

ALASKA WORKERS' COMPENSATION MEDICAL SERVICES REVIEW COMMITTEE MEETING



August 11, 2020

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TAB 1

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING

August 11, 2020

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

AGENDA

August 11, 2020

- 9:00 am** Call to order
- Roll call - establishment of quorum
- 9:10 am** Approval of Agenda
- 9:15 am** Introduction of newly hired Workers' Compensation Director
- 9:20 am** Review Meeting Packet
- 9:30 am** Reading/Approval of minutes from July 10, 2020 meeting
- 9:40 am** Review of 2021 MSRC Fee Schedule Issues
- Use as guide during meeting; during "Mark Up" Draft Fee Schedule review
- 9:50 am** COVID-19 WC Claims Update
- 10:00 am** Break
- 10:15 am** Public Comment Period
- 11:15 am** Break
- 11:30 am** Review Draft 2021 Medical Fee Schedule w/ Mark Ups
- Reference to Fee Schedule Issues during Step-Thru
- 12:30 pm** Lunch Break
- 1:30 pm** Roll Call
- 1:35 pm** Cont: Review Draft 2021 Medical Fee Schedule w/ Mark Ups
- 3:00 pm** Break
- 3:15 pm** Vote to accept Draft 2021 Medical Fee Schedule
- 3:30 pm** Discuss/Propose MSRC meetings dates for CY2021
- 4:00 pm** Open Discussion
- 5:00 pm** Adjournment

TAB 2

***Workers' Compensation
Medical Services Review Committee
Meeting Minutes
July 10, 2020***

I. Call to order

Acting Director Joseph Knowles, Chair of the Medical Services Review Committee, called the Committee to order at 9:02 am on Friday, July 10, 2020. Due to concerns related to the COVID-19 public health disaster, the meeting was held by telephone and video conference.

II. Roll call

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

Dr. Mary Ann Foland Jennifer House Susan Kosinski Pam Scott
Misty Steed

Members Vince Beltrami and Dr. Robert Hall were excused. Member Timothy Kanady was absent.

III. Introduction of New Members and Guests

Acting Director Knowles introduced senior staff present, and Carla Gee with Optum.

IV. Approval of Agenda

A motion to adopt the agenda was made by member Scott and seconded by member Foland. The agenda was adopted unanimously.

V. Review of Minutes

A motion to adopt the June 19, 2020 minutes was made by member Foland and seconded by member Kosinski. The June 19, 2020 minutes were unanimously adopted by the committee.

VI. Fee Schedule Guidelines Development Discussion

Acting Chief of Adjudications Ronald Ringel discussed fees for out-of-state providers. Carla Gee reminded everyone that the committee had proposed language at the June 19, 2020 meeting, to clarify that the lower of the either the Alaska GPCI or the GPCI in the state where the treatment occurs, if applicable. Carla will provide updated language at the August 11, 2020 meeting.

Acting Director Knowles presented the updated Fee Schedule issues for consideration.

The committee discussed access to care. Each member reiterated that from their role within the workers' compensation system, whether as physician or hospital representative, or as insurer or claim administrator, they do not see access to care as an issue.

Break 9:50 am – 10:15 am

VII. Public Comment

Sandy Travis - representing self

- Stated that the Public Notice does not meet requirements under the public meetings act.
- Stated she is unable to make public comment because she received the meeting packet on July 9, 2020 and has not had time to read it all.
- Stated that the “New drug program” increases claims due to the side effects and reactions of the drugs, and that the program favors pharmaceutical companies.
- Stated that Administrative Officer Alexis Newman has discriminated against disabled people.

Barbara Williams - representing Injured Workers’ Alliance

- Stated that under Section 4 of the American’s with Disabilities Act, the Division has an obligation to provide accommodations for disabled individuals.
- Stated the Division holds multiple public meetings at the same time to prevent the public from being able to attend.
- Stated SIME doctors should be held to the same fee schedule as other physicians.

VIII. Fee Schedule Guidelines Development Discussion Continued

Carla Gee and Nanette Orme from Optum stepped through proposed changes for the 2021 Medical Fee Schedule.

The Committee reviewed the proposed language that a provider shall not require a deposit from the patient, in response to their discussion at the June 19, 2020 meeting regarding a particular provider who was requiring a deposit for hearing aids. The committee agreed to the proposed language.

The Committee reviewed the proposed language regarding “mixed” drugs, in response to their discussion at the June 19, 2020 meeting. The committee made additional suggestions, and Carla will present the new language at the August 11, 2020 meeting.

The Committee reviewed the proposed language regarding transcutaneous electrical nerve stimulation (TENS) Units. Member Foland provided anecdotal information that further demonstrated this was a problem area. Carla presented the TENS Unit language under Colorado’s Fee Schedule, and data surrounding the four billing codes. The committee discussed rental language, and possible ways to cap the cost such as requiring a physician assessment after two months. Carla will present new language at the August 11, 2020 meeting.

The Committee reviewed the proposed language regarding hearing aids. Member Steed suggested that additional dispensing codes be added and the committee agreed. Member Steed also noted that she spoke to several audiologists since the last meeting. Unanimously, they had stated that they do not charge for any evaluations within the warranty period, therefore the proposed global billing period would not be an issue for the audiologist community. Member Steed also provided documentation that she had received from an audiologist that she spoke to. Member Kosinski suggested that the committee adopt language similar to Wyoming, which states that a replacement hearing aid requires a written report from

the physician specifying that a new hearing aid is required. The Committee reviewed hearing aid language from other state Fee Schedules. The committee voiced particular interest in adopting verbiage similar to Wyoming and Washington.

Lunch 12:07 pm – 1:10 pm

The Committee discussed conversion factors. Due to the COVID-19 pandemic, hospitals and physicians already face hardship and the committee was averse to making large cuts that would further negatively affect them. However, if no cuts were made, Alaska rates would quickly rise as Medicare rates increase annually. The committee agreed minimal reductions were necessary to stay in line with national rates. Carla Gee presented data comparing Alaska rates to the region and country. The Committee agreed upon 5% reductions to surgery, radiology, anesthesia, ambulatory surgery centers, and Durable Medical Equipment.

Member Scott motioned to approve the proposed 5% reductions to surgery, radiology, anesthesia, ambulatory surgery centers, and durable medical equipment. Member Foland seconded. The motion passed unanimously.

Acting Director Knowles reminded the Committee that the next MSRC meetings were scheduled for August 11, 2020 and the joint meeting of the MSRC and the Workers' Compensation Board was scheduled for August 28, 2020. These meetings would be held by teleconference and video conference.

Motion to adjourn was made by Member Kosinski, and seconded by Member Steed. The motion passed unanimously.

Meeting Adjourned 2:07 pm

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

August 23, 2019

I. Call to order

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

II. Roll call

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

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

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

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

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

Members Vince Beltrami and Misty Steed were excused.

III. Agenda Approval

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

IV. Approval of MSRC August 9, 2019 Meeting Minutes

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

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

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

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

Sandy Travis – representing self

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

Greg Weaver – representing self

- Alleged that the Board is biased towards the employer.

Eric McDonald – representing self

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

Barbara Williams – representing Injured Workers' Alliance

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

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

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

Sue Sumpter – representing Creekside Surgery Center (written comment)

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

VII. MSRC's Presentation of Recommendations to Board

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

VIII. Reed Group Presentation

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

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

Lunch Break 12:45pm - 2:05pm

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

The MSRC continued to present the recommendation to the Board.

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

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

X. Proposed Regulation Changes

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

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

Meeting Adjourned 4:10pm

TAB 3

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

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

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

Committee Membership as of May 20, 2020

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

TAB 4



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

Department of Labor and Workforce Development

Office of the Commissioner

PO Box 111149
Juneau, Alaska 99811
Main: 907.465.2700

August 20, 2019

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

Dear Alaska Workers' Compensation Board,

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

Sincerely,

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

Dr. Tamika L. Ledbetter
Commissioner

cc: Director Grey Mitchell



Workers' Compensation Medical Fee Schedule Recommendations

August 16, 2019

Medical Services Review Committee

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



THE STATE
of **ALASKA**

GOVERNOR MICHAEL J. DUNLEAVY

**Department of Labor and
Workforce Development**

DIVISION OF WORKERS' COMPENSATION

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

August 16, 2019

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

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

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

Sincerely,

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

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

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ACKNOWLEDGEMENTS

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

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

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

EXECUTIVE SUMMARY

PURPOSE OF THIS REPORT

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

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

BACKGROUND

The MSRC is composed of

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

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

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

RECOMMENDATIONS OF THE MSRC

Alaska Workers' Compensation Medical Fee Schedule Guidelines

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

Medical Fee Schedule

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

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

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

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

Hearing Aids

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

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

Clinical Diagnostic Laboratory

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

Treatments outside Scope of Practice

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

Experimental Treatments

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

Ambulatory Surgical Centers

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

Work Hardening and Functional Capacity Exam (physical therapy)

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

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

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

2020 Objectives

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

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

TAB 5

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE

Updated: 5 Aug 2020

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

2021 Fee Schedule Issues for Consideration

- Review Draft Fee Schedule with mark-ups to account for CMS adjustments.
 - CMS changes to E&M category; changes to the Evaluation and Management section of codes are discussed in more detail in the Evaluation and Management section of this fee schedule.
 - Expand telemedicine descriptions and clarify any limitations; suggest telehealth verbiage to cover and reimburse vs. remain silent
 - Clarify scenario in which relative weight is non-existent, but a payment rate exists in Addendum B (OPPS file) – e.g. for CPT® 90375, pay at ASP value/multiplier; suggest verbiage for procedures without a relative weight in Addendum B shall use a payment rate where available with the conversion factor 221.79 multiplier of 2.08 for ASCs and 2.75 for outpatient facilities
 - Critical Access Hospitals – currently agree to retain current fee schedule which allows lowest of 100% of billed charge, charge to general public, or negotiated price between provider and employer for **implant** reimbursement vs. limited based on invoice cost
 - **Confirm suggested verbiage in fee schedule**
- TENS units and commitment to auto deliveries/lifetime resupply default; suggest verbiage for annual renewal assessments and rent for two months w/ re-evaluation to determine continued rental or purchase; electrodes supplies “2 months, then as needed” @ invoice plus 2%0
- Concerns expressed that employees are asked to prepay/make deposits/finance treatment & services; suggest verbiage re; an employee shall not be required to pay a fee or charge for medical treatment or service provided under this chapter including prepayment, deposit, or balance billing for services (Alaska Statute 23.90.097(f))
- Review conversion factors/multiplier category (compare to national & regional charges) – previous focus area for 10 July’s meeting (w/ Idaho, Montana, & Wyoming)
 - Optum’s excel files reflect culmination of MSRC inputs
 - 10 July Committee agreed upon reductions to Surgery, Radiology, Anesthesia, Ambulatory Surgery Center and Durable Medical Equipment
 - **VERIFY PATHOLOGY & LAB/CLINICAL LAB both @ ZERO/no change**
- Work Hardening – acceptable for individual treatment in a group setting?
 - **Confirm suggested verbiage in fee schedule if necessary**
- Application of Alaska’s GPCIs vs. other state’s when calculating total RVU
 - Suggest verbiage of services by out-of-state providers shall be reimbursed at the lower of the *Alaska Workers' Compensation Medical Fee Schedule* or the workers compensation fee schedule of the state where the service is rendered
- Reimbursement for compound “Pre-Mix” of Over the Counter drugs – high billing as a prescription; suggest verbiage that compounded and mixed drugs shall be limited to medical necessity and must be FDA-approved combinations, as well as reimbursed at lowest generic NDC for each/comp^{arable} to prepaid or private plans

- Recurring review for any access challenges to medical care for injured workers
 - None noted thus far by MSRC members
 - MSRC members will continue to solicit feedback from their various and diverse colleagues
- Inpatient Hospital conversion factors – evaluate methodology and consider conversion factor adjustments/consolidation; currently believed to be competitive
 - Committee desires to compare to regional charges when data available
- Adoption of evidence-based treatment guidelines and/or evidence based drug formulary; awaiting drug formulary work group’s results/recommendations
- Evaluate any available data related to 2020’s adjustment: (Awaiting relevant 2019 data)
 - Impact on utilization associated with work hardening and functional capacity exam increases;
 - Impact of hearing aids/parts limitation of mfr invoice + 30% for fitting and dispensing (HCPCS V5011& V5160) and “gap-fill” relative values;
 - Impact of scope of practice and off label use limitations
- Consolidation toward a single conversion factor; retained for possible future MSRC consideration
- Other Issues

TAB 6

Official

ALASKA

WORKERS' COMPENSATION

◆ ————— *MEDICAL FEE SCHEDULE*

Effective January 1, 2020



Commented [ONE1]: Effective date will be January 1, 2021

STATE OF ALASKA DISCLAIMER

This document establishes professional medical fee reimbursement amounts for covered services rendered to injured employees in the State of Alaska and provides general guidelines for the appropriate coding and administration of workers' medical claims. Generally, the reimbursement guidelines are in accordance with, and recommended adherence to, the commercial guidelines established by the AMA according to CPT guidelines. However, certain exceptions to these general rules are proscribed in this document. Providers and payers are instructed to adhere to any and all special rules that follow.

NOTICE

The *Official Alaska Workers' Compensation Medical Fee Schedule* is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

This publication is made available with the understanding that the publisher is not engaged in rendering legal and other services that require a professional license.

QUESTIONS ABOUT WORKERS' COMPENSATION

Questions regarding the rules, eligibility, or billing process should be addressed to the State of Alaska Workers' Compensation Division.

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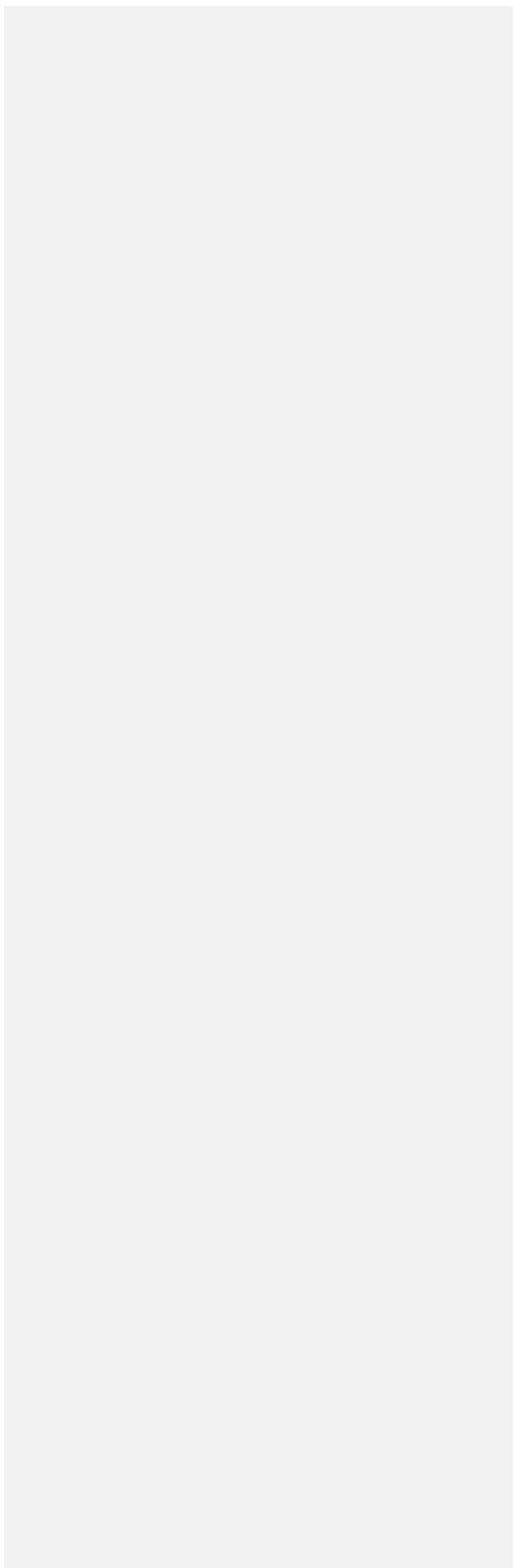
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Introduction

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

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

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

[An employee shall not be required to pay a fee or charge for medical treatment or service provided under this chapter including prepayment, deposit, or balance billing for services \(Alaska Statute 23.90.097\(f\)\).](#)

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

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

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

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

The MAR for medical services that do not have valid Current Procedural Terminology (CPT[®]) or Healthcare Common Procedure Coding System (HCPCS) codes, a currently assigned CMS relative value, or an established conversion factor is the lowest of:

- 85 percent of billed charges,
- The charge for the treatment or service when provided to the general public, or

- The charge for the treatment or service negotiated by the provider and the employer

SCOPE OF PRACTICE LIMITS

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

ORGANIZATION OF THE FEE SCHEDULE

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

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

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

[Proposed 2021 changes to the Evaluation and Management \(E/M\) section of codes are discussed in more detail in the Evaluation and Management section of this fee schedule.](#)

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

PROVIDER SCHEDULE

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

Some surgical, radiology, laboratory, and medicine services and procedures can be divided into two components—the professional and the technical. A professional service is one that must be rendered by a physician or other certified or

licensed provider as defined by the State of Alaska working within the scope of their licensure. The total, professional component (modifier 26) and technical component (modifier TC) are included in the Provider Schedule as contained in the Resource-Based Relative Value Scale (RBRVS).

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

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

[\[H3\] Services by Out-of-State Providers](#)

[Services by out-of-state providers shall be reimbursed at the lower of the \[ITAL\] Alaska Workers' Compensation Medical Fee Schedule \[END ITAL\] or the workers compensation fee schedule of the state where the service is rendered. See Alaska Statute 23.30.097\(k\).](#)

DRUGS AND PHARMACEUTICALS

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

The maximum allowable reimbursement for prescription drugs is as follows:

1. Brand name drugs shall be reimbursed at the manufacturer's average wholesale price plus a \$5 dispensing fee;
2. Generic drugs shall be reimbursed at the manufacturer's average wholesale price plus a \$10 dispensing fee;
- ~~3. Reimbursement for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's average wholesale price for each drug included in the compound, listed separately by National Drug Code, plus a single \$10 compounding fee.~~
- ~~3. Compounded and mixed drugs shall be limited to medical necessity and must be FDA-approved combinations. Reimbursement for compounded or mixed drugs will be:~~
 - ~~[BULLETED LIST]~~
 - ~~n Comparable to prepaid or private healthcare plans in the community~~
 - ~~n At the lowest generic NDC for each specific or over the counter drug~~

HCPCS LEVEL II

Durable Medical Equipment

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

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

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

Ambulance Services

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

OUTPATIENT FACILITY

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

INPATIENT HOSPITAL

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

DEFINITIONS

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

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

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

Board — the Alaska Workers' Compensation Board.

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

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

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

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

Day — a continuous 24-hour period.

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

Drugs — a controlled substance as defined by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Preoperative diagnosis
- Postoperative diagnosis
- A step-by-step description of the surgery
- Identification of problems that occurred during surgery
- Condition of the patient when leaving the operating room, the provider's office, or the health care organization.

Optometrist — an individual licensed to practice optometry.

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

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

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

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

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

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

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

Procedure — a unit of health service.

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

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

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

Prosthesis — an artificial substitute for a missing body part.

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

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

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

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

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

General Information and Guidelines

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

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

BILLING AND PAYMENT GUIDELINES

Fees for Medical Treatment

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

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.03	1.500	1.545
Practice Expense RVU x Practice Expense GPCI	1.611.6 4	1.1171. 118	1.798371. 83352
Malpractice RVU x Malpractice GPCI	0.140.1 3	0.7080. 661	0.099120. 08593
Total RVU			3.442493. 46445

Data for the purpose of example only

Calculation using example data:

$$1.03 \times 1.500 = 1.545$$

$$\begin{aligned}
&+ \underline{1.61 \times 1.117 = 1.798371.64 \times 1.118 = 1.83352} \\
&+ \underline{0.14 \times 0.708 = 0.099120.13 \times 1.661 = 0.08593} \\
&= \underline{3.442493.46445} \\
&\underline{3.442493.46445} \times \$\underline{132.00125.00} \text{ (CF)} = \underline{454.40868457.3074433.0563} \\
&\text{Payment is rounded to } \$\underline{454.41457.31433.06}
\end{aligned}$$

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

[Services by out-of-state providers shall be reimbursed at the lower of the Alaska Workers' Compensation Medical Fee Schedule or the workers compensation fee schedule of the state where the service is rendered. See Alaska Statute 23.30.097\(k\).](#)

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

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

MEDICAL SERVICE	CPT CODE RANGE	CONVERSION FACTOR
Surgery	10004–69990	\$132.00 <u>125.00</u>
Radiology	70010–79999	\$141.00 <u>134.00</u>
Pathology and Lab	80047–89398	\$122.00
Medicine (excluding anesthesia)	90281–99082 and 99151–99199 and 99500–99607	\$80.00
Evaluation and Management	99091, 99201 <u>99202</u> –99499	\$80.00
Anesthesia	00100–01999 and 99100–99140	\$110.00 <u>105.00</u>

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

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

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

RBRVS Status Codes

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

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

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

N	<p><u>Non-covered Services.</u> These services are not covered by Medicare.</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>
P	<p><u>Bundled/Excluded Codes.</u> There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.</p> <ul style="list-style-type: none"> • If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) • If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act. 	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>
Q	<p><u>Therapy functional information code (used for required reporting purposes only).</u></p>	<p>These codes are supplemental to other covered services and for informational purposes only.</p>
R	<p><u>Restricted Coverage.</u> Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D." We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)</p>	<p>The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i>. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</p>

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

Add-on Procedures

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

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

Add-on procedures that are performed bilaterally are reported as two line items, and modifier 50 is not appended. These codes are identified with CPT-specific language at the code or subsection level. Modifiers RT and LT may be appended as appropriate.

Exempt from Modifier 51 Codes

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

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

Professional and Technical Components

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

Global Days

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

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

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

[H3] Telehealth Services

Telehealth services are a covered service and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star [INSERT BLACK STAR ICON] icon and/or in CPT

appendix P. ~~The~~In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the appropriate telephone codes (99441—99443). ~~These~~Telehealth services should be reported with modifier 95 appended.

Supplies and Materials

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

Medical Reports

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

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

Off-label Use of Medical Services

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

Off-label use of medical services will be reviewed annually by the Alaska Workers' Compensation Medical Services Review Committee (MSRC).

Payment of Medical Bills

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

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

Scope of Practice Limits

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

Board Forms

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

Applicable HCPCS Modifiers

Modifier TC—Technical Component

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

Modifier QZ—CRNA without medical direction by a physician

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

State-Specific Modifiers

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

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

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

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

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

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

Data for the purpose of example only

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

[When a PA or advanced practice registered nurse \(APRN\) provides care to a patient, modifier PE is appended. If an APRN assists, a surgery modifier PE is added.](#) Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

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

Procedure 1 (Modifier PE)	\$150.00
Procedure 2 (Modifier PE, 51)	\$130.00

Reimbursement	$\$182.75 [(\$150.00 \times .85) + ((130.00 \times .85) \times .50)]$
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Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

When exact text of the AMA [2019-2020](#) CPT® guidelines is used, the text is either in quotations or is preceded by a reference to the CPT book, CPT instructional notes, or CPT guidelines.

BILLING AND PAYMENT GUIDELINES

[H3] Telehealth Services

Telehealth services are a covered service and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star [INSERT BLACK STAR ICON] icon and in CPT appendix P. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the appropriate telephone codes (99441–99443). These Telehealth services should be reported with modifier 95 appended.

New and Established Patient Service

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

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

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

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

E/M Service Components

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

1. The history component is categorized by four levels:

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

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

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

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

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

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

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

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

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

The CPT book identifies the following body areas:

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

The CPT book identifies the following organ systems:

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

Contributory Components

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

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

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

E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. Per CPT guidelines for office encounters, count only the time spent face-to-face with the patient and/or family; for hospital or other inpatient encounters, count the time spent in the patient's unit or on the patient's floor. The

time assigned to each code is an average and varies by physician. **Note:** Time is not a factor when reporting emergency room visits (99281–99285) like it is with other E/M services.

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

[H3] 2021 Changes to E/M Coding as Proposed by CPT

At the time of adoption of this fee schedule, the American Medical Association (AMA) stated that the following changes would be made to CPT E/M codes for 2021. Please refer to your 2021 CPT for final changes.

[H4] Codes 99202-99215

Beginning with 2021, the office or other outpatient services codes 99202–99215 will have revised language and code 99201 is deleted. Code selection will be based on time or medical decision making (MDM). The time element must still be documented with the content of the patient discussion. Note that and the time required for each visit has been revised. Time for 99202–99215 will include non-face-to-face time such as chart review including test results and charting. Medical decision making (MDM) has been revised with a new MDM table which. The MDM table is similar to the Table of Risk but is specific to medical decision making for codes 99202–99215. History and exam are not required elements but should be performed and documented as appropriate to the patient encounter. Many of the terms specific to E/M services and specifically MDM have been defined. Additional information is available in the 2021 CPT or the AMA web-site

<https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>

[H4] Other E/M Codes

The changes described for CPT codes 99202–99215 are not applicable to the other E/M services. History, exam, and MDM are the key elements and should be documented. The Table of Risk is one element to determining the level of MDM for E/M codes other than 99202–99215, but the. The new MDM table is not referenced. When time is utilized to select a level of E/M (for codes other than 99202–99215), only the face-to-face time is considered, and the counseling coordination of care must be documented.

Subcategories of Evaluation and Management

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

Office or Other Outpatient Services (99201~~99202~~–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary. Support the claim with documentation. The description and requirements for office and other outpatient services are revised beginning in 2021. See [above the section 2021 Changes to E/M Coding as Proposed by CPT](#) for more details.

Hospital Observation Services (9921~~78~~–99220, 99224–99226)

CPT codes ~~99217–99218~~ through ~~99220 and 99224 through~~ 99226 report E/M services provided to patients designated or admitted as “observation status” in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

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

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

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

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

Observation Care Discharge Services (99217)

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

Hospital Inpatient Services (99221–99223, 99231–99239)

The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge-day management. Per CPT guidelines for inpatient care, the time component includes not only face-to-face time with the patient but also the physician’s time spent in the patient’s unit or on the patient’s floor. This time may include family counseling or discussing the patient’s condition with the family; establishing and reviewing the patient’s record; documenting within the chart; and communicating with other health care professionals such as other physicians, nursing staff, respiratory therapists, and so on.

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

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

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

Consultations (99241–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations. For Follow-up Inpatient Consultations, see Subsequent Hospital Care codes 99231–99233 and Subsequent Nursing Facility Care codes 99307–99310. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (~~99201~~99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both subcategories. The general rules and requirements of a consultation are defined by the CPT book as follows:

- A consultation is a “a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem.”
- Most requests for consultation come from an attending physician or other appropriate source, and the necessity for this service must be documented in the patient’s record. Include the name of the requesting physician on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (~~99201~~99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both consultation subcategories.
- The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.
- The opinion rendered and services ordered or performed must be documented in the patient’s medical record and a report of this information communicated to the requesting entity.
- Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.
- When the consultant assumes responsibility for the management of any or all of the patient’s care subsequent to the consultation encounter, consultation codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

Emergency Department Services (99281–99288)

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

Critical Care Services (99291–99292)

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

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

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

Nursing Facility Services (99304–99318)

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

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

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

Home Services (99341–99350)

Services and care provided at the patient’s home are coded from this subcategory. Code selection is based upon new or established patient status and the level of history, exam, and MDM provided. Time may be used to select a level of E/M when counseling or coordination of care dominate the service.—

Prolonged Services (99354–99360, ~~99415–99416~~)

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

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

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

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

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

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

[BOLD] Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision [END BOLD]

When prolonged services are provided by clinical staff under the direction of the physician or other qualified health care professional codes 99415 and 99416 are reported. The prolonged service is face to face by the clinical staff and is reported in addition to the E/M service provided by the physician or other qualified health care professional at the same session. The face to face time is counted even if not contiguous. Report 99415 for the first hour and 99416 for each additional 30 minutes. A minimum of 45 minutes must be documented to report 99415 and services must extend 15 minutes or more into the next time period to be reportable.

Physician Standby Services

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

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

Case Management Services (99366–99368)

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

Care Plan Oversight Services (99374–99380)

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

[BOLD] Telephone Services (99441–99443, 99446–99449, 99451–99452) [END BOLD]

Telephone services are reported for telehealth services where only audio communication is available. Usually initiated by the patient or guardian, these codes are not reported if the telephone call results in a face-to-face encounter within 24 hours or the next available visit. Telephone services are not reported if provided within seven days of a face-to-face encounter or during the follow-up time associated with a surgical procedure.

Special Evaluation and Management Services (99450, 99455–99456)

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

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

99455	10.63
99456	21.25

Other Evaluation and Management Services (99499)

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

MODIFIERS

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

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

State-Specific Modifier

Modifier PE: Physician Assistants and Advanced Practice Registered Nurses

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

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

Anesthesia

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

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

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

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

Time for Anesthesia Procedures

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

Calculating Anesthesia Charges

The following scenario is for the purpose of example only:

01382 Anesthesia for arthroscopic procedure of knee joint

Dollar Conversion Unit = \$110.00

Base Unit Value = 3

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

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

Anesthesia Fee = \$110.00 x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = \$1,210.00

Physical status modifiers and qualifying circumstances⁷ are discussed below. Assigned unit values are added to the base unit for calculation of the total maximum allowable reimbursement (MAR).

Anesthesia Supervision

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

Anesthesia Monitoring

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

Other Anesthesia

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

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

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

ANESTHESIA MODIFIERS

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

Physical Status Modifiers

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

MODIFIER	DESCRIPTION
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease

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

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

Qualifying Circumstances

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

CODE	DESCRIPTION
99100	Anesthesia for patient of extreme age: younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

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

Modifiers

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

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

Applicable HCPCS Modifiers

Modifier AA Anesthesia services performed personally by anesthesiologist—This modifier indicates that the anesthesiologist personally performed the service. When this modifier is used, no reduction in physician payment is made.

Payment is the lower of billed charges or the MAR.

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

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

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

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

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

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

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

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

Surgery

GENERAL INFORMATION AND GUIDELINES

Definitions of Surgical Repair

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

BILLING AND PAYMENT GUIDELINES

Global Reimbursement

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

In addition to the surgical procedure, global reimbursement includes:

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

Follow-up Care for Diagnostic Procedures

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

Follow-up Care for Therapeutic Surgical Procedures

Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring

additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges. The workers' compensation carrier is responsible only for charges related to the compensable injury or illness.

Additional Surgical Procedure(s)

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

Incidental Procedure(s)

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

Suture Removal

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

Aspirations and Injections

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

Surgical Assistants

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

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

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

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

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

Data for the purpose of example only

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

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. If an APRN assists, a surgery modifier PE is added. Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

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

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

Data for the purpose of example only

Anesthesia by Surgeon

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

Multiple or Bilateral Procedures

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

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued, then both sides are reported with modifier 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR. Add-on procedures performed bilaterally should be reported as two line items, modifier items. Modifier 50 is not appended to the second code although modifiers RT or LT may be appended.

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

- Major (highest valued) procedure: maximum reimbursement is the lower of the billed charge or 100 percent of the MAR

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

Note: CPT codes listed in Appendix D of the CPT book and designated as add-on codes have already been reduced in RBRVS and are not subject to the 50 percent reimbursement reductions listed above. CPT codes listed in Appendix E of the CPT book and designated as exempt from modifier 51 are also not subject to the above multiple procedure reduction rule. They are reimbursed at the lower of the billed charge or MAR.

Example:

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

Data for the purpose of example only

Endoscopic Procedures

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

Example:

Code	MAR	Adjusted amount
29827	\$6,412.49 <u>5,167.92</u>	\$6,412.49 <u>5,167.92</u> (100%)
29824	\$4,004.43 <u>3,222.09</u>	\$1,200.32 <u>988.35</u> (the value of 29824 minus the value of 29805)
29805	\$2,804.11 <u>2,233.74</u>	
	Total	\$7,612.81 <u>6,156.27</u>

Data for the purpose of example only

Arthroscopy

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

For multiple endoscopic procedures please see the Endoscopic Procedures section above.

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

State-Specific Modifiers

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

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

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. If an APRN assists, a surgery modifier PE is added. Modifier AS is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

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

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

Data for the purpose of example only

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

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

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

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

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Review of Diagnostic Studies

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

Written Reports

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

Multiple Radiology Procedures

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

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

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

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

See example below under Reimbursement Guidelines for CPT Modifiers.

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific CPT modifiers shall be reimbursed as follows:

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

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

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

Alaska MAR:

72142	\$1,540.83 <u>1,488.6</u> 1
72142-TC	\$1,019.43 <u>998.14</u>
72142-26	\$491.40 <u>490.48</u>
72147	\$1,503.53 <u>1,479.1</u> 5

72147-TC	\$1,013.13 <u>990.25</u>
72147-26	\$490.40 <u>488.90</u>

Data for the purpose of example only

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

Technical Component:

72142-TC	\$1,019.4 <u>998.14</u>	100% of the TC
72147-TC	\$506.574 <u>95.13</u>	(50% of the TC for the second procedure)
Total	\$1,526.0 01,493.2 <u>7</u>	

Professional Component:

72142-26	\$491.404 <u>90.48</u>	100% of the 26
72147-26	\$465.884 <u>64.456</u>	(95% of the 26 for the second procedure)
Total	\$957.289 <u>54.934</u>	

Global Reimbursement:

72142	\$1,510.8 <u>1,488.61</u> <u>3</u>	100% of the global
72147-51	\$972.459 <u>59.589</u>	(\$506.574 <u>95.13</u> + \$465.884 <u>64.465</u> TC and 26 above)
Total	\$2,483.2 82,447.6 <u>82,448.2</u> <u>019</u>	

Applicable HCPCS Modifiers

TC Technical Component—

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

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

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	0.37	1.500	0.555
Practice Expense RVU x Practice Expense GPCI	0.260 25	1.117 1.118	0.290420 .2795
Malpractice RVU x Malpractice GPCI	0.02	0.708 0.661	0.014160 .0132232
Total RVU			0.859580 .8477287 2

Data for the purpose of example only

Calculation using example data:

$$0.37 \times 1.500 = 0.555$$

$$+ \cancel{0.26 \times 1.117} - \cancel{0.29042,25} \times 1.118 = 0.2795$$

$$+ 0.02 \times \cancel{0.708} - \cancel{0.014160,661} = 0.0132232$$

$$= \cancel{0.859580,84772}$$

$$\cancel{0.859580,84772782} \times \$122.00 \text{ (CF)} = \cancel{104.86876103,4218434042184}$$

Payment is rounded to **\$104.87103.4232**

Laboratory services not valued in the RBRVS but valued in the Centers for Medicare and Medicaid Services (CMS) Clinical Diagnostic Laboratory Fee Schedule (CLAB) file use a multiplier of 4.43 for the values in the payment rate column in effect at the time of treatment or service.

The CLAB may also be referred to as the Clinical Laboratory Fee Schedule (CLFS) by CMS.

For example, if CPT code 81001 has a payment rate of ~~\$3.523.17~~ in the CLAB file, this is multiplied by 4.43 for a MAR of ~~\$15.5914.04~~

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Organ or Disease Oriented Panels

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

Drug Screening

Drug screening is reported with CPT codes 80305–80307. These services are reported once per patient encounter. These codes are used to report urine, blood, serum, or other appropriate specimen. Drug confirmation is reported with codes G0480–G0483 dependent upon the number of drug tests performed. These codes are valued in the CLAB schedule and the multiplier is 4.43.

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

Medicine

GENERAL INFORMATION AND GUIDELINES

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

BILLING AND PAYMENT GUIDELINES

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

Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries.

See modifier section below for examples of the reduction calculations.

Separate Procedures

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

Materials Supplied by Physician

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

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

[H3] Telehealth Services

Telehealth services are a covered service and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star [INSERT BLACK STAR ICON] icon and in CPT

appendix P. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the appropriate telephone codes (99441–99443). These Telehealth services should be reported with modifier 95 appended.

Physical Medicine

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

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

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

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

TENS Units

TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription. An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be comparable to prepaid or private healthcare plans in the community with the purchase price equal to the lower of billed charges or the submitted manufacturer's invoice without markup. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges.

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

Publications, Books, and Videos

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

Functional Capacity Evaluation

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

Work Hardening

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

97545	3.41
97546	1.36

Osteopathic Manipulative Treatment

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

- Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.
- Evaluation and management services may be reported separately if, the patient’s condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the OMT. Different diagnoses are not required for the reporting of the OMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.
- Recognized body regions are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

Chiropractic Manipulative Treatment

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

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

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

Specific modifiers shall be reimbursed as follows:

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

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

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

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

Alaska MAR:

93303	\$631.79 <u>625.68</u>
93303-TC	\$431.85 <u>425.90</u>
93303-26	\$199.94 <u>199.79</u>
93351	\$638.10 <u>643.18</u>
93351-TC	\$370.19 <u>375.45</u>
93351-26	\$267.91 <u>267.73</u>

Data for the purpose of example only

Technical Component:

93303-TC	\$431.85 <u>425.90</u>	100% of the TC
93351-TC	\$277.64 <u>281.59</u>	(75% of the TC for the second procedure)
Total	\$709.49 <u>707.49</u>	

Global Reimbursement:

93303	\$631.79 <u>625.68</u>	100%
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93351	\$545.55 <u>549.32</u>	(75% of the TC for the second procedure + 100% of the 26) (\$281.59 277.64 + \$267. 73 91 = \$545.55 <u>549.32</u>)
Total	\$1,177.3 <u>41,175.0</u> <u>0</u>	

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

Alaska MAR:

92060	\$183.12 <u>180.45</u>
92060-TC	\$65.80 <u>64.03</u>
92060-26	\$117.32 <u>116.42</u>
92132	\$88.07 <u>88.04</u>
92132-TC	\$37.20
92132-26	\$50.86 <u>50.84</u>

Data for the purpose of example only

Technical Component:

92060-TC	\$65.80 <u>64.03</u>	100% of the TC
92132-TC	\$29.76	(80% of the TC for the second procedure)
Total	\$95.56 <u>93.79</u>	

Global Reimbursement:

92060	\$183.121 <u>80.45</u>	100% of the global
92132	\$80.62 <u>80.60</u>	(80% of the TC for the second procedure + 100% of the 26) (\$29.76 + \$50.84 6 = \$80.60 2)
Total	\$263.742 <u>61.05</u>	

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

Alaska MAR:

97016	\$37,363 <u>64</u>
$[(.18 \times 1.5) + (.17 \times 1,117.16 \times 1.118) + (0.01 \times .708,661)] \times 80$	
97024	\$19,381 <u>36</u>
$[(.06 \times 1.5) + (.13 \times 1,117.118) + (0.01 \times .708,661)] \times 80$	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	\$29,762 <u>28</u>
$[(.18 \times 1.5) + ((.17 \times 1,117.16 \times 1.118) \times .5) + (0.01 \times .708,661)] \times 80$	
97024	\$13,571 <u>54</u>
$[(.06 \times 1.5) + ((.13 \times 1,117.118) \times .5) + (0.01 \times .708,661)] \times 80$	

Example:

97016	\$37,363 <u>44</u>
97016 (2nd unit same date)	\$29,762 <u>28</u>
97024 (additional therapy same date)	\$13,571 <u>54</u>

Applicable HCPCS Modifiers

TC Technical Component

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

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

Category II

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

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

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

Category III

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

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

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

CATEGORY III MODIFIERS

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

HCPCS Level II

GENERAL INFORMATION AND GUIDELINES

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

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

MEDICARE PART B DRUGS

For drugs and injections coded under the Healthcare Common Procedure Coding System (HCPCS) the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges.

Note: The corresponding National Drug Code (NDC) number should be included in the records for the submitted HCPCS codes.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value [for Alaska](#) in effect at the time of treatment or service multiplied by ~~1.841.75~~ or billed charges. If no CPT code identifies the supply, bill using the appropriate HCPCS code with a copy of the manufacturer/supplier's invoice for supplies.

TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription. An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be comparable to prepaid or private healthcare plans in the community with the purchase price the lower of billed charges or the submitted manufacturer's invoice without markup. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges.

Hearing Aids

The patient must be referred by a physician for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes one year of follow-up care including all evaluations, adjustments, repairs, or reprogramming of the hearing aids. New hearing aids may be dispensed when new medical evaluation documents the necessity for change of device prescription only as related to the work-related injury or replacement of a nonworking device that is no longer covered by warranty. Repairs will not be paid when a device is still under the manufacturer's warranty. An evaluation and management service shall not be billed at the time of any hearing aid evaluations or testing. The dispensing of hearing aids is reported with the appropriate HCPCS Level II codes and a copy of the manufacturer/supplier's invoice. Reimbursement is the lower of the manufacturer/supplier's invoice cost plus 30 percent or billed charges including dispensing and fitting cost. HCPCS codes V5011, V5090, V5110, ~~and~~ V5160, V5240, and V5241 are not separately reimbursed services.

Hearing Aid Services

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

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

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

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

AMBULANCE SERVICES

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

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

Charter Air Carrier Note: The limitations on allowable reimbursements apply to air carriers who have on-demand, emergent, and unscheduled flights, including, but not limited to, intra-state air services responding to "911"

emergency calls. The employer may require the air carrier to provide the carrier's operating certificate along with the initial billing for services under this section.

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

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers' Compensation Act), a conversion factor shall be applied to the hospital outpatient relative weights established for each *Current Procedural Terminology* (CPT®) or *Ambulatory Payment Classifications* (APC) code adopted by reference in 8 AAC 45.083(m). The outpatient facility conversion factor will be \$221.79 and the ambulatory surgical center (ASC) conversion factor will be ~~\$177.00~~168.00. Payment determination, packaging, and discounting methodology shall follow the CMS OPSS methodology for hospital outpatient and ambulatory surgical centers (ASCs). For procedures performed in an outpatient setting, implants shall be paid at manufacturer/supplier's invoice plus 10 percent.

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

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

- (1) medical services for which there is no *Ambulatory Payment Classifications* weight listed are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (2) status indicator codes C, E, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (3) two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;
- (4) a payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent;
- (5) ~~procedures without a relative weight in Addendum B shall use a payment rate where available with the conversion factor 221.79 multiplier of 2.08 for ASCs and 2.75 for outpatient facilities.-~~

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

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

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

J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
J2	Hospital Part B services that may be paid through a comprehensive APC	<p>Paid under OPPS; addendum B displays APC assignments when services are separately payable.</p> <p>(1)Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.</p> <p>(2)Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1.</p> <p>(3)In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.</p>
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine	Not paid under OPPS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS.

N	Items and services packaged into APC rates	<p>Paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.</p> <p><i>Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.</i></p>
P	Partial hospitalization	<p>Paid under OPPS; per diem APC payment.</p> <p><i>Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i></p>
Q1	STV packaged codes	<p>Paid under OPPS; addendum B displays APC assignments when services are separately payable.</p> <p>(1)Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI of S, T, or V.</p> <p>(2)Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.</p> <p>(3)In other circumstances, payment is made through a separate APC payment.</p>
Q2	T packaged codes	<p>Paid under OPPS; addendum B displays APC assignments when services are separately payable.</p> <p>(1)Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI T.</p> <p>(2)In other circumstances, payment is made through a separate APC payment.</p>

Q3	Codes that may be paid through a composite APC	<p>Paid under OPPS; addendum B displays APC assignments when services are separately payable.</p> <p>(1) Composite APC payment on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.</p> <p>(2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.</p>
Q4	Conditionally packaged laboratory tests	<p>Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS).</p> <p>(1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published OPSI J1, J2, S, T, V, Q1, Q2, or Q3.</p> <p>(2) In other circumstances, laboratory tests should have an SI = A and payment is made under the CLFS.</p>
R	Blood and blood products	Paid under OPPS; separate APC payment.
S	Procedure or service, not discounted when multiple	Paid under OPPS; separate APC payment.
T	Procedure or service, multiple reduction applies	<p>Paid under OPPS; separate APC payment.</p> <p><i>Alaska Specific Guideline: Two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classification's calculated amount and all other status indicator code T items paid at 50 percent.</i></p>
U	Brachytherapy sources	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPPS; separate APC payment.
Y	Non-implantable durable medical equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC.

SURGICAL SERVICES

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

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

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

DRUGS AND BIOLOGICALS

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

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

EQUIPMENT, DEVICES, APPLIANCES, AND SUPPLIES

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

Example:

- Syringe for drug administration
- Patient gown
- IV pump

SPECIALTY AND LIMITED-SUPPLY ITEMS

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

Example:

- Unna boot for a postoperative podiatry patient
- Crutches for a patient with a fractured tibia

USE OF OUTPATIENT FACILITY AND ANCILLARY SERVICES

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

NURSING AND RELATED TECHNICAL PERSONNEL SERVICES

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

SURGICAL DRESSINGS, SPLINTING, AND CASTING MATERIALS

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

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

Example of Implant Outlier:

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

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

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

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

EXEMPT FROM THE MS-DRG

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

SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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

PREPARING TO DETERMINE A PAYMENT

The CMS Inpatient PC Pricer is normally posted by CMS one to two months after the Inpatient Prospective Payment System rule goes into effect each October 1. The version that is available on January 1, ~~2020~~2021 remains in effect, unless the Alaska Workers’ Compensation Division publishes a notice that a new version is in effect. Besides the PC Pricer software, two additional elements are required to determine a payment:

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

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

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

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

Payers (and others) who wish to verify the MS-DRG assignment for the claim will need an appropriate grouping software package. The current URL for the Medicare grouper software is:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software> ~~<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html>~~

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

The current version of the PC Pricer tool may be downloaded here:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html>

Guidelines for downloading and executing the PC Pricer can be downloaded here:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/Guidelines.html>

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

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

REPLACE THREE PRICER SCREENSHOTS

Welcome to the Inpatient PPS PC Pricer!

Version Information

Fiscal Year: 2019
Provider Specific File Update: 1st Quarter Calendar Year 2019
Claim Discharge Dates Processed: 10/01/2018 - 09/30/2019

About the Application

The PC Pricer is a tool used to estimate Medicare PPS payments. The final payment may not be precise to how payments are determined in the Medicare claims processing system due to the fact that some data is factored in the PC Pricer payment amount that is paid by Medicare via provider cost reports. In addition, variance between actual Medicare payment and a PC Pricer estimate may exist due to a 3-month lag in quarterly updates to provider data. In such situations, the PC Pricer offer flexibility by allowing users to modify provider data to reflect different values. Users are encouraged to refer to the User Manual for the applicable Pricer to access downloading and data entry instructions.

Click on one of the buttons below to begin using the IPPS Pricer...

Enter Claim

Provider Directory

PC Pricer Help

Exit

Claim Entry

IPPS Claim Entry Form

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

Provider Number: Patient ID:
 Admit Date: Discharge Date:
 DRG Code: Charges Claimed:
 Short-Term Acute Transfer? HMO Paid Claim?
 Post-Acute Transfer? Cost Outlier Threshold?

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

Procedure Codes:	<input type="text"/>	<input type="text"/>	Diagnosis Codes:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>

The PC Pricer instructions are included below:

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

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

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

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

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

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

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

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

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

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

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

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

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

FY 2019 Inpatient Prospective Payment (IPPS) Payment Results

Calculator Version: C19.0

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

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

A Note on Pass-through Payments in the PC Pricer

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

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

Determining the Final Maximum Allowable Reimbursement (MAR)

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

CMS Inpatient PC Pricer Total Payment amount	\$36,264.91 <u>37,050.79</u>
Multiplied by Providence Alaska Medical Center multiplier	x <u>2.38</u>
Alaska Workers' Compensation Payment	\$86,310.49 <u>88,180.88</u>

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

GENERAL INFORMATION AND GUIDELINES

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

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

TAB 7



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

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

SUMMARY OF CHANGES

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

Provider Schedule

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

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

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

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

Ambulatory Surgical Center (ASC)

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

ACTUARIAL ANALYSIS

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

1. Calculate the percentage change in maximum reimbursements

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

² Current Procedural Terminology maintained by the American Medical Association.



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

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

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

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

Provider Fee Schedule

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



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

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

*Healthcare Common Procedure Coding System

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

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

Ambulatory Surgical Centers Fee Schedule

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

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

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



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

SUMMARY OF IMPACTS

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

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

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



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

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

SUMMARY OF CHANGES

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

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

Provider Schedule

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

Hospital Outpatient and Ambulatory Surgical Center (ASC)

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

Hospital Inpatient

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

ACTUARIAL ANALYSIS

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

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

² Current Procedural Terminology maintained by the American Medical Association.



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

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

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

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



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

SUMMARY OF IMPACTS

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

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

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

APPENDIX

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

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

*Healthcare Common Procedure Coding System



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

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

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

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

Director Mitchell –

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

Kindly advise if you need any further information.

Todd Johnson, CPCU

State Relations Executive, External & Government Affairs

National Council on Compensation Insurance

The Source You Trust

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

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

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

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

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

Thanks Todd.

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

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

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

I appreciate your assistance. Thanks again.
Grey

Grey Mitchell
Director
(907)465-2790

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

Hello Director Mitchell –

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

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

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

Todd Johnson, CPCU

State Relations Executive, External & Government Affairs

National Council on Compensation Insurance

The Source You Trust

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

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

Todd_Johnson@NCCI.com | NCCI.com

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TAB 8



Department of Labor and
Workforce Development
DIVISION OF WORKERS'
COMPENSATION
Web: <http://labor.state.ak.us/wc>

STATE OF ALASKA

DIVISION OF WORKERS' COMPENSATION

2018 ANNUAL REPORT

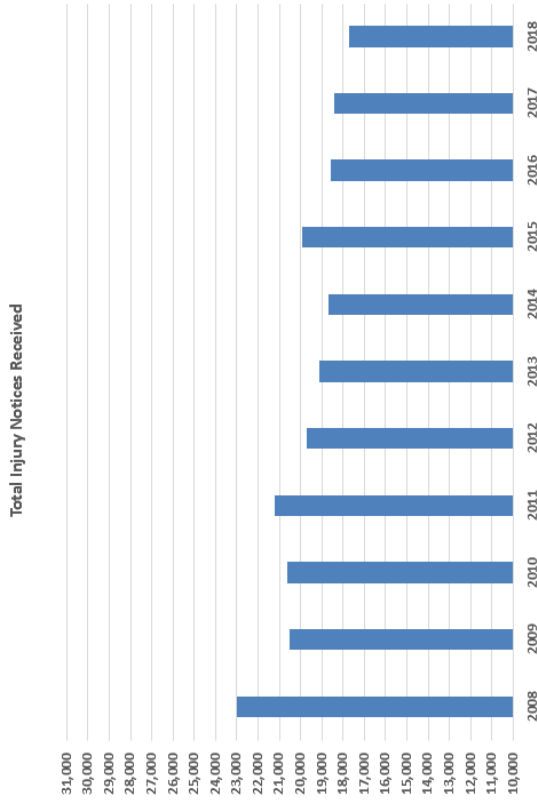


2018 ANNUAL REPORT

Analysis of Workers' Compensation Claims Data

Department of Labor and
Workforce Development
DIVISION OF WORKERS'
COMPENSATION

Web: <http://labor.state.ak.us/wc>



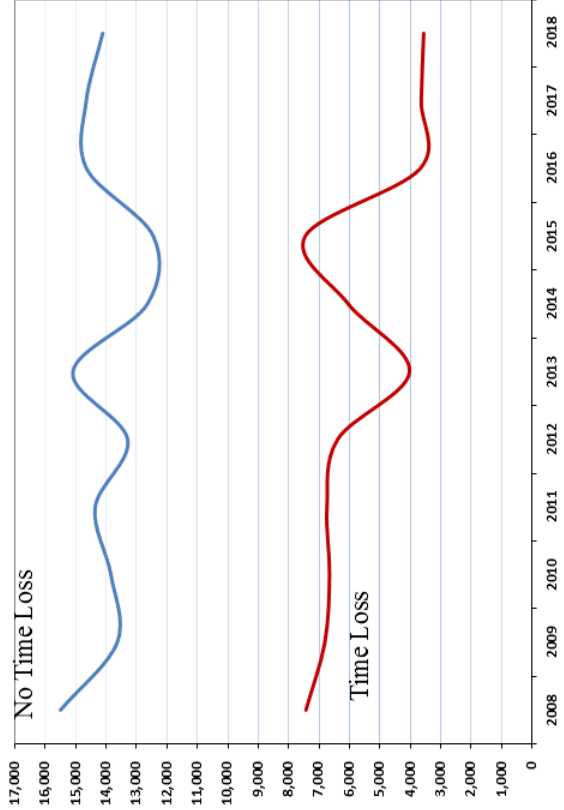
In 2018, there were 17,694 reports of injury and occupational illness filed with the Workers' Compensation Division, a 3.8% decrease from 18,396 reports filed in 2017.

The Alaska Workers' Compensation Board held 231 hearings in 2018, compared to 255, in 2017.

The Alaska Workers' Compensation Appeals Commission held 10 hearings in 2018, compared to 16 in 2017.

Of the case files established in 2018:

- No-time-loss cases: 14,121 cases, 79.8%
- Time-loss cases: 3,554 cases, 20.2%
- Notification only cases: 4,209 cases
- Fatalities: 19 cases





2018 ANNUAL REPORT

Analysis of Workers' Compensation Claims Data

Department of Labor and
Workforce Development
DIVISION OF WORKERS'
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Web: <http://labor.state.ak.us/wc>

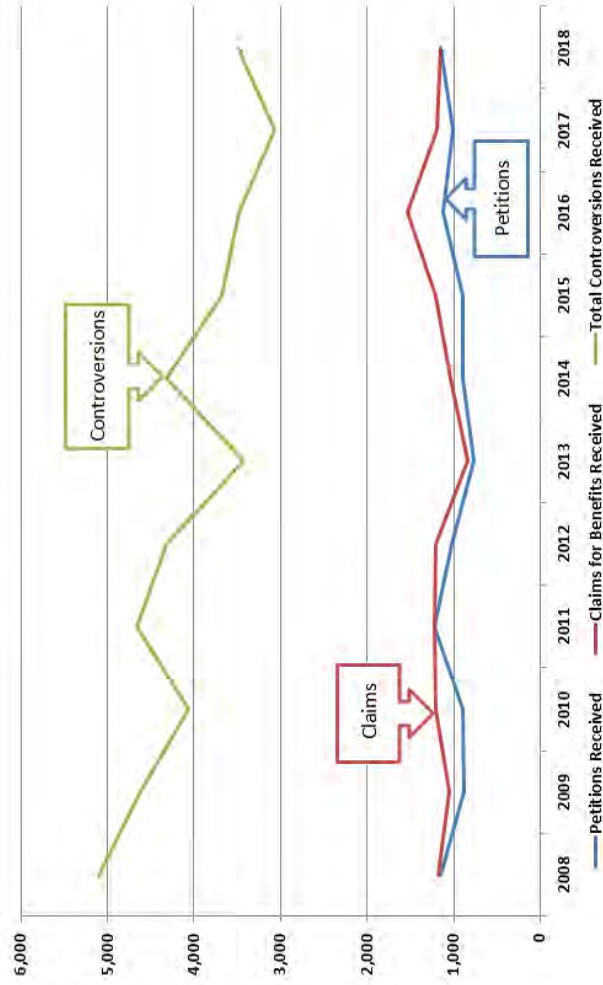
In 2018, there were 1,155 claims filed, a 3.6% decrease from 1,198 claims filed in 2017.

There were 1,151 petitions filed in 2018, a 13.7% increase from 1,012 petitions filed in 2017.

There were 3,495 controversion notices filed in 2018, a 14.1% increase from the all time low of 3,064 in 2017.

The number of cases controverted in 2018 totaled 2,573, a 12.8% increase from 2,281 cases in 2017.

Filed Claims, Controversions, and Petitions





2018 ANNUAL REPORT

ANNUAL REPORTING OF TOTAL PAID COMPENSATION

Financial Reports and Audits

MONITORING: This section of the report provides information from the prior calendar year.

Under Alaska Statute 23.30.155(m), each insurer, providing workers' compensation coverage in Alaska or their adjuster must file an annual report with the Alaska Workers' Compensation Board providing number of claims filed, the type of claims filed, total dollars spent on medical, lost wages compensation, death benefits, rehabilitation costs and claim litigation costs. The annual report requirement also applies to self-insured employers and uninsured employers.

Along with the annual report, each insurer, adjuster, self-insured employer, or uninsured employer must submit payment of their Second Injury Fund (SIF) contribution and their Workers' Safety and Compensation Administration Account fee (WSCAA). These fees fund reimbursements from the SIF and help support the Division's operations.

➤ This report covers activity from:

- CY = Calendar Year Period from January 1, 2018 to December 31, 2018
- FY = Fiscal Period from July 1, 2018 to June 30, 2019

Notes:

Medical Costs Totals for CY 2018 include the following Medical Costs: Physical Therapy, Chiropractic Fees, Durable Medical expenses, Medical Travel, Employee Medical-Legal Costs. The costs were previously captured in the other category for CY2014, CY2015, CY2016, and CY2017.

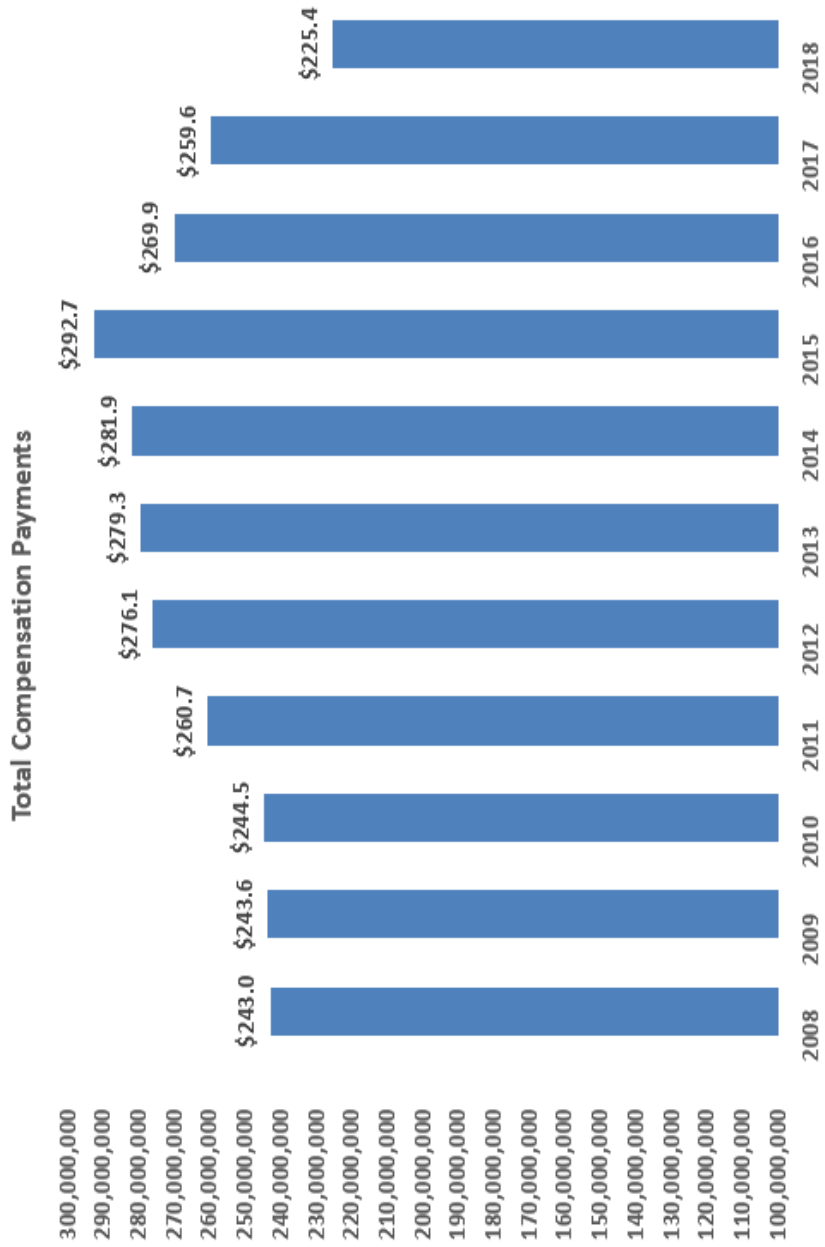
Other Costs for CY 2018 include: Unspecified Lump Sum Payment/Settlement, interest, penalty and SIF Contribution Fee.



2018 ANNUAL REPORT

Total Compensation Payments

A total of \$225.4 million was paid in workers' compensation benefits during calendar year 2018 by 202 market-insured employers and self-insured employers. This is a decrease of 13.1% from \$259.6 million in 2017.

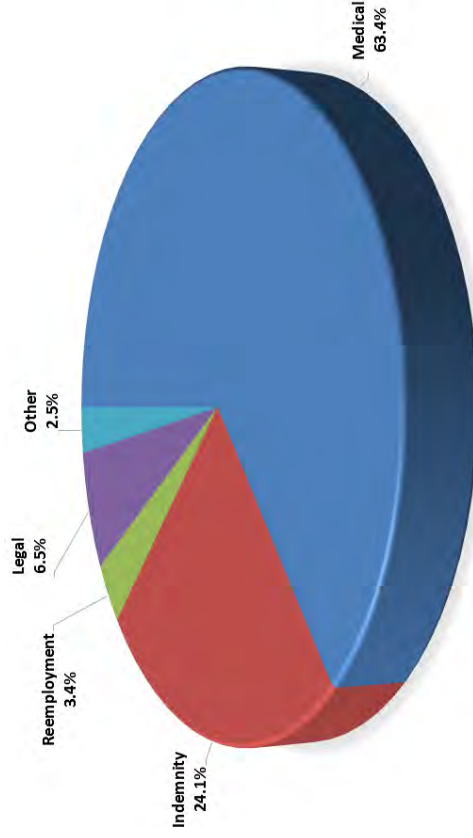




2018 ANNUAL REPORT

Total Compensation Payments Distribution

Benefit Type	Amount Paid	% of Cost to Total Cost
Medical	\$143,119,431	63.4%
Indemnity	\$54,272,071	24.1%
Reemployment	\$7,745,962	3.4%
Legal	\$14,586,179	6.5%
Other*	\$5,681,984	2.5%
Total	\$225,405,628	



*Other costs include interest, penalty, Second Injury Fund contribution.



2018 ANNUAL REPORT

Department of Labor and
Workforce Development
DIVISION OF WORKERS'
COMPENSATION
Web: <http://labor.state.ak.us/wc>

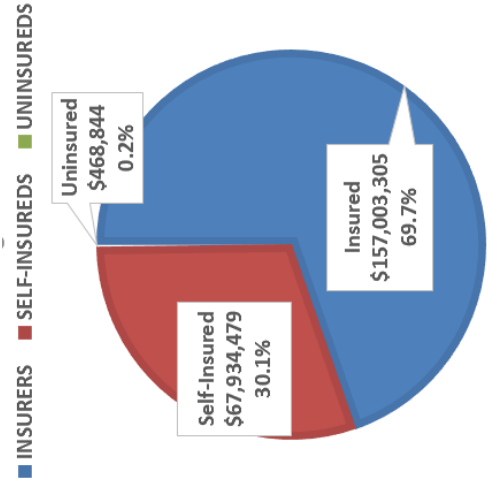
Total Benefits Paid by Top Twenty Insurers/Self-Insured Employers

Of total benefits paid, market-insured employers paid \$157.0 million (69.7%), self-insured employers paid \$67.9 million (30.1%).

The top twenty insurers and self-insured employers paid \$147.5 million, or 65.5% of total workers' compensation benefits paid in 2018. This compares to \$176.2 million, or 67.9%, in 2017.

Rank		Total Benefits Paid
1	ALASKA NATIONAL INS CO	\$ 31,864,598
2	ALASKA, STATE OF	\$ 20,002,247
3	AMERICAN ZURICH INS CO	\$ 9,983,922
4	ANCHORAGE, MUNICIPALITY OF	\$ 6,957,732
5	NEW HAMPSHIRE INSURANCE CO	\$ 6,402,126
6	AMERICAN INTERSTATE INSURANCE CO	\$ 6,128,723
7	ACE AMERICAN INSURANCE COMPANY	\$ 5,952,535
8	LIBERTY INSURANCE CORP	\$ 5,893,058
9	COMMERCE AND INDUSTRY INS CO	\$ 5,809,056
10	LIBERTY NORTHWEST INSURANCE CO	\$ 5,764,342
11	ARCTIC SLOPE REGIONAL CORP	\$ 5,289,797
12	ANCHORAGE SCHOOL DISTRICT	\$ 5,257,417
13	JUNEAU, CITY & BOROUGH	\$ 4,921,151
14	BERKSHIRE HATHAWAY HOMESTATE INS CO	\$ 4,211,735
15	REPUBLIC INDEMNITY CO OF AMERICA	\$ 4,209,399
16	INDEMNITY INS CO OF NORTH AMERICA	\$ 4,109,289
17	ALASKA INS GUARANTY ASSN	\$ 4,036,817
18	ZURICH AMERICAN INS CO	\$ 3,929,195
19	TRAVELERS PROPERTY CASUALTY CO OF AM	\$ 3,688,503
20	PROVIDENCE HEALTH SYSTEM - WASHINGTON	\$ 3,167,593
Total		\$147,579,234

INSURER TYPE	Total Benefits Paid	% of Total Costs
Insurer	\$157,003,304	69.7%
Market Insurer	\$152,900,855	
Guaranty Associations	\$4,102,449	
Self-Insured Employers	\$67,934,479	30.1%
Uninsured	\$468,844	0.2%
AK Benefits Guaranty Fund	\$466,800	
Uninsured Employer	\$2,044	
Total	\$225,406,628	



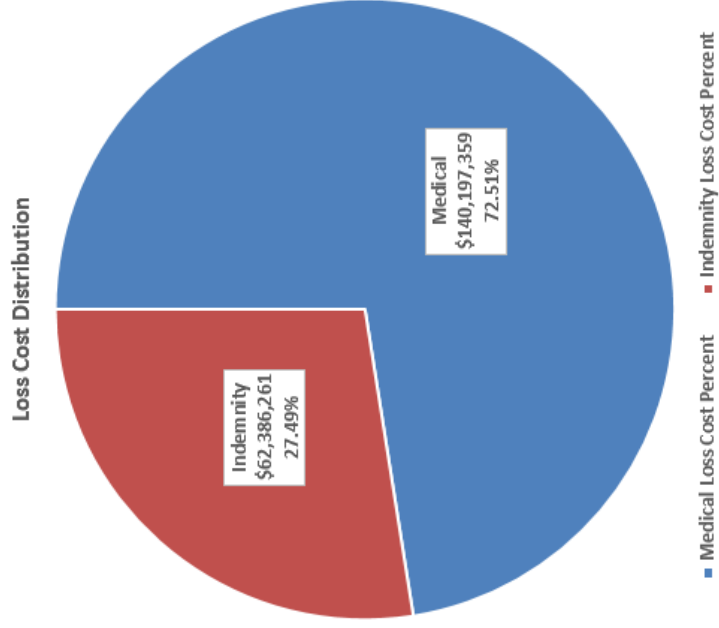
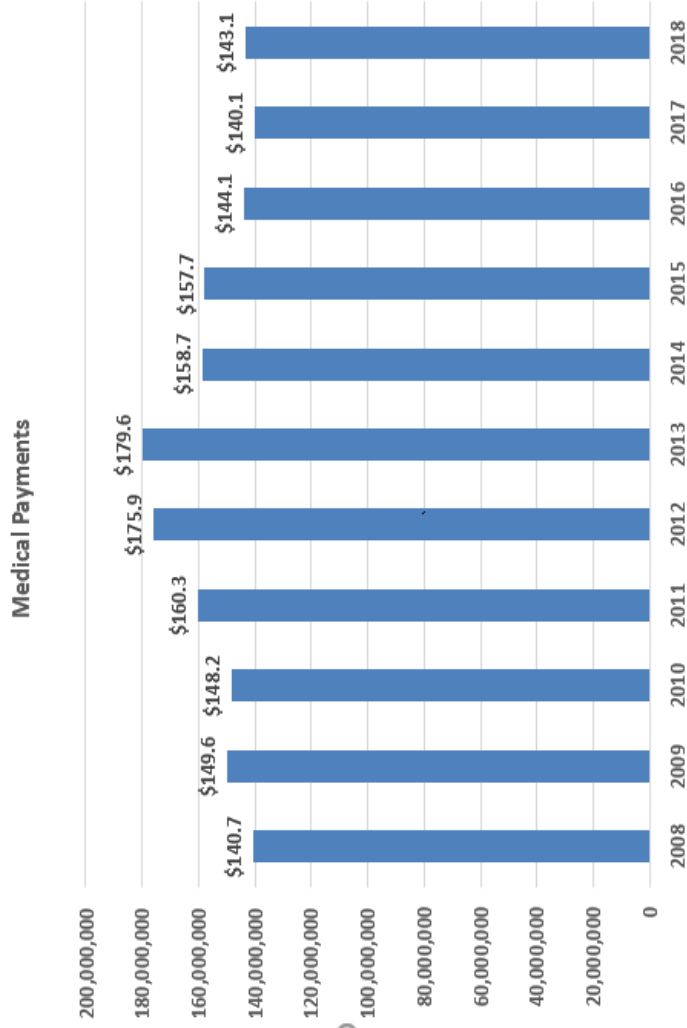


2018 ANNUAL REPORT

Medical Benefits

In the calendar year 2018, medical benefits totaled \$143.1 million, a 2% increase from \$140.1 million in 2017.

Medical benefits were 63.5% of total benefits paid and 72.5% of loss costs in 2018, compared to 54% of total benefits paid and 69.2% of loss costs in 2017.



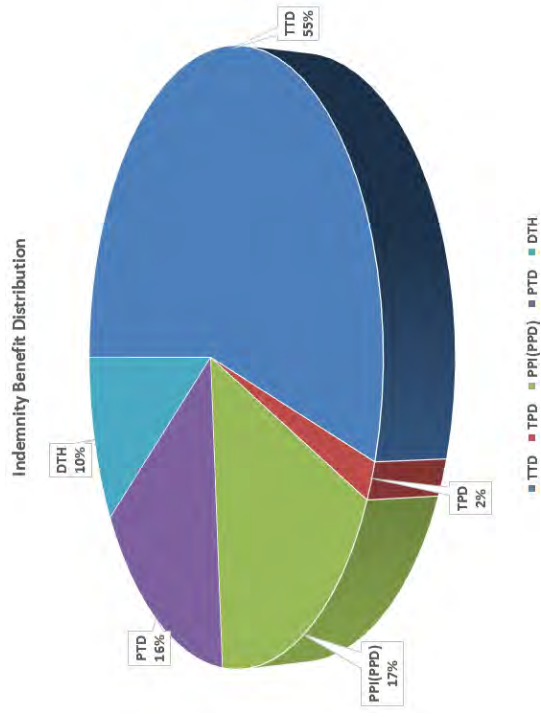
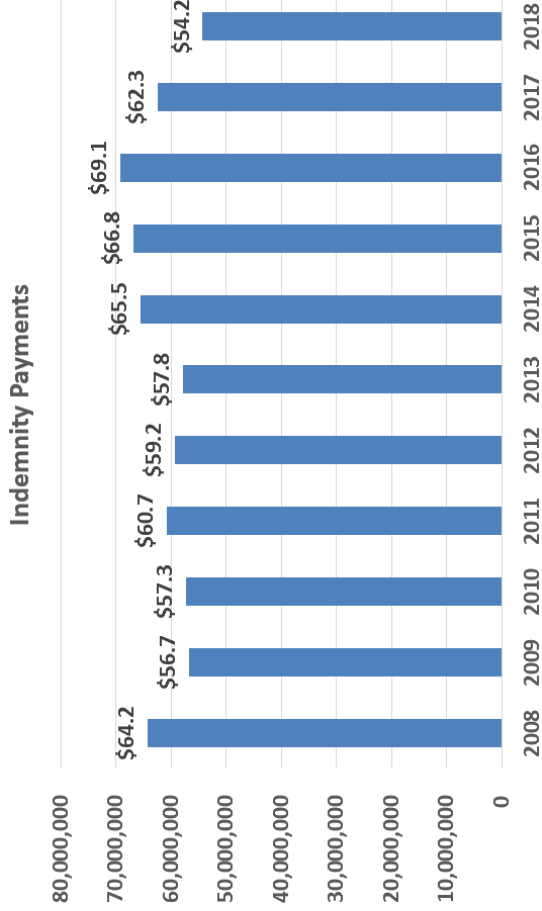
“Loss Costs” = medical and indemnity benefit costs only.



2018 ANNUAL REPORT

Indemnity Benefits

Department of Labor and
Workforce Development
DIVISION OF WORKERS'
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For calendar year 2018 indemnity benefits (TTD, TPD, PPI, PTD & Death Benefits) totaled \$54.2 million, a 13% decrease from \$62.3 million in 2017.

- TTD benefits totaled \$29.6 million in 2018, a 12.9% decrease from \$34 million in 2017.
- TPD benefits totaled \$976,419 in 2018, a 37.2% decrease from \$1.5 million in 2017.
- PPI benefits totaled \$9.4 million in 2018, a 18.9% decrease from \$11.5 million in 2017.
- PTD benefits totaled \$8.7 million in 2018, a 11.3% decrease from \$9.9 million in 2017.
- Death benefits totaled \$5.4 million in 2018, a 3.6% increase from \$5.29 million in 2017.



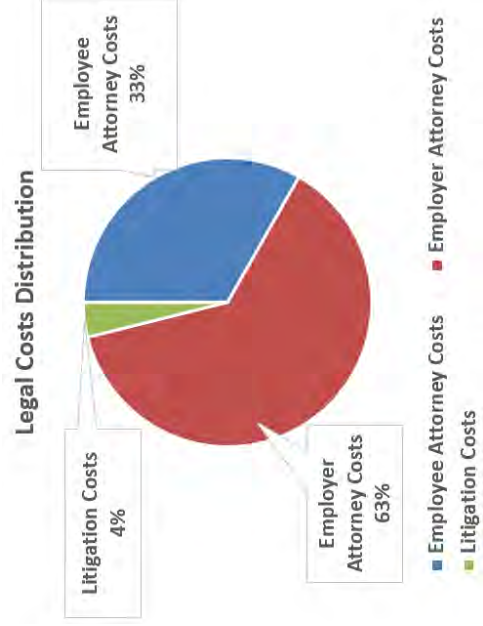
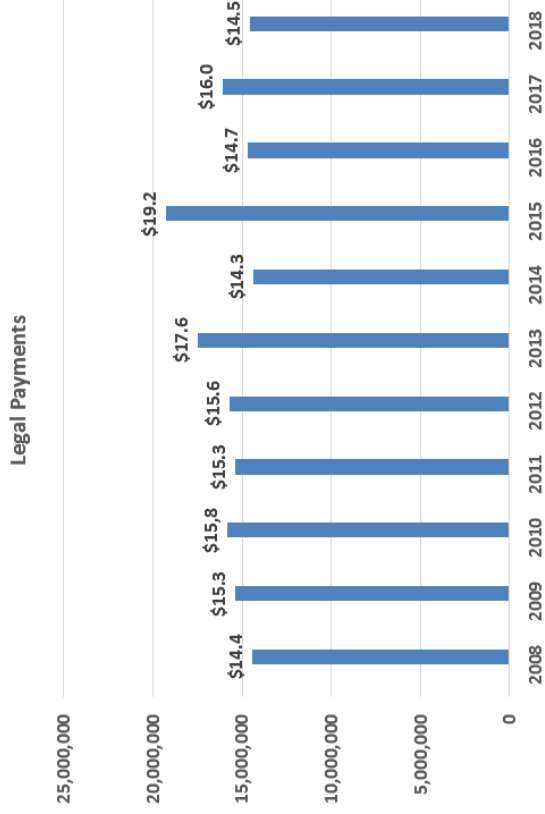
2018 ANNUAL REPORT

Legal Costs

For calendar year 2018, legal expenses totaled \$14.5 million, a 9.3% decrease from \$16 million in 2017.

- Employee attorney fees were \$4.8 million in 2018, a 20.5% decrease from \$6.1 million in 2017.
- Employer attorney fees were \$9.1 million in 2018, a 3.4% decrease from \$9.5 million in 2017.
- Litigation costs totaled \$566,983 in 2018, a 16.6% increase from \$485,933 in 2017.
- Litigation costs include:
 - Total Expert Witness Fees
 - Total Court Reporter Fees
 - Total Private Investigator Fees

*Some Legal costs may have been reported in lump sum settlements as a total benefit payment.

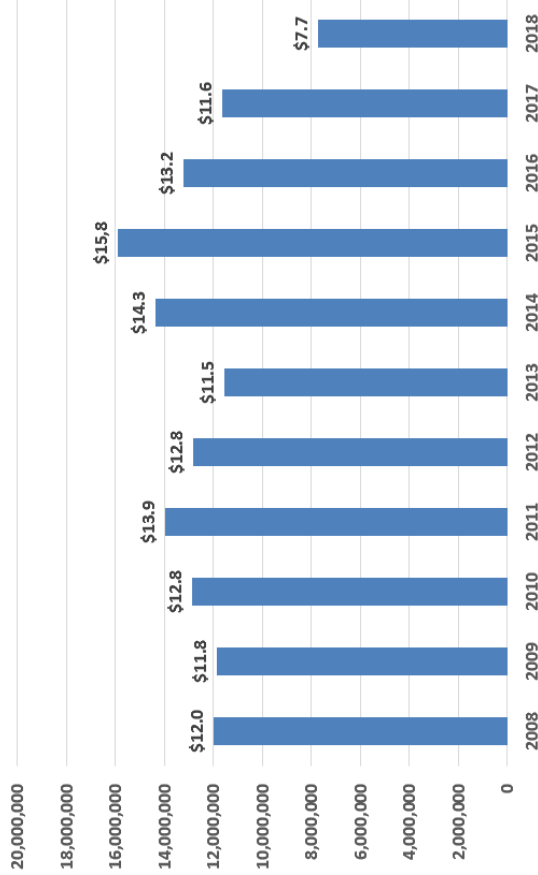




2018 ANNUAL REPORT

Reemployment Benefits

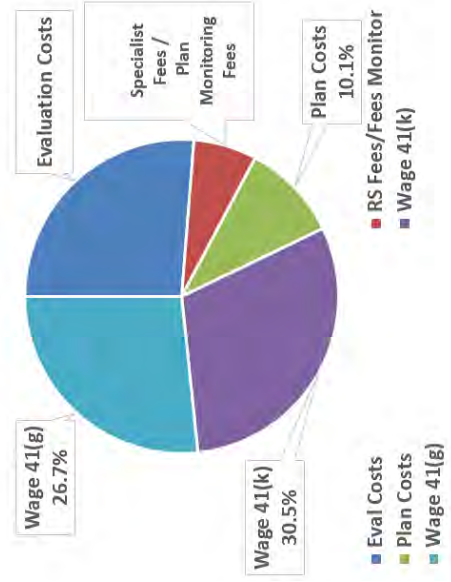
Reemployment Benefit Payments



Total reemployment benefit payments totaled \$7.7 million in 2018, a 33.3% decrease from \$11.6 million in 2017.

- Rehabilitation benefit costs under AS 23.30.041(k) totaled \$2.3 million in 2018, a 46.5% decrease from \$4.4 million in 2017.
- Employee evaluation costs totaled \$2.0 million in 2018, a 4.8% decrease from \$1.9 million in 2017.
- Rehabilitation specialist fees/plan monitoring fees totaled \$324,449 in 2018, a 49.5% increase from \$216,961 in 2017.
- Plan development costs totaled \$781,518 in 2018, a 48.8% decrease from \$1.5 million in 2017.
- Rehabilitation benefit costs under AS 23.30.041(g) totaled \$2.0 million in 2018, a 33.5% decrease from \$3.1 million in 2017.

Reemployment Costs Distribution



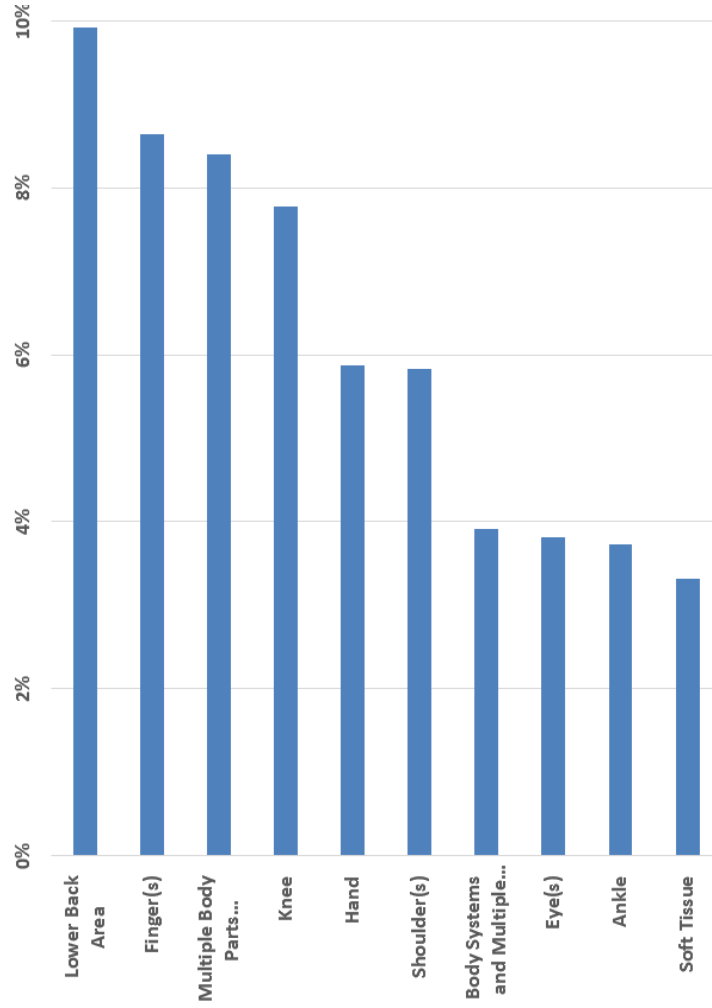


2018 ANNUAL REPORT

Top Ten Injuries by Body Part Injured

Department of Labor and
Workforce Development
DIVISION OF WORKERS'
COMPENSATION
Web: <http://labor.state.ak.us/wc>

	Body Part Injured	Cases	%
1.	Lower Back	1755	10%
2.	Finger(s)	1528	9%
3.	Multiple Body Parts	1487	8%
4.	Knee	1376	8%
5.	Hand	1038	6%
6.	Shoulder(s)	1031	6%
7.	Body Systems /Multiple	693	4%
8.	Eye(s)	675	4%
9.	Ankle	659	4%
10.	Soft Tissue	587	3%





2018 ANNUAL REPORT

Alaska Injury Frequency

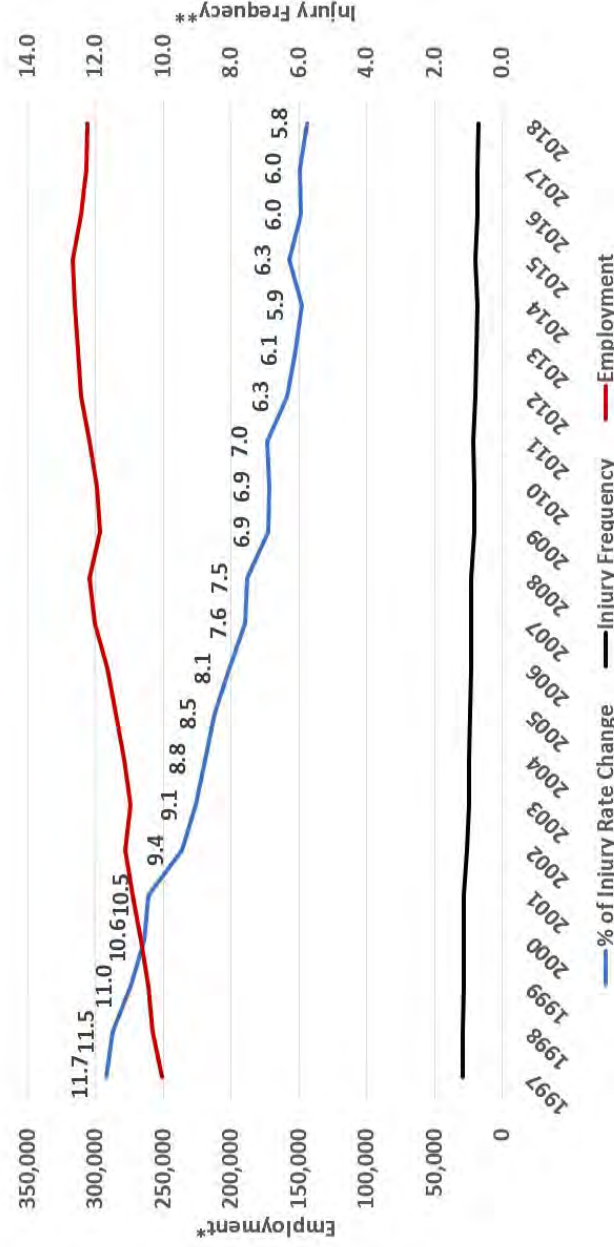
In 2018, 17,694 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.8%. In 2017, 18,396 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.9%.

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment, employment totaled 321,079 in 2018, a 2.1% decrease from 327,963 in 2017. Excluding 14,868 federal employees, the number of workers covered under the Alaska Workers' Compensation Act in 2018 was approximately 306,211 a 2.13% decrease from 312,886 in 2017.

Employment in Alaska ↓

Year	Injury Frequency	Employment
2018	17,694	306,211
2017	18,396	307,063
2016	18,555	311,091
2015	19,909	316,757
2014	18,686	315,331
2013	19,140	313,278
2012	19,726	311,060
2011	21,213	305,015
2010	20,628	299,311
2009	20,516	296,814
2008	22,996	304,833

Alaska Injury Frequency ↓



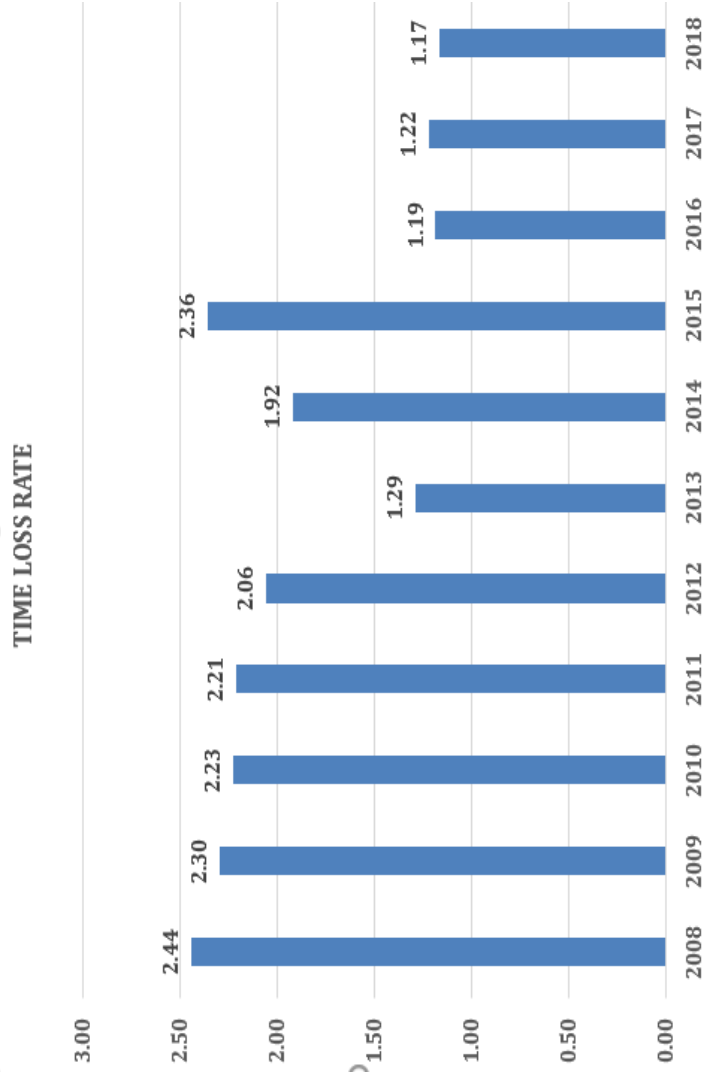
*Based on Department of Labor and Workforce Development, Research and Analysis Section Data, Average Alaska Monthly Employment.
 **Alaska injury frequency rate equals annual reported claims divided by Average Alaska Monthly Employment.



2018 ANNUAL REPORT

Time Loss Rate

Using the number of time-loss claims established by the Workers' Compensation Division divided by average monthly employment statewide (less Federal Government), the time loss rate per 100 employees in 2018 was 1.17, a 2.64% decrease from a time loss rate of 1.20 in 2017.



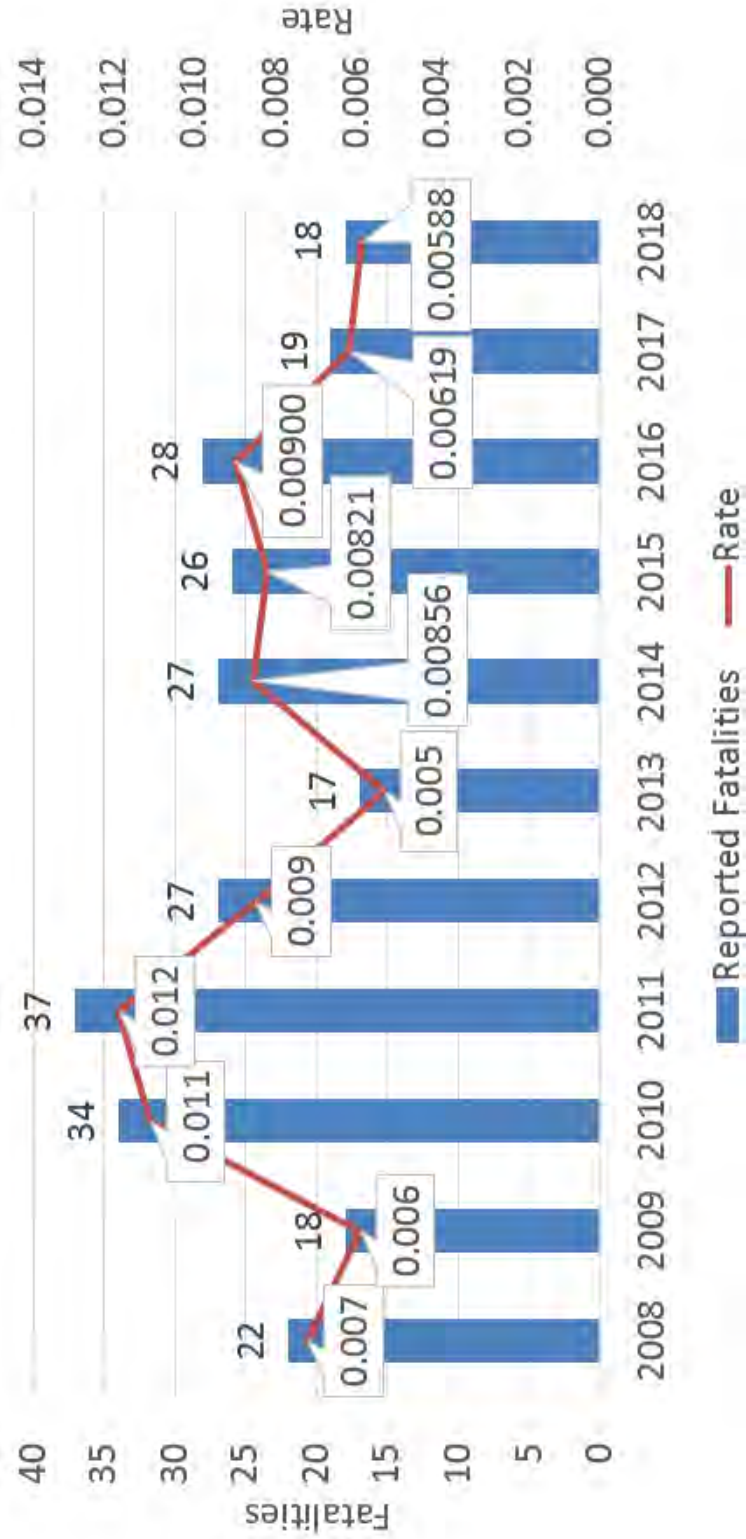
A lost time claim is the compensation (financial, leave, other benefits) that is paid to a worker who remains absent for 3 days or more because of a work related injury.



2018 ANNUAL REPORT

Fatality Rate

There were 18 fatalities reported in 2018, a 5.5% decrease from 19 fatalities reported in 2017. The fatality rate per 100 employees in 2018 was .00588, compared to .00619 in 2017.



Fatality Rate = Fatalities / (average Alaska employment wage less Federal wages) * 100



2018 ANNUAL REPORT

Direct Written Premiums

Calendar Year	Direct Written Premiums (000s)
2018	240,150*
2017	\$251,110
2016	\$268,052
2015	\$281,738

*Estimate based on The Division of Insurance Calendar Year 2018 reconciliation report for Workers' Compensation Service Fee.

For the period January 1, 2015 through December 31, 2017, the servicing carriers for the Workers' Compensation Assigned Risk Plan are Alaska National Insurance Company, LM Insurance Corporation, Riverport Insurance Company, and Travelers Property Casualty Company of America. American Interstate Insurance Company is a direct assignment carrier.

For 2017, the 7,511 assigned risk policies made up 41.8% of all workers' compensation policies. The \$37.1 million in premium was approximately 12.0% of total workers' compensation premium. Of the 7,511 assigned risk policies, 4,900 had premiums of less than \$2,500.

Assigned Risk Data Source: Department of Commerce, Community and Economic Development,
 Alaska Division of Insurance, 2018 Annual Report



2018 ANNUAL REPORT

Active Self-Insured Employers

There were 24 active self-insured employers in 2018

Active Alaska Self-Insured Employers	Start Date of Self-Insurance	Active Alaska Self-Insured Employers	Start Date of Self-Insurance
Alaska Air Group, Inc.	5/1/1980	Fred Meyer Stores, Inc.	10/1/1996
Alaska Railroad Corp.	7/1/1996	GCI Holdings, LLC*	12/31/2017
Alyeska Pipeline Service Co.	7/1/1983	Harnish Group Inc.	5/1/2005
Anchorage School District	6/1/2004	Jacobs Engineering Group**	7/1/2018
Arctic Slope Regional Corp.	6/1/2005	Kenai Peninsula Borough & School District	2/16/1992
Bristol Bay Area Health Corporation	2/1/2005	Matanuska-Susitna Borough	8/15/2008
Chevron Corporation	5/12/1999	Matanuska-Susitna School District	7/1/1994
Chugach Electric Assn. Inc.	1/1/2014	Municipality of Anchorage	1/1/2004
City & Borough of Juneau	4/1/2004	Nabors Alaska Drilling, Inc.	1/1/1987
Costco Wholesale Corp.	9/3/1999	Providence Health System – WA	4/1/1995
Fairbanks North Star Borough & School District	7/1/1977	State of Alaska	11/24/2003
Federal Express Corp.	10/10/1990	University of Alaska	2/1/2004

*GCI Holdings, LLC acquired General Communications, Inc.

** Jacobs Engineering Group Inc. acquired CH2M Hill



2018 ANNUAL REPORT

LEGISLATION PASSED IN 2018

HB 79

An Act relating to workers' compensation; relating to the second injury fund; relating to service fees and civil penalties for the workers' safety programs and the workers' compensation program; relating to incorporation of reference materials in workers' compensation regulations; excluding independent contractors from workers' compensation coverage; establishing the circumstances under which certain nonemployee executive corporate officers and members of limited liability companies may obtain workers' compensation coverage; establishing a legislative workers' compensation working group; and providing for an effective date. The workers' compensation reforms passed by the State of Alaska Legislature on May 11, 2018, (SCS CSHB 79(FIN)) provided for:

- The closure of the Second Injury Fund (SIF)
- The closure of issuing Executive Officer Waiver Program
- Definition of Employee and Independent Contractor



2018 ANNUAL REPORT

Workers' Compensation Premium Rate Ranking

Department of Labor and
Workforce Development
DIVISION OF WORKERS'
COMPENSATION
Web: <http://labor.state.ak.us/wc>

2018 Ranking	2016 Ranking	State	Index Rate	Percent of study median	Effective Date	Percent of 2016 study median
1	3	New York	3.08	181%	October 1, 2017	154%
2	1	California	2.87	169%	January 1, 2018	176%
3	2	New Jersey	2.84	167%	January 1, 2018	158%
4	5	Alaska	2.51	148%	January 1, 2018	149%
5	6	Delaware	2.50	147%	December 1, 2017	126%
6	27	Georgia	2.27	134%	March 1, 2017	98%
7	5	Connecticut	2.20	129%	January 1, 2018	149%
8	9	Rhode Island	2.19	129%	August 1, 2017	119%
9	14	Vermont	2.09	123%	April 1, 2017	110%
10	10	Louisiana	2.05	121%	January 1, 2018	115%
11	12	Wisconsin	2.02	119%	October 1, 2017	112%
13	17	Hawaii	2.01	118%	January 1, 2018	107%
13	11	Montana	2.01	118%	July 1, 2017	114%
14	18	South Carolina	1.95	115%	September 1, 2016	105%
16	15	Washington	1.87	110%	January 1, 2018	107%
16	23	Wyoming	1.87	110%	January 1, 2018	101%
17	26	Pennsylvania	1.85	109%	April 1, 2017	100%
19	22	North Carolina	1.84	108%	April 1, 2017	103%
19	14	Maine	1.84	108%	April 1, 2017	110%
21	28	Idaho	1.81	106%	January 1, 2018	97%
21	33	Florida	1.81	106%	January 1, 2018	90%
22	8	Illinois	1.80	106%	January 1, 2018	121%
23	32	South Dakota	1.73	102%	July 1, 2017	91%
24	8	Oklahoma	1.71	101%	January 1, 2018	121%
26	17	New Hampshire	1.70	100%	January 1, 2018	106%
26	32	Nebraska	1.70	100%	February 1, 2017	91%
27	20	Missouri	1.68	99%	January 1, 2018	104%
28	22	Minnesota	1.67	98%	January 1, 2018	104%
29	25	Alabama	1.65	97%	March 1, 2017	100%
30	24	Iowa	1.64	96%	January 1, 2018	101%
31	29	Mississippi	1.54	91%	March 1, 2017	92%
32	30	Tennessee	1.52	89%	March 1, 2017	91%
33	36	Kentucky	1.51	89%	October 1, 2017	82%
34	20	New Mexico	1.50	88%	January 1, 2018	104%
35	35	Colorado	1.43	84%	January 1, 2018	84%
36	40	Ohio	1.40	82%	July 1, 2017	79%
37	34	Michigan	1.38	81%	January 1, 2017	85%
38	44	Massachusetts	1.37	81%	July 1, 2016	70%
39	38	Maryland	1.33	78%	January 1, 2018	82%
40	38	Arizona	1.30	76%	January 1, 2018	82%
41	47	Virginia	1.28	75%	April 1, 2017	67%
42	42	District of Columbia	1.25	74%	November 1, 2017	74%
43	40	Texas	1.21	71%	July 1, 2017	79%
44	43	Nevada	1.18	69%	March 1, 2017	71%
46	41	Kansas	1.15	68%	January 1, 2018	77%
46	45	OREGON	1.15	68%	January 1, 2018	68%
47	46	Utah	1.06	62%	December 1, 2017	69%
48	48	West Virginia	1.01	59%	November 1, 2017	66%
49	49	Arkansas	0.90	53%	July 1, 2017	57%
50	50	Indiana	0.87	51%	January 1, 2018	57%
51	51	North Dakota	0.82	48%	July 1, 2017	48%

Source: Oregon Department of Consumer and Business Services



STATE OF ALASKA

DIVISION OF WORKERS' COMPENSATION

2018 MEDICAL DATA REPORT

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

This report illustrates the breakdown of services by the following categories:

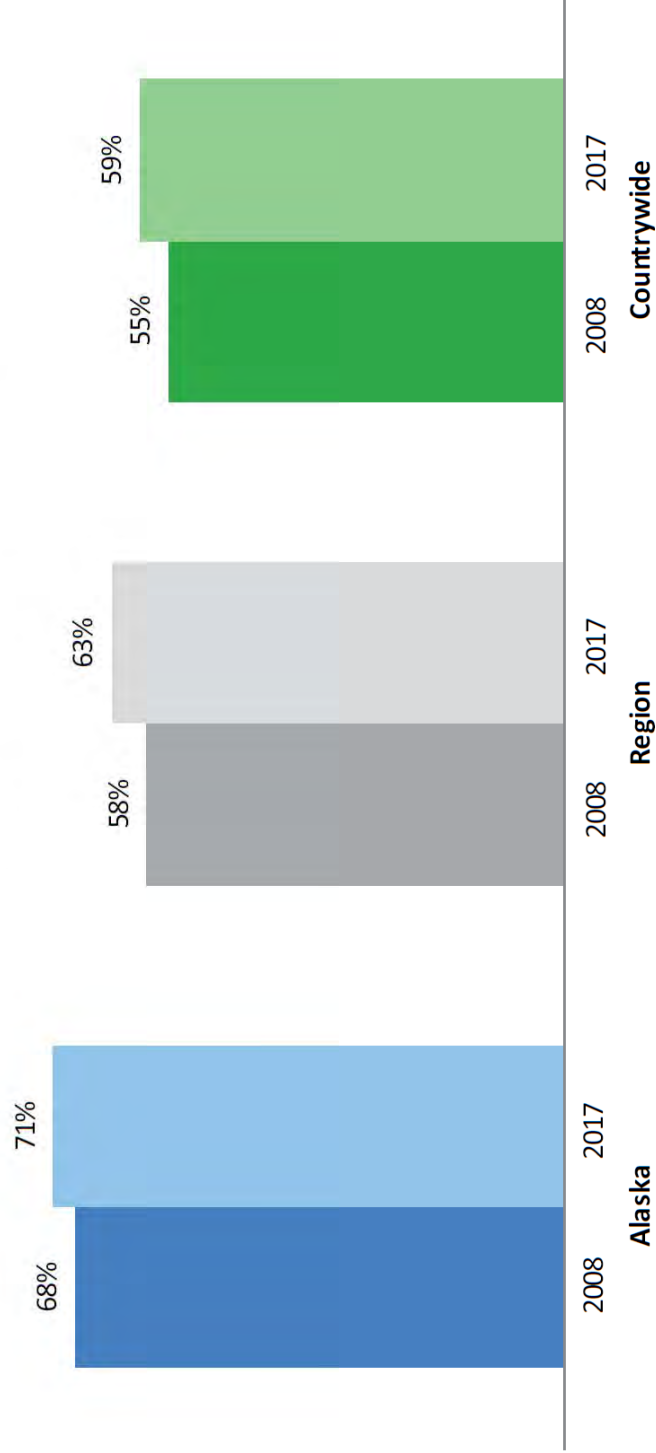
- Physician
- Hospital Outpatient
- Hospital Inpatient
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies
- Other

Self-insured data is not included



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Medical Share of Total Benefit Costs by Accident Year

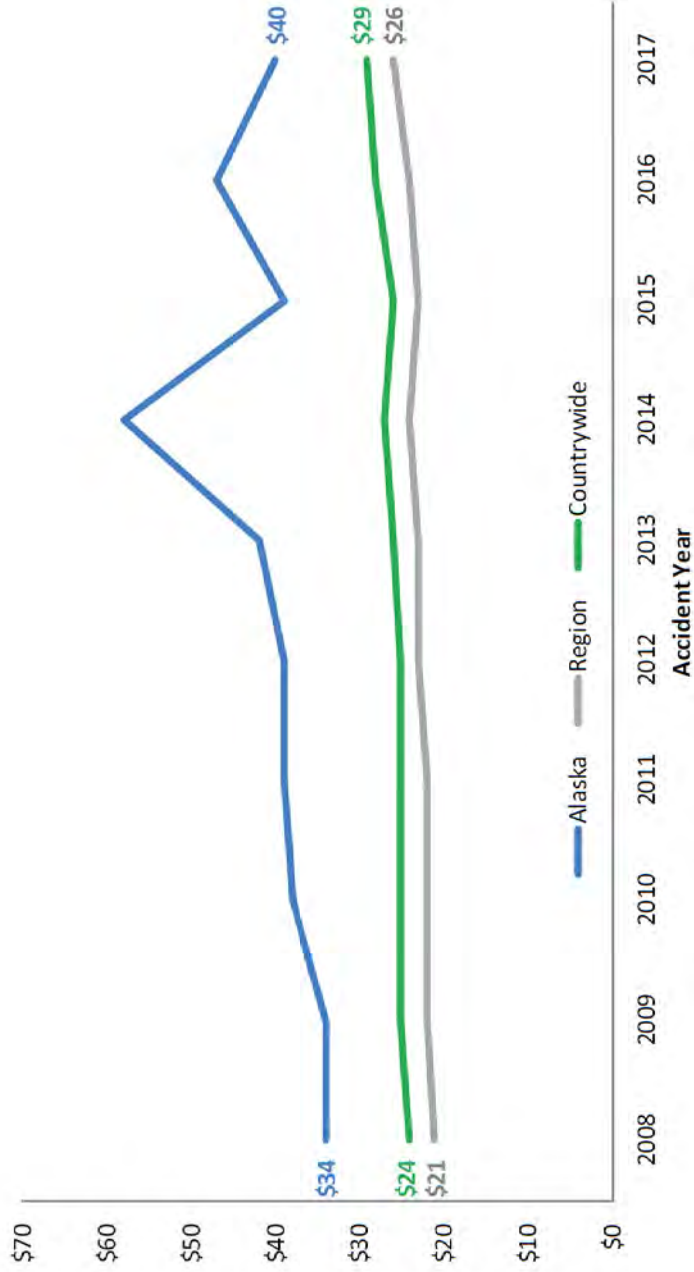


Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

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

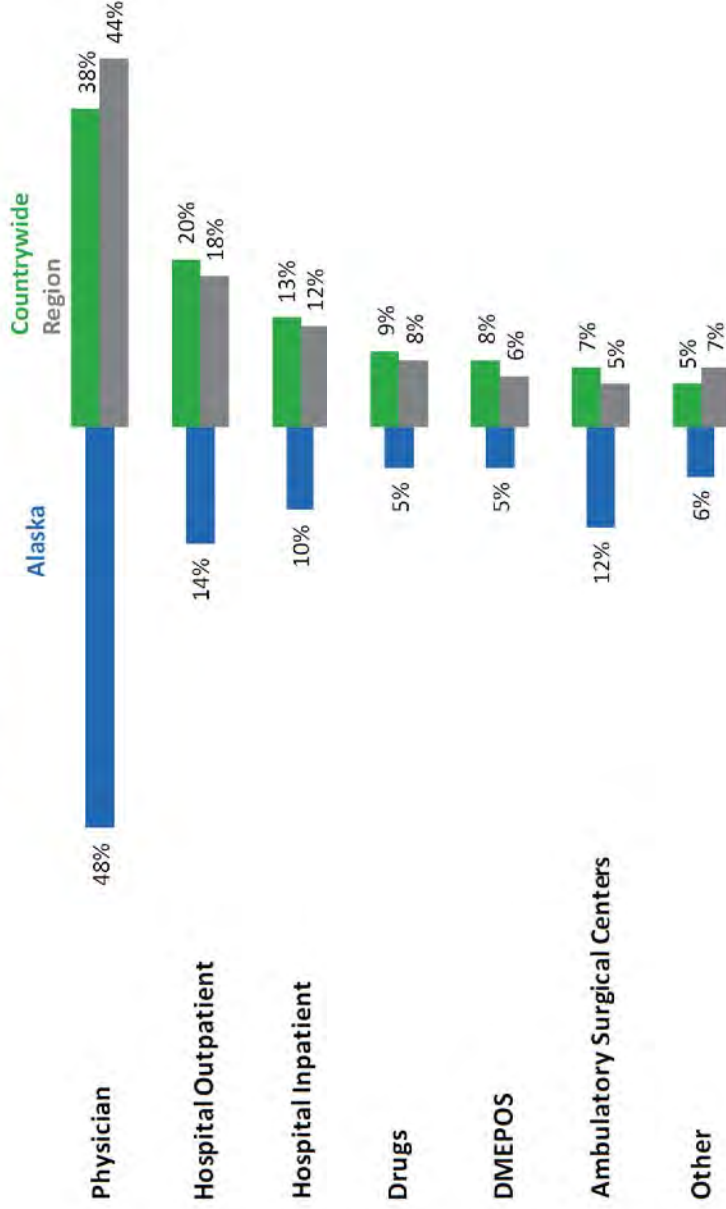


Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance
Averaging more than 2% in annual growth for the United States Personal Healthcare Spending per capita.



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Distribution of Medical Payments





STATE OF ALASKA

DIVISION OF WORKERS' COMPENSATION

2018 MEDICAL DATA REPORT

Physician Payments as a Percentage of Medicare

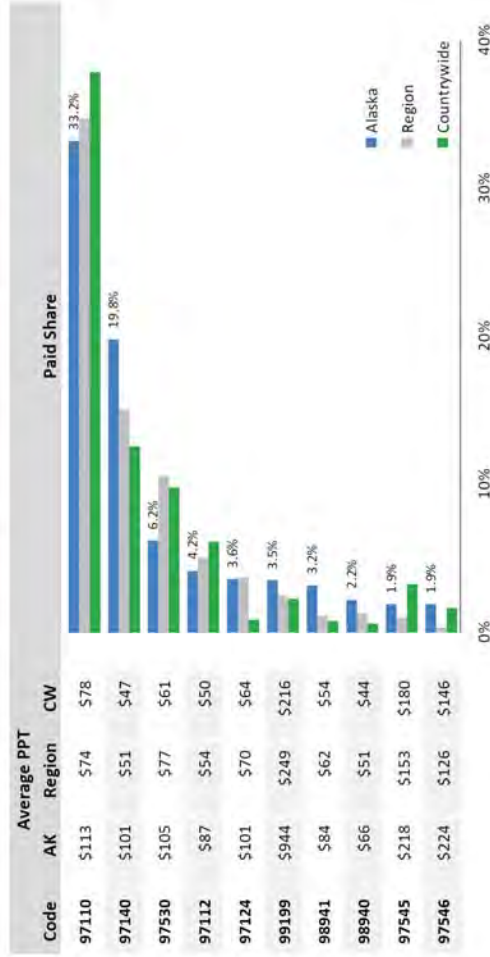
Physician Service Category	Alaska	Region	Countrywide
General and Physical Medicine	162%	133%	131%
Surgery	368%	210%	269%
Evaluation and Management	183%	151%	142%
Radiology	450%	212%	228%
Anesthesia	292%	233%	281%
All Physician Services	226%	158%	167%

Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance
Average percentage of Medicare schedule reimbursement amounts for physician payments.



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Top 10 Physical and General Medicine Procedure Codes by Amount Paid



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
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
99199	Unlisted special service procedure or report
98941	Chiropractic manipulative treatment (CMT); spinal 3-4 regions
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
97545	Work hardening/conditioning: initial 2 hours
97546	Work hardening/conditioning: each additional hour

Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Top 10 Surgery Procedure Codes by Amount Paid



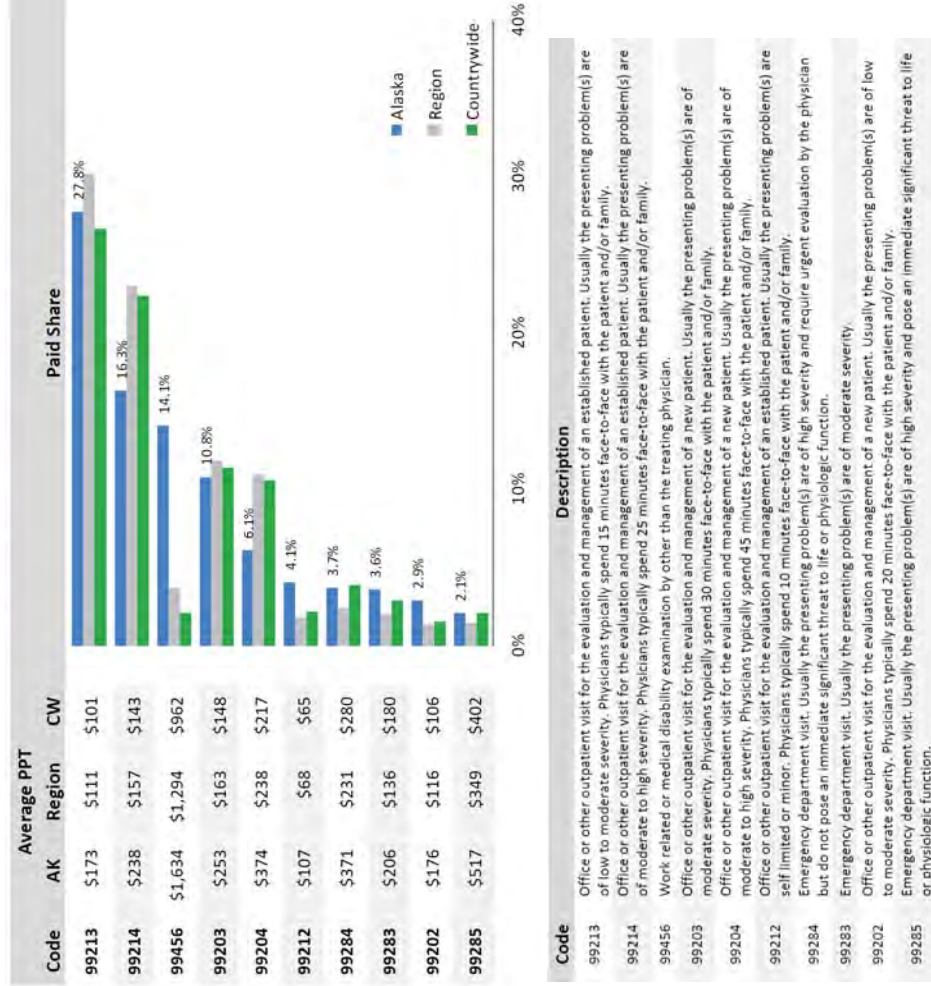
Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23430	Tenodesis of long tendon of biceps
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29807	Arthroscopy, shoulder, surgical; repair of superior labral tear from anterior to posterior (SLAP) lesion
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
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

Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance
PPT = average amount paid per transaction



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Top 10 Evaluation and Management Procedure Codes by Amount Paid

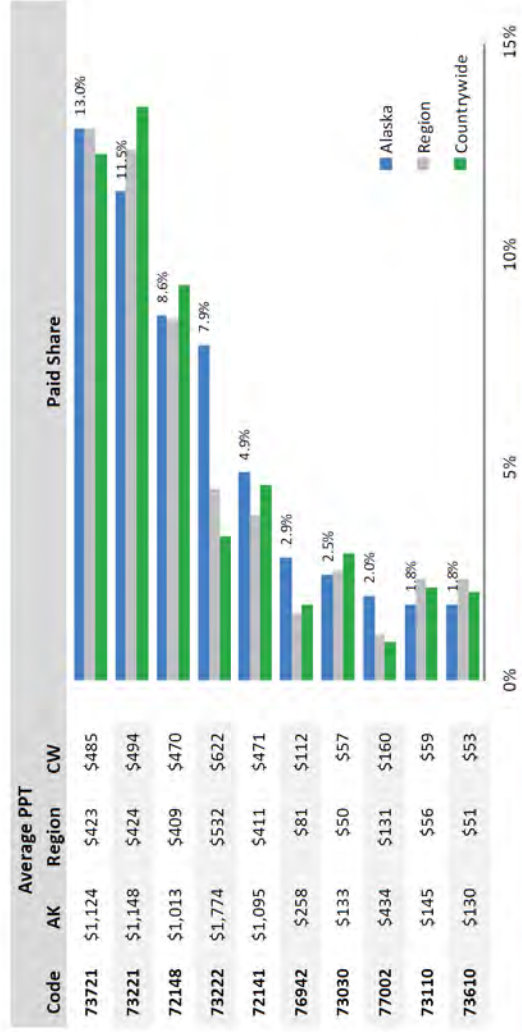


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
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. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
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.
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. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Top 10 Radiology Procedure Codes by Amount Paid



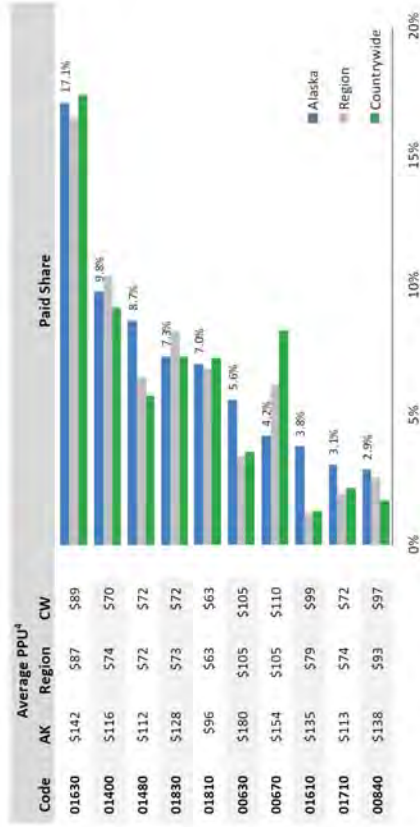
Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, 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
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
73030	Radiologic examination, shoulder; complete minimum of 2 views
77002	Fluoroscopic guidance for needle placement (e.g., biopsy aspiration injection localization device)
73110	Radiologic examination, wrist; complete minimum of 3 views
73610	Radiologic examination, ankle; complete minimum of 3 views

Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Top 10 Anesthesia Procedure Codes by Amount Paid



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
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; 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
00630	Anesthesia for procedures in lumbar region; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Alaska	Region	Countrywide
Hospital Inpatient	172%	181%	198%

Hospital Outpatient Payments as a Percentage of Medicare

Medical Cost Category	Alaska	Region	Countrywide
Hospital Outpatient	236%	197%	244%

ASC Payments as a Percentage of Medicare

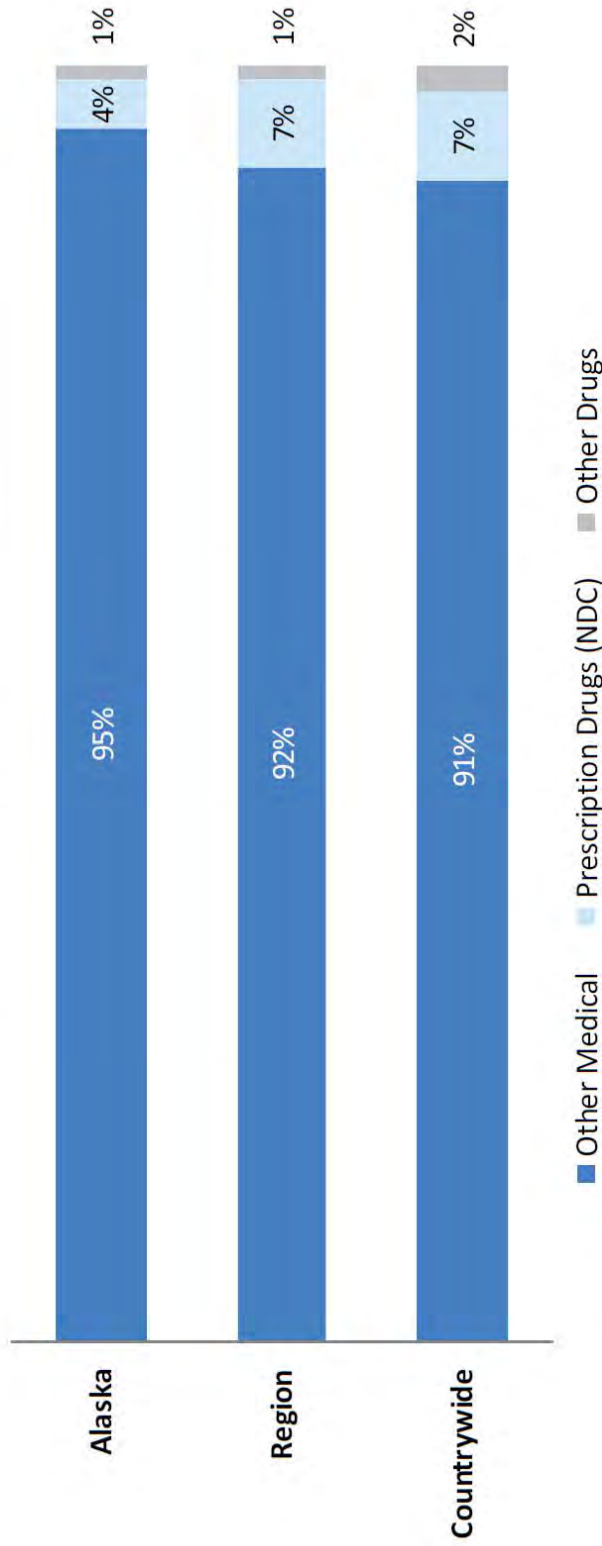
Medical Cost Category	Alaska	Region	Countrywide
Ambulatory Surgical Center	397%	217%	279%

Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance
A review of physician costs in workers compensation compared to group health results show that WC costs are 77% higher than group health costs.
Physical medicine services in WC are almost three times the costs of group health, largely due to the number of services provided. PPT = the average amount paid per transaction.



STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION 2018 MEDICAL DATA REPORT Opioid Utilization

Drug Share of Medical Payments

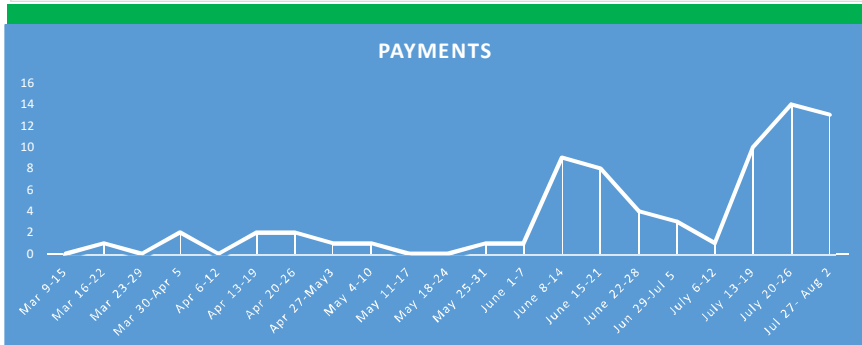
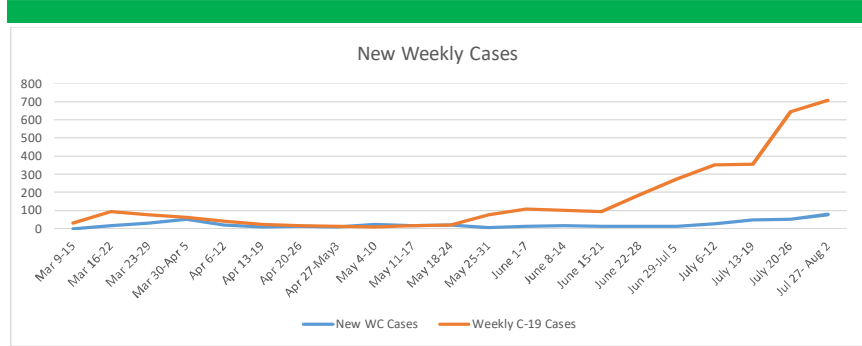
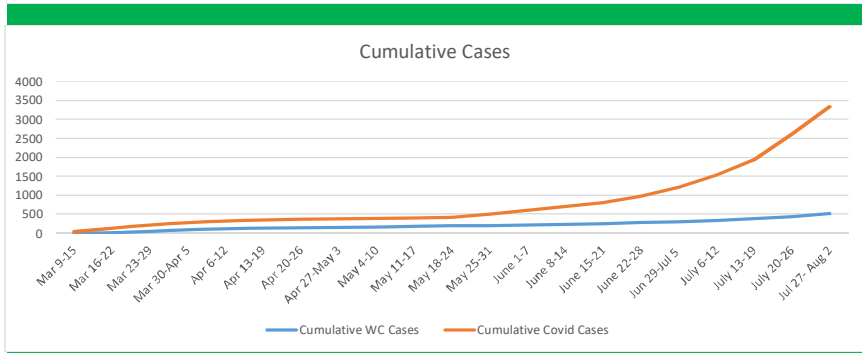
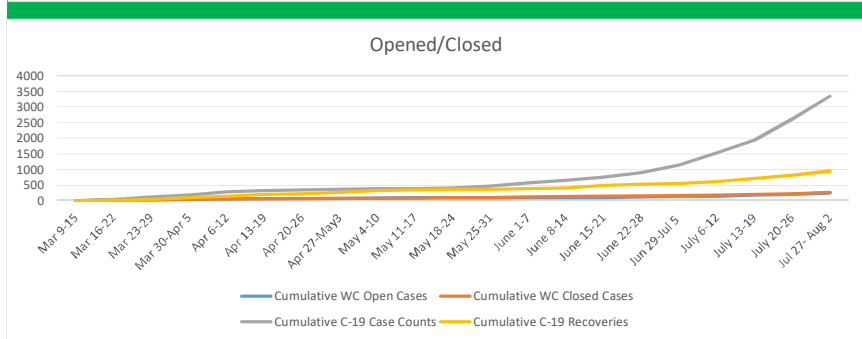
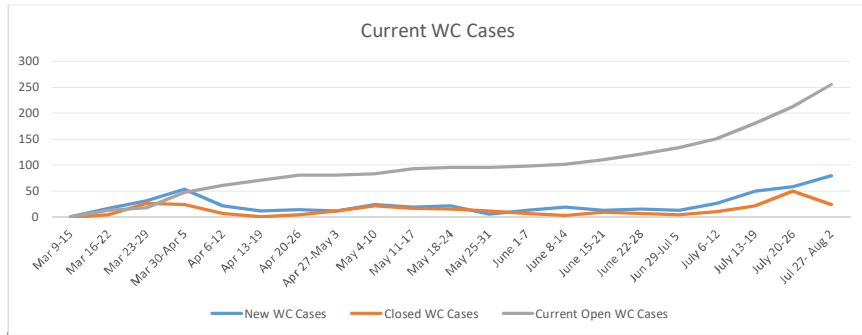


Source: 2019 Alaska State Advisory Forum, National Council on Compensation Insurance
For Service Year 2018, Alaska spent \$3 million on 15,000 prescriptions for workers compensation claims.

TAB 9

Opened	Closed	Current	Paid	BTC to date	OBT to date
518	264	254	65	\$119,428.84	\$13,032.39

As of 8/2



TAB 10



Viral pandemic management (COVID-19)

Published April 3, 2020

Body system:

Infectious Diseases

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

ODG Criteria

Criteria for employees and employers (CDC, 2020):

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

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

Isolation Recommendations:

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

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

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

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

Additional Recommendations:

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

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

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

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

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

Emerging Treatment:

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

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

Evidence Summary

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

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

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



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

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

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

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

Contact ODG at odghelp@mcg.com or 1-800-488-5548 or visit www.mcg.com/odg for more information.



FOR IMMEDIATE RELEASE: April 13, 2020

Contact: jguerriero@mdguidelines.com

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

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

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

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

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

Workplace Safety

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

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

Treatment Recommendations

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

Recommended:

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

Not recommended:

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

No recommendation:

- Favipiravir

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

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

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

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

About ACOEM and Practice Guidelines

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

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

About MDGuidelines

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

###

Introduction

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

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

Panel Composition

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

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

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

The names, affiliations, and conflict of interest disclosures of the Panel members, ex-officio members, and support staff are provided in the [Panel Roster](#) and [Financial Disclosures](#).

Development of the Guidelines

Each section of the Guidelines was developed by a working group of Panel members with expertise in the section's area of interest. Each working group was responsible for identifying relevant information and published scientific literature, and conducting a systematic, comprehensive review of that information and literature. The working groups will propose updates to the Guidelines based on the latest published research findings and evolving clinical information.

Each guideline section has been reviewed, modified as necessary, and voted on by the entire Panel. A majority vote was required for a recommendation to be included in the posted Guidelines. Panel members are required to keep all Panel deliberations and unpublished data considered during the development of the guidelines confidential.

Method of Synthesizing Data and Formulating Recommendations

The working groups critically review and synthesize the available data to develop recommendations. Aspects of the data that are considered include, but are not limited to, the type of study (e.g., case series, prospective cohort, randomized controlled trial), the quality and suitability of the methods, the number of participants, and the effect sizes observed. Each recommendation is assigned two ratings according to the scheme presented in Table 1.

Table 1. Recommendation Rating Scheme

Strength of Recommendation	Quality of Evidence for Recommendation
A: Strong recommendation for the statement	I: One or more randomized trials with clinical outcomes and/or validated laboratory endpoints
B: Moderate recommendation for the statement	II: One or more well-designed, nonrandomized trials or observational cohort studies
C: Optional recommendation for the statement	III: Expert opinion

It is important to note that at present, to develop the recommendations in these Guidelines, the Panel relied heavily on experience with other diseases, supplemented with evolving personal clinical experience with COVID-19, and incorporated the rapidly growing published scientific literature on COVID-19. When information existed in other published Guidelines that the Panel felt important to include in these Guidelines, the information was included with permission from the original sources.

Evolving Knowledge on Treatment for COVID-19

Currently there are no Food and Drug Administration (FDA)-approved drugs for COVID-19. However, an array of drugs approved for other indications, as well as multiple investigational agents, are being studied for the treatment of COVID-19 in several hundred clinical trials around the globe. These trials can be accessed at [ClinicalTrials.gov](#). In addition, providers can access and prescribe investigational drugs or agents approved

or licensed for other indications through various mechanisms, including Emergency Use Authorizations (EUA), Emergency Investigational New Drug (EIND) applications, compassionate use or expanded access programs with drug manufacturers, and/or off-label use.

For this reason, whenever possible, the Panel recommends that promising, unapproved or unlicensed treatments for COVID-19 be studied in well-designed controlled clinical trials. This includes drugs that have been approved or licensed for other indications. The Panel recognizes the critical importance of clinical research in generating evidence to address unanswered questions regarding the safety and efficacy of potential treatments for COVID-19. However, the Panel also realizes that many patients and providers who cannot access such trials are still seeking guidance about whether to use these agents.

Finally, it is important to stress that the rated treatment recommendations in these Guidelines should not be considered mandates. The choice of what to do or not to do for an individual patient is ultimately decided by the patient together with their provider.

Therapeutic Options for COVID-19 Currently Under Investigation

Summary Recommendations

At present, no drug has been proven to be safe and effective for treating COVID-19. There are no Food and Drug Administration (FDA)-approved drugs specifically to treat patients with COVID-19. Although reports have appeared in the medical literature and the lay press claiming successful treatment of patients with COVID-19 with a variety of agents, definitive clinical trial data are needed to identify optimal treatments for this disease. Recommended clinical management of patients with COVID-19 includes infection prevention and control measures and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated. As in the management of any disease, treatment decisions ultimately reside with the patient and their health care provider.

Antivirals:

- There are insufficient clinical data to recommend either for or against using **chloroquine** or **hydroxychloroquine** for the treatment of COVID-19 **(AIII)**.
 - If chloroquine or hydroxychloroquine is used, clinicians should monitor the patient for adverse effects, especially prolonged QTc interval **(AIII)**.
- There are insufficient clinical data to recommend either for or against using the investigational antiviral drug **remdesivir** for the treatment of COVID-19 **(AIII)**.
 - Remdesivir as a treatment for COVID-19 is currently being investigated in clinical trials and is also available through expanded access and compassionate use mechanisms for certain patient populations.
- Except in the context of a clinical trial, the COVID-19 Treatment Guidelines Panel (the Panel) **recommends against** the use of the following drugs for the treatment of COVID-19:
 - The combination of **hydroxychloroquine plus azithromycin (AIII)** because of the potential for toxicities.
 - **Lopinavir/ritonavir (AI)** or other **HIV protease inhibitors (AIII)** because of unfavorable pharmacodynamics and negative clinical trial data.

Host Modifiers/Immune-Based Therapy:

- There are insufficient clinical data to recommend either for or against the use of **convalescent plasma** or **hyperimmune immunoglobulin** for the treatment of COVID-19 **(AIII)**.
- There are insufficient clinical data to recommend either for or against the use of the following agents for the treatment of COVID-19 **(AIII)**:
 - **Interleukin-6 inhibitors** (e.g., sarilumab, siltuximab, tocilizumab)
 - **Interleukin-1 inhibitors** (e.g., anakinra)
- Except in the context of a clinical trial, the Panel **recommends against** the use of other immunomodulators, such as:
 - **Interferons (AIII)**, because of lack of efficacy in treatment of severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) and toxicity.
 - **Janus kinase inhibitors** (e.g., baricitinib) **(AIII)**, because of their broad immunosuppressive effect.

TAB 11



ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION PROPOSED TO BE EFFECTIVE JANUARY 1, 2020

NCCI estimates that the implementation of the Official Disability Guidelines Workers' Compensation Drug Formulary Appendix A (the ODG drug formulary) would result in an estimated impact of -0.1% to -0.6% (\$-0.3M to \$-1.5M¹) on overall workers compensation system costs in Alaska. An effective date of January 1, 2020 is assumed for purposes of this proposal.

The impact of the implementation of the American College of Occupational and Environmental Medicine's (ACOEM) treatment guidelines, ODG treatment guidelines, or other evidence-based drug formularies may reduce overall workers compensation system costs in Alaska; however, the magnitude of any potential savings cannot be quantified.

BACKGROUND AND SUMMARY OF PROPOSED CHANGES

The Alaska Division of Workers' Compensation has requested an estimate of the potential savings associated with the adoption of the ODG drug formulary.

The ODG drug formulary is a detailed list of prescription drugs that are frequently used in the treatment of injured workers. Within this list, there is a status indicator that identifies whether each drug requires prior authorization. Drugs with a status indicator of "N" (N-drugs) require prior authorization by the employer or workers compensation insurer, while drugs with a status indicator of "Y" (Y-drugs²) do not require prior authorization.

ACTUARIAL ANALYSIS

In this analysis, NCCI relies primarily on the following data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call (MDC) for Alaska for Service Year 2018.
- The share of benefit costs attributed to medical benefits based on NCCI's Financial Call data for Alaska from Policy Years 2015, 2016, and 2017, projected to January 1, 2020.

In some components of the analysis, NCCI may rely on other data sources, which are referenced where applicable.

¹ The estimated dollar impacts are the percentage impacts displayed multiplied by 2017 written premium of \$251M from NAIC Annual Statement data for Alaska. These figures do not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impacts assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impacts on overall system costs inclusive of self-insurance are estimated to be between \$-0.3M to \$-2.0M, where data on self-insurance is approximated using the National Academy of Social Insurance's October 2018 publication "Workers' Compensation Benefits, Costs, and Coverage, 2016."

² In this analysis, drugs whose status may vary based on intended use are assumed to be treated as Y-drugs.



ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION PROPOSED TO BE EFFECTIVE JANUARY 1, 2020

To evaluate the cost impact of the ODG drug formulary implementation, NCCI identified drugs dispensed for workers compensation claims in Alaska classified by the formulary as N-drugs or NA-drugs (i.e., drugs not listed on the formulary). Based on MDC data for Service Year 2018, N-drugs represent 22.1% of all Alaska drug payments, while NA-drugs represent 23.4% of all Alaska drug payments.

There are several factors that affect the estimated cost impact of implementing a formulary, including:

- The degree to which Y-drugs or other non-drug treatments would be substituted for N-drugs
- The degree of elimination of N-drugs
- The degree of authorization of N-drugs

To estimate a cost impact of the implementation on N-drugs, NCCI considered several potential cost impact estimates:

ODG Drug Formulary in Texas

The ODG drug formulary was implemented in Texas on September 1, 2011 for new claims (and applied to legacy claims as of September 1, 2013). The Texas Department of Insurance has calculated a 78% reduction in the total N-drug costs from Fiscal-Accident Year 2011 (ending August 31, 2011) to Fiscal-Accident Year 2012³. NCCI's own analysis has shown a 75% decrease in average N drug costs per claim in Texas between Service Year 2010 and Service Year 2014, and a 92% decrease in N-drug average cost per claim for Accident Year (AY) 2014 relative to AY 2010 at 12-month maturity.

NCCI Research

NCCI research on recent ODG drug formulary implementations⁴ in Tennessee and Arizona has suggested a more muted initial impact when compared to that observed in Texas. In these states, utilization of N-drugs after formulary adoption decreased by approximately 7% to 14% beyond the utilization decreases observed in nonformulary states. Post-reform experience in Texas may have differed from experience in Arizona and Tennessee for several reasons, including:

- Texas law does not permit the settlement of future medical benefits.
- Texas began implementation of its drug formulary in 2011. Since that time, increased awareness of the opioid epidemic along with rising drug prices have prompted workers compensation insurers to pay greater attention to pharmaceutical experience.

³ *Impact of the Texas Pharmacy Closed Formulary*, Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, July 2016.

⁴ Hendrick, Paul "Formulary Implementations and Initial Impacts on Workers Compensation" National Council on Compensation Insurance, Inc., June 2019, available at <https://www.ncci.com/Articles/Documents/Insights-Research-Brief-Formulary-Post-Reform-june2019.pdf>



ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION
PROPOSED TO BE EFFECTIVE JANUARY 1, 2020

Other Considerations

As an alternative estimate, NCCI also compared the average cost per script by reimbursement status (“Y” and “N”) for Service Year 2018 for Alaska. The average cost per script for Y-drugs (\$127.68) was 45.6% of the average cost per script for N-drugs (\$279.70). This relativity implies a -54.4% ($= \$127.68/\$279.70 - 1.0$) impact on N-drug costs, assuming substitution of each N-drug script for a Y-drug script at the average Y-drug cost per script.

In addition to these estimates, NCCI also considered that other factors could affect the impact of the proposed ODG drug formulary in Alaska:

- In the aforementioned NCCI research, other recent prescription drug cost containment efforts, such as increased use of pharmacy benefit managers and restrictions on drug repackaging and physician dispensing, may already be causing shifts in workers compensation drug utilization patterns.
- The proposal does not explicitly state if NA-drugs would require preauthorization. NCCI expects that the degree of substitution, elimination, and authorization would differ between N-drugs and NA-drugs for several reasons, including:
 - NA-drugs may be relatively new to the market with no alternative Y-drugs currently available for substitution
 - Insurers may have less familiarity with NA-drugs than more commonly used N-drugs and may thus grant prior authorization at different rates than more common N-drugs.

COST IMPACT

Based on the cost impact considerations above, NCCI estimates that the impact on drug costs in Alaska due to the proposed implementation of the ODG drug formulary would be between -3.3% and -16.6%. These estimated impacts are then multiplied by the percentage of medical costs attributed to drug costs in Alaska (5.4%) to arrive at an estimated impact on medical costs between -0.2% and -0.9%. These estimated impacts are then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an estimated impact of -0.1% to -0.6% on overall workers compensation system costs.

The above estimates only consider the cost impact of the proposed formulary implementation on N-drugs. The cost impact may differ substantially between N-drugs and NA-drugs. Any cost impact of the ODG drug formulary implementation on NA-drugs, if adopted, would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings in Alaska.



**ANALYSIS OF ALASKA ODG DRUG FORMULARY IMPLEMENTATION
PROPOSED TO BE EFFECTIVE JANUARY 1, 2020**

SUMMARY OF ESTIMATED IMPACTS

Based on impact on N-drugs from the proposed ODG drug formulary in Alaska, assumed to be effective January 1, 2020, is summarized in the following table. Any cost impact on NA-drugs of the ODG drug formulary implementation cannot be reasonably quantified and if adopted, would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings in Alaska.

	(A)	(B)	(C) = (A) x (B)	(D)	(E) = (C) x (D)
Type of Service	Estimated Impact on Type of Service	Share of Medical Costs	Estimated Impact on Medical Costs	Medical Costs as a Share of Overall Costs	Estimated Impact on Overall Costs
Drugs	-3.3% to -16.6%	5.4%	-0.2% to -0.9%	70%	-0.1% to -0.6%

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

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National Council of Insurance Legislators (NCOIL)

Model Workers’ Compensation Drug Formulary Act

**Sponsored by Rep. Matt Lehman (IN)*

**Adopted by the Workers’ Compensation Insurance Committee on December 12th, 2019 and the Executive Committee on December 13th, 2019.*

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Section 1. Short Title

This Act shall be known as the “Model Workers’ Compensation Drug Formulary Act”

Section 2. Purpose

The purpose of this Act shall be to require the establishment of a drug formulary for use in a state’s workers’ compensation system in order to facilitate the safe and appropriate use of prescription drugs in the treatment of work-related injury and occupational disease.

Section 3. Selection or Development of Drug Formulary

(A) It is the intent of the Legislature that the [insert appropriate state agency/department] select a nationally recognized, evidence-based drug formulary, for use in the workers’ compensation system, or to develop such a formulary, by rule. Such formulary shall apply to prescription drugs that are prescribed and dispensed for outpatient use in

connection with workers' compensation claims with a date of injury on or after [insert date]. The drug formulary shall not apply to care provided in an emergency department or inpatient setting.

(B) In developing by rule or selecting a nationally recognized, evidence-based drug formulary for adoption, the [department] shall consider the following factors:

- (1) Whether the formulary focuses on medical treatment specific to workers' compensation.
- (2) Whether the basis for the formulary is readily apparent and publicly available.
- (3) Whether the formulary includes measures to aid in management of opioid medications.
- (4) The cost of implementation and post-implementation associated costs of the formulary.
- (5) Evidence-based guidelines for the treatment of workplace injury and disease.

(C) Within [thirty (30)] days of the effective date of this Act, the [department] shall solicit public comments regarding the selection of a nationally recognized, evidence-based prescription drug formulary under this section. The public comment period shall be [ninety (90) days]. During the public comment period, the [department] shall conduct at least one public hearing on the selection of a drug formulary. The [department] shall publish notice of the public comment period and public hearings on its website. The public hearing shall include, but not be limited to, employers, insurers, private sector employee representatives, public sector employee representatives, treating physicians actively practicing medicine, pharmacists, pharmacy benefit managers, attorneys who represent applicants, and injured workers.

(D) Commencing [insert date], and concluding with the implementation of the formulary, the [administrative director] shall publish at least two interim reports on the internet web site of the [division of workers' compensation] describing the status of the selection of the formulary.

(E) The [department] shall [annually] review updates issued by the formulary publisher to the selected formulary.

(F) The [department] shall ensure that the current nationally recognized, evidence-based prescription drug formulary is available through its publicly accessible Internet website for reference by physicians and the general public.

Section 4. Operation of Formulary

(A) Beginning [insert date] reimbursement is not permitted for a claim for payment of a drug that:

(1) is prescribed for use by an employee who files a notice of injury under this Act; and

(2) is listed but not approved in the formulary, or omitted from the formulary, unless the employee begins use of such drug after [insert date], and the use continues after [insert date].

(3) if the employee begins use of the such drug before [insert date], and the use continues after [insert date], reimbursement is permitted for such drug until [insert date].

(B) If a prescribing physician submits to an employer a request to permit use of a drug that is listed but not approved in the formulary, or omitted from the formulary, including the prescribing physician's reason for requesting use of such drug and the employer approves the request, the prescribing physician may prescribe such drug for use by the injured employee.

(C) If the employer does not approve the prescribing physician's request under subsection (B) to permit use of a drug that is listed but not approved in the formulary, or omitted from the formulary, the employer shall:

(1) send the request to a third party that is certified by the [Utilization Review Accreditation Commission (URAC) or another Accreditation Organization] to make a determination concerning the request. The use by the employer of an independent review organization selected by the [department] shall also satisfy this subsection; and

(2) notify the prescribing physician and the injured employee of the third party's determination not more than [three (3)] business days after receiving the request.

(D) If an employer fails to provide the notice required by subsection (C)(2), the prescribing physician's request under subsection (B) is considered approved, and reimbursement of the drug that is listed but not approved in the formulary, or omitted from the formulary, and prescribed for use by the injured employee is authorized.

(E) If the third party's determination under subsection (C) is to deny the prescribing physician's request to permit the use of the drug that is listed but not approved on the formulary, or omitted from the formulary:

(1) the employer shall notify the prescribing physician and the injured employee; and

(2) the injured employee may apply to [workers' compensation board] for a final determination concerning the third party's determination under subsection (C)

(F) Notwithstanding subsections (A) through (E), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is a drug that is listed but not approved on the formulary, or omitted from the formulary.

Section 5. Third Party Conflict of Interest

(A) The URAC certified third party identified in Section 4(C)(1) shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state.

(B) No URAC certified third party identified in Section 4(C)(1) shall have any material professional, material familial, or material financial affiliation with any of the following:

- (1) The employer, insurer or claims administrator.
- (2) Any officer, director, employee of the employer, or insurer or claims administrator.
- (3) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.
- (4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.
- (5) The development or manufacture of the drug proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.
- (6) The injured employee or the employee's immediate family, or the employee's attorney.

Section 6. Rules

The [state department] shall promulgate rules necessary for the implementation of the formulary.

Section 7. Effective Date

This Act shall take effect [xxx days] following enactment.

TAB 12

Hospital Free Profile Data from American Hospital Directory (ahd.com)
 Financial Date for hospital cost report period ending 9/30/2018

Facility	PC Pricer Mult.	Beds	Type	Profit/NP	TTL Patient \$	TTL Patient Days	TTL Discharges	Other \$	Ttl Rev. \$	Net Income/Loss	Rev./Patient Day	Income/P Day
Providence AK Med. Center	2.38	401	ST Acute Care	NP	\$ 2,440,247,354	109,991	15,660	\$(1,809,950)	\$ 2,438,437,404	\$ 109,915,625	\$ 22,169	\$ 999
Mat-Su Regional Med. Center	1.84	74	ST Acute Care	Corp.	\$ 744,061,843	19471	4324	\$ 844,216	\$ 744,906,059	\$ 56,890,637	\$ 38,257	\$ 2,922
Bartlett Regional Hospital	1.79	57	ST Acute Care	Govt	\$ 1,750,075,666	6733	1647	\$ 9,565,651	\$ 184,573,217	\$ 5,512,697	\$ 27,413	\$ 819
Foundation Health - FBKS Mem Hosp	1.48	212	ST Acute Care	NP	\$ 501,562,381	20829	4467	\$ 5,055,831	\$ 506,618,212	\$ 19,012,586	\$ 24,323	\$ 913
Alaska Regional Hospital	2.32	174	ST Acute Care	Corp.	\$ 1,135,761,469	34726	6388	\$ 530,506	\$ 1,136,291,975	\$ 62,828,656	\$ 32,722	\$ 1,809
Yukon-Kuskokwim Delta Reg. Hosp	2.63	34	ST Acute Care	Govt	\$ -	4963	1822	\$ -	\$ -	\$ (187,756,831)	\$ -	\$ (37,831)
Central Peninsula Gen Hosp	1.38	109	ST Acute Care	NP	\$ 377,679,563	11969	2525	\$ 5,354,675	\$ 383,034,238	\$ 8,132,565	\$ 32,002	\$ 679
AK Native Medical Center	2.53	174	ST Acute Care	Govt	\$ -	38396	8376	\$ -	\$ -	\$ (556,553,788)	\$ -	\$ (14,495)

Alaska Workers' Compensation Analysis

The goal of this project was to build an Alaska workers' compensation benchmark, providing guidance in developing a Medicare-derived payment system.

We had two different datasets available, one from FAIR Health and the other from NCCI. We used the NCCI data for this analysis based on several factors including:

- NCCI data had Alaska utilization (volume) information, FAIR Health did not.
- NCCI provided two years of data allowing a comparison for year over year.

Using the NCCI data, we did the following:

Hospital Inpatient

- We used the appropriate relative weights (i.e., FFY 2012 for 2012 data, FFY 2013 for 2013 data). It's worth noting that Medicare inpatient is based on the federal fiscal year while outpatient is on a calendar year.
- We summed the relative weights and total payments for each year's inpatient claims. For 2013 data this was 357.72 and \$8,719,881.99. Dividing the total payments by the total relative weights produces an effective Medicare base rate of \$21,449.74. (Cells D2, G2, H2 in spreadsheet IP2013.)
- As a cross-check, this produced a workers' compensation case mix index of 1.873 which is in line with Optum's national calculations and what we have seen in other states.
- The 2015 total "all in" base rates range from \$7,498.69 for Central Peninsula General Hospital to \$12,991.50 for Yukon Kuskokwim Delta Regional Hospital. (See spreadsheet labeled Hospital IP Rates.) The average rate was \$8,944.40. Because we did not have volumes by hospital, we could not adjust the rate to reflect different utilization patterns. The committee may wish to consider whether the average rate is appropriate or some other rate would be more reflective. We also used the 2015 average rate for the 2012 analysis in order to keep relativity between the 2012/2013 data.
- We did not include the disproportionate (DSH) per claim amount in the calculation. Some Alaska hospitals qualify for DSH per claim payments; some do not. The average DSH per claim amount in Alaska is \$973.25. (Including the DSH per claim payment would increase the total payments by \$185,891 for 2013 data.)
- Based on this, we estimate the current payments as 239.8% compared with Medicare. For 2012, the percentage to Medicare was 255.7%.

Hospital Outpatient

- Hospital Outpatient followed a similar process except that we used the 2015 Medicare weights for both the 2012 and 2013 data. This is because Medicare has been moving various CPT/HCPCS codes into differing APCs and changing their weight, sometimes substantially. We wanted to keep relativity between the data years for accurate comparison.
- We summed the relative weights and total payments for each year's outpatient claims. For 2013 data this was 31,750.6 and \$7,042,049.83. Dividing the total payments by the total relative weights produces an effective Medicare base rate of \$221.79. (Cells D2, F2, G2 in spreadsheet OP2013.)
- It's useful to note that this weight calculation leaves out a number of services that Medicare pays under a differing payment methodology and not on an APC system. Such items include some laboratory, DME and therapy codes.
- Under the Ambulatory Payment Calculation (APC) system, Medicare bundles some items together and only establishes a payment for the primary service. We used all payments reported so bundled items are included in the calculation where they exist. However, because NCCI data only consisted of a data sample (66%) the calculation presumes a 1:1 correlation between bundled items and primary items that may not exist. The result may somewhat over- or under-state the payments because of this. Typically, bundled payment items represent relatively small amounts. Based on an analysis of national Medicare data, we estimate the margin of error is likely to be within 1-3% either way.
- Hospital outpatient only has a single adjustment between hospitals, by wage index. The formula is
$$\text{Hospital rate} = \begin{array}{l} (\text{national rate}) * 60\% * (\text{hospital wage index}) \\ + (\text{national rate}) * 40\% \end{array}$$
- There are two 2015 wage indexes in Alaska (1.3042 and 1.9343) with a substantial difference between them. As with inpatient, because we did not have volumes by hospital, we used an average to determine the comparison base rate of \$101.72. The panel may wish to consider whether this is an appropriate approach.
- Although the volumes differed between 2012 and 2013, the comparison to Medicare produced almost the same results for each year. The 2013 calculation estimated the percentage to Medicare as 218.0%.

TAB 13

2020 WORKERS' COMPENSATION HEARING CALENDAR

MONTH	JUNEAU REG HRG	FAIRBANKS REG HRG	ANCHORAGE REG HRG			
	TUE	TH	TUE	W	TH	FRI
JANUARY						
	7	2	7		2	10
		16		15		
			21	22	23	
	28		28	29	30	
FEBRUARY						
		6	4	5	6	
	11			12		
		20	18	19	20	
	25		25	26	27	
MARCH						
		5	3	4	5	
	10			11		
		19	17	18	19	
	24		24	25	26	
APRIL						
	7	9	7	8	9	
				15		
	21	23	21	22	23	
			28	29	30	
MAY						
	5		5	6	7	8
		14	12	13	14	
	19		19	20		
		28	26	27	28	
JUNE						
	2	4	2	3	4	
				10		
	16	18	16	17	18	19
			23	24	25	
JULY						
	7	9	7	8	9	10
				15		
	21	23	21	22	23	
			28	29	30	
AUGUST						
	4	6	4	5	6	7
				12		
	18	20	18	19	20	
			25	26	27	
SEPTEMBER						
				2	3	
		10	8	9	10	
	15			16		
		24	22	23	24	
	29					
OCTOBER						
		8	6	7	1	2
				14	8	
	13		20	21	22	
		22	27	28	29	
	27					
NOVEMBER						
	3	5	3	4	5	
				11		
	17	19	17	18	19	
DECEMBER						
	1	3	1	2	3	
				9		
	15	17	15	16	17	

NOTES: Hearings may be held twice in Ketchikan during 2020, as needed.
Jan. 9-10, May 7-8 and Oct. 1-2 are AWCBC public board meetings, not hearing dates.
May 20, June 19, July 10, and Aug 11 are MSRC public meetings, not hearing dates.
 Additional hearing days will be added as necessary.
 Additional board meetings will be added as necessary.

2020 calendar revised 5/20/20

2021 WORKERS' COMPENSATION HEARING CALENDAR

MONTH	JUNEAU REG HRG	FAIRBANKS REG HRG	ANCHORAGE REG HRG			
	TUE	TH	TUE	W	TH	FRI
JANUARY						
	12	7	5	6 13	7 14	15
	26	21	19 26	20 27	21 28	
FEBRUARY						
	9	4	2	3 10	4 18	
	23	18	16 23	17 24	25	
MARCH						
	9	4	2	3 10	4 18	
	23	18	16 23 30	17 24 31	25	
APRIL						
	6	1	6	7 14	8 22	
	20	15	20 27	21 28	29	
MAY						
	4	6	4	5 12	6 13	14
	18	20	11 25	19 26	27	
JUNE						
	1	3	1	2 9	3 10	
	15	17	8 22 29	16 23 30	24	
JULY						
	6	1	6	7 14	8 22	
	20	15	20 27	21 28	29	
AUGUST						
	3	5	3	4 11	5	
	17	19	17 24 31	18 25	19 26	
SEPTEMBER						
	7	2	7	1 8	2 9	
	21	16	21 28	15 22 29	23 30	
OCTOBER						
	5	7	5	6 13	7 14	15
	19	21	12 26	20 27	28	
NOVEMBER						
	2	4	2	3 10	4	
	16	18	9 23 30	17 24		
DECEMBER						
	7	2	7	1 8	2 9	
	21	16	21	15 22	23	

NOTES: Hearings may be held twice in Ketchikan during 2021, as needed.
Jan. 14-15, May 13-14 and Oct. 14-15 are AWCB public board meetings, not hearing dates.

Additional hearing days will be added as necessary.
 Additional board meetings will be added as necessary.

2021 calendar, 05/07/2020