	100	100
Texas[a]	85	80	80	80	79	80	80	80	81	80	126
Utah	65	54	68	72	92	73	76	62	52	98	97
Vermont[b]	34	32	-13	179	n/a	162	n/a	8	31	111	87
Virginia[a]	115	340	78	219	470	277	199	179	71	224	218
Washington	67	67	68	66	77	64	63	72	65	68	67
West Virginia	35	35	35	35	34	34	35	35	34	35	35
Wyoming	40	78	-10	214	485	140	43	12	9	18	156

Notes: Positive numbers in this table, from Fomenko and Liu (2022), reflect a percentage above the Medicare fee schedule levels for a state, and negative numbers in this table reflect a percentage below the Medicare fee schedule levels for a state. The 30 fee schedule states that are included in this MPI-WC report are in bold typeface.

NCCI also charts workers' compensation reimbursement to Medicare schedule reimbursement as shown here:

The chart below shows the average percentage of Medicare schedule reimbursement[3] amounts for physician payments by category for Alaska, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the categories listed in the chart, and the state comparison reflects Medicare's geographic adjustments. In Alaska, 93% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

Physician Service Category	Alaska	Region	Countrywide
General and Physical Medicine	162%	139%	136%
Surgery	308%	207%	276%
Evaluation and Management	184%	146%	135%
Radiology	350%	197%	229%
Anesthesia	302%	261%	319%
All Physician Services	**209%**	**156%**	**167%**

Goals for 2024 Alaska Medical Fee Schedule

Continue the work with an overall goal of staying in the 10th to 12th range on the Oregon biannual workers' compensation rating list. The MSRC believes this range when compared to other jurisdictions nationwide is an appropriate goal for the committee.

A more detailed look at the costs and reimbursement in the Ambulatory Surgery Center fees as compared to Hospital Outpatient. Medical services provided at both are very important and the MSRC is committed to understanding the proper reimbursement level. Currently some difference in the costs of like procedures have given rise to concern for employers and their insurance adjusters.

The MSRC will also carefully consider both treatment guidelines and drug formularies at next year's meetings. As the continued concern over "continuing and multiple treatments of a similar nature" a consensus among the committee on the benefits an evidence-based guideline was discussed. The MSRC has asked to be updated on the status of other jurisdictions who have moved to this process. Further work on the subject is proposed for the summer of 2023.

Should the schedule include a section on addiction preventive practice or counseling?

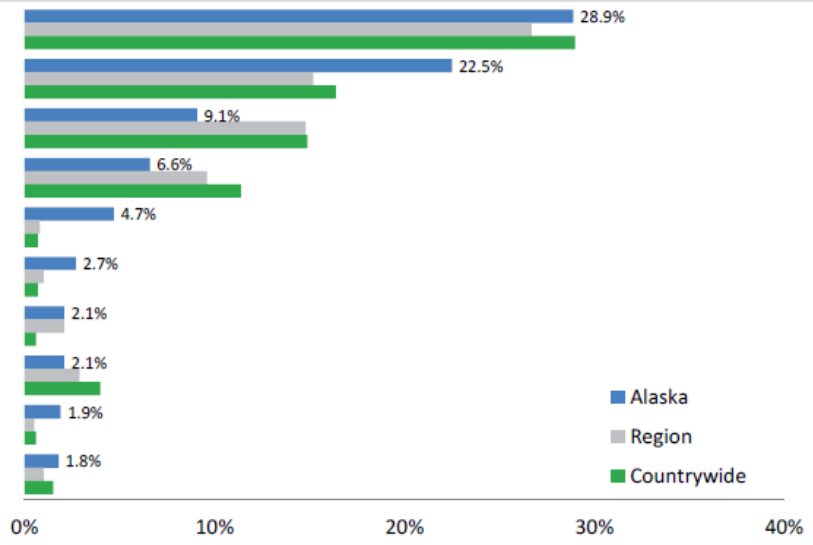
Alaska Utilization Performance

The following chart shows the top codes for utilization from the annual Medical Data Report.

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPU AK	Region	CW
97110	$65	$42	$42
97140	$59	$39	$39
97530	$74	$54	$47
97112	$70	$47	$43
98941	$87	$67	$56
98940	$70	$53	$45
97124	$54	$36	$36
97014	$34	$20	$22
97012	$39	$21	$22
97035	$35	$20	$23



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97012	Application of a modality to 1 or more areas; traction, mechanical
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes

E & M Codes in Alaska

Top Evaluation and Management Codes 2020			
CPT	Transactions	Gross Total	Location of Performance
99213	6,682	$ 1,209,864.51	Established patient office or other outpatient visit, 20-29 minutes
99214	3,002	$ 769,932.82	Established patient office or other outpatient visit, 30-39 minutes
99456	364	$ 614,821.33	Work related medical disability examination by other than treating physician, complex evaluation
99203	1,609	$ 448,113.08	New patient office or other outpatient visit, 30-44 minutes
99204	545	$ 240,610.06	New patient office or other outpatient visit, 45-59 minutes
99284	711	$ 556,381.95	Emergency room vist of moderate complexity with injury of high severity
99283	1,605	$ 750,142.03	Emergency room vist of moderate complexity
99212	1,296	$ 153,144.07	Established patient office or other outpatient visit, 10-19 minutes
99202	526	$ 105,331.27	New patient office or other outpatient visit, 15-29 minutes
99285	238	$ 237,274.23	Emergency room vist of moderate complexity with injury of high severity and significant threat to life
99232	258	$ 46,590.39	Subsequent hospital care, per day, for evaluation and management of patient

Top Evaluation and Management Codes 2021			
CPT	**Transactions**	**Gross Total**	**Location of Performance**
99213	6768	$ 1,396,239.05	Established patient office or other outpatient visit, 20-29 minutes
99214	2431	$ 663,011.80	Established patient office or other outpatient visit, 30-39 minutes
99456	340	$ 565,898.14	Work related medical disability examination by other than treating physician, complex evaluation
99203	1844	$ 513,129.87	New patient office or other outpatient visit, 30-44 minutes
99204	738	$ 299,000.02	New patient office or other outpatient visit, 45-59 minutes
99284	356	$ 156,341.51	Emergency room vist of moderate complexity with injury of high severity
99283	622	$ 180,070.82	Emergency room vist of moderate complexity
99212	1338	$ 174,596.36	Established patient office or other outpatient visit, 10-19 minutes
99202	408	$ 74,415.42	New patient office or other outpatient visit, 15-29 minutes
99285	180	$ 120,661.72	Emergency room vist of moderate complexity with injury of high severity and significant threat to life
99232	207	$ 38,904.96	Subsequent hospital care, per day, for evaluation and management of patient

CPT Codes used by Chiropractors in Alaska

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. CPT © 2022 American Medical Association. All Rights Reserved. 33 Medicine 2023 Alaska Workers' Compensation Medical Fee Schedule

• 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.

Chiropractic Specific Codes 2020			
CPT	Transactions	Gross Total	Treatment
97014	741	$ 29,102.19	Electrical Stimulation
97810	203	$ 17,472.95	Initial Acupuncture
97811	69	$ 15,344.18	Subsequent unit of Acupuncture
97813	24	$ 3,872.07	Initial Acupuncture with electrical stimulation
97814	18	$ 2,544.53	Subsequent unit of Acupuncture with electrical stimulation
98940	955	$ 133,846.13	Chiropractic manipulative treatment Spinal 1-2 regions
98941	1903	$ 285,475.21	Chiropractic manipulative treatment Spinal 3-4 regions
98942	62	$ 14,481.88	Chiropractic manipulative treatment Spinal 5 regions
98943	567	$ 56,295.91	Chiropractic manipulative treatment Extraspinal 1 or more regions

Other common billed codes by Alaskan chiropractors in 2020 were:

Chiropractic Specific Codes 2020			
CPT	Transactions	Gross Total	Treatment
97140	2668	$382,970.76	Manual Therapy
97012	1303	$ 51,518.13	Mechanical Traction
97124	928	$107,684.33	Massage Therapy
97110	830	$ 83,917.73	Therapeutic Procedure
97035	593	$ 22,637.01	Ultrasound Therapy
97026	421	$ 5,512.09	Infrared Light Therapy

Compared to 2021

Chiropractic Specific Codes 2021			
CPT	Transactions	Gross Total	Treatment
97012	1134	$ 45,760.05	Mechanical Traction
97014	584	$ 21,758.15	Electrical Stimulation
97026	335	$ 4,701.27	Infrared Light Therapy
97035	702	$ 27,359.47	Ultrasound Therapy
97810	149	$ 11,821.95	Initial Acupuncture
97811	125	$ 7,996.49	Subsequent unit of Acupuncture
97813	13	$ 991.98	Initial Acupuncture with electrical stimulation
97814	12	$ 854.14	Subsequent unit of Acupuncture with electrical stimulation
98940	1873	$ 130,364.94	Chiropractic manipulative treatment Spinal 1-2 regions
98941	3313	$ 288,416.41	Chiropractic manipulative treatment Spinal 3-4 regions
98942	220	$ 21,040.41	Chiropractic manipulative treatment Spinal 5 regions
98943	1289	$ 79,060.69	Chiropractic manipulative treatment Extraspinal 1 or more regions

Some codes are used by other providers.

97012	**39**	**52151.67**	**37.33**	**0**	**1333**
Chiropractor	16	45760.05	0	0	1134
Clinic/Center	4	920.61	0	0	39
Family Medicine	1	130.26	0	0	3
General Practice	6	602.71	37.33	0	17
Orthopaedic Surgery	1	152.36	0	0	4
Physical Therapist	10	4433.32	0	0	132
Single Specialty	1	152.36	0	0	4

The chiropractic codes have been referenced for this meeting as a request for a wording change has been put forth by the Alaska Chiropractic Society to reduce confusion. The current Alaska Workers' Compensation medical fee schedule on page 33 refers to certain CPT codes that may be reported by Chiropractors. This statement has caused a

few reimbursement companies to decide these were the limiting codes a chiropractor may use. While this was installed to give guidance to providers to what was allowed it has been construed as a limiting factor upon occasion.

A possible solution is to place language that refers providers to bill those codes that fall within the scope of practice for their profession. The medical fee schedule is a publication of the Alaska Workers' Compensation Board and as such must adhere to direction of billing under the workers' compensation act and refrain from directing any provider to operate outside of the scope of their license. The practice of allowing the proper authority to dictate the procedures allowable under a license from the State of Alaska has served the AWCB well historically.

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. (Compensation, 2023)

HCPCS Level II

The Division has received several inquiries on Durable Medical Equipment reimbursement issues. The providers and medical billing professionals have expressed confusion on the proper reimbursement when an item is not identified by code. An answer may require the production of an invoice from the provider for each item not covered by a unique code.

The dispensing, fitting, and adjusting of hearing aids is still a factor. This issue continues to plague our partners and injured workers suffer from the misapplication of the fee schedule. Several instances of billing to injured workers for an adjustment or supplies have been noted.

Treatment Plans

AS 23.30.095 Medical services, treatments and examinations.

(c) A claim for medical or surgical treatment, or treatment requiring continuing and multiple treatments of a similar nature, is not valid and enforceable against the employer unless, within 14 days following treatment, the physician or health care provider giving the treatment or the employee receiving it furnishes to the employer and the board notice of the injury and treatment, preferably on a form prescribed by the board. The board shall, however, excuse the failure to furnish notice within 14 days when it finds it to be in the interest of justice to do so, and it may, upon application by a party in interest, make an award for the reasonable value of the medical or surgical treatment so obtained by the employee. When a claim is made for a course of treatment requiring continuing and multiple treatments of a similar nature, in addition to the notice, the physician or health care provider shall furnish a written treatment plan if the course of treatment will require more frequent outpatient visits than the

standard treatment frequency for the nature and degree of the injury and the type of treatments. The treatment plan shall be furnished to the employee and the employer within 14 days after treatment begins. The treatment plan must include objectives, modalities, frequency of treatments, and reasons for the frequency of treatments. If the treatment plan is not furnished as required under this subsection, neither the employer nor the employee may be required to pay for treatments that exceed the frequency standard. The board shall adopt regulations establishing standards for frequency of treatment.

Would guidance inserted into the Fee Schedule assist providers and payers in setting up and reimbursing properly for ongoing treatments? Alaska statute and regulations thoroughly cover what constitutes a treatment plan, however questions and concerns arise in the implementation and continuation of these plans.

The committee has discussed the possibility of Evidence Based Medicine guides in the past with no clear direction provided. Presentations have been provided by vendors of the service with implementation plans, but the AWCB has not decided to move that direction.

Compensation, A. W. (2023, January 29). Official Alaska Workers' Compensation Medical Fee Schedule. Juneau, Alaska.

TAB 5

Workers' Compensation
Medical Services Review Committee
Meeting Minutes

August 5, 2022

I. Call to order

Director of Workers' Compensation Charles Collins, Chair of the Medical Services Review Committee, called the Committee to order at 9:04 am on Friday, August 5, 2022. The meeting was held by telephone and video conference.

II. Roll call

Director Collins conducted a roll call. The following Committee members were present, constituting a quorum:

Dr. Mary Ann Foland	Jeffery Gilbert	Susan Kosinski	Mason McCloskey
Valerie Mittelstead	Pam Scott	Misty Steed	

Member Jeffery Moore was excused. Director Collins introduced the senior staff present, and Carla Gee and Nan Orme with Optum.

III. Approval of Agenda

The Committee reviewed the agenda. The agenda was adopted unanimously.

IV. Review of Minutes

A motion to approve the July 15, 2022 meeting minutes was made by member Foland and seconded by member Gilbert. The motion passed unanimously.

V. Fee Schedule Guidelines Development Discussion

Carla Gee and Nan Orme of Optum presented the draft 2023 Fee Schedule.

The committee discussed a regulation loophole that when a diagnosis is changed, a provider may continue to treat outside of the guidelines for continuing and multiple treatments of a similar nature.

The Committee discussed changes to the Physician's Report, form 07-6102.

The committee discussed the CMS Web Pricer.

Break 10:00 am – 10:15 am

VI. Public Comment

Written public comment was received from Healthesystems, LLC, regarding treatment guidelines and progress reports.

Mike Hamilton, representing Med Data

- Commented on the CMS Web Pricer pass-through function.

VII. Fee Schedule Guidelines Development Discussion, continued

The committee discussed the CMS Web Pricer pass-through. Carla will add information to the CMS Web Pricer example provided in the Fee Schedule.

The committee discussed dates for the 2023 MSRC meetings. The proposed meeting dates in 2023 were May 24, June 16, July 14, and August 4, and joint meeting August 25.

The Committee discussed goals for 2023. Member Steed suggested that the Committee draft a legislative proposal regarding treatment guidelines. Member Kosinski suggested that the Committee review data regarding ambulatory surgical centers versus hospital outpatient facilities and consider changing the conversion factors.

Member Foland motioned to approve the 2023 Fee Schedule as discussed and amended, and member Kosinski seconded. The motion passed unanimously.

A motion to adjourn was made by Member Kosinski and seconded by Member Gilbert. The motion passed unanimously.

Meeting Adjourned 12:10 pm

TAB 6

STATE OF ALASKA
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICES REVIEW COMMITTEE

NOTICE OF PUBLIC MEETINGS: The Medical Services Review Committee will hold a series of public meetings on the following dates. These meetings are open to the public. Please note the differing start times and Participation options.

Meeting Date	Time	Public Comment	Participation
May 31, 2023	1:00 PM to 5:00 PM	2:00 to 3:00	In-Person and Zoom
June 16, 2023	9:00 AM to 5:00 PM	10:15 to 11:15	Zoom Only
July 14, 2023	9:00 AM to 5:00 PM	10:15 to 11:15	Zoom Only
August 4, 2023	9:00 AM to 5:00 PM	10:15 to 11:15	In-Person and Zoom

- In-Person meetings will be held at 3301 Eagle St. Rm 208, Anchorage, AK 99503
- To participate telephonically, call 877-853-5247, Meeting ID: 817 3076 3835
- To participate by Zoom Video Conference: https://us02web.zoom.us/j/81730763835

The purpose of these meetings is to discuss and make recommendations to the department and the Workers' Compensation Board involving the appropriateness, necessity, and cost of medical and related services provided under the Workers' Compensation Act (see AS 23.30.095(j). The primary deliverable shall be recommendations relating to Alaska Medical Fee Schedule to be adopted under 8 AAC 45.083 for calendar year 2024.

Public comment will be taken at each meeting at the times noted in the above table and may be extended to accommodate those on the present before the start time. If you are unable to participate telephonically, you may submit written comments prior to the meeting for consideration. Send written comments to:

Medical Services Review Committee
PO Box 115512
Juneau, AK 99811-5512
workerscomp@alaska.gov

Individuals or groups of people with disabilities, who require special accommodations, should contact Alexis Hildebrand at (907) 465-6059 or alexis.hildebrand@alaska.gov at least five working days in advance of each meeting. Please provide as much advance notice as possible for the Department of Labor and Workforce Development to take the necessary steps to accommodate your needs.

For additional information regarding this meeting, please contact the Division of Workers' Compensation at 465-2790 or workerscomp@alaska.gov.

TAB 7

Medical Data Report

For the state of

ALASKA

October 2022

NCCI's **Medical Data Report** and its content are intended to be used as a reference tool and for informational purposes only. No further use, dissemination, sale, assignment, reproduction, preparation of derivative works, or other disposition of this report or any part thereof may be made without the prior written consent of NCCI.

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Introduction

Medical costs have been growing over the last 30 years. Today, in many states, close to 60% of workers compensation benefits are attributed to medical costs. Managing the cost and delivery of medical care is one of the major concerns facing workers compensation (WC) stakeholders now and in the foreseeable future. The availability of medical data on WC claims is essential for the pricing of proposed state legislation and assessing impacts of changes to fee schedules.

This publication is a data source for regulators and others who are interested in the driving forces behind changing medical costs in WC claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that underlie the financial soundness of the WC system. When making comparisons to the region and countrywide (CW), it is important to note that some states in this report do not have a fee schedule.

Knowing how payments for different services contribute to WC medical benefit costs provides insight into the growth of medical benefits. This report illustrates the breakdown of services by category, namely:

- Physician
- Hospital Outpatient
- Hospital Inpatient
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Other

The report drills down into these categories to show which procedures represent the greatest share of payments and which are performed the most.

There is one important caveat: Information in this report may not coincide with an analysis of a medical fee schedule change performed in the future. An analysis of a medical fee schedule change requires evaluation of the specific procedures covered by the fee schedule, which may be different from how payments are categorized in this report.

The data contained in this report represents medical transactions for Service Year 2021 (medical services delivered from January 1, 2021, to December 31, 2021), except where otherwise noted. WC insurance carriers must report paid medical transactions if, over the most recent three years, they write at least 1% of the market share in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, it is required to report for all applicable states in which it writes WC insurance. All carriers within an insurance group are required to report.

No data adjustments have been made for the reporting of COVID-19-related claims. For more information on the impacts of COVID-19 on medical losses, please see the Medical Indicators & Trends dashboard[1] on **ncci.com**.

Changes made to this edition of the Medical Data Report include:

- The addition of Texas data for 2019 and beyond
- A revision to the definition of major surgery to include spine/spinal cord neurostimulators surgical procedures (previously categorized as nonmajor surgery)
- The American Medical Association (AMA) updates for some evaluation and management procedure codes (i.e., removal of code 99201 and revised severity and time phraseology for Codes 99202–99205 and 99211–99215)

[1] www.ncci.com/Articles/Pages/Insights-Medical-Indicators-Trends-Dashboard.aspx

For Alaska in Service Year 2021, the reported number of transactions was more than 142,000, with more than $47,751,300 paid, for more than 7,000 claims. This represents data from 92% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

Unless otherwise noted, the source for all data in this report is NCCI's Medical Data Call, Service Year 2021.
Also:

- Region includes data from the following states: AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT.
- Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV
- Texas data is included for Service Year 2019 and beyond

Additional information regarding the data underlying this report is available in the Appendix.

Table of Contents

Medical Cost Statistics

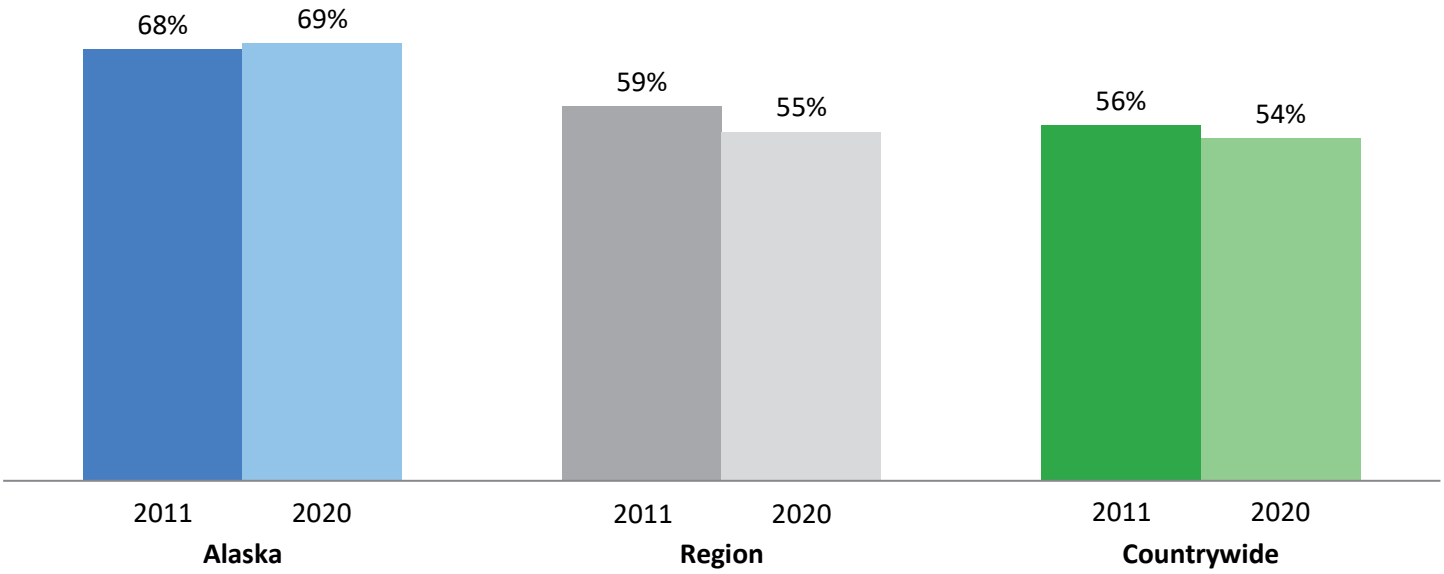
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost drivers for workers compensation claims on a countrywide basis. Because this is a relative measure and benefits for both indemnity and medical may vary from state to state, the share of medical benefit costs may vary across states. In particular, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

Chart 1 displays the medical percentage of total benefit costs for Alaska, the region, and countrywide for Accident Years 2011 and 2020.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data 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.

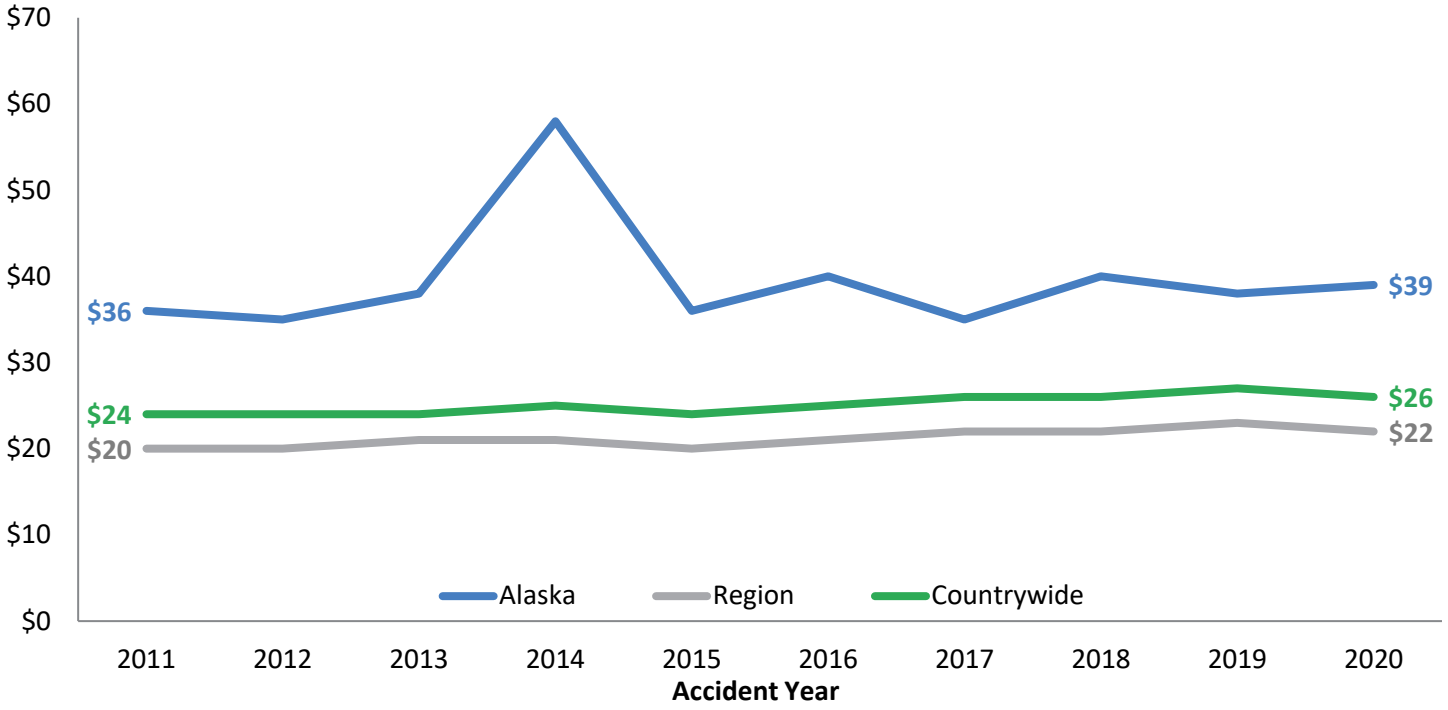
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 1% from Accident Years 2011 to 2020; this has increased at a slightly lower rate than the United States Personal Healthcare Spending per capita.[2] Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for Alaska, the region, and countrywide.

Medical losses are at historical benefit levels and historical dollar values—meaning that no adjustment for inflation or changes in benefits has been made. Since the data is aggregated for medical losses of lost-time claims by accident year, the results shown in this chart provide a high-level perspective of the average medical cost per case.

This chart illustrates how Alaska compares to the regional and countrywide average for each individual accident year and allows for the comparison of the growth in average medical costs.

Chart 2

Overall Medical Average Cost per Lost-Time Claim (in 000s)



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data 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.

[2] **State of the Line Report, *Annual Issues Symposium***, May 2022, www.ncci.com/Articles/Pages/AIS2022-SOTL-Presentation.pdf

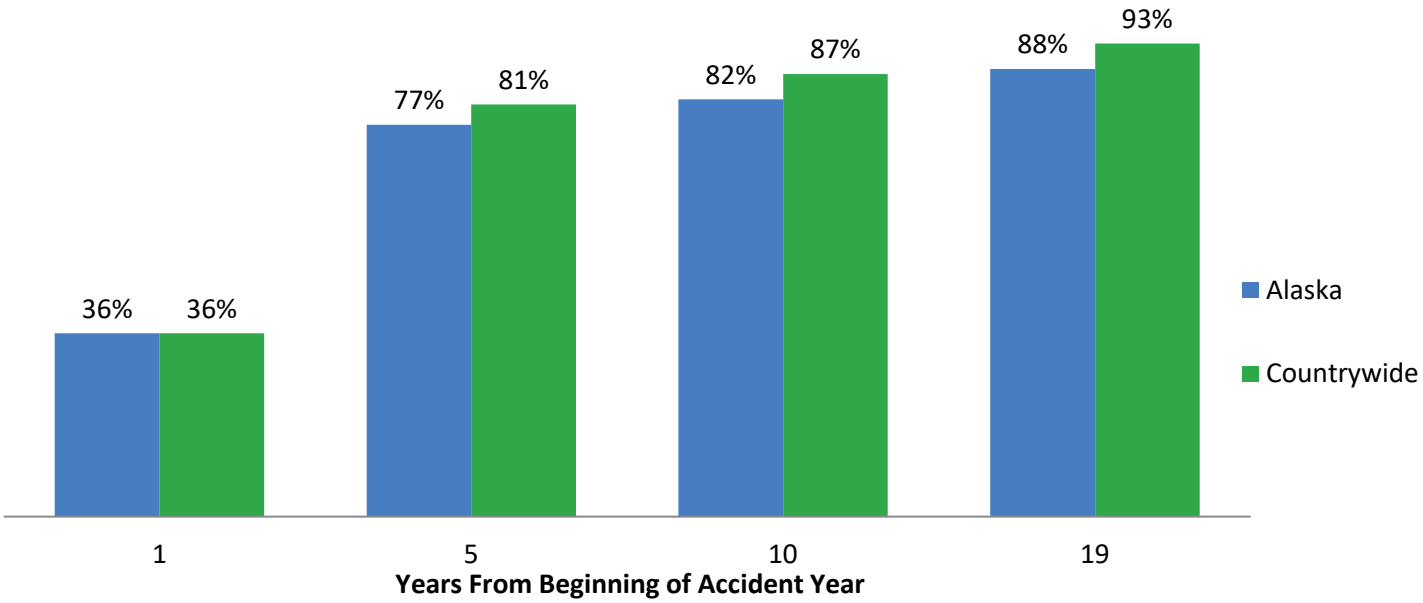
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will be for services provided more than two decades into the future.

A key determinant driving payment patterns for medical services is the effectiveness of dispute resolution processes, settlement practices, and statutory provisions for medical benefits. An aging workforce and continued changes in rules for Medicare set-asides have created a shifting environment for the settlement of claims and, particularly, medical benefits.

Chart 3 shows the percentage of medical benefits paid (including medical settlements) at different claim maturities for Alaska and countrywide.

Chart 3

Percentage of Medical Paid by Claim Maturity



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Countrywide data 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, and VT. The data for year 19 above does not include NV or TX.

Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits.

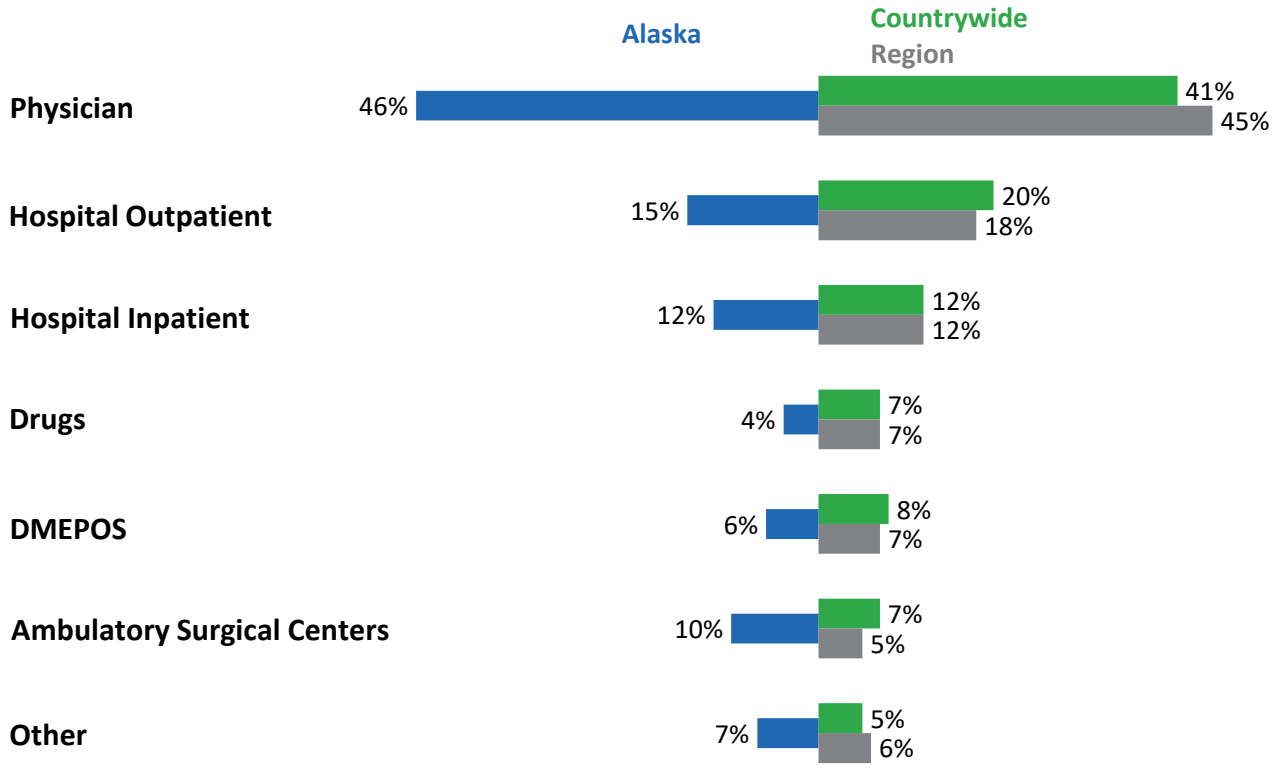
Payments categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services) are based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the remaining categories—Physicians, Hospital Outpatient, Hospital Inpatient, and Ambulatory Surgical Centers (ASC)—NCCI relies on a combination of:

- Provider taxonomy code—identifies the type of provider that billed for, and is being paid for, a medical service
- Procedure code—alphanumeric code used to identify procedures performed by medical professionals
- Place of services—alphanumeric code used to identify places where procedures were performed (e.g., physician's office or ambulatory surgical center)

Chart 4 displays the distribution of medical payments by type of service.

Chart 4

Distribution of Medical Payments



Physicians

In the 1970s, fewer than a dozen states had physician fee schedules in place. In the 1990s, several states established such schedules. Today, few states remain without a physician fee schedule. Recent changes in the schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability. NCCI's most recent study, "The Impact of Fee Schedule Updates on Physician Payments" (December 2018), shows that:

- Approximately 80% of any change in the maximum allowable reimbursement (MAR) for a physician service will be realized as a change in prices paid
- Most of the impact of a MAR change on prices paid is realized within one year from the date of a fee schedule change

One measure of workers compensation medical costs is a comparison of current payments to the Medicare rates adjusted for your state.

The chart below shows the average percentage of Medicare schedule reimbursement[3] amounts for physician payments by category for Alaska, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the categories listed in the chart, and the state comparison reflects Medicare's geographic adjustments. In Alaska, 93% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

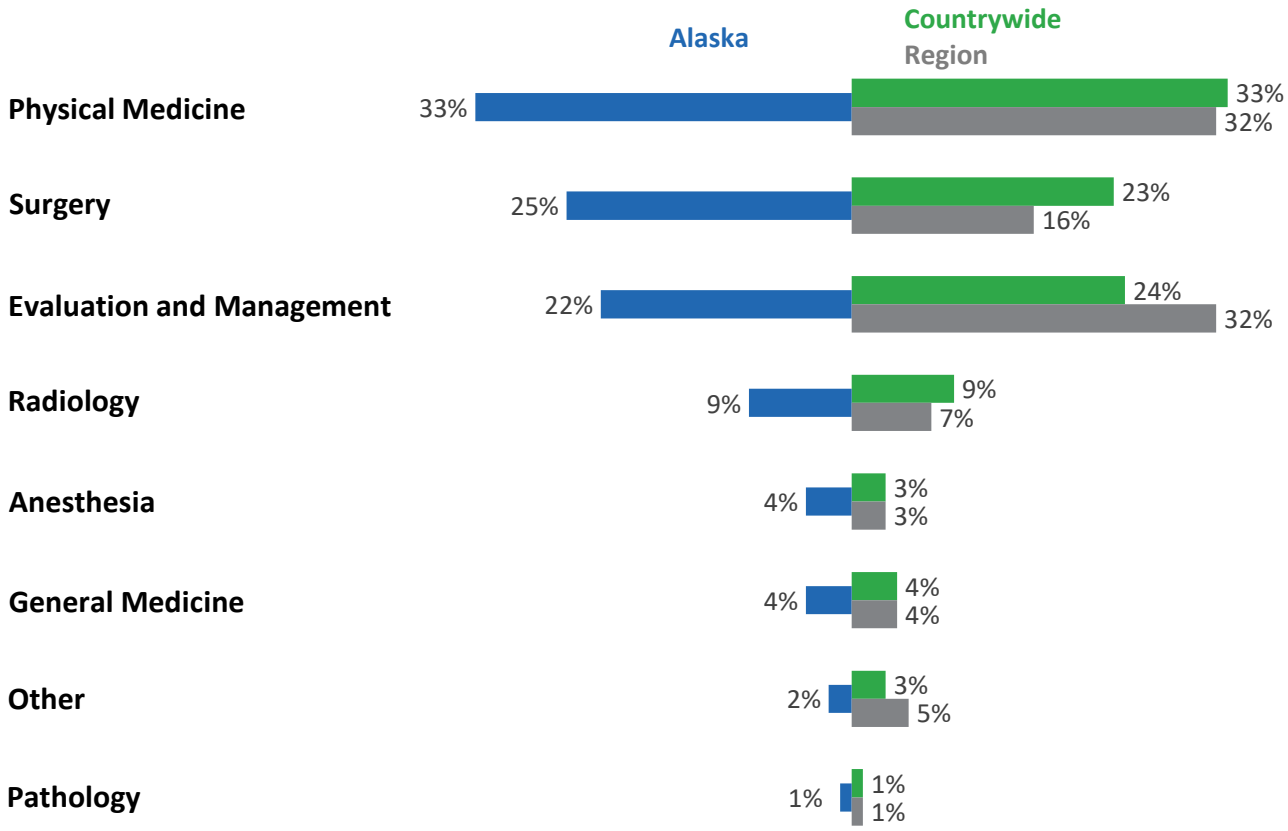
Physician Service Category	Alaska	Region	Countrywide
General and Physical Medicine	162%	139%	136%
Surgery	308%	207%	276%
Evaluation and Management	184%	146%	135%
Radiology	350%	197%	229%
Anesthesia	302%	261%	319%
All Physician Services	**209%**	**156%**	**167%**

[3] The calculation for Surgery takes into account Medicare's endoscopic procedures reimbursement rules.

Chart 6 displays the distribution of physician payments by service category for Alaska, the region, and countrywide.

Chart 6

Distribution of Physician Payments by AMA Service Category



In 2019, NCCI conducted a review of physician costs in workers compensation as compared to group health (GH). Results[4] show that WC physician costs are 77% higher than GH in general, with variation across states ranging from 0% to 200%. The difference in costs for physician services is due to both prices and utilization of services. Most notably, physical medicine services in WC are almost three times the costs of physical medicine services in GH, largely due to the number of services provided.

Physicians typically use current procedural terminology (CPT) codes to identify the services that they provide to claimants. These codes are specific and provide detailed information on what service was performed. The charts below display the top 10 procedure codes reported by physicians for the following service categories: anesthesia, surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code is displayed in the corresponding table below each chart.

Except for anesthesia codes and physical & general medicine codes, the charts also include the average amount paid per transaction (PPT) for these codes in Alaska, in the region, and countrywide. The average PPT is calculated by taking the total payments for the procedure code and dividing by the number of transactions for the procedure code. Other fields, such as the secondary paid procedure code, modifier, diagnosis code, place of service, and quantity/units, may need to be considered when evaluating average payments per service. The charts for the top 10 anesthesia codes and physical & general medicine codes include the average amount paid per unit (PPU) for the codes in Alaska, in the region, and countrywide. The PPU is calculated by taking the total payments for the procedure code and dividing by the number of units for the procedure code. For these codes, a unit is typically a measurement of time (15-minute increment, 30-minute increment, 1-hour increment, etc.) but can also be one transaction. The procedure code description will indicate the unit measurement.

The Top 10 charts rank the procedure codes for each service category using two different methods. The first method ranks procedure codes by total payments. Procedure codes are sorted from highest total payments to lowest total payments. The procedure code with the highest amount paid is ranked first, the procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows those procedures that represent the highest percentage share of payments.

The second method ranks procedure codes by total count of transactions. The procedure code with the highest total transaction count is ranked first, the procedure code with the second highest total transaction count is ranked second, and so on. This method reveals the most frequently used procedures.

Additional charts show time until first treatment and results for telemedicine services. Time to initial treatment (TTT) is a measure of the availability of medical services and is measured by the number of days between the date of injury and the date on which the worker first received medical services. Telemedicine services charts are based on transactions reported with a telemedicine-specific procedure code, modifier, or place of service and show the distribution, as well as the top 10 procedure codes, for telemedicine service.

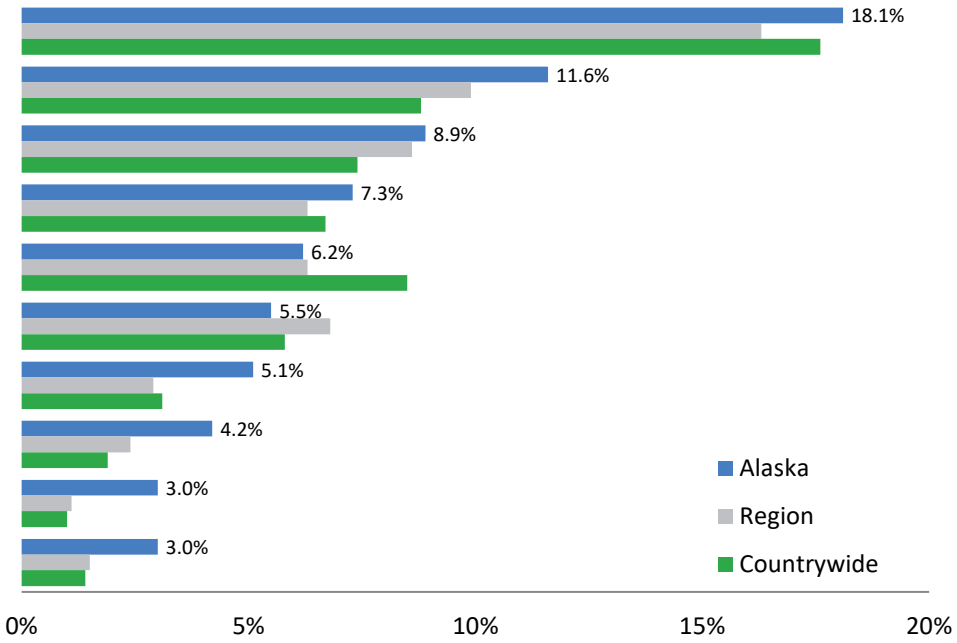
[4] Lipton, Barry, *Work Comp vs. Group Health—The Price We Pay* (Channel NCCI, video file), May 23, 2019, www.youtube/fb3tnbQoMSY

In Alaska, physician payments for anesthesia services provided in 2021 are, on average, 302% of Medicare-scheduled reimbursement amounts, compared to 261% in the region and 319% countrywide. Payments for these services comprise 4% of physician payments, compared to 3% in the region and 3% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid

	Average PPU[5]			
Code	**AK**	**Region**	**CW**	**Paid Share**
01630	$142	$86	$97	18.1%
01400	$131	$92	$100	11.6%
01830	$128	$76	$81	8.9%
01810	$145	$85	$96	7.3%
00670	$174	$102	$111	6.2%
01480	$121	$71	$75	5.5%
00630	$176	$109	$109	5.1%
00840	$152	$91	$102	4.2%
01610	$158	$91	$101	3.0%
01402	$170	$88	$96	3.0%



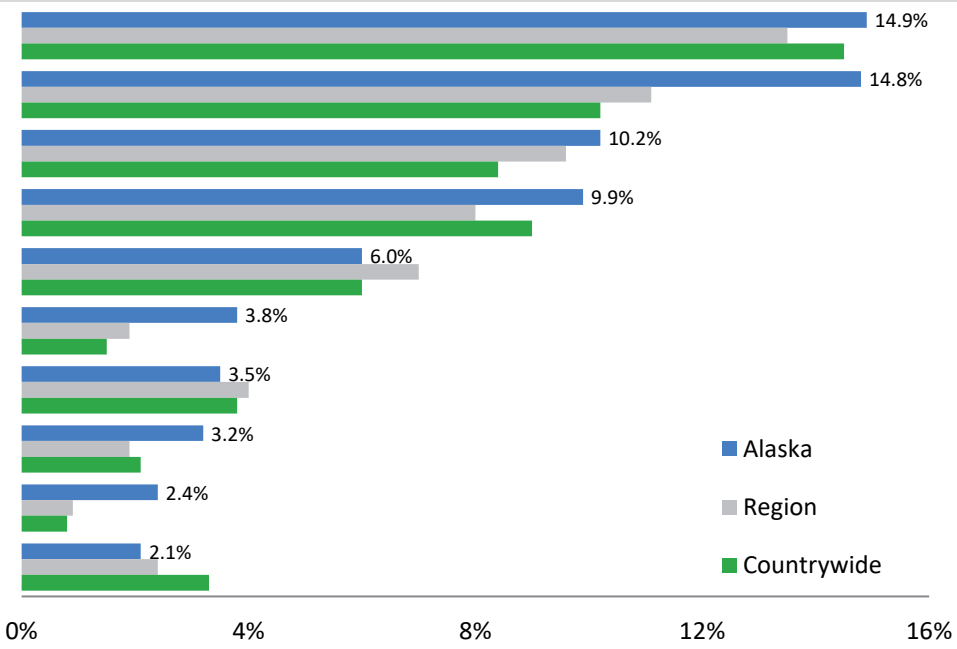
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
00630	Anesthesia for procedures in lumbar region; not otherwise specified
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty

[5] A unit is an increment of 15 minutes unless otherwise defined in the description.

Chart 8

Top 10 Anesthesia Procedure Codes by Transaction Counts

Code	Average PPU AK	Region	CW
01630	$142	$86	$97
01400	$131	$92	$100
01830	$128	$76	$81
01810	$145	$85	$96
01480	$121	$71	$75
00840	$152	$91	$102
00400	$122	$73	$81
00630	$176	$109	$109
01610	$158	$91	$101
00670	$174	$102	$111



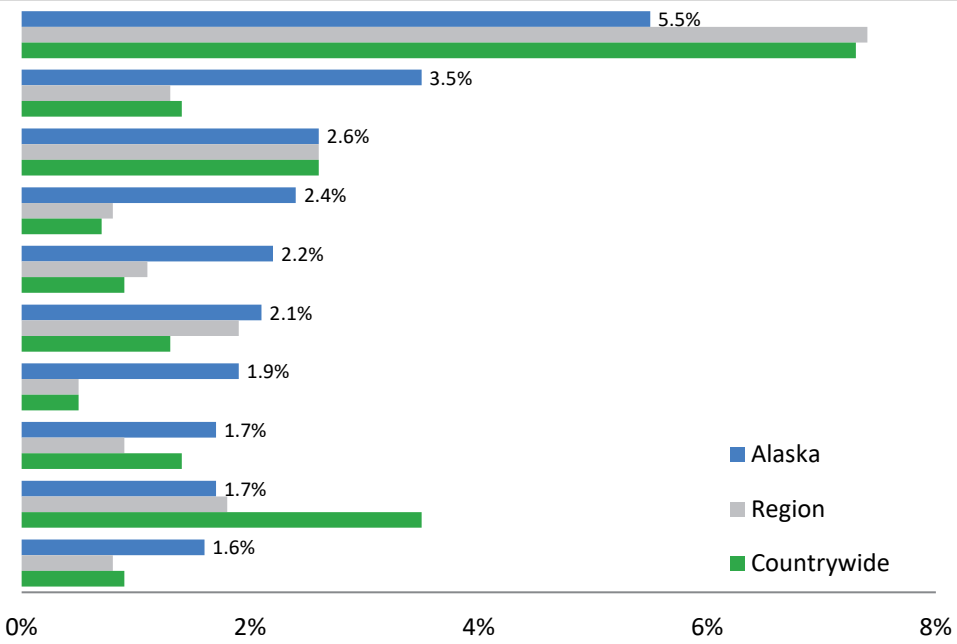
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
00630	Anesthesia for procedures in lumbar region; not otherwise specified
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)

In Alaska, physician payments for surgery services provided in 2021 are, on average, 308% of Medicare-scheduled reimbursement amounts, compared to 207% in the region and 276% countrywide. Payments for these services comprise 25% of physician payments, compared to 16% in the region and 23% countrywide.

Chart 9

Top 10 Surgery Procedure Codes by Amount Paid

Code	Average PPT AK	Region	CW
29827	$3,040	$1,780	$2,253
23430	$1,469	$813	$1,227
29881	$2,196	$1,021	$1,515
29807	$4,339	$1,866	$2,495
29806	$3,925	$2,128	$2,899
29888	$3,132	$1,730	$2,133
23412	$2,586	$1,219	$1,741
29824	$1,090	$627	$857
29826	$764	$445	$993
27447	$3,844	$2,193	$2,925

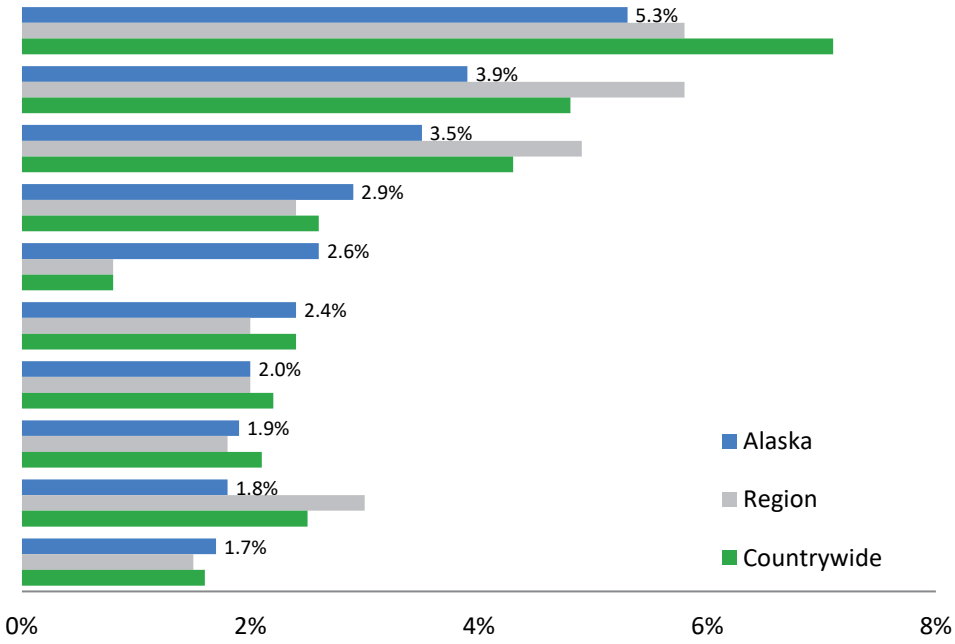


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23430	Tenodesis of long tendon of biceps
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
29807	Arthroscopy, shoulder, surgical; repair of superior labral tear from anterior to posterior (SLAP) lesion
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)

Chart 10

Top 10 Surgery Procedure Codes by Transaction Counts

Code	Average PPT AK	Region	CW
20610	$246	$118	$135
12001	$308	$156	$186
36415	$13	$11	$11
64415	$345	$157	$291
23430	$1,469	$813	$1,227
29826	$764	$445	$993
29827	$3,040	$1,780	$2,253
64483	$855	$440	$625
12002	$406	$192	$217
20550	$216	$100	$114

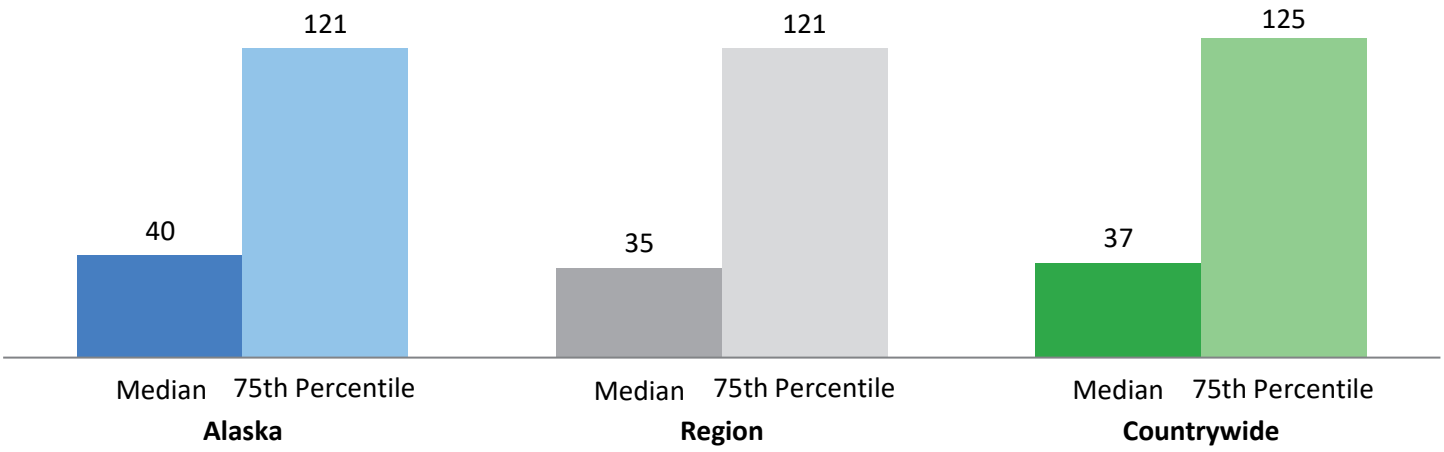


Code	Description
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
36415	Collection of venous blood by venipuncture
64415	Injection, anesthetic agent; brachial plexus, single
23430	Tenodesis of long tendon of biceps
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
20550	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)

Chart 11 shows the median and 75th percentile[6] time until first treatment for major surgery for Alaska, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 11

Time Until First Treatment for Major Surgery[7] (in Days)



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

[6] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 11 indicates that out of 100 claimants, 75 will receive a major surgery within 121 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

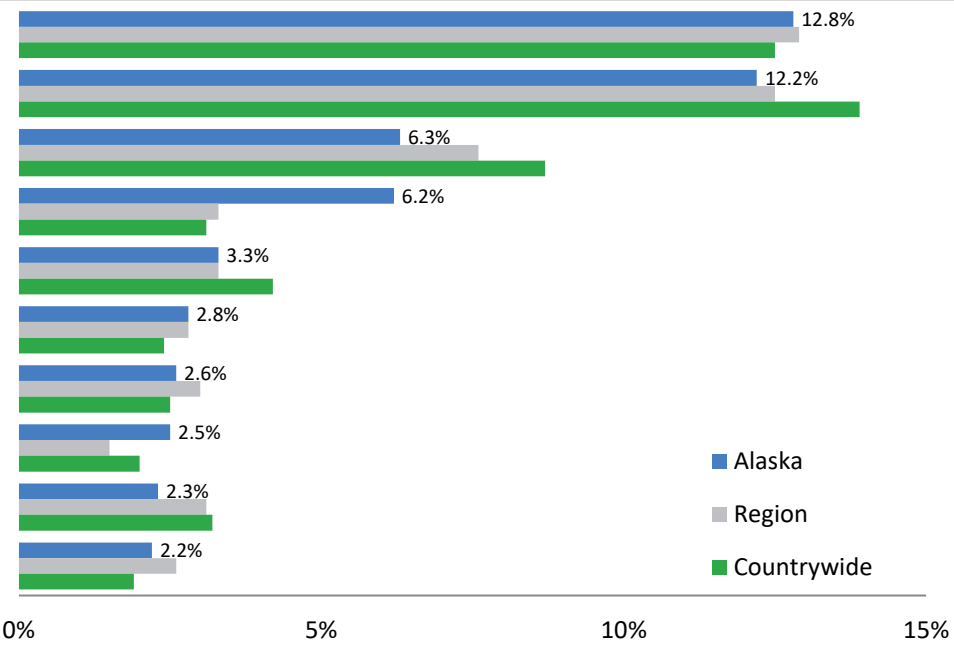
[7] A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, or the procedure involves spine/spinal cord neurostimulators.

In Alaska, physician payments for radiology services provided in 2021 are, on average, 350% of Medicare-scheduled reimbursement amounts, compared to 197% in the region and 229% countrywide. Payments for these services comprise 9% of physician payments, compared to 7% in the region and 9% countrywide.

Chart 12

Top 10 Radiology Procedure Codes by Amount Paid

Code	Average PPT AK	Region	CW
73721	$807	$395	$476
73221	$876	$394	$489
72148	$716	$381	$465
73222	$1,270	$521	$640
72141	$784	$372	$462
73110	$134	$61	$65
73610	$124	$55	$59
76942	$172	$74	$115
73030	$117	$54	$61
73562	$135	$63	$66

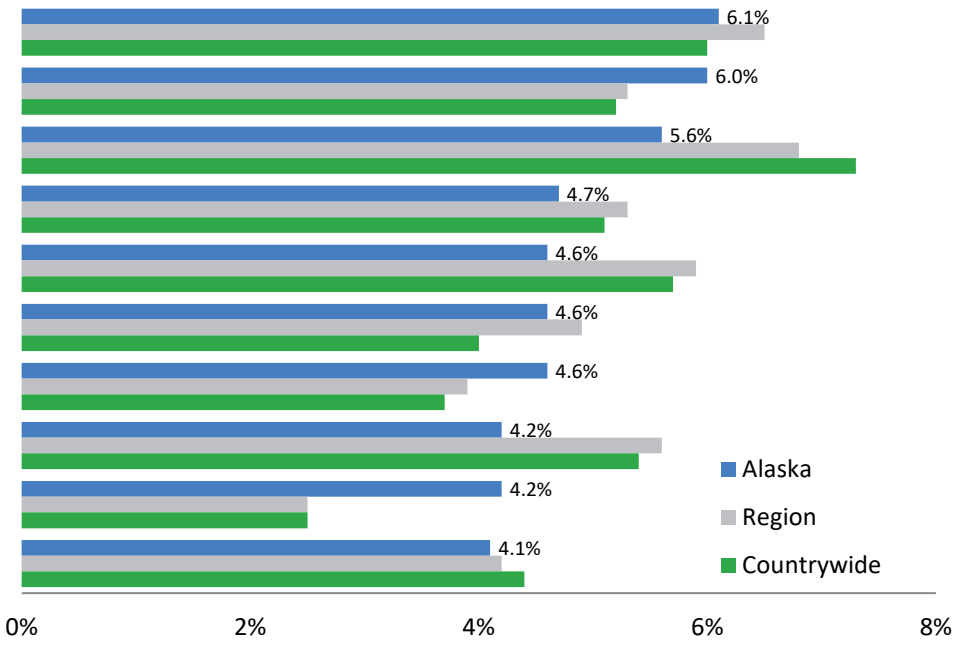


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
73110	Radiologic examination, wrist; complete minimum of 3 views
73610	Radiologic examination, ankle; complete minimum of 3 views
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
73030	Radiologic examination, shoulder; complete minimum of 2 views
73562	Radiologic examination, knee; 3 views

Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts

Code	Average PPT AK	Region	CW
73610	$124	$55	$59
73110	$134	$61	$65
73030	$117	$54	$61
73140	$121	$54	$57
73630	$122	$53	$56
73562	$135	$63	$66
73721	$807	$395	$476
73130	$114	$55	$57
76942	$172	$74	$115
72100	$134	$66	$68

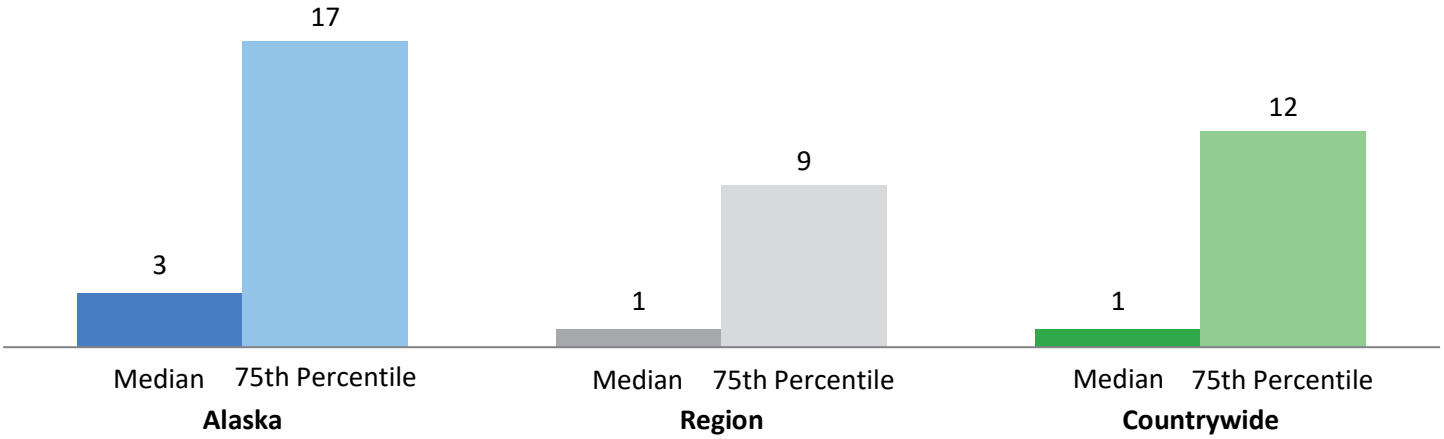


Code	Description
73610	Radiologic examination, ankle; complete minimum of 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73030	Radiologic examination, shoulder; complete minimum of 2 views
73140	Radiologic examination, finger(s); minimum of 2 views
73630	Radiologic examination, foot; complete minimum of 3 views
73562	Radiologic examination, knee; 3 views
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73130	Radiologic examination, hand; minimum of 3 views
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views

Chart 14 shows the median and 75th percentile time until first treatment for radiology procedures for Alaska, the region, and countrywide.

Chart 14

Time Until First Treatment for Radiology (in Days)



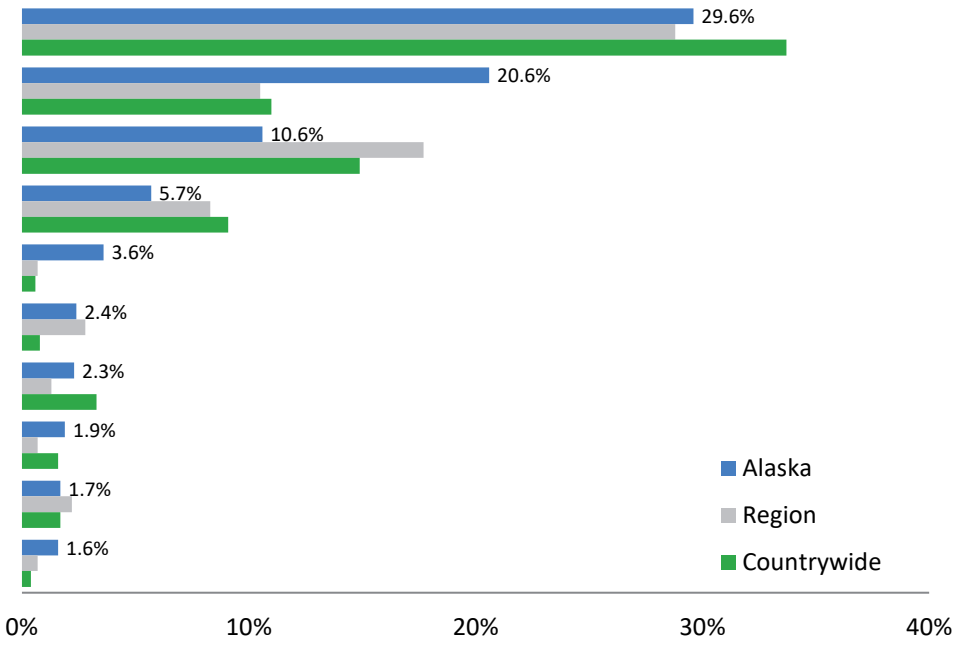
Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

In Alaska, physician payments for physical and general medicine services provided in 2021 are, on average, 162% of Medicare-scheduled reimbursement amounts, compared to 139% in the region and 136% countrywide. Payments for these services comprise 37% of physician payments, compared to 36% in the region and 37% countrywide.

Chart 15

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

	Average PPU			
Code	**AK**	**Region**	**CW**	**Paid Share**
97110	$65	$42	$42	
97140	$59	$39	$39	
97530	$74	$54	$47	
97112	$70	$47	$43	
98941	$87	$67	$56	
97124	$54	$36	$36	
97545	$221	$135	$189	
97546	$88	$62	$83	
97161	$203	$137	$130	
98940	$70	$53	$45	

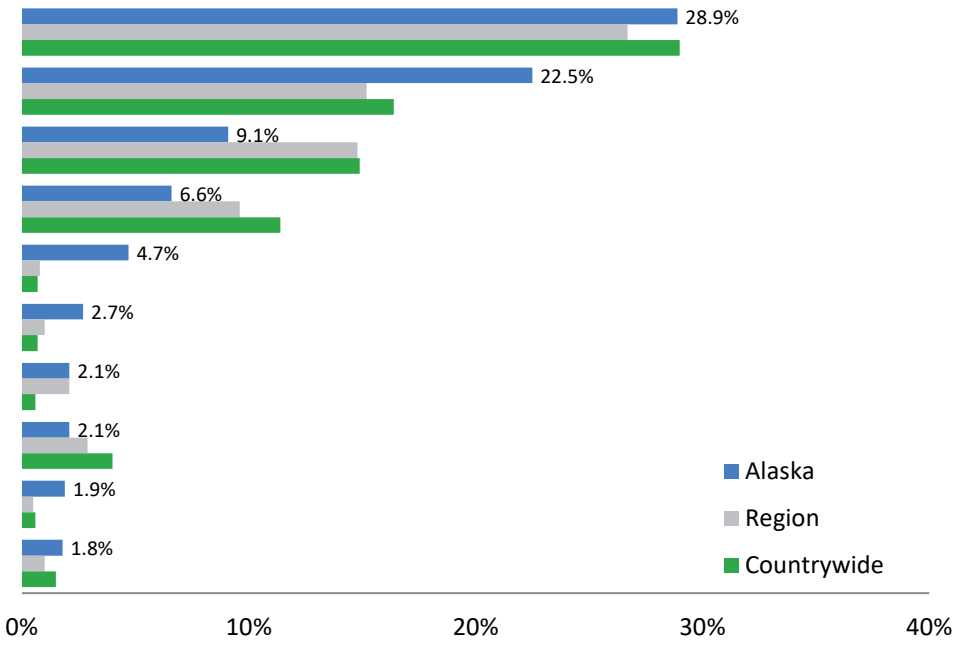


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPU AK	Region	CW
97110	$65	$42	$42
97140	$59	$39	$39
97530	$74	$54	$47
97112	$70	$47	$43
98941	$87	$67	$56
98940	$70	$53	$45
97124	$54	$36	$36
97014	$34	$20	$22
97012	$39	$21	$22
97035	$35	$20	$23

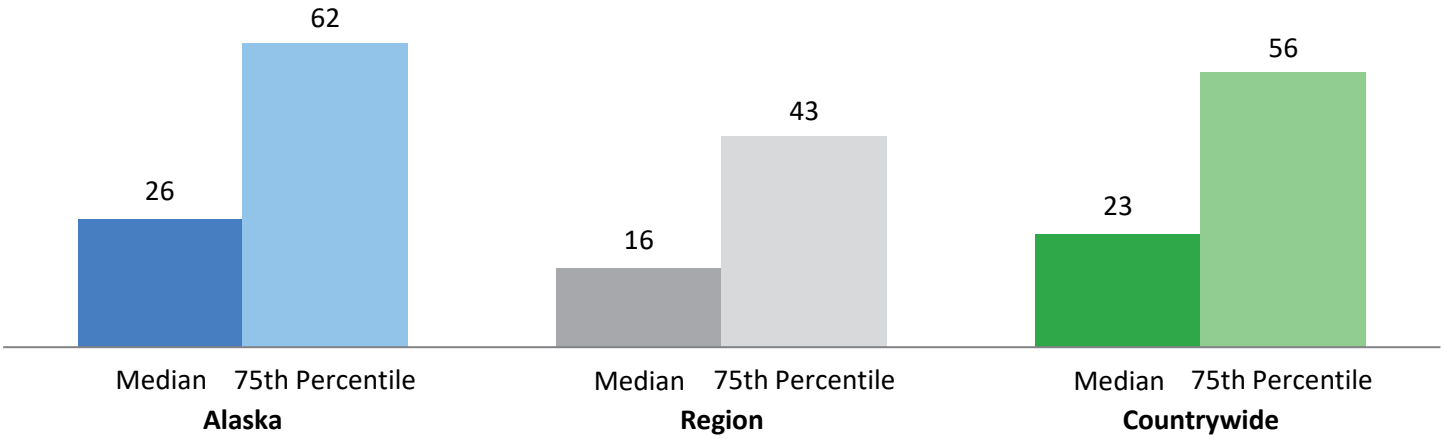


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97012	Application of a modality to 1 or more areas; traction, mechanical
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes

Chart 17 shows the median and 75th percentile time until first treatment for physical and general medicine procedures for Alaska, the region, and countrywide.

Chart 17

Time Until First Treatment for Physical and General Medicine (in Days)



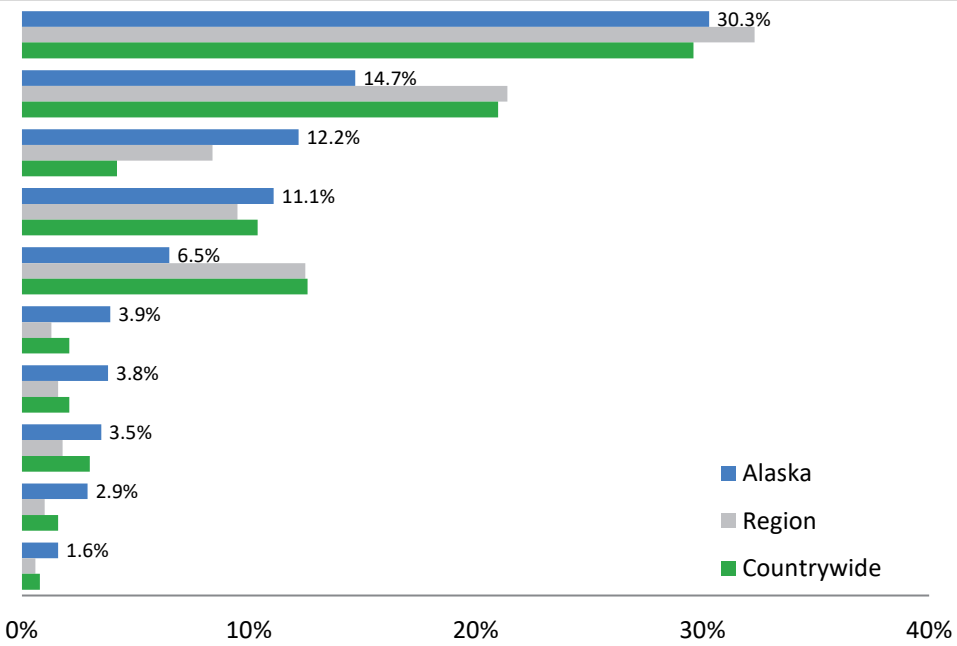
Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

In Alaska, physician payments for evaluation and management services provided in 2021 are, on average, 184% of Medicare-scheduled reimbursement amounts, compared to 146% in the region and 135% countrywide. Payments for these services comprise 22% of physician payments, compared to 32% in the region and 24% countrywide.

Chart 18

Top 10 Evaluation and Management Procedure Codes by Amount Paid

Code	Average PPT AK	Region	CW
99213	$206	$128	$115
99214	$273	$183	$161
99456	$1,664	$635	$712
99203	$278	$169	$158
99204	$405	$258	$236
99283	$290	$159	$199
99212	$131	$78	$73
99284	$441	$248	$296
99285	$684	$362	$419
99202	$182	$111	$107

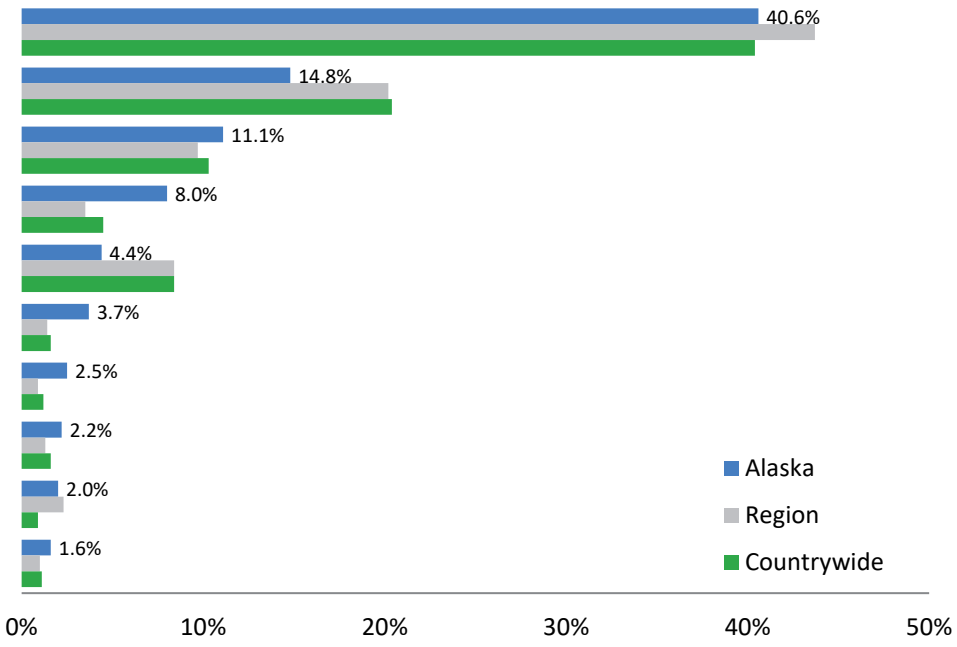


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99456	Work related or medical disability examination by other than the treating physician.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires straightforward medical decision making. 15-29 minutes of total time is spent on the date of the encounter.

Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts

Code	Average PPT AK	Region	CW
99213	$206	$128	$115
99214	$273	$183	$161
99203	$278	$169	$158
99212	$131	$78	$73
99204	$405	$258	$236
99283	$290	$159	$199
99202	$182	$111	$107
99284	$441	$248	$296
99456	$1,664	$635	$712
99232	$196	$120	$107

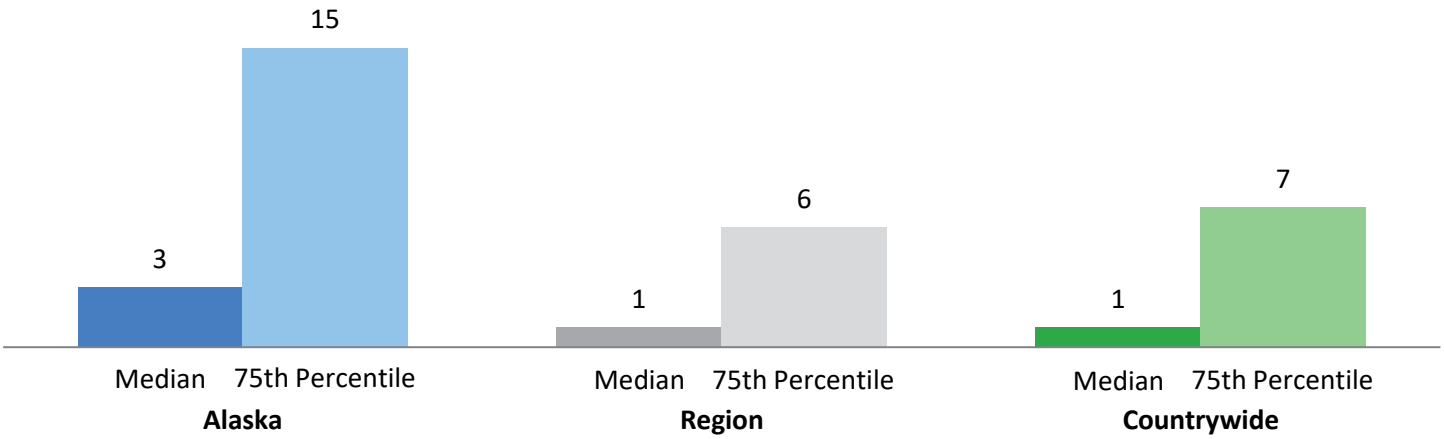


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires straightforward medical decision making. 15-29 minutes of total time is spent on the date of the encounter.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99456	Work related or medical disability examination by other than the treating physician.
99232	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Chart 20 shows the median and 75th percentile time until first treatment for evaluation and management procedures for Alaska, the region, and countrywide.

Chart 20

Time Until First Treatment for Evaluation and Management (in Days)



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

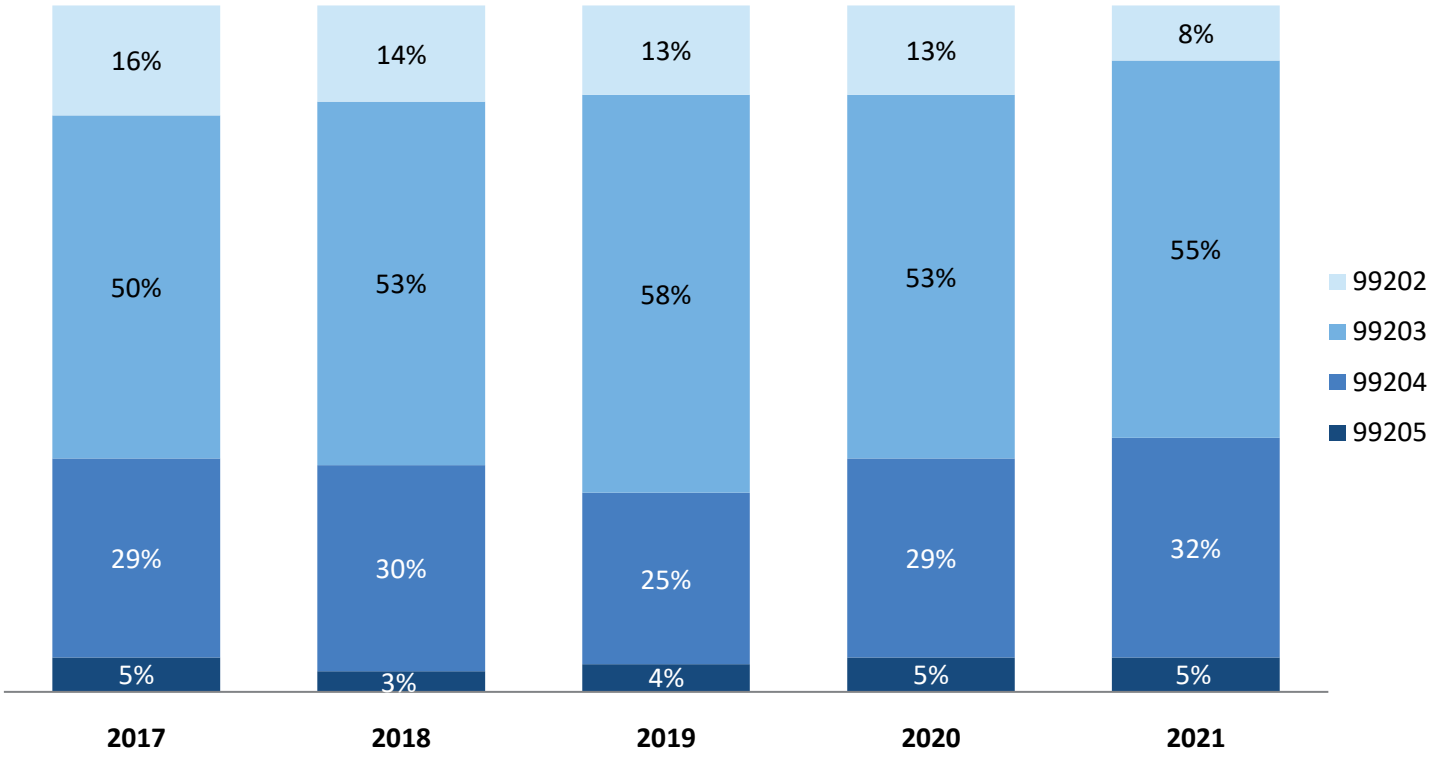
Evaluation and Management services consist largely of office or outpatient visits for a new patient or an established patient.

There are four periods of time spent with a *new* patient, ranging from 15–29 minutes for Procedure Code 99202 to 60–74 minutes for Procedure Code 99205. Chart 21 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for new patients.

Chart 21

Office or Other Outpatient Visit for the Evaluation and Management of a New Patient

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2017 to 2021.
Severity/Time description updated January 1, 2021.

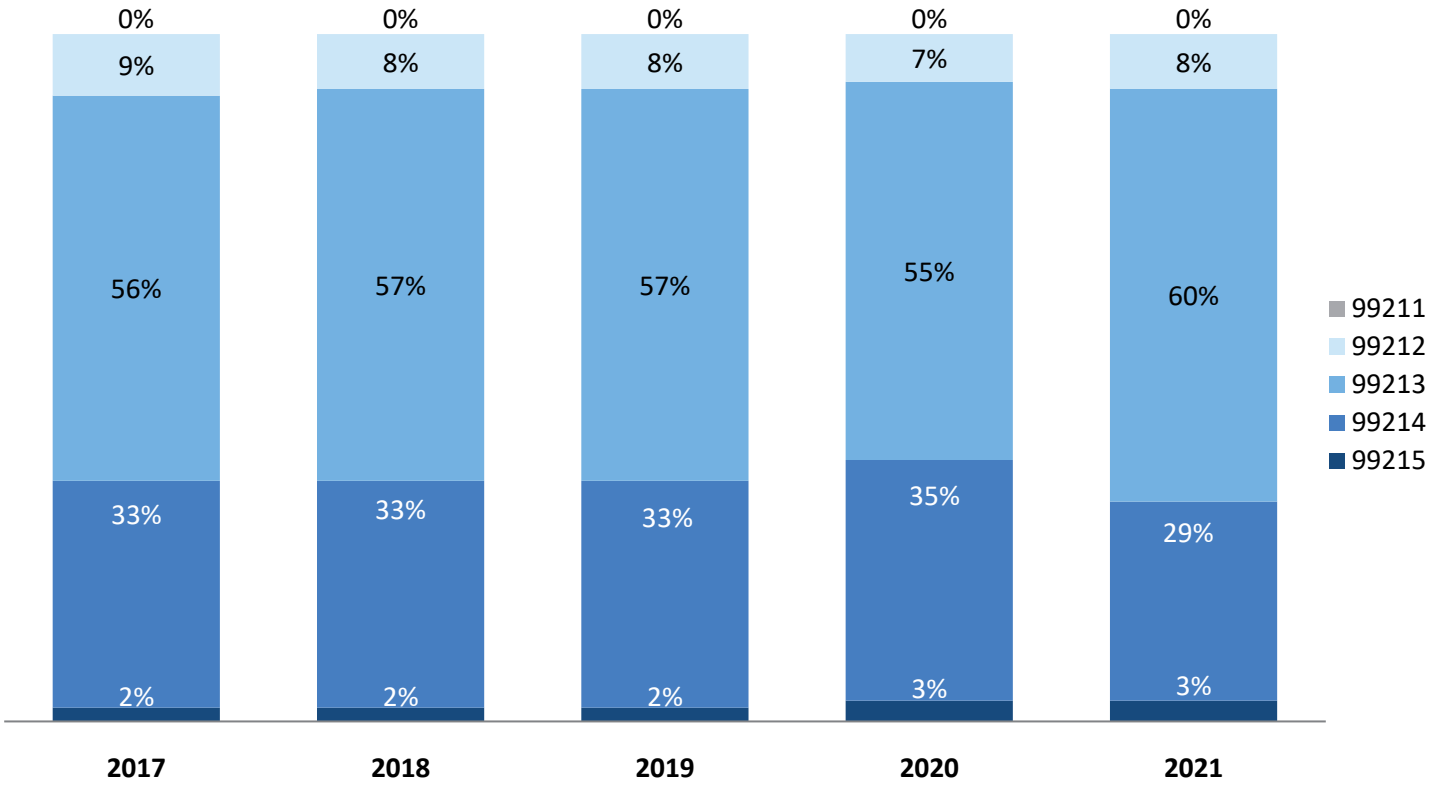
		Average PPT				
Code	**Severity/Time**	**2017**	**2018**	**2019**	**2020**	**2021**
99202	Straightforward; 15-29 minutes with patient	$181	$176	$179	$182	$182
99203	Low; 30-44 minutes with patient	$256	$253	$261	$261	$278
99204	Moderate; 45-59 minutes with patient	$377	$376	$383	$383	$405
99205	High; 60-74 minutes with patient	$422	$402	$454	$495	$530

Similarly, for established patients, there are five periods of time spent with the patient, ranging from a patient not requiring any time with a physician for Procedure Code 99211 to 40–54 minutes for Procedure Code 99215. Chart 22 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for an established patient.

Chart 22

Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2017 to 2021.
Severity/Time description updated January 1, 2021.

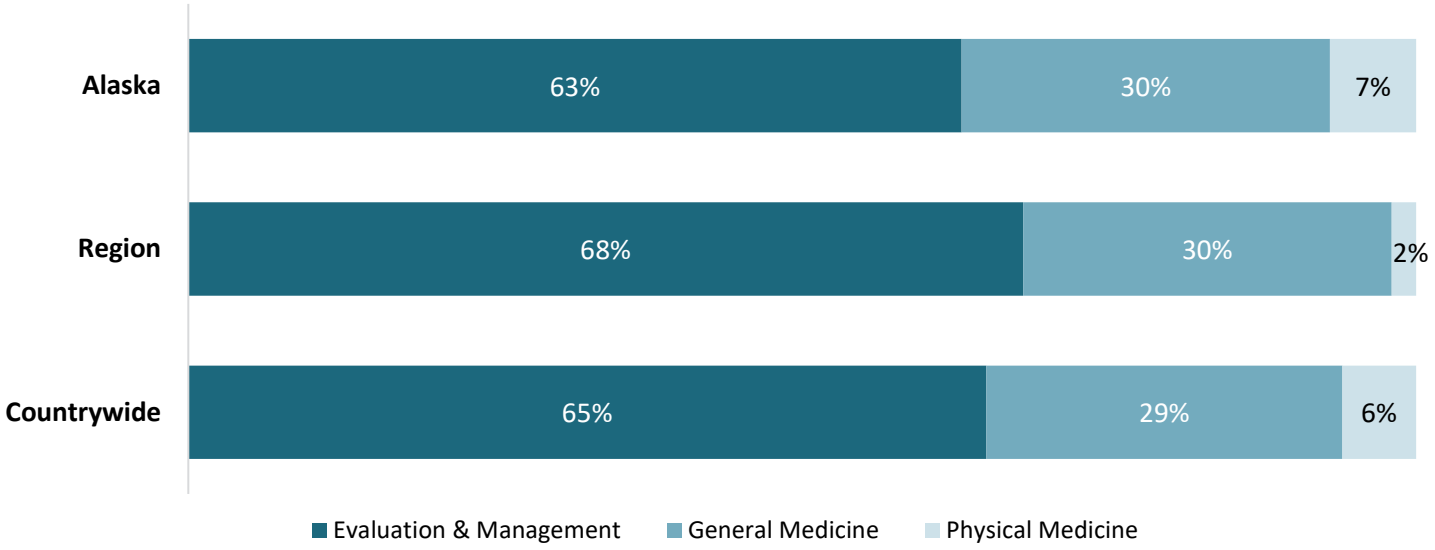
		Average PPT				
Code	**Severity/Time**	**2017**	**2018**	**2019**	**2020**	**2021**
99211	Minimal; May not require physician	$52	$51	$61	$57	$52
99212	Straightforward; 10-19 minutes with patient	$108	$107	$109	$111	$131
99213	Low; 20-29 minutes with patient	$171	$173	$176	$179	$206
99214	Moderate; 30-39 minutes with patient	$235	$238	$244	$250	$273
99215	High; 40-54 minutes with patient	$268	$276	$291	$311	$377

Telemedicine services have been utilized more than in years prior to 2020[8] and are generally observed in the evaluation and management, physical medicine, and general medicine physician service categories. In Service Year 2021, telemedicine services represent about 1% of the physician costs in these categories countrywide. The share of payments varies across jurisdictions, ranging from about 0% to about 4%.

In Alaska, the share of claimants receiving physician services (evaluation and management, physical medicine, and general medicine) who had telemedicine encounters changed from 11.6% in 2020 to 7.5% in 2021. Chart 23 shows the distribution of telemedicine payments for these physician service categories in Alaska, the region, and countrywide.

Chart 23

Distribution of Telemedicine Payments by Physician Service Category



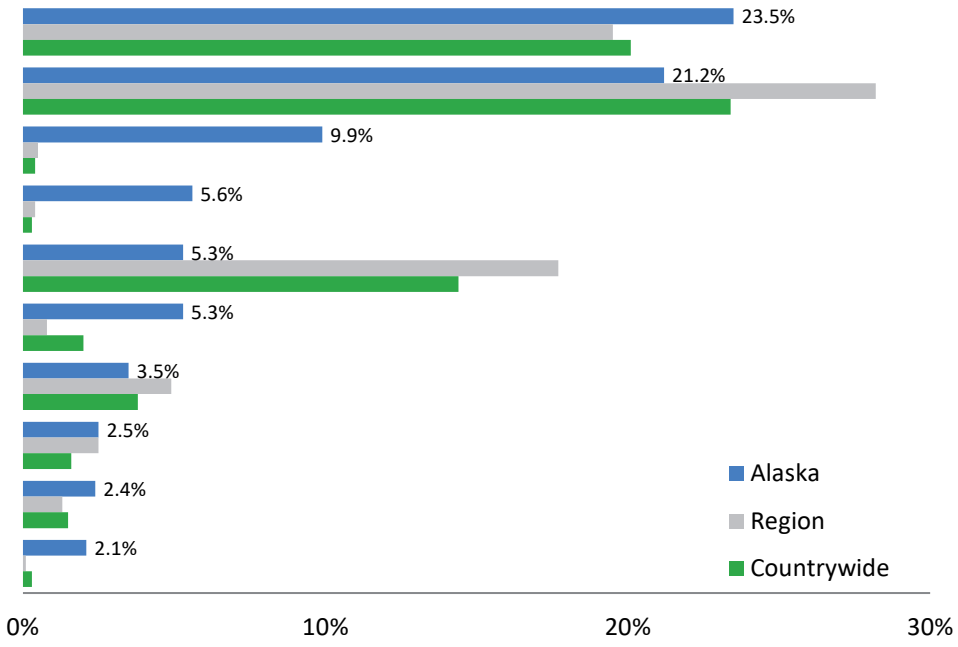
[8] www.ncci.com/Articles/Documents/Insights-COVID-19-Impact-Medical-Treatment-Workers-Comp-3QTR-2020-Perspective.pdf

Chart 24 shows the top 10 procedure codes reported as a telemedicine service by paid amount for Alaska with comparative values for the region and countrywide.

Chart 24

Top 10 Procedure Codes by Amount Paid for Telemedicine Services

Code	Average PPU[9] AK	Region	CW
99214	$272	$170	$152
99213	$191	$126	$114
96158	$184	$123	$131
96159	$63	$48	$52
90837	$225	$224	$190
97110	$65	$44	$44
99442	$149	$108	$97
99441	$79	$70	$56
99212	$113	$76	$72
92507	$200	$98	$115



Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
90837	Psychotherapy, 60 minutes with patient
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.
99441	Telephone evaluation and management service by a physician or other qualified health care professional; 5-10 minutes of medical discussion.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

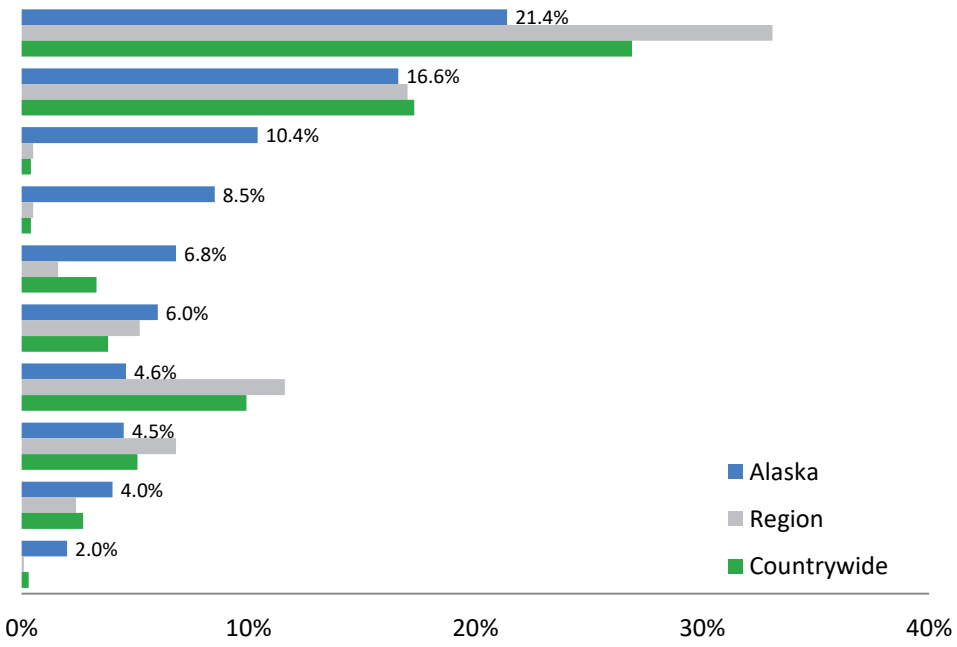
[9] Based on the number of units for the procedure code (typically in increments of time) but can also be one transaction.

Chart 25 shows the top 10 procedure codes reported as a telemedicine service by transaction count for Alaska with comparative values for the region and countrywide.

Chart 25

Top 10 Procedure Codes by Transaction Counts for Telemedicine Services

Code	Average PPU AK	Region	CW
99213	$191	$126	$114
99214	$272	$170	$152
96158	$184	$123	$131
96159	$63	$48	$52
97110	$65	$44	$44
99441	$79	$70	$56
90837	$225	$224	$190
99442	$149	$108	$97
99212	$113	$76	$72
92507	$200	$98	$115



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
99441	Telephone evaluation and management service by a physician or other qualified health care professional; 5-10 minutes of medical discussion.
90837	Psychotherapy, 60 minutes with patient
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

Hospital Inpatient

Payments attributed to facilities represent hospital inpatient services, hospital outpatient services, and ambulatory surgical center services. General healthcare trends may be the primary driver of the cost distribution; however, the fee schedule may also play a role. In many states, the fee schedule varies by type of facility, which may help explain differences observed between states.

Hospital inpatient fee schedules in workers compensation vary across jurisdictions. Some states have fee schedules based on a group of facility services related to the hospital admission, such as a Medicare Severity Diagnosis-Related Group (MS-DRG or DRG for short); others are on a per-diem basis, with some variation on the per-diem amount by type of admission. Other states have provisions for the reimbursement to be a certain percentage of hospital charges. Several states remain without any regulation today.

A hospital inpatient stay is typically reported with one of two types of codes: DRG code or revenue code. Data reporters are instructed to report the code that is consistent with how the reimbursement was determined.

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Alaska, 82% of hospital inpatient payments are reported with a DRG code.

Comparisons by procedure code for inpatient costs should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide. Some measures for hospital inpatient services include the average cost of an inpatient stay, the average length of stay, or the average cost per day.

Unless otherwise stated, the inpatient results are based on inpatient stays with a discharge date in 2021.

A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital inpatient payments for Alaska, the region, and countrywide, based on hospital episodes that are reported with a DRG code.

Chart 26

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Alaska	Region	Countrywide
Hospital Inpatient	185%	169%	191%

Source: NCCI's Medical Data Call for inpatient stays discharged in Calendar Year 2021. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

The distribution of medical payments for hospital inpatient is 12% for Alaska, 12% for the region, and 12% for countrywide. One comparative measure of inpatient service costs is the average payment per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 27 displays the average amount paid per stay for hospital inpatient services, while Chart 28 displays the average amount paid per day for hospital inpatient services for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 27

Average Amount Paid per Stay for Hospital Inpatient Services

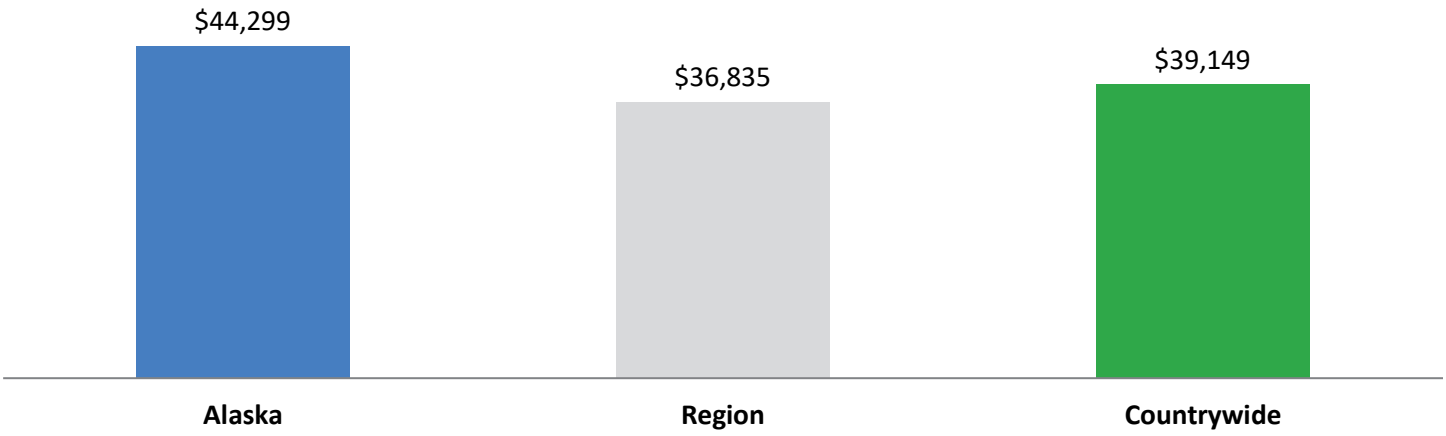


Chart 28

Average Amount Paid per Day for Hospital Inpatient Services

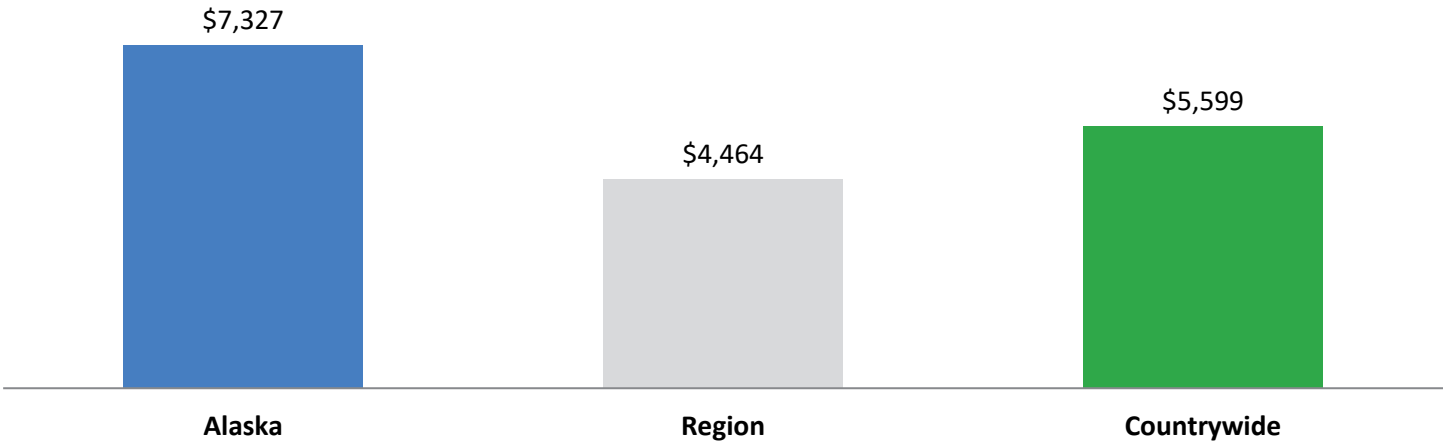


Chart 29 displays the average number of hospital inpatient stays per 1,000 active claims in 2021 for Alaska, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 30 displays the average and median length of stay for hospital inpatient services for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 29

Average Number of Inpatient Stays per 1,000 Active Claims

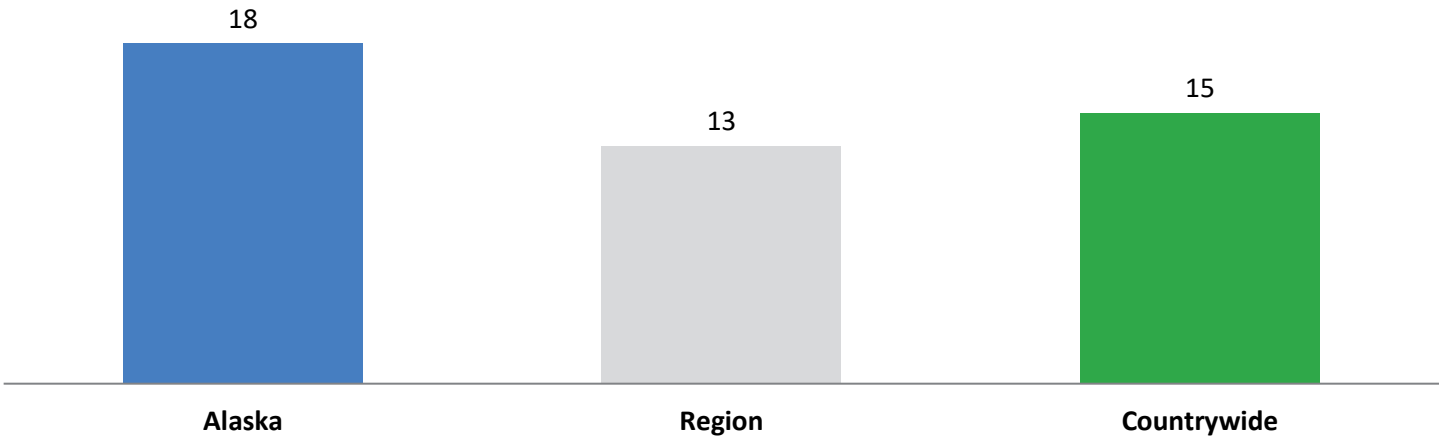


Chart 30

Length of Stay for Hospital Inpatient Services (in Days)

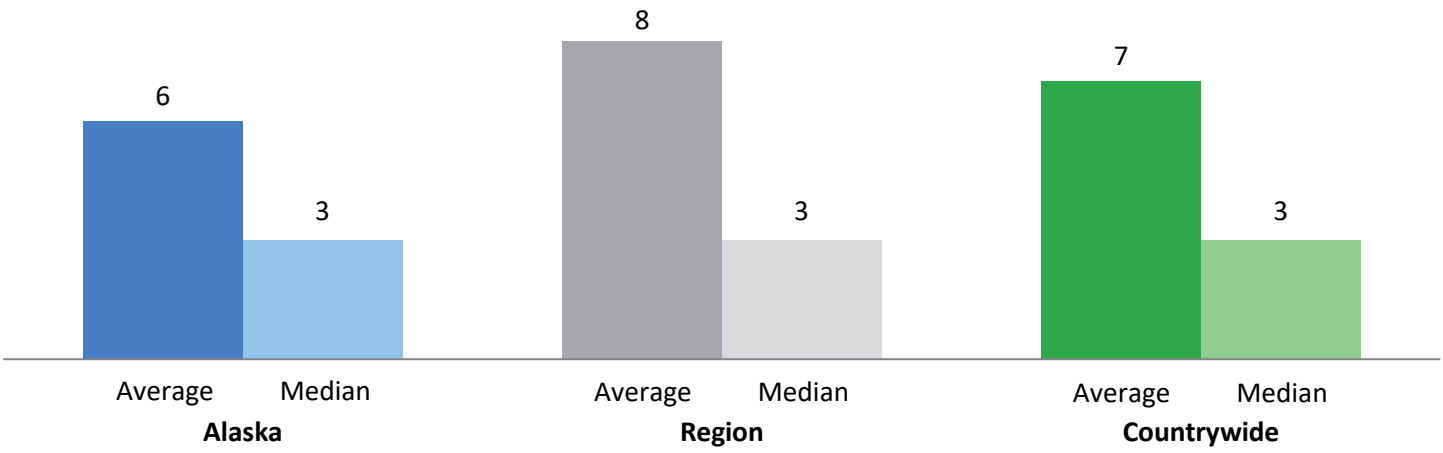
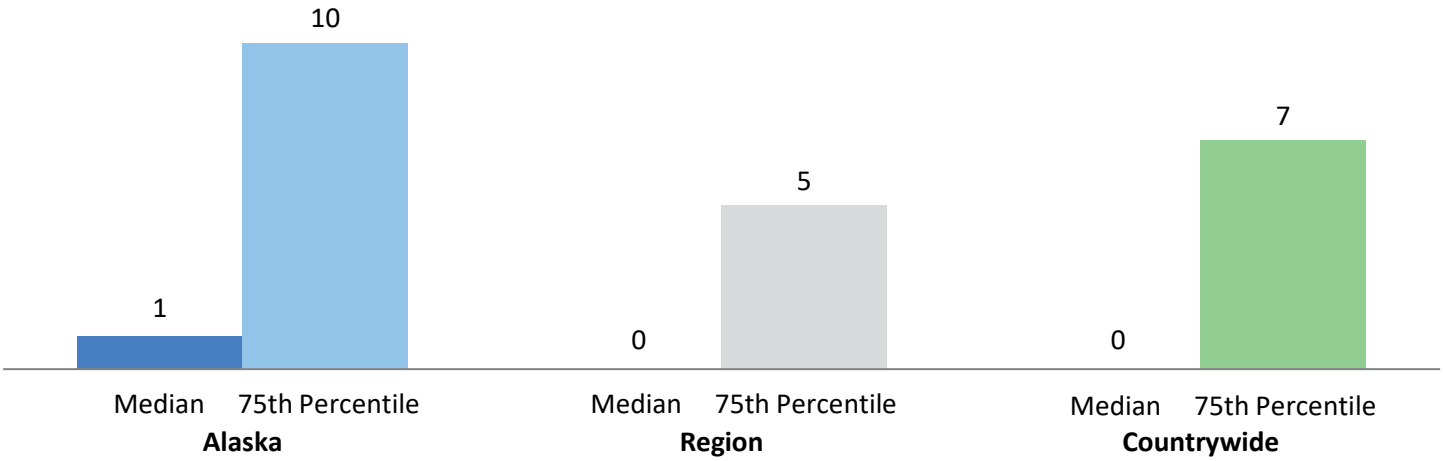


Chart 31 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Alaska, the region, and countrywide.

Chart 31

Time Until First Treatment for Hospital Inpatient Stays (in Days)



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

Charts 32 and 33 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient stays. A diagnosis group is identified for each stay based on an ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments for hospital inpatient services in Alaska. A brief description of each DRG code is displayed in the table below chart 33. The information is based on inpatient stays with a discharge date in 2020 or 2021.

Chart 32

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

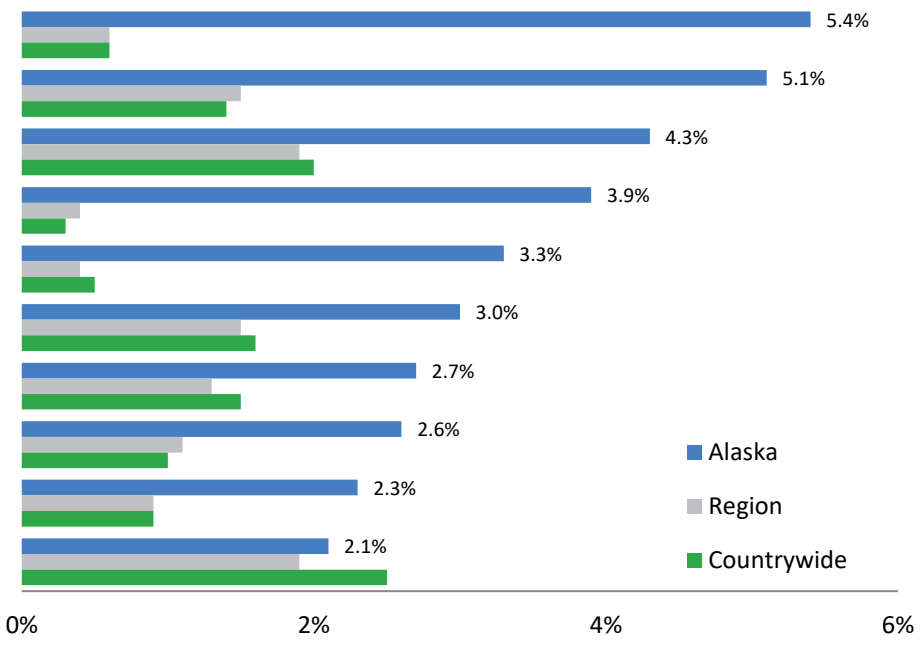
		Median Amount Paid per Stay		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
COVID-19	10.1%	$40,036	$20,435	$20,814
Lumbar spine degeneration	8.2%	$63,697	$37,497	$37,477
Tibia/fibula fracture	7.4%	$46,021	$21,452	$23,945
Hip/pelvis fracture/major trauma	5.1%	$37,929	$20,645	$21,602
Complication from surgical device	4.7%	$27,968	$23,184	$23,283
Traumatic brain injury	4.6%	$42,821	$27,472	$29,027
Cervical radiculopathy/myelopathy	3.5%	$60,267	$22,383	$25,302
Cervical spine degeneration	3.4%	$59,583	$25,169	$27,060
Chest trauma major	3.3%	$28,277	$22,488	$22,574
Femur fracture	2.9%	$58,416	$22,261	$26,474

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in Calendar Year 2020 or 2021.

Chart 33

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay AK	Region	CW
177	$41,419	$21,390	$21,530
454	$113,561	$55,217	$56,383
455	$79,599	$42,995	$43,969
463	$212,364	$60,246	$72,785
472	$63,576	$27,921	$31,349
494	$40,347	$19,638	$20,815
493	$45,555	$25,463	$27,874
956	$93,512	$51,112	$59,476
481	$46,585	$24,267	$26,470
460	$76,428	$39,604	$39,582



Code	Description
177	Respiratory infections and inflammations with major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
463	Wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders with major complications or comorbidities
472	Cervical spinal fusion with complications or comorbidities
494	Lower extremity and humerus procedures except hip, foot, and femur without complications or comorbidities/major complications or comorbidities
493	Lower extremity and humerus procedures except hip, foot, and femur with complications or comorbidities
956	Limb reattachment, hip, and femur procedures for multiple significant trauma
481	Hip and femur procedures except major joint with complications or comorbidities
460	Spinal fusion, except cervical, without major complications or comorbidities

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in 2020 or 2021. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.
Note: In Alaska, 82% of hospital inpatient payments are reported with a DRG code.

Hospital Outpatient

Hospital outpatient services are reported with several types of procedure codes. Data reporters are instructed to report the code that is consistent with the way the reimbursement was determined.

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by current procedural terminology (CPT) or other healthcare common procedure coding system (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by a specific ambulatory payment classification (APC) code. An APC code represents a group of services provided by the facility on an outpatient basis.

If the hospital outpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type. Revenue codes are very generic and do not provide much information about the specific services that were performed.

Comparisons by procedure code for outpatient benefits should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide. One comparative measure of outpatient service costs is the average cost per outpatient visit. A visit is defined as any service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claim may have more than one visit.

Hospital outpatient visits can vary in nature and the level of reimbursement varies considerably by type of visit. A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services (CMS), or the procedure involves spine/spinal cord neurostimulators. A hospital outpatient visit could be the result of an emergency visit and those visits are shown separately. Nonemergency outpatient visits are shown separately for those with and without major surgery services; those without a major surgery service are referred to as “Other” outpatient visits.

The distribution of medical payments for hospital outpatient is 15% for Alaska, 18% for the region, and 20% for countrywide.

One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital outpatient payments for Alaska, the region, and countrywide. In Alaska, 78% of hospital outpatient payments are included in the chart below.

Chart 34

Hospital Outpatient Payments as a Percentage of Medicare

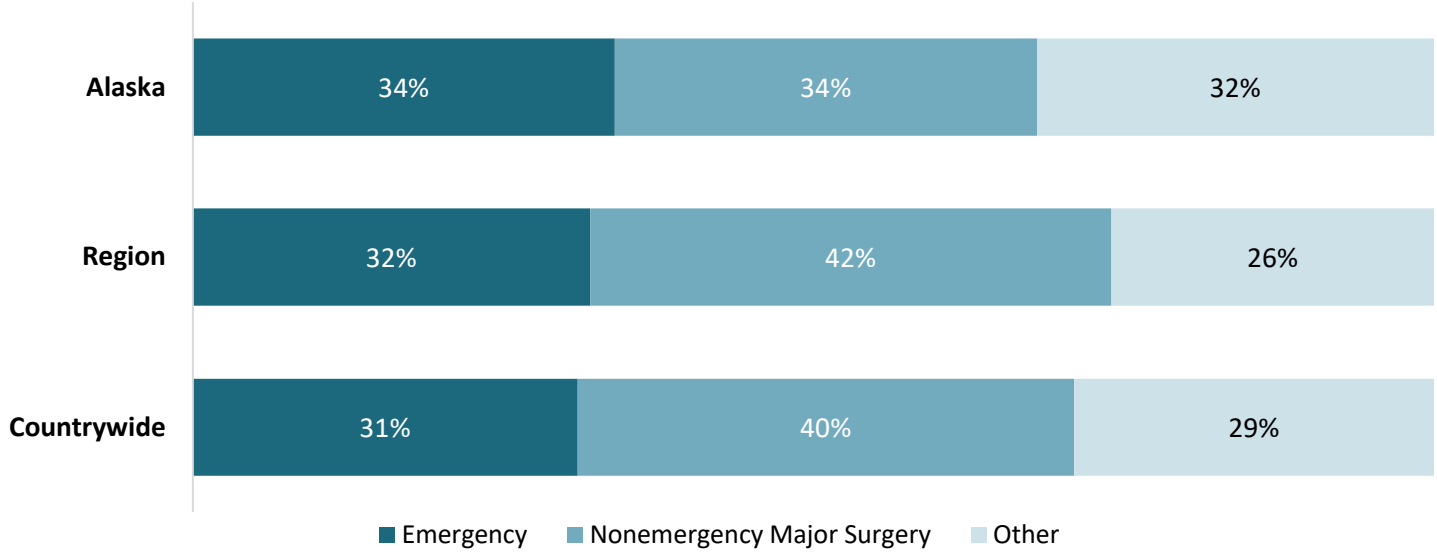
Medical Cost Category	Alaska	Region	Countrywide
Hospital Outpatient	214%	194%	236%

Source: NCCI’s Medical Data Call for Service Year 2021. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

Chart 35 displays the distribution of hospital outpatient payments by visit type for Alaska, the region, and countrywide.

Chart 35

Distribution of Payments for Outpatient Services by Hospital Outpatient Visit Type



Emergency hospital outpatient visits represent 34% of hospital outpatient payments in Alaska. Chart 36 displays the average amount paid per emergency visit for outpatient services, while Chart 37 displays the average number of emergency hospital outpatient visits per 1,000 active claims for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 36

Average Amount Paid for Hospital Outpatient Services per Emergency Visit

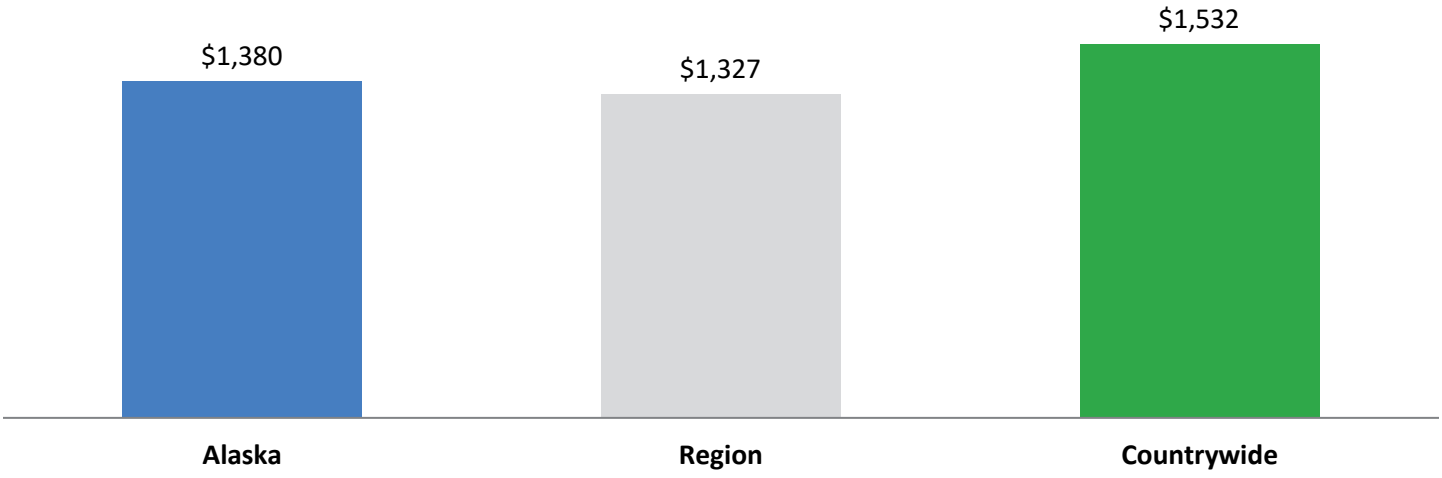


Chart 37

Average Number of Emergency Hospital Outpatient Visits per 1,000 Active Claims

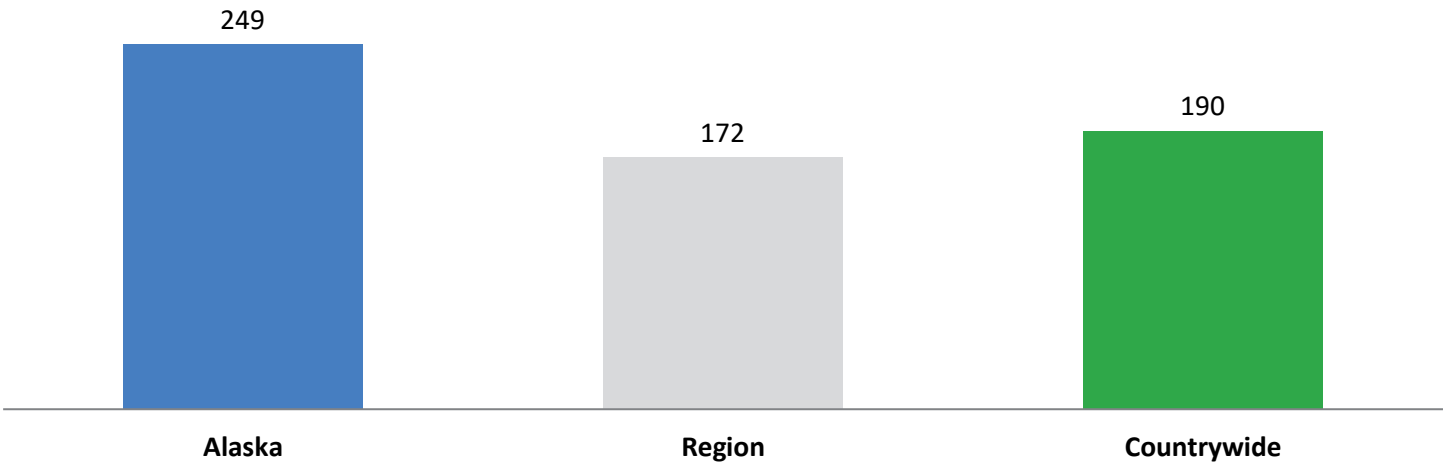


Chart 38 displays the top 10 diagnosis groups for emergency outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Alaska.

Chart 38

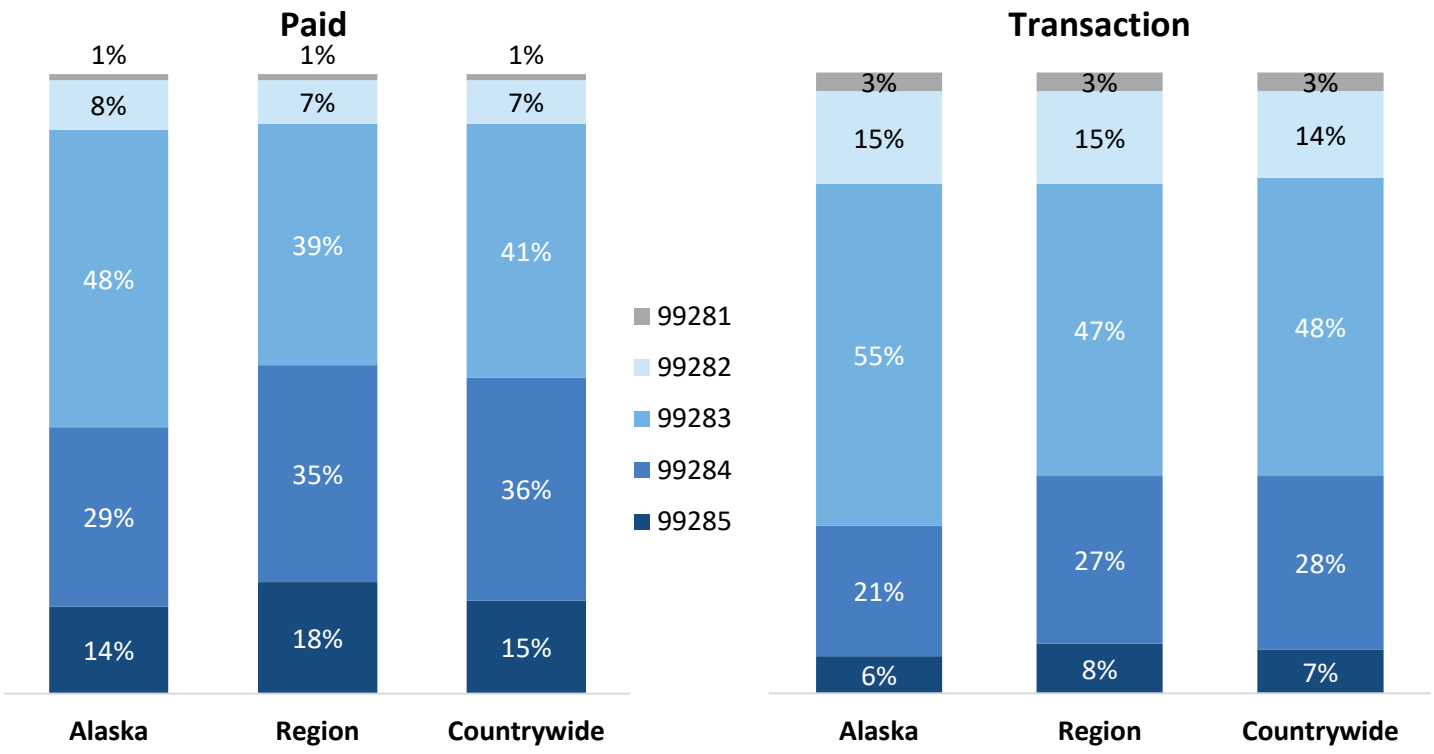
Top 10 Diagnosis Groups by Amount Paid for Emergency Hospital Outpatient Visits

		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Minor hand/wrist injuries	13.3%	$743	$646	$713
Femur fracture	5.2%	$63,378	$1,521	$1,517
Hand/wrist fracture	4.8%	$1,273	$1,006	$1,114
Low back pain	4.3%	$738	$717	$800
Head/face wound	3.6%	$1,042	$858	$922
Concussion/minor traumatic brain injury	3.6%	$1,235	$1,037	$1,159
Minor knee injury	2.8%	$763	$646	$728
Minor ankle/foot injuries	2.6%	$795	$613	$709
Nonspecific cardiopulmonary	2.6%	$1,512	$1,004	$1,153
Elbow/forearm fracture	2.5%	$1,253	$1,004	$1,234

For emergency room visits, there are five levels of severity, ranging from limited or minor problems reported with Procedure Code 99281 to life-threatening situations reported with Procedure Code 99285. About 80% of all emergency visits had outpatient services. Chart 39 shows the distribution of emergency room outpatient services by procedure code for both paid amount and transactions for Service Year 2021 as well as the average payment per transaction.

Chart 39

Distribution of Emergency Room Outpatient Services by Procedure Code



Emergency Room Outpatient Paid per Transaction by Procedure Code

		Average PPT		
Code	Severity	Alaska	Region	Countrywide
99281	Minor	$215	$173	$201
99282	Low to Moderate	$348	$276	$291
99283	Moderate	$585	$479	$504
99284	High	$891	$729	$754
99285	High and immediately life-threatening	$1,612	$1,200	$1,164

Nonemergency outpatient visits with major surgery services represent 34% of hospital outpatient payments in Alaska. Chart 40 displays the average amount paid per major surgery visit for outpatient services, while Chart 41 displays the average number of major surgery hospital outpatient visits per 1,000 active claims for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 40

Average Amount Paid for Hospital Outpatient Services per Nonemergency Major Surgery Visit

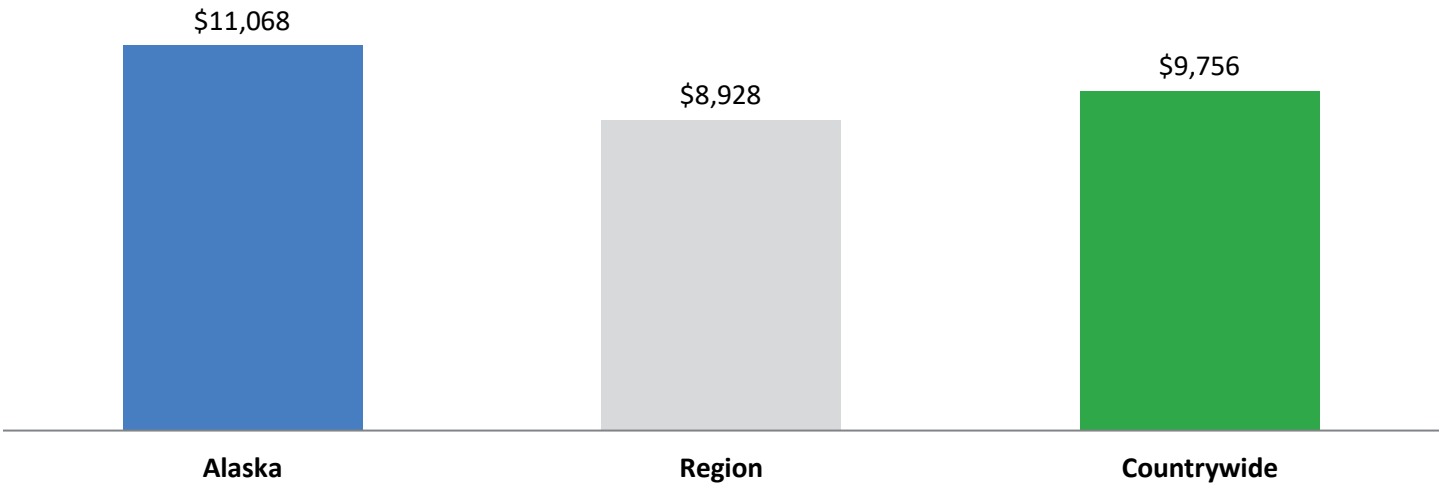


Chart 41

Average Number of Nonemergency Major Surgery Hospital Outpatient Visits per 1,000 Active Claims

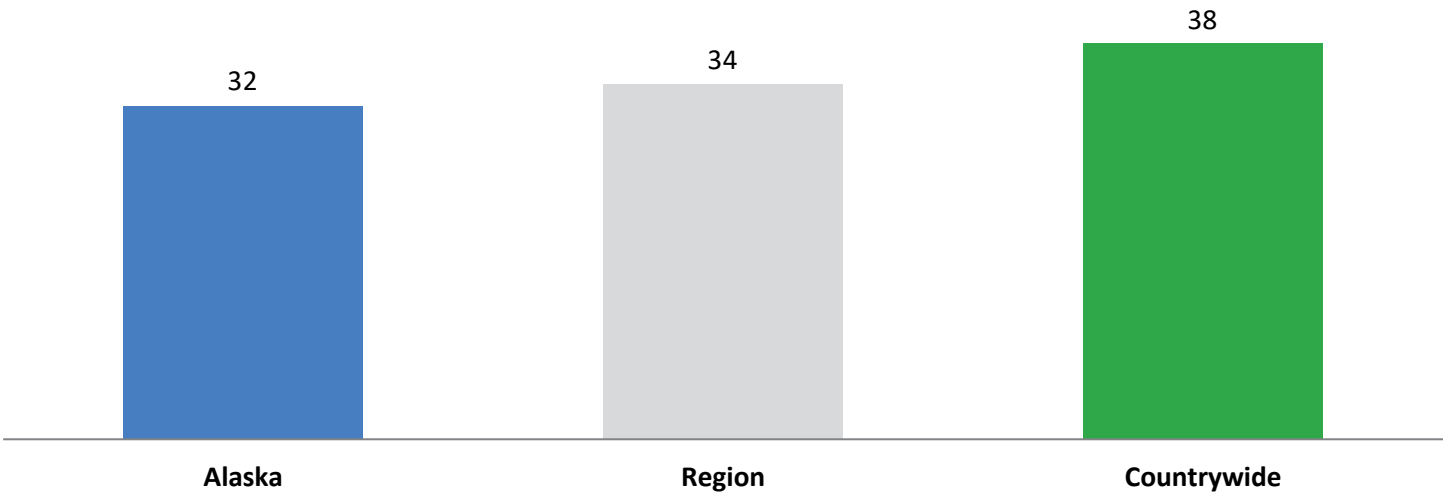
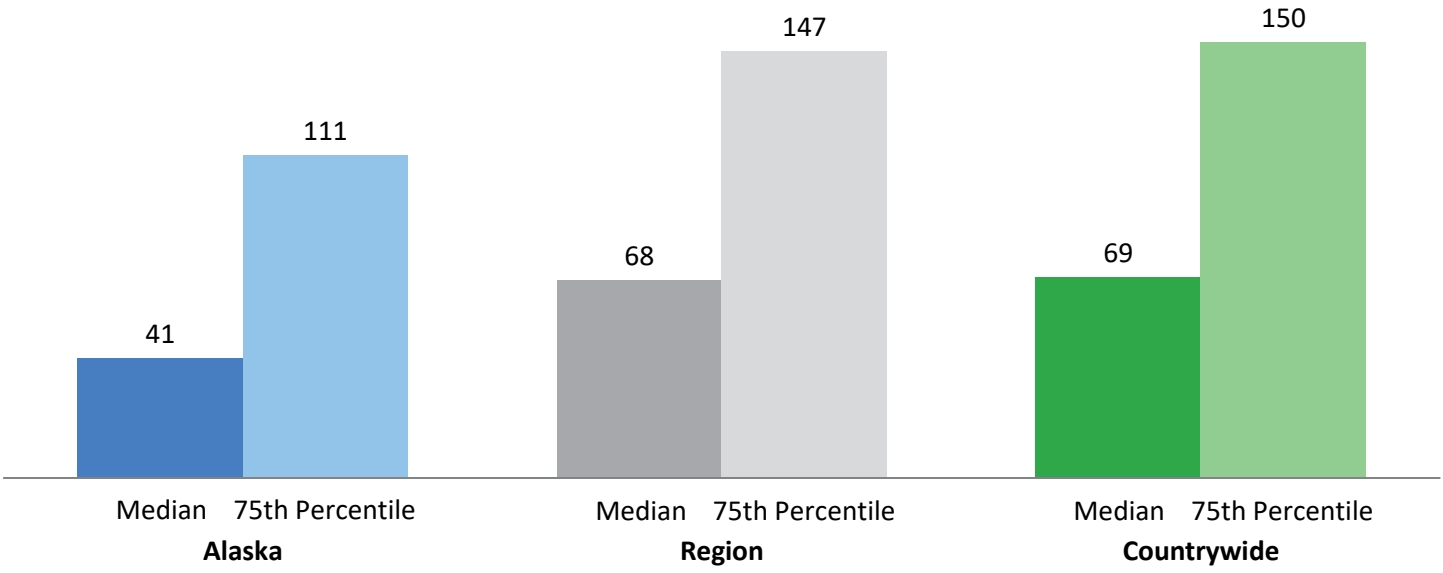


Chart 42 shows the median and 75th percentile time until first treatment for nonemergency major surgery outpatient visits for Alaska, the region, and countrywide.

Chart 42

Time Until First Treatment for Nonemergency Major Surgery Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

Chart 43 displays the top 10 diagnosis groups for nonemergency major surgery outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Alaska.

Chart 43

Top 10 Diagnosis Groups by Amount Paid for Nonemergency Major Surgery Hospital Outpatient Visits

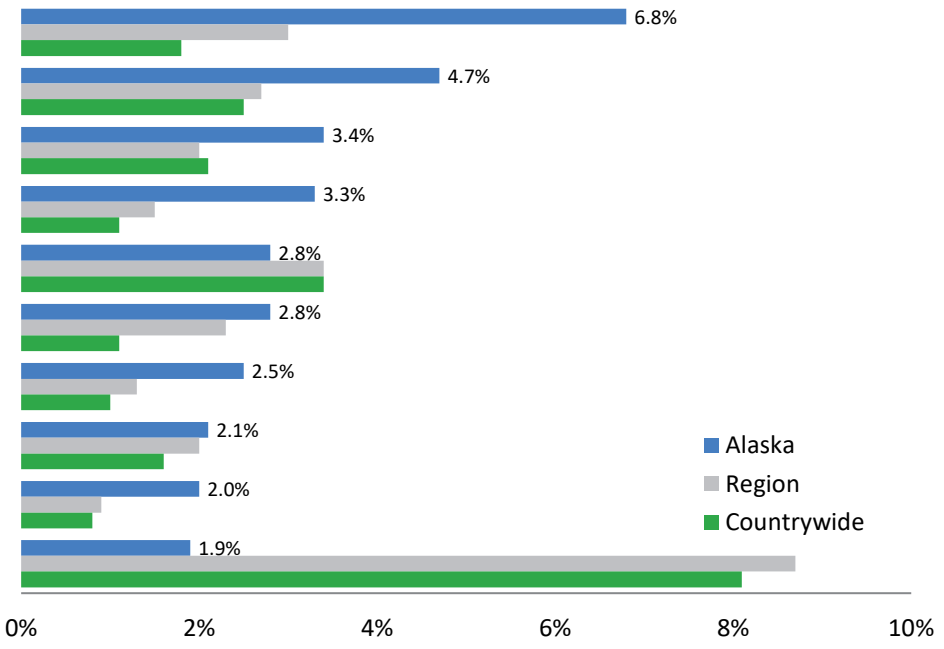
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Alaska	Region	Countrywide
Inguinal hernia	7.7%	$12,878	$7,360	$8,150
Hand/wrist fracture	7.2%	$7,582	$5,703	$6,002
Tibia/fibula fracture	6.4%	$19,694	$11,443	$10,911
Knee internal derangement - cruciate ligament tear	5.9%	$14,265	$11,200	$10,936
Knee internal derangement - meniscus injury	5.5%	$7,228	$5,122	$5,491
Lumbosacral intervertebral disc disorders	4.8%	$16,782	$10,444	$10,732
Minor shoulder injury	4.6%	$14,265	$9,779	$9,585
Superior labral tear from anterior to posterior (SLAP) lesion	3.8%	$16,111	$9,488	$9,575
Ventrical incisional hernia	3.8%	$13,169	$6,217	$6,925
Rotator cuff tear	3.6%	$7,430	$10,547	$10,499

Charts 44 displays the average amount paid per nonemergency major surgery visit for outpatient services in Alaska, the region, and countrywide for the top 10 CPT codes in Alaska. The codes are ranked based on total outpatient payments in Alaska, where the code shown below is the code with the highest total paid on a nonemergency major surgery visit. In 2021, 92% of Hospital Outpatient costs were reported with a CPT code being the highest paid code. A brief description of each code is displayed in the table below.

Chart 44

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Nonemergency Major Surgery Visits

Code	Average Paid per Visit AK	Region	CW
29888	$16,946	$12,312	$12,771
49650	$11,763	$8,794	$10,463
63030	$17,215	$10,853	$12,645
25609	$13,580	$11,697	$11,491
29881	$8,678	$5,575	$6,861
63685	$70,986	$37,519	$28,513
29807	$12,360	$11,150	$12,135
23430	$13,118	$11,004	$12,109
27792	$16,930	$11,173	$11,816
29827	$8,112	$10,853	$12,509



Code	Description
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
49650	Laparoscopy, surgical; repair initial inguinal hernia
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
29807	Arthroscopy, shoulder, surgical; repair of superior labral tear from anterior to posterior (SLAP) lesion
23430	Tenodesis of long tendon of biceps
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair

Nonemergency outpatient visits without a major surgery service, referred to as "Other" outpatient visits, represent 32% of hospital outpatient payments in Alaska. Chart 45 displays the average amount paid per other visit for hospital outpatient services, while Chart 46 displays the average number of other visits per 1,000 active claims for hospital outpatient services for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 45

Average Amount Paid for Hospital Outpatient Services per Other Outpatient Visit

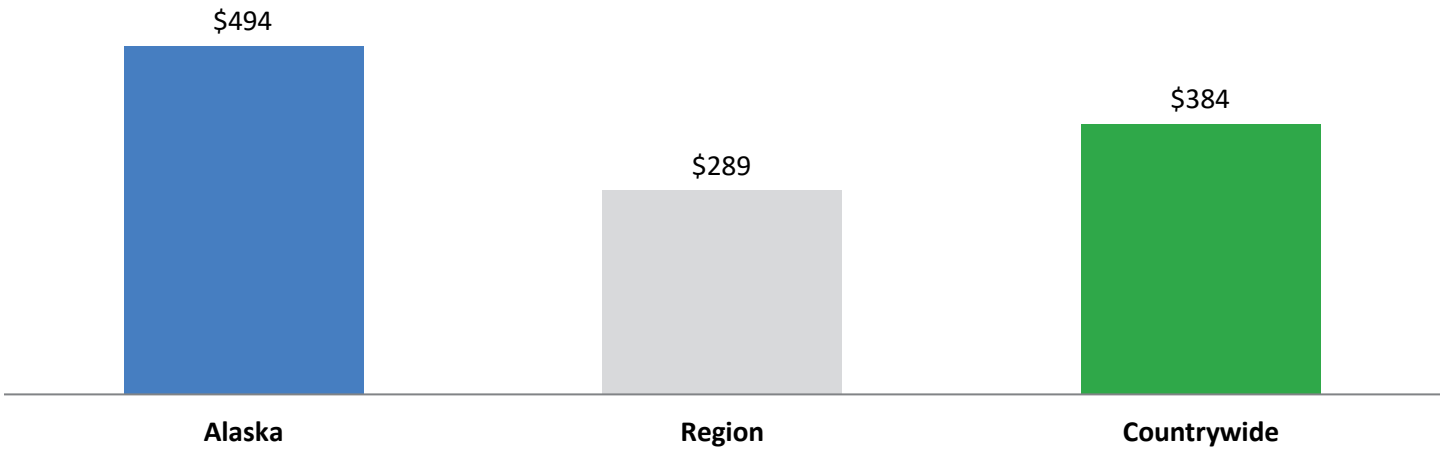


Chart 46

Average Number of Other Hospital Outpatient Visits per 1,000 Active Claims

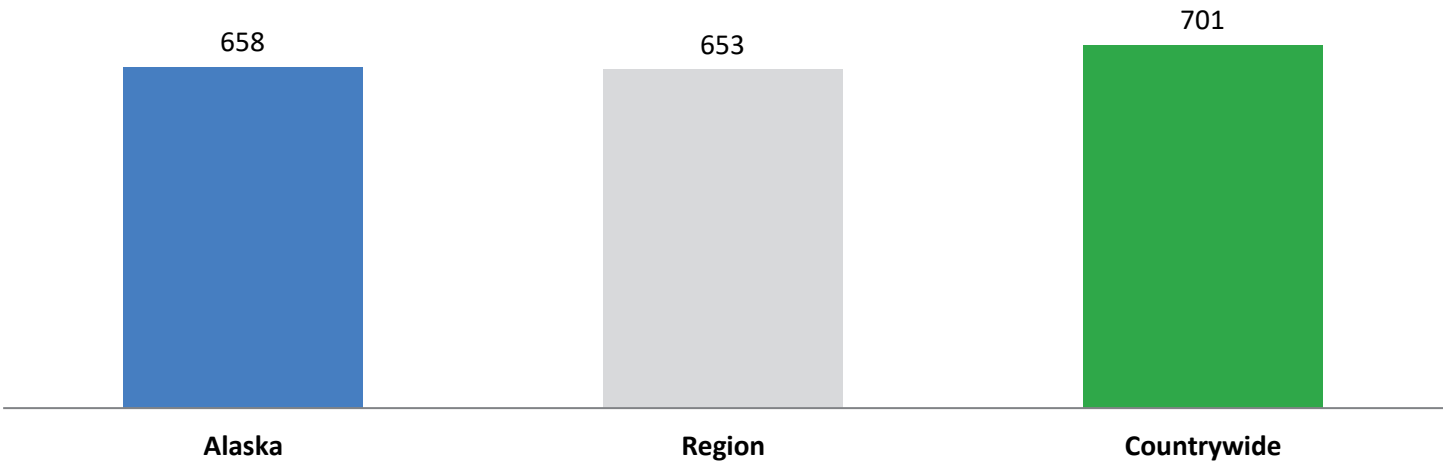
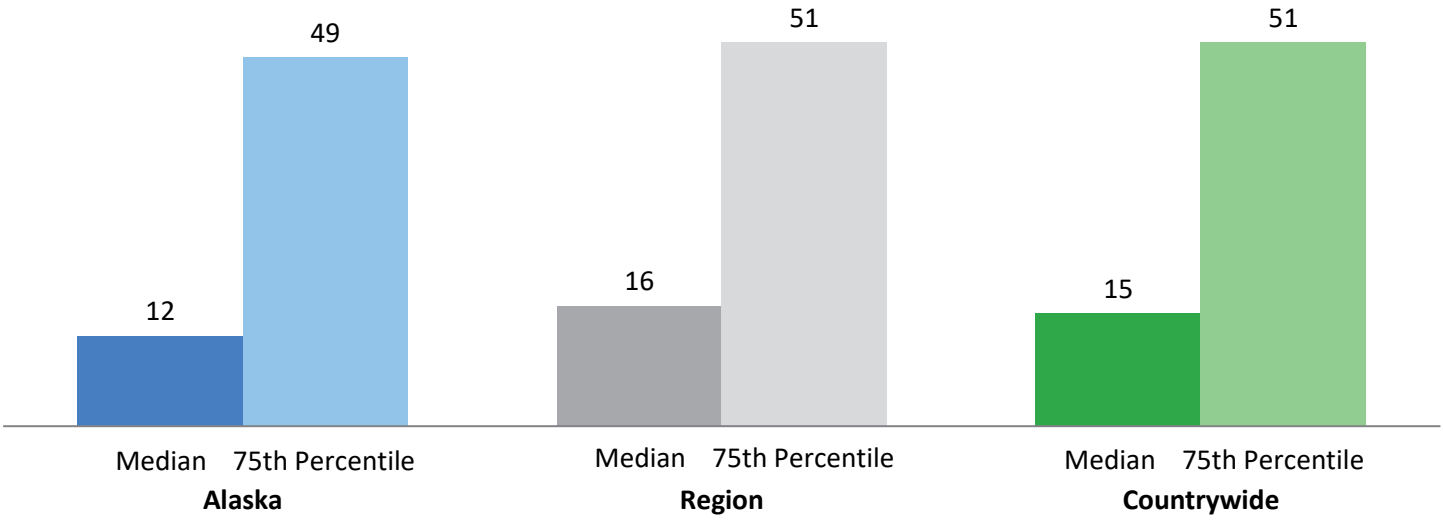


Chart 47 shows the median and 75th percentile time until first treatment for other outpatient visits for Alaska, the region, and countrywide.

Chart 47

Time Until First Treatment for Other Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

Chart 48 displays the top 10 diagnosis groups for other outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Alaska.

Chart 48

Top 10 Diagnosis Groups by Amount Paid for Other Hospital Outpatient Visits

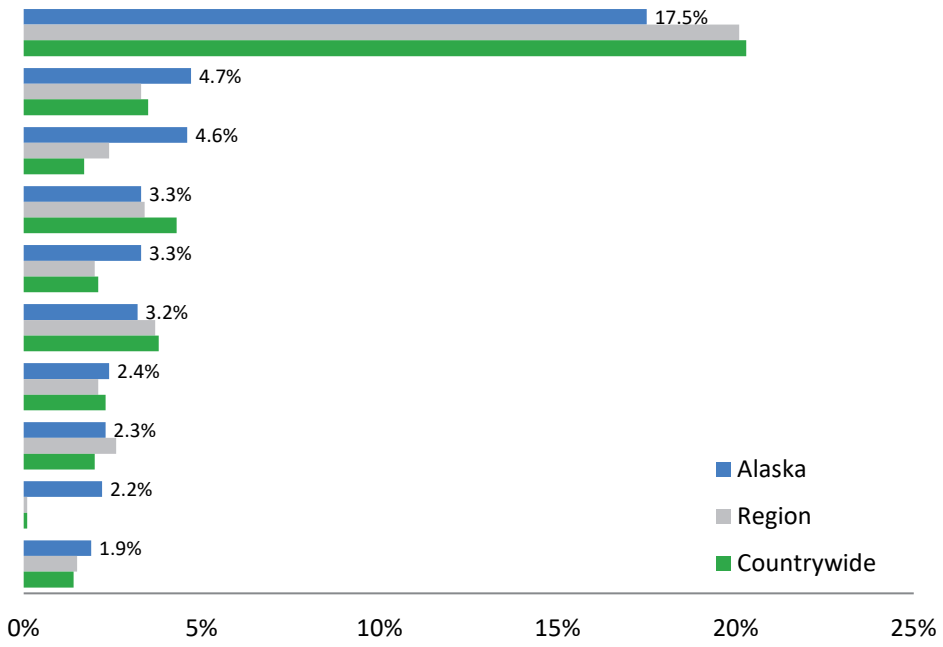
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Minor shoulder injury	6.0%	$285	$150	$172
Low back pain	4.6%	$339	$155	$172
Rotator cuff tear	4.2%	$369	$146	$171
Minor knee injury	4.0%	$423	$154	$178
Minor hand/wrist injuries	3.1%	$297	$141	$167
Orthopedic aftercare	2.6%	$292	$155	$167
Other postprocedural states	2.6%	$442	$138	$189
Lumbosacral intervertebral disc disorders	2.4%	$586	$210	$283
Traumatic brain injury	2.2%	$529	$375	$331
Knee internal derangement - meniscus injury	2.2%	$413	$155	$193

Charts 49 displays the average amount paid per other visit for outpatient services in Alaska, the region, and countrywide for the top 10 CPT codes in Alaska. The codes are ranked based on total outpatient payments in Alaska, where the code shown below is the code with the highest total paid on an "Other" outpatient visit. A brief description of each code is displayed in the table below.

Chart 49

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Other Visits

Code	Average Paid per Visit AK	Region	CW
97110	$321	$152	$204
97140	$355	$148	$211
G0463	$281	$232	$211
73221	$1,250	$750	$1,330
73222	$3,474	$1,624	$2,614
73721	$1,051	$748	$1,253
72148	$1,223	$784	$1,328
97530	$341	$175	$230
93656	$50,588	$45,587	$44,914
97112	$333	$164	$224



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
G0463	Hospital outpatient clinic visit for assessment and management of a patient
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Ambulatory Surgical Centers

An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries. The distribution of medical payments for ASCs is 10% for Alaska, 5% for the region, and 7% for countrywide.

Typically, surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes.

One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for ASC payments for Alaska, the region, and countrywide. In Alaska, 91% of ASC payments are included in the chart below.

Chart 50

ASC Payments as a Percentage of Medicare

Medical Cost Category	Alaska	Region	Countrywide
Ambulatory Surgical Center	305%	190%	251%

Source: NCCI's Medical Data Call for Service Year 2021. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

ASC visits with major surgery services represent 95% of ASC payments in Alaska. Other ASC visits typically include minor procedures, with injections for therapeutic or diagnostic purposes being the most common. Chart 51 displays the average amount paid per major surgery visit for ASC services, while Chart 52 displays the average number of major surgery ASC visits per 1,000 active claims for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 51

Average Amount Paid per Major Surgery Visit for ASC Services

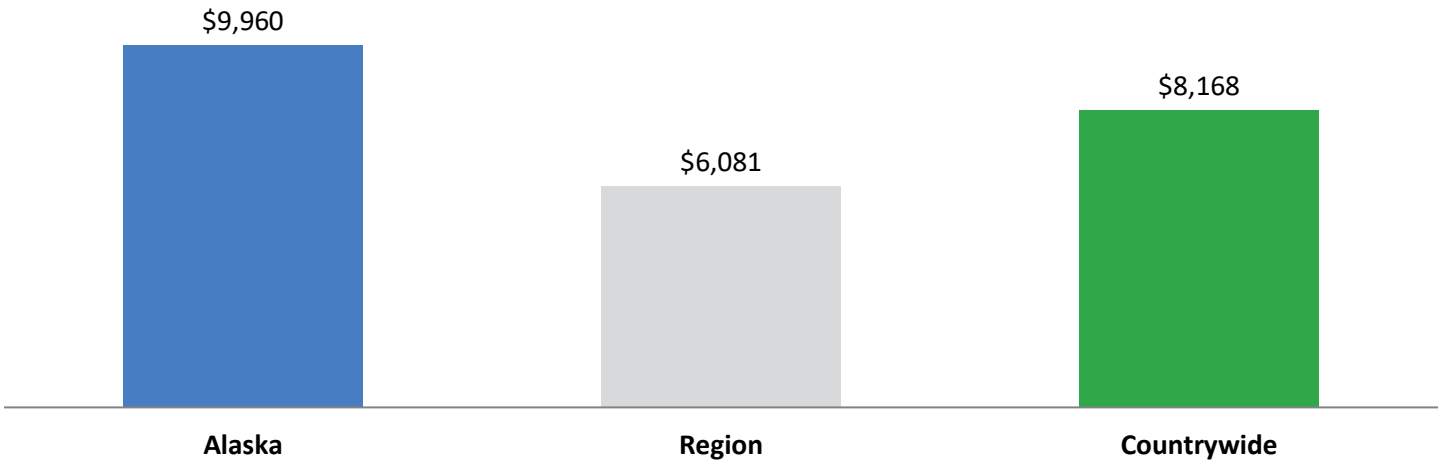


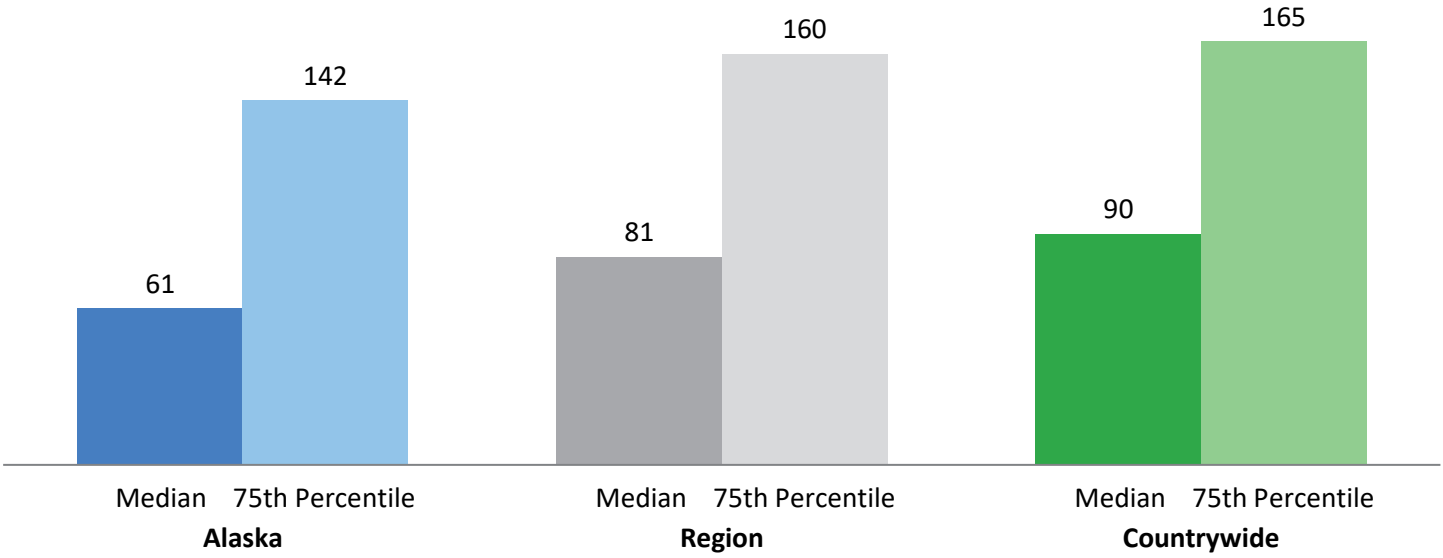
Chart 52

Average Number of ASC Major Surgery Visits per 1,000 Active Claims

Chart 53 shows the median and 75th percentile time until first treatment for ASC major surgery visits for Alaska, the region, and countrywide.

Chart 53

Time Until First Treatment for ASC Major Surgery Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

Chart 54 displays the top 10 diagnosis groups for ASC major surgery visits. The diagnosis groups are ranked based on total payments for ASC services in Alaska.

Chart 54

Top 10 Diagnosis Groups by Amount Paid for ASC Major Surgery Visits

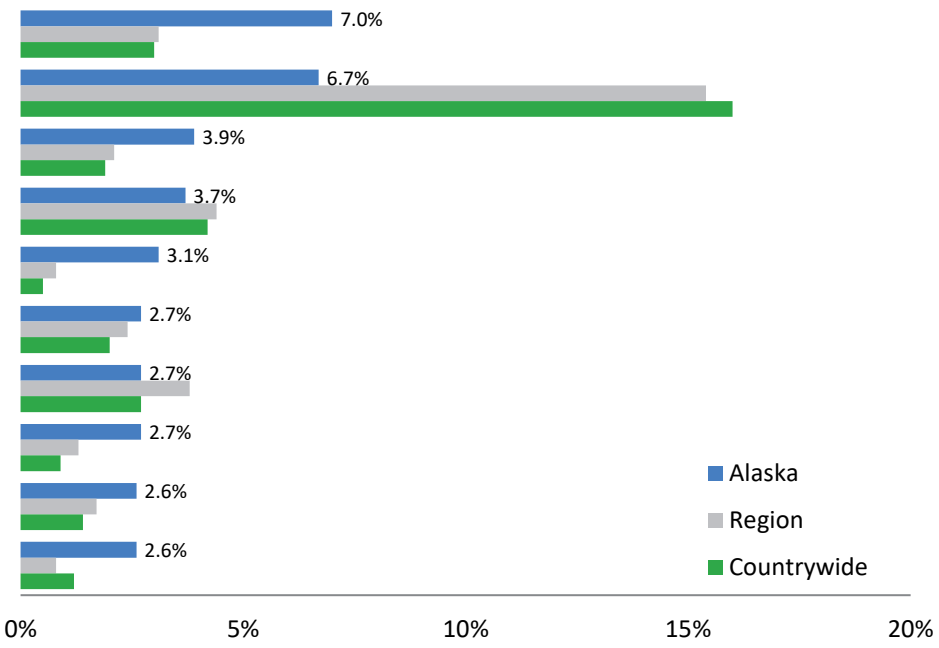
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Rotator cuff tear	14.9%	$12,712	$8,237	$9,839
Minor shoulder injury	7.4%	$12,712	$6,703	$7,780
Hand/wrist fracture	6.8%	$5,743	$3,979	$5,369
Knee internal derangement - meniscus injury	6.3%	$5,743	$3,145	$4,188
Inguinal hernia	3.9%	$10,268	$4,519	$5,038
Superior labral tear from anterior to posterior (SLAP) lesion	3.6%	$12,712	$6,962	$8,949
Knee internal derangement - cruciate ligament tear	3.3%	$12,712	$7,669	$9,322
Degenerative arthritis, hand/wrist	3.0%	$10,028	$4,105	$6,035
Knee degenerative/overuse injuries	3.0%	$21,239	$4,177	$5,770
Complication from surgical device	2.9%	$4,809	$3,074	$3,441

Chart 55 displays the average amount paid per major surgery visit for ASC services in Alaska, the region, and countrywide for the top 10 CPT codes in Alaska. The codes are ranked based on total ASC payments in Alaska, where the code shown below is the code with the highest total paid on a major surgery visit. A brief description of each procedure code is displayed in the table beneath the chart. Chart 56 displays similar results for visits in an outpatient setting for the list of codes in Chart 55, if applicable.

Chart 55

Top 10 Procedure Codes by Amount Paid for ASC Services in Major Surgery Visits

Code	Average Paid per Visit AK	Region	CW
23430	$12,711	$8,940	$12,537
29827	$12,644	$8,656	$12,087
29806	$14,404	$8,442	$10,050
29881	$5,891	$3,640	$4,638
49650	$12,266	$6,154	$7,680
24342	$13,042	$6,307	$7,233
29888	$14,373	$8,811	$10,898
23410	$12,868	$7,969	$10,625
20680	$4,947	$3,241	$4,086
29807	$12,267	$7,834	$11,479



Code	Description
23430	Tenodesis of long tendon of biceps
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
49650	Laparoscopy, surgical; repair initial inguinal hernia
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
29807	Arthroscopy, shoulder, surgical; repair of superior labral tear from anterior to posterior (SLAP) lesion

Chart 56

Major Surgery Outpatient Visit Comparisons for Procedure Codes in Chart 55

Code	Average Paid per Visit in AK ASC	Outpatient	Distribution of Major Surgery Visits in AK in an ASC or Outpatient Setting
23430	$12,711	$13,118	87% / 13%
29827	$12,644	$8,112	81% / 19%
29806	$14,404	$12,712	87% / 13%
29881	$5,891	$8,678	79% / 21%
49650	$12,266	$11,763	55% / 45%
24342	$13,042	$12,144	83% / 17%
29888	$14,373	$16,946	47% / 53%
23410	$12,868	$15,943	91% / 9%
20680	$4,947	$6,419	89% / 11%
29807	$12,267	$12,360	67% / 33%

Prescription Drugs

The distribution of medical payments for drugs is 4% for Alaska, 7% for the region, and 7% for countrywide. Prescription drugs are uniquely identified by a national drug code (NDC). Charts 57 through 62 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

The Controlled Substances Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups of drugs, determined by varying qualifications, such as the drug's medical uses, if any, and its potential for abuse. For example, Schedule V drugs are defined as having the lowest potential for abuse, while Schedule I drugs are illegal at the federal level, mainly because they are defined as having no currently accepted medical uses and a high potential for abuse.

In Alaska, the share of claims observed in Service Year 2021 with at least one controlled substance was 8%. This compares to the region and countrywide shares of 8% and 8%, respectively. In 2021, Alaska spent $0.2M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 57 shows the distribution of prescription drug payments by CSA schedule in Alaska, the region, and countrywide.

Chart 57

Distribution of Prescription Drug Payments by CSA Schedule

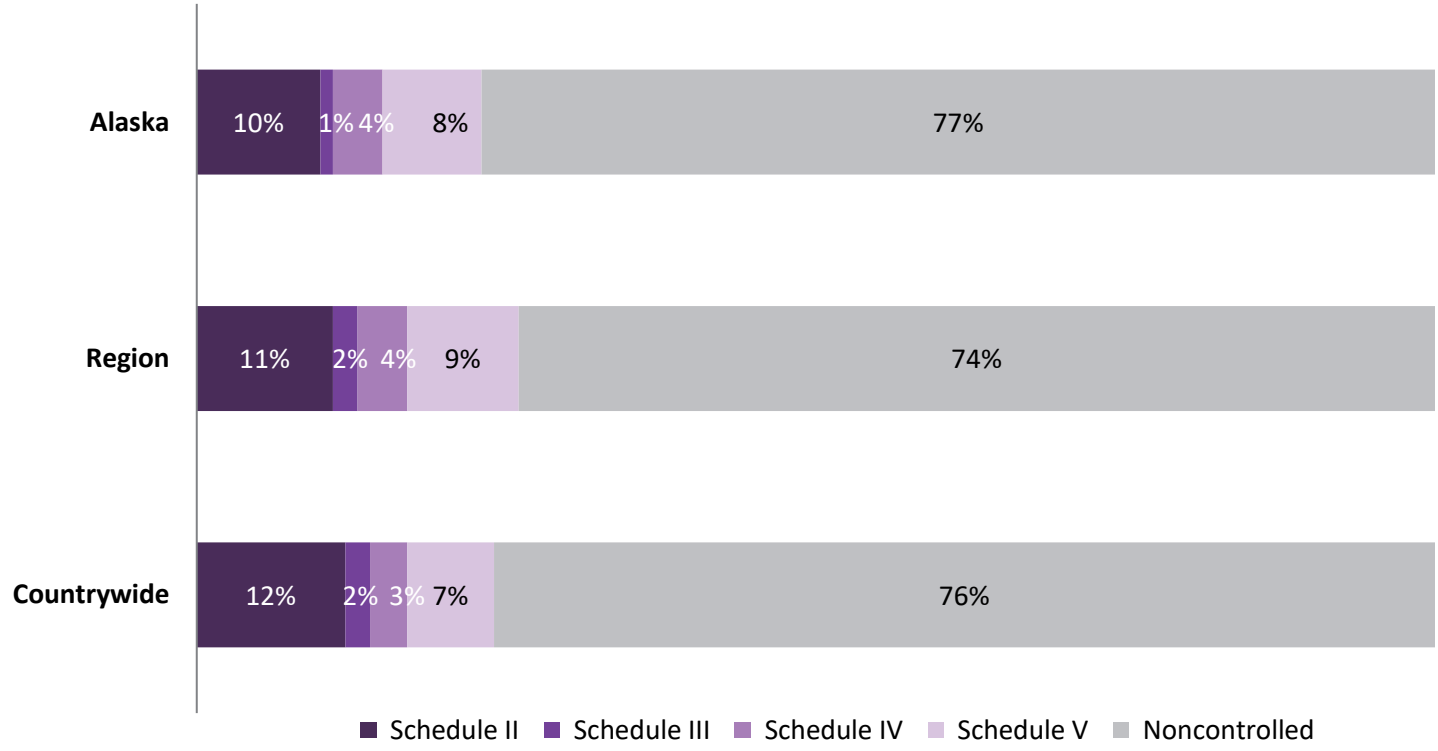


Chart 58 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Alaska. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See the Glossary for the definition of *units*.)

Chart 58

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU AK	Region	CW	Alaska Paid Share
Pregabalin	$4.33	$4.58	$4.50	7.2%
MACI®	$35,389.81	$51,480.26	$49,165.86	6.1%
Gabapentin	$0.79	$0.94	$0.90	3.6%
Oxycontin®	$10.17	$9.18	$9.91	3.1%
Aptiom®	$37.02	$36.48	$37.90	2.9%
Dupixent®	$841.52	$1,013.99	$844.07	2.5%
Lidocaine	$4.86	$5.62	$6.22	2.4%
Oxycodone HCl-Acetaminophen	$1.27	$1.33	$1.24	2.4%
Celecoxib	$3.78	$4.44	$5.25	2.4%
Ledipasvir-Sofosbuvir	$437.26	$468.13	$452.69	2.1%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	1
MACI®	B	N/A	Skin/Mucous Membrane	None	42
Gabapentin	G	Neurontin®	Anticonvulsants	None	4
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	7
Aptiom®	B	N/A	Anticonvulsants	None	174
Dupixent®	B	N/A	Immunosuppressants	None	85
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	5
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	11
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	3
Ledipasvir-Sofosbuvir	G	N/A	Antivirals	None	461

Chart 59 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in Alaska. This chart reveals the most frequently prescribed drugs and the average PPU.

Chart 59

Top 10 Workers Compensation Drugs by Prescription Counts

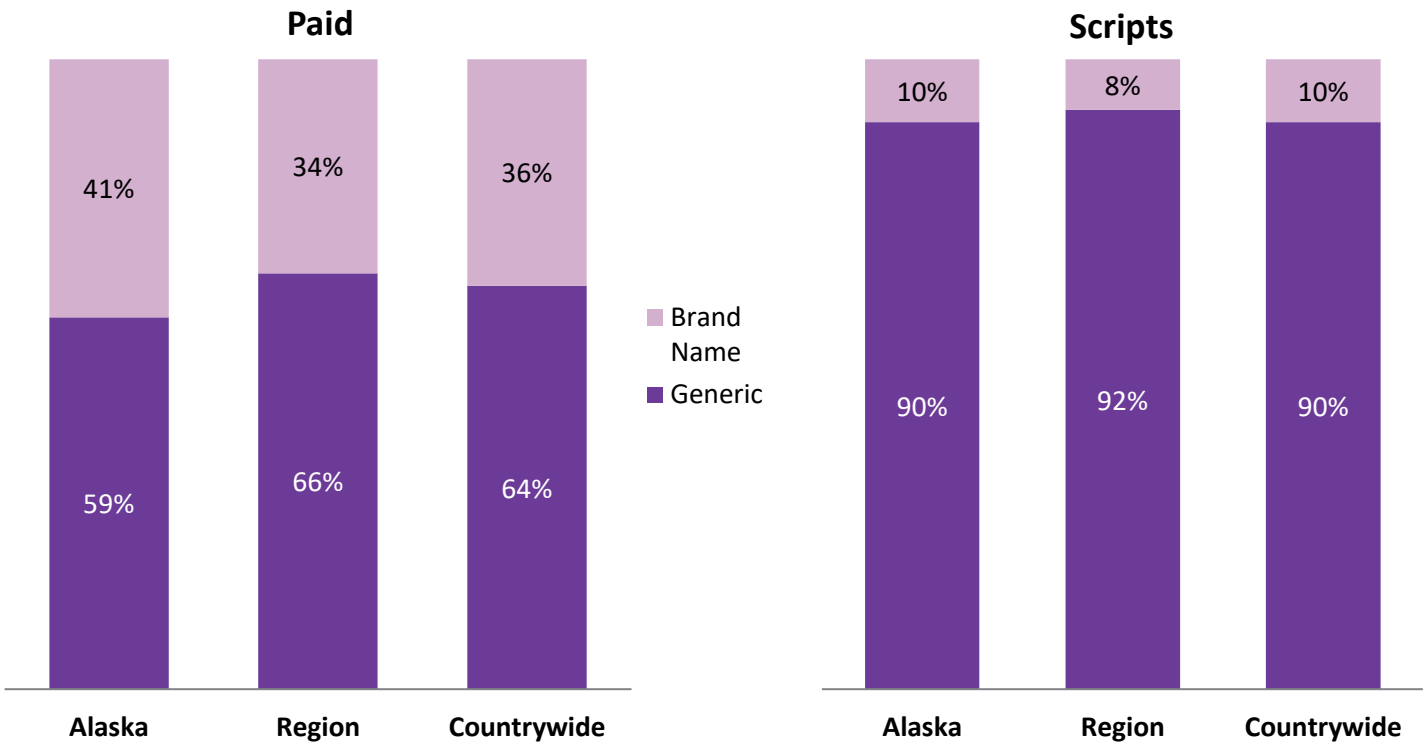
Drug Name	Average PPU AK	Average PPU Region	Average PPU CW	Alaska Prescription Share
Hydrocodone Bitartrate-Acetaminophen	$0.51	$0.50	$0.49	7.5%
Gabapentin	$0.79	$0.94	$0.90	6.4%
Oxycodone HCl-Acetaminophen	$1.27	$1.33	$1.24	4.5%
Oxycodone HCl	$0.67	$0.59	$0.70	4.5%
Tramadol HCl	$0.57	$0.68	$0.75	3.5%
Pregabalin	$4.33	$4.58	$4.50	3.3%
Cyclobenzaprine HCl	$0.80	$1.16	$1.88	3.2%
Tizanidine HCl	$1.06	$1.05	$1.04	3.0%
Celecoxib	$3.78	$4.44	$5.25	2.3%
Ibuprofen	$0.29	$0.54	$0.49	2.2%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	8
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	12
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	6
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	10
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Tizanidine HCl	G	Zanaflex®	Muscle Relaxants, Skeletal	None	11
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	13
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	4

Chart 60 shows the distribution of prescription drugs by brand name and generic for Alaska, the region, and countrywide. The share between brand name and generic is displayed based on the prescription counts and the payments. Typically, a higher percentage of drugs is given in the generic form; however, higher costs occur when brand name drugs are prescribed. In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs.

Chart 60

Distribution of Drugs by Brand Name and Generic



The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into the drivers of drug costs.

Chart 61 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for Alaska, the region, and countrywide.

Chart 61

Distribution of Drugs by Pharmacy and Nonpharmacy

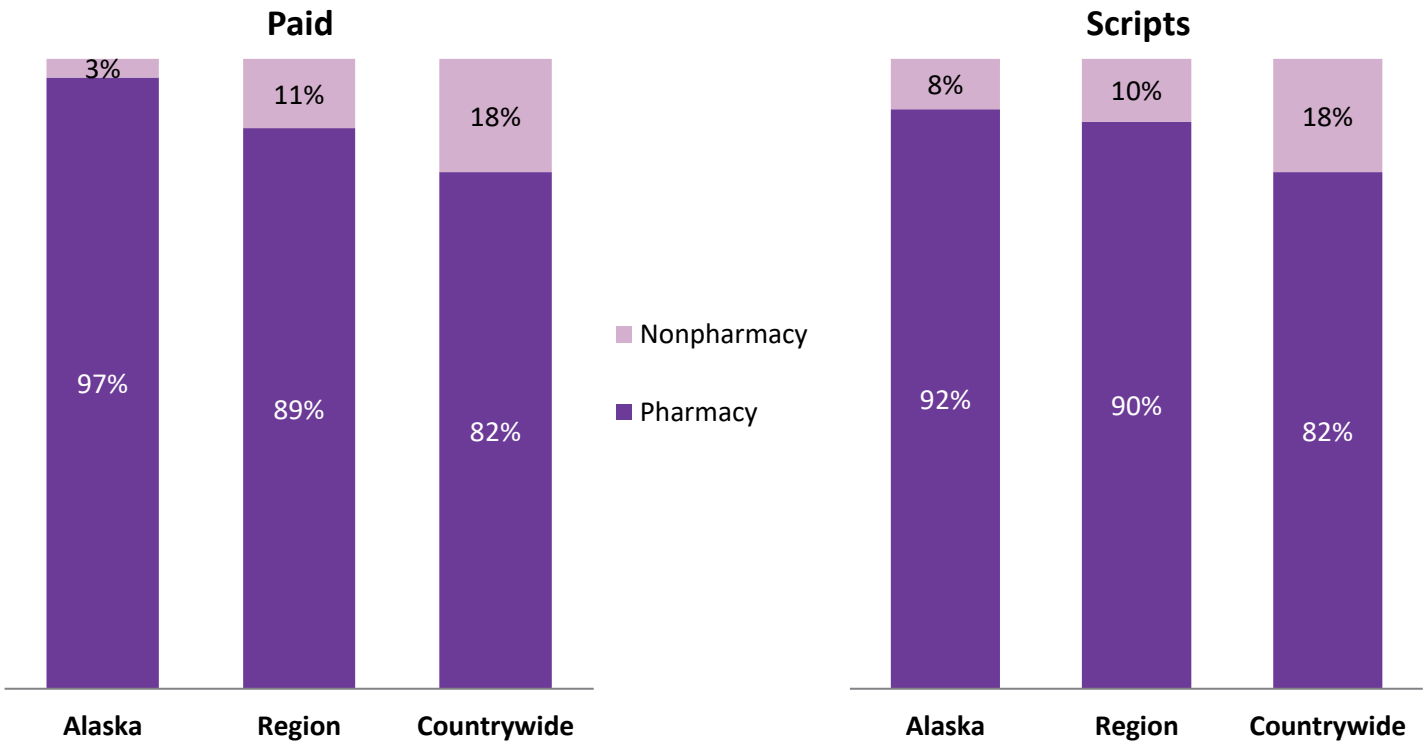


Chart 62 displays the shares of the payments for the top 5 nonpharmacy-dispensed prescription drugs used in workers compensation treatment, by amount paid in Alaska. It also provides a comparison for those same drugs when dispensed in a pharmacy for the state, region, and countrywide.

Chart 62

Top 5 Nonpharmacy-Dispensed Drugs by Amount Paid with Pharmacy-Dispensed Comparison

	Nonpharmacy-dispensed				Pharmacy-dispensed			
Drug Name	Paid Share	AK PPU	Region PPU	CW PPU	Paid Share	AK PPU	Region PPU	CW PPU
Daptomycin	18.6%	$508.45	$100.62	$55.24	N/A	N/A	$153.14	$117.35
Botox®	17.6%	$219.89	$360.42	$295.89	N/A	N/A	$789.93	$785.65
Botox Cosmetic®	8.3%	$238.70	$532.85	$312.74	N/A	N/A	N/A	N/A
Ertapenem	7.3%	$68.73	$80.32	$83.03	N/A	N/A	$49.09	$83.13
Adacel®	3.5%	$68.49	$64.59	$61.96	N/A	N/A	$56.68	$97.60

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	Nonpharmacy CW Rank
Daptomycin	G	Cubicin®	Antibiotics	None	21
Botox®	B	N/A	Toxins	None	10
Botox Cosmetic®	B	N/A	Toxins	None	234
Ertapenem	G	Invanz®	Antibiotics	None	87
Adacel®	B	N/A	Serums, Toxoids, Vaccines	None	36

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

The distribution of medical payments for DMEPOS is 6% for Alaska, 7% for the region, and 8% for countrywide.

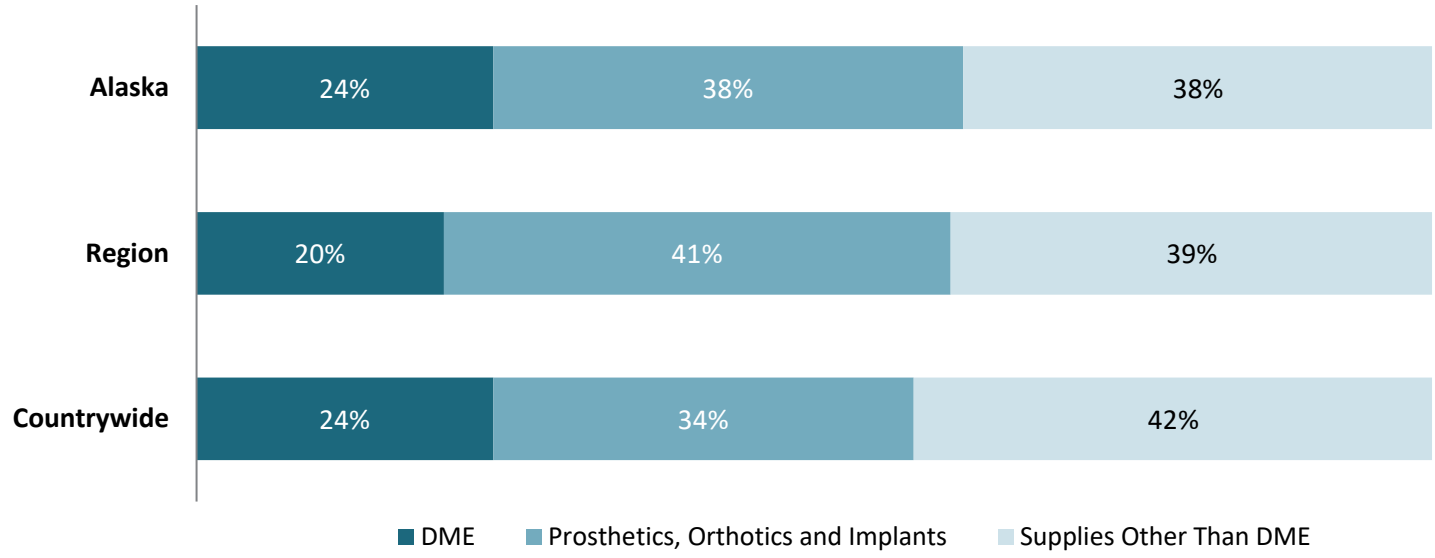
Chart 63 displays the distribution of payments among three separate DMEPOS categories:

- Durable Medical Equipment (DME)
- Prosthetics, Orthotics, and Implants
- Supplies Other Than DME

Payments are mapped to each of these categories based on the procedure code reported, regardless of who provides the service or where the service is performed.

Chart 63

Distribution of Payments by DMEPOS



Injuries that include an implant or prosthetic device tend to be more expensive than other injuries. Chart 64 shows the top 10 diagnosis groups for claims that include an implant or a prosthetic device by total paid amount. Chart 65 shows the same diagnosis groups with the average amount paid per claim for claims that do not include an implant or prosthetic.

Chart 64

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2020 for Claims *With* an Implant or Prosthetic

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Lumbar spine degeneration	7.2%	$124,427	$85,071	$94,065
Rotator cuff tear	6.4%	$46,022	$30,850	$39,232
Diabetes	6.3%	$543,024	$67,293	$68,712
Minor shoulder injury	5.4%	$46,990	$23,889	$29,463
Knee degenerative/overuse injuries	5.3%	$76,049	$40,072	$49,322
Hip/pelvis fracture/major trauma	4.5%	$97,246	$77,429	$84,823
Knee internal derangement - cruciate ligament tear	4.4%	$42,316	$31,005	$36,485
Tibia/fibula fracture	4.1%	$59,580	$65,423	$75,001
Hand/wrist fracture	4.0%	$26,859	$27,760	$29,246
Ankle fracture	3.1%	$38,833	$34,888	$38,185

Chart 65

Average Amount Paid per Claim *Without* an Implant or Prosthetic for Diagnosis Groups in Chart 64

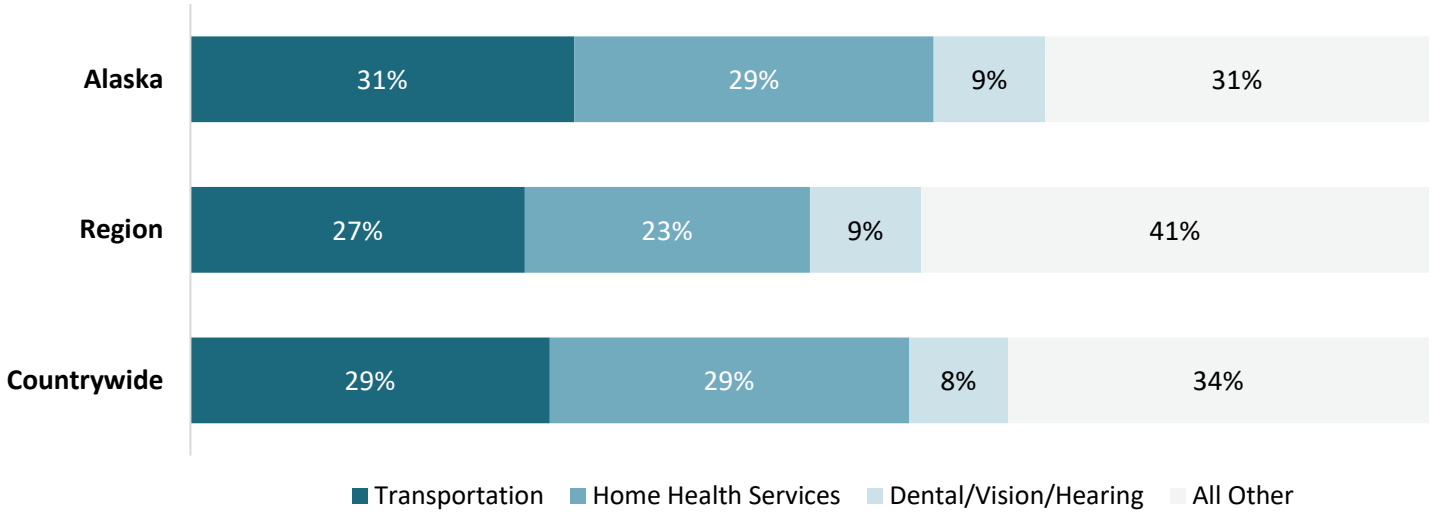
	Average Amount Paid Per Claim		
Diagnosis Group	**Alaska**	**Region**	**Countrywide**
Lumbar spine degeneration	$14,731	$11,791	$14,778
Rotator cuff tear	$23,525	$15,359	$20,188
Diabetes	$588	$8,471	$10,772
Minor shoulder injury	$8,576	$3,754	$4,252
Knee degenerative/overuse injuries	$5,429	$6,851	$8,897
Hip/pelvis fracture/major trauma	$18,234	$28,644	$31,714
Knee internal derangement - cruciate ligament tear	$20,744	$17,762	$21,791
Tibia/fibula fracture	$28,987	$14,220	$16,248
Hand/wrist fracture	$9,094	$6,118	$6,212
Ankle fracture	$20,910	$14,738	$14,982

Other Medical Services

For Service Year 2021, other medical services represent 5% of total medical costs countrywide. Chart 66 shows the distribution of these services by four categories: transportation, home health services, dental/vision/hearing, and all other. The "All Other" category typically includes services that may have a missing, invalid, or unlisted procedure, in addition to some other valid services (e.g., payments for interpreters, vehicle modifications, etc.).

Chart 66

Distribution of Other Medical Services Payments



Diagnosis Group and Body System

Charts 67 and 68 display the top 10 body systems and diagnosis groups, respectively. A body system and diagnosis group are identified for each claim based on an ICD-10 code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for Alaska. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2020, and December 31, 2020, and they include all reported services provided for those claims through December 31, 2021.

Chart 67

Top Body Systems by Amount Paid for Dates of Injury in 2020

		Average Amount Paid Per Claim		
Body System	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Shoulder	20.2%	$17,229	$7,961	$10,188
Lumbar spine	12.3%	$7,850	$3,815	$4,786
Hand/wrist	11.5%	$3,873	$2,351	$2,609
Knee	9.3%	$8,811	$5,694	$6,477
Neck	7.0%	$12,057	$4,834	$6,662
Ankle/foot	6.3%	$5,588	$3,493	$3,863
Leg	5.9%	$11,207	$5,757	$6,796
Arm	4.8%	$11,893	$5,861	$6,403
Head	3.2%	$4,367	$4,331	$4,308
Abdomen	2.0%	$11,338	$6,667	$8,475

Chart 68

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2020

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Minor shoulder injury	6.7%	$10,225	$4,132	$4,769
Rotator cuff tear	6.5%	$26,593	$17,398	$22,884
Minor hand/wrist injuries	4.3%	$1,981	$1,303	$1,407
Low back pain	4.1%	$4,014	$2,569	$2,499
Hand/wrist fracture	3.5%	$11,120	$7,467	$7,619
Lumbar spine degeneration	3.5%	$26,401	$16,655	$21,043
Tibia/fibula fracture	2.9%	$35,105	$26,098	$28,413
Knee internal derangement - meniscus injury	2.4%	$12,000	$11,827	$13,637
Lumbosacral intervertebral disc disorders	2.4%	$25,027	$16,167	$19,868
Minor knee injury	2.3%	$3,691	$2,622	$2,833

Comparison of Selected Results by Year

The charts in this section provide a comparison of results for Alaska. These comparisons are over the latest five service years unless otherwise noted. Analysis in the growth of shares may provide additional insight into medical cost drivers above and beyond an analysis at a specific point in time.

Results in the charts below may vary compared to medical reports from previous years. This is due to a lag in reporting, as well as improved derivations affecting categories for certain charts.

Distribution of Medical Payments (Chart 4)

Medical Category	2017	2018	2019	2020	2021
Physician	48%	48%	47%	44%	46%
Hospital Outpatient	14%	14%	14%	15%	15%
Hospital Inpatient	12%	9%	10%	10%	12%
Drugs	5%	6%	4%	5%	4%
DMEPOS	4%	5%	5%	6%	6%
ASC	11%	12%	12%	12%	10%
Other	6%	6%	8%	8%	7%

Distribution of Physician Payments by AMA Service Category (Chart 6)

AMA Service Category	2017	2018	2019	2020	2021
Physical Medicine	31%	32%	34%	35%	33%
Surgery	28%	26%	26%	26%	25%
Evaluation and Management	18%	20%	19%	21%	22%
Radiology	14%	12%	11%	9%	9%
Anesthesia	4%	4%	4%	4%	4%
General Medicine	3%	4%	3%	3%	4%
Other	1%	1%	2%	2%	2%
Pathology	1%	1%	1%	0%	1%

Median Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)[10]

Medical Category	AY 2016	AY 2017	AY 2018	AY 2019	AY 2020
Physicians – Major Surgery	33	32	41	28	40
Physicians – Radiology	2	2	2	2	3
Physicians – Physical and General Medicine	22	25	22	26	26
Physicians – Evaluation and Management	4	4	3	3	3
Hospital Inpatient	1	1	1	0	1
Hospital Outpatient – Major Surgery	41	39	52	48	41
Hospital Outpatient – All Other	12	10	10	10	12
ASC – Major Surgery	56	51	50	55	61

75th Percentile of Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53) [10]

Medical Category	AY 2016	AY 2017	AY 2018	AY 2019	AY 2020
Physicians – Major Surgery	104	101	114	102	121
Physicians – Radiology	13	14	14	14	17
Physicians – Physical and General Medicine	61	57	56	63	62
Physicians – Evaluation and Management	17	16	14	13	15
Hospital Inpatient	8	10	6	7	10
Hospital Outpatient – Major Surgery	117	103	133	102	111
Hospital Outpatient – All Other	44	37	36	38	49
ASC – Major Surgery	142	142	130	151	142

Hospital Inpatient Statistics (Charts 27 and 29)

	2017	2018	2019	2020	2021
Average Amount Paid Per Stay	$45,486	$46,386	$42,598	$40,593	$44,299
Number of Stays per 1,000 Active Claims	18	15	15	17	18

[10] In the charts displaying the distribution of time until first treatment, the data is organized by the year in which the injury occurred, rather than by service year, and includes services performed within 365 days of the date of injury.

Distribution of Hospital Outpatient Payments by Outpatient Visit Type (Chart 35)

Visit Type	2017	2018	2019	2020	2021
Emergency	33%	38%	39%	37%	34%
Nonemergency Major Surgery	33%	27%	30%	32%	34%
Other	34%	35%	31%	31%	32%

Emergency Hospital Outpatient Statistics (Charts 36 and 37)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	$1,121	$1,149	$1,233	$1,350	$1,380
Number of Visits per 1,000 Active Claims	283	278	289	260	249

Emergency Room Outpatient Services Paid per Transaction (Chart 39)

Code	Severity	2017	2018	2019	2020	2021
99281	Minor	$210	$250	$221	$242	$215
99282	Low to moderate	$312	$332	$349	$358	$348
99283	Moderate	$597	$599	$593	$601	$585
99284	High	$993	$989	$996	$985	$891
99285	High and immediately life-threatening	$1,559	$1,635	$1,980	$1,777	$1,612

Nonemergency Major Surgery Hospital Outpatient Statistics (Charts 40 and 41)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	$9,912	$9,314	$10,078	$10,353	$11,068
Number of Visits per 1,000 Active Claims	32	25	28	30	32

Other Hospital Outpatient Statistics (Charts 45 and 46)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	$441	$449	$470	$448	$494
Number of Visits per 1,000 Active Claims	739	651	610	663	658

ASC Major Surgery Statistics (Charts 51 and 52)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	$12,265	$11,983	$11,396	$10,460	$9,960
Number of Visits per 1,000 Active Claims	55	55	59	70	67

Distribution of Prescription Drug Payments by CSA Schedule (Chart 57)

CSA Schedule	2017	2018	2019	2020	2021
Schedule II	23%	20%	17%	15%	10%
Schedule III	3%	2%	3%	2%	1%
Schedule IV	5%	5%	6%	6%	4%
Schedule V	11%	11%	13%	10%	8%
Noncontrolled	58%	62%	61%	67%	77%

Distribution of Drug Payments by Brand Name and Generic (Chart 60)

Type of Drug	2017	2018	2019	2020	2021
Brand Name	40%	43%	39%	35%	41%
Generic	60%	57%	61%	65%	59%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 61)

Type of Provider	2017	2018	2019	2020	2021
Pharmacy	94%	93%	93%	97%	97%
Nonpharmacy	6%	7%	7%	3%	3%

Distribution of Payments by DMEPOS (Chart 63)

Category	2017	2018	2019	2020	2021
DME	18%	13%	14%	22%	24%
Prosthetics, Orthotics and Implants	44%	52%	46%	39%	38%
Supplies Other Than DME	38%	35%	40%	39%	38%

Distribution of Payments by Other Medical Services (Chart 66)

Category	2017	2018	2019	2020	2021
Transportation	49%	52%	45%	32%	31%
Home Health Services	11%	9%	27%	25%	29%
Dental/Vision/Hearing	10%	14%	9%	10%	9%
All Other	30%	25%	19%	32%	31%

Glossary

75th Percentile: The point on a distribution that is higher than 75% of observations and lower than 25% of observations.

Accident Year: A loss accounting definition in which experience is summarized by the calendar year in which an accident occurred.

Ambulatory Payment Classification (APC): Unit of payment under Medicare's Outpatient Prospective Payment System (OPPS) for hospital outpatient services where individual services are grouped based on similar characteristics and similar costs.

Ambulatory Surgical Center (ASC): A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of physicians, has continuous physician and nursing care, and does not provide for overnight stays. An ASC can bill for facility fees much like a hospital, but it generally has a separate fee schedule.

Controlled Substances: Drugs that are regulated by the Controlled Substances Act (CSA) of 1970. Each controlled substance is contained in one of five schedules based on its medical use(s) and its potential for abuse and addiction.

CPT Code Modifiers: Modifiers are codes added to a CPT code that further describe the procedure performed without changing the meaning of the original code.

Current Procedural Terminology (CPT): A numeric coding system maintained by the American Medical Association (AMA). The CPT coding system consists of five-digit codes that are primarily used to identify medical services and procedures performed by physicians and other healthcare professionals.

Diagnosis Groups: Based on ICD-10 codes; groups based on similar injuries and parts of body.

Diagnosis-Related Groups (DRG): A system of hospital payment classifications that groups patients with similar clinical problems who are expected to require similar amounts of hospital resources.

Drugs: Includes any data reported by a National Drug Code (NDC), which is referred to as a prescription drug. Also included are data for revenue codes, the Healthcare Common Procedure Coding System (HCPCS), and other state-specific codes that represent drugs.

Durable Medical Equipment (DME): Equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and is not generally useful to a person in the absence of an illness or injury.

Emergency Services: Services performed for patients requiring immediate attention.

Emergency Visit: A visit where emergency services are performed.

Healthcare Common Procedure Coding System (HCPCS): Alphanumeric codes that include mostly nonphysician items or services such as medical supplies, ambulatory services, prostheses, etc. These are items and services not covered by Current Procedural Terminology (CPT) procedures.

ICD-10 Codes: The *International Classification of Diseases, Tenth Revision,* is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States.

Hospital Inpatient Service: Services for a patient who is admitted to a hospital for treatment that requires at least one overnight stay (more than 24 hours in a hospital).

Hospital Inpatient Stay: A hospital admission of a patient requiring hospitalization of at least one 24-hour period.

Hospital Outpatient Service: Any type of medical or surgical care, performed at a hospital, that is not expected to result in an overnight hospital stay (less than 24 hours in a hospital).

International Statistical Classification of Diseases and Related Health Problems (ICD-10): A classification of diseases and other health problems based on a diagnosis maintained by the World Health Organization (WHO).

Length of Stay: The amount of time, in days, between admission to a hospital and discharge.

Major Surgery Visit: A visit in which at least one surgery procedure is performed based on the reported procedure code, and where the surgical procedure is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, or the procedure involves spine/spinal cord neurostimulators.

Medical Data Call: Captures transaction-level detail for medical billings that were processed on or after July 1, 2010. All medical transactions with the jurisdiction state in any applicable Medical Data Call state are reportable. This includes all workers compensation claims, including medical-only claims.

Other Outpatient Visit: A nonemergency outpatient visit where no major surgery services are performed.

(Paid) Procedure Code: A code from the jurisdiction-approved code table that identifies the procedure associated with the reimbursement. Examples include CPT code or revenue code.

Revenue Code: A numeric coding system used in hospital billings that provides broad classifications of the types of services provided. Some examples are emergency room, operating room, recovery room, room and board, and supplies.

Service Year: A loss accounting definition where experience is summarized by the calendar year in which a medical service was provided.

Taxonomy Code: A code that identifies the type of provider that billed for, and is being paid for, a medical service. Data reporters are instructed to use the provider taxonomy list of standard codes maintained by the National Uniform Claim Committee.

Telemedicine Service: Services reported with a telemedicine-specific procedure code, modifier, or place of service.

Time to Treatment (TTT): The amount of time, measured in days, between the date on which an accident occurs and the date on which the first medical service in a given category is provided.

Transaction: A line item of a medical bill.

Units: The number of units of service performed or the quantity of drugs dispensed. For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug:

- For tablets, capsules, suppositories, nonfilled syringes, etc., *units* represent the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the procedure code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement, such as milliliters, grams, or ounces. For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as four units.

Visit: Any hospital outpatient or ASC service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claimant may have more than one visit.

Appendix

The data contained in this report is reported under the jurisdiction state—the state under whose workers compensation act the claimant's benefits are being paid. Medical transactions must continue to be reported until the transactions no longer occur (i.e., the claim is closed) or 30 years from the accident date. There are nearly 30 data elements reported.

Wherever possible, standard industry codes are used because they provide a clear definition of the data, improve its accuracy and quality, and increase efficiency of computer systems.

Carriers differ in their handling of medical data reporting. Some carriers retain all medical claims handling internally and submit the data themselves. Others use business partners for various aspects of medical claim handling, such as third party administrators or medical bill review vendors. It is possible for a carrier to authorize its vendor to report the data on its behalf. Some carriers may use a combination of direct reporting and vendors. Although data may have been provided by an authorized vendor on behalf of a carrier, the quality, timeliness, and completeness of the data is the responsibility of the carrier.

Before a medical data provider can send files, each submitter's electronic data file must pass certification testing. This ensures that all connections, data files, and systems are functioning and processing correctly. Each medical data provider within a reporting group is required to pass certification testing. If a medical data provider reports data for more than one reporting group, that data must be certified for each group.

For more information about the Medical Data Call, please refer to the ***Medical Data Call Reporting Guidebook*** on **ncci.com**.