

ALASKA WORKERS' COMPENSATION MEDICAL SERVICES REVIEW COMMITTEE MEETING



August 9, 2019

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TAB 1

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING

August 9, 2019

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
3301 Eagle Street, Room 208
Anchorage, Alaska

AGENDA

Friday, August 9, 2019

10:00 am	Call to order Roll call establishment of quorum
10:05 am	Approval of Agenda
10:10 am	Approval of minutes from June 26 2019 meeting
10:15 am	Public Comment Period
11:15 am	Break
11:30 am	Review Draft Fee Schedule Guidelines and Report
1:00 pm	Lunch Break
2:00 pm	Review Draft Fee Schedule Guidelines and Report
3:00 pm	Break
3:15 pm	Review Draft Fee Schedule Guidelines and Report
5:00 pm	Adjournment

TAB 2

***Workers' Compensation
Medical Services Review Committee
Meeting Minutes
July 26, 2019***

I. Call to order

Director Mitchell, acting as Chair of the Medical Services Review Committee, called the Committee to order at 10:04am on Friday, July 26, 2019, in Anchorage, Alaska.

II. Roll call

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

Vince Beltrami	Dr. Mary Ann Foland	Dr. Robert Hall	Jennifer House
Timothy Kanady	Pam Scott	Misty Steed	

III. Approval of Agenda

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

IV. Review of Minutes

A motion to adopt the June 21, 2019 minutes was made by member Steed and seconded by member Beltrami. The June 21, 2019 minutes were unanimously adopted by the committee.

V. Public Comment

No public comment.

VI. Fee Schedule Guidelines Development Discussion

Carla Gee with Optum stepped through the proposed changes for the 2020 Medical Fee schedule, then presented an interactive tool that models the effects of multiplier changes.

The committee discussed potential reduction rates. It was agreed that 5% reductions would not be sufficient to meet their 4-year goal, and more progressive reductions were needed. Using the modeling tool from Optum, the committee focused on reductions to laboratory, radiology and surgery. The committee suggested a long-term goal of bringing the Alaska fee schedule within 185% of Medicare.

Lunch Break 12:18 pm – 1:35pm

The committee continued discussion of the reduction rates and tentatively agreed on 20% for the radiology and surgery, and 7% for laboratory. Carla will provide additional data at the next meeting for discussion before a final decision is made.

The committee discussed an issue that was brought up in public comment at the previous meeting, regarding a chiropractor who was performing procedures outside the normal chiropractic scope of practice. The committee discussed the option to establish a standard in the fee schedule to limit a medical provider from being reimbursed for treatments provided

outside their scope of practice as defined by the State licensing agency. Sherri Ryan with the Alaska Chiropractic Society was invited by the committee to provide comment. She explained that scope of practice is provided by statute, while the governing licensure board of each medical profession determines how the scope is administered. The committee chose to do more research before taking a stance on the issue.

The committee discussed payment standards for non-FDA approved procedures. Carla provided a comparison of guidelines from other states. Kaylee Von with Corvel Corporation provided comment to clarify guidelines from Oregon and Washington. The committee opted to adopt language similar to Wyoming, which states the medical provider must document the necessity of an off-label medical service. Carla will provide draft language at the next meeting.

The committee discussed hearing aid hardware and services. Carla provided a comparison of guidelines from other states. At the will of the committee, Carla will provide draft clarification language for specific hearing aid and service codes, based on NCCI data.

The committee discussed evidence based treatment guidelines. The committee agreed that they did not have enough information or data to make any decisions for the 2020 Fee Schedule.

The next meeting is scheduled for August 9, 2019. This meeting will be telephonic for those members outside of Anchorage.

Meeting Adjourned 3:11pm

TAB 3

2020 Alaska Medical Fee Schedule Proposed Action Items

1. Determine whether conversion factors can be effectively consolidated
2. Determine Physical Therapist and other non-physician reimbursement
3. Determine whether hearing aids/services require guidelines
4. Determine payment standards for procedures that are medically unproven (e.g. non-FDA approved experimental treatments, etc.)
5. Determine payment standards for scope of medical practice issues (e.g. chiropractic injections, etc.)
6. Refine the fee schedule narrative
7. Evaluate the appropriateness, necessity, and cost of medical and related services for Workers' Compensation and make recommendations to the Department and Board (e.g. evidence based treatment guideline adoption)
8. Other items identified by the MSRC membership

TAB 4

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 August 9, 2019

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 5

Official

ALASKA

WORKERS' COMPENSATION

◆ ————— *MEDICAL FEE SCHEDULE*

Effective January 1, 2020



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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Introduction

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

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

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

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

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

The **maximum allowable reimbursement (MAR)** is 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. 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

ORGANIZATION OF THE FEE SCHEDULE

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

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

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

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

PROVIDER SCHEDULE

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

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

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

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

both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

DRUGS AND PHARMACEUTICALS

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

The maximum allowable reimbursement for prescription drugs is as follows:

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

HCPCS LEVEL II

Durable Medical Equipment

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

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

- 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	1.61	1.117	1.79837
Malpractice RVU x Malpractice GPCI	0.14	0.708	0.09912
Total RVU			3.44249

Data for the purpose of example only

Calculation using example data:

$$1.03 \times 1.500 = 1.545$$

$$+ 1.61 \times 1.117 = 1.79837$$

$$+ 0.14 \times 0.708 = 0.09912$$

$$= 3.44249$$

$$3.44249 \times \$165.00 \text{ (CF)} = 568.01085$$

Payment is rounded to \$568.01

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

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

2020 Alaska Workers' Compensation Medical Fee Schedule—General Information and Guidelines

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	\$165.00
Radiology	70010–79999	\$196.00
Pathology and Lab	80047–89398	\$135.00
Medicine (excluding anesthesia)	90281–99082 and 99151–99199 and 99500–99607	\$80.00
Evaluation and Management	99091, 99201–99499	\$80.00
Anesthesia	00100–01999 and 99100–99140	\$121.82

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	Active Code. 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	Bundled Code. 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.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
C	Contractors price the code. 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	Deleted Codes. 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	Excluded from Physician Fee Schedule by regulation. 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	Deleted/Discontinued Codes. (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	Not valid for Medicare purposes. 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	Deleted Modifier. 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	Not valid for Medicare purposes. 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	Anesthesia Services. 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	Measurement Codes. Used for reporting purposes only.	These codes are supplemental to other covered services and for informational purposes only.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
N	<u>Non-covered Services.</u> These services are not covered by Medicare.	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	<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. <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. 	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.
Q	<u>Therapy functional information code</u> (used for required reporting purposes only).	These codes are supplemental to other covered services and for informational purposes only.
R	<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.)	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.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
T	<u>Injections.</u> There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)	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.
X	<u>Statutory Exclusion.</u> These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)	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.

Add-on Procedures

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

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

Exempt from Modifier 51 Codes

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

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

Professional and Technical Components

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

Global Days

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

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

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

Supplies and Materials

Supplies and materials provided by the physician (e.g., sterile trays, supplies, drugs, etc.) over and above those

usually included with the office visit may be charged separately.

Medical Reports

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

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

Off-label Use of Medical Services

All services should be medically necessary, having a reasonable expectation of cure or significant relief of a covered condition and supported by medical record documentation. Medications, treatments, procedures or other medical services 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.

Payment of Medical Bills

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

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

Board Forms

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

Applicable HCPCS Modifiers

Modifier TC—Technical Component

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

Modifier QZ—CRNA without medical direction by a physician

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

State-Specific Modifiers

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

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

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

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

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

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

Data for the purpose of example only

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

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

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

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

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

Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

When exact text of the AMA 2019 CPT® guidelines is used, the text is either in quotations or is preceded by a reference to the CPT book, CPT instructional notes, or CPT guidelines.

BILLING AND PAYMENT GUIDELINES

New and Established Patient Service

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

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

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

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

E/M Service Components

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

1. The history component is categorized by four levels:

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

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

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

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

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

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

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

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

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

The CPT book identifies the following body areas:

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

The CPT book identifies the following organ systems:

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

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

Contributory Components

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

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

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

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

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

Subcategories of Evaluation and Management

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

Office or Other Outpatient Services (99201–99215)

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

Hospital Observation Services (99217–99226)

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

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

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

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

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

Observation Care Discharge Services (99217)

This code reports observation care discharge services. Use this code only if discharge from observation status occurs on a date other than the initial date of observation status. The

code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. If a patient is admitted to, and subsequently discharged from, observation status on the same date, see codes 99234–99236.

Hospital Inpatient Services (99221–99239)

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

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

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

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

Consultations (99241–99255)

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

in both subcategories. The general rules and requirements of a consultation are defined by the CPT book as follows:

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

Emergency Department Services (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The CPT guidelines clearly define an emergency department as “an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available

24 hours a day.” Care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Critical Care Services (99291–99292)

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

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

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

Nursing Facility Services (99304–99318)

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

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

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

Home Services (99341–99350)

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

Prolonged Services (99354–99360, 99415–99416)

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

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

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

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

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

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

Physician Standby Services

Code 99360 reports the circumstances of a physician who is requested by another physician to be on standby, and the standby physician has no direct patient contact.

The standby physician may not provide services to other patients or be proctoring another physician for the time to be reportable. Also, if the standby physician ultimately provides services subject to a surgical package, the standby is not separately reportable.

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

Case Management Services (99366–99368)

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

Care Plan Oversight Services (99374–99380)

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

Special Evaluation and Management Services (99450–99456)

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

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

99455	10.63
99456	21.25

Other Evaluation and Management Services (99499)

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

MODIFIERS

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

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

State-Specific Modifier

Modifier PE: Physician Assistants and Advanced Practice Registered Nurses

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

certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

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

Anesthesia

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

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

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

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

Time for Anesthesia Procedures

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

Calculating Anesthesia Charges

The following scenario is for the purpose of example only:

01382 Anesthesia for arthroscopic procedure of knee joint

Dollar Conversion Unit = \$121.82

Base Unit Value = 3

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

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

Anesthesia Fee = \$121.82 x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = \$1,340.02

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

Anesthesia Supervision

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

Anesthesia Monitoring

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

Other Anesthesia

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

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

anesthesia services that are performed. No additional time units are allowed.

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

ANESTHESIA MODIFIERS

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

Physical Status Modifiers

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

MODIFIER	DESCRIPTION
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

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

Qualifying Circumstances

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

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

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

Modifiers

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

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

Applicable HCPCS Modifiers

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

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

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

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

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

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

Modifier QX CRNA service: with medical direction by a physician—This modifier is appended to CRNA or

anesthetist assistant (AA) claims. This informs a payer that a CRNA or AA provided the service with direction by an anesthesiologist. Payment is the lower of billed charges or 50 percent of the MAR.

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

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

Surgery

GENERAL INFORMATION AND GUIDELINES

Definitions of Surgical Repair

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

BILLING AND PAYMENT GUIDELINES

Global Reimbursement

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

In addition to the surgical procedure, global reimbursement includes:

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

Follow-up Care for Diagnostic Procedures

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

Follow-up Care for Therapeutic Surgical Procedures

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

Additional Surgical Procedure(s)

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

Incidental Procedure(s)

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

Suture Removal

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

Aspirations and Injections

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

Surgical Assistants

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

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

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

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

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

Data for the purpose of example only

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

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

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

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

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

Data for the purpose of example only

Anesthesia by Surgeon

Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Reimbursement is the lower of the billed charge or the anesthesia base unit amount

multiplied by the anesthesia conversion factor. No additional time is allowed.

Multiple or Bilateral Procedures

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

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

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

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

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

Example:

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

Data for the purpose of example only

Endoscopic Procedures

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

Example:

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

Data for the purpose of example only

Arthroscopy

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

Modifier 51—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session

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

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

State-Specific Modifiers

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

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

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

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

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

Procedure 1 (Modifier AS)	\$1,350.00
Procedure 2 (Modifier AS, 51)	\$1,100.00
Reimbursement	\$285.00 [(\$1,350.00 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.

2020 Alaska Workers' Compensation Medical Fee Schedule—Surgery

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

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

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

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Review of Diagnostic Studies

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

Written Reports

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

Multiple Radiology Procedures

CMS multiple procedure payment reduction (MPPR) guidelines for the professional component (PC) and technical component (TC) of diagnostic imaging procedures apply if a procedure is billed with a subsequent diagnostic imaging procedure performed by the same physician (including physicians in a group practice) to the same patient in the same session on the same day.

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

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific CPT modifiers shall be reimbursed as follows:

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

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

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

Alaska MAR:

72142	\$2,100.16
72142-TC	\$1,442.05
72142-26	\$683.08
72147	\$2,090.01
72147-TC	\$1,433.30
72147-26	\$681.69

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	\$1,442.05	100% of the TC
72147-TC	\$716.65	(50% of the TC for the second procedure)
Total	\$2,158.70	

Professional Component:

72142-26	\$683.08	100% of the 26
72147-26	\$647.61	(95% of the 26 for the second procedure)
Total	\$1,330.69	

Global Reimbursement:

72142	\$2,100.16	100% of the global
72147-51	\$1,057.50	(\$716.85 + \$340.85 TC and 26 above)
Total	\$3,157.66	

Applicable HCPCS Modifiers

TC Technical Component—

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

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

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

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

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

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

The conversion factor for Pathology and Laboratory codes (80047–89398) is \$135.00 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	0.26	1.117	0.29042
Malpractice RVU x Malpractice GPCI	0.02	0.708	0.01416
Total RVU			0.85958

Data for the purpose of example only

Calculation using example data:

$$0.37 \times 1.500 = 0.555$$

$$+ 0.26 \times 1.117 = 0.29042$$

$$+ 0.2 \times 0.708 = 0.01416$$

$$= 0.85958$$

$$0.85958 \times \$135.00 \text{ (CF)} = 116.0433$$

Payment is rounded to \$116.04

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 6.33 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 \$3.52 in the CLAB file, this is multiplied by 6.33 for a MAR of \$22.28.

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Organ or Disease Oriented Panels

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

Drug Screening

Drug screening is reported with CPT codes 80305–80307. These services are reported once per patient encounter. These codes are used to report urine, blood, serum, or other appropriate specimen. Drug confirmation is reported with codes G0480–G0483 dependent upon the number of drug tests performed. These codes are valued in the CLAB schedule and the multiplier is 6.33.

MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code

appended in the appropriate field for electronic or paper submission of the billing.

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

Specific CPT modifiers shall be reimbursed as follows:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

Medicine

GENERAL INFORMATION AND GUIDELINES

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

BILLING AND PAYMENT GUIDELINES

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

Multiple Procedures

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

Separate Procedures

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

Materials Supplied by Physician

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

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

Physical Medicine

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

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

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

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

TENS Units

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

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

Publications, Books, and Videos

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

Work Hardening

Work hardening codes are a covered service. They are valued with the following total RVUs:

97545	3.41
97546	1.36

Osteopathic Manipulative Treatment

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

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

Chiropractic Manipulative Treatment

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

- Chiropractic manipulative treatment (CMT) is a form of manual treatment using a variety of techniques for treatment of joint and neurophysiological function. The chiropractic manipulative treatment codes include a premanipulation patient assessment.
- Evaluation and management services may be reported separately if, the patient's condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the CMT. Different diagnoses are not required for the reporting of the CMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.
- There are five spinal regions recognized in the CPT book for CMT: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and

pelvic (sacroiliac joint) region. There are also five recognized extraspinal regions: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.

- Chiropractors may report codes 97014, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943.

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

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

Specific modifiers shall be reimbursed as follows:

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

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

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

Cardiovascular services—Full payment is made for the TC service with the highest MAR. Payment is made at 75 percent for subsequent TC services furnished by the same physician

(or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a “6” in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

93303	\$631.79
93303-TC	\$431.85
93303-26	\$199.94
93351	\$638.10
93351-TC	\$370.19
93351-26	\$267.91

Data for the purpose of example only

Technical Component:

93303-TC	\$431.85	100% of the TC
93351-TC	\$277.64	(75% of the TC for the second procedure)
Total	\$709.49	

Global Reimbursement:

93303	\$631.79	100%
93351	\$545.55	(75% of the TC for the second procedure + 100% of the 26) (\$277.64 + \$267.91 = \$545.55)
Total	\$1,177.34	

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
92060-TC	\$65.80
92060-26	\$117.32
92132	\$88.07
92132-TC	\$37.20
92132-26	\$50.86

Data for the purpose of example only

Technical Component:

92060-TC	\$65.80	100% of the TC
92132-TC	\$29.76	(80% of the TC for the second procedure)
Total	\$95.56	

Global Reimbursement:

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

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	\$37.36
[(.18 x 1.5) + (.17 x 1.117) + (0.01 x .708)] x 80	
97024	\$19.38
[(.06 x 1.5) + (.13 x 1.117) + (0.01 x .708)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	\$29.76
[(.18 x 1.5) + (.17 x 1.117) x .5 + (0.01 x .708)] x 80	
97024	\$13.57
[(.06 x 1.5) + (.13 x 1.117) x .5 + (0.01 x .708)] x 80	

Example:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

Category II

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

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

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

Category III

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

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

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

CATEGORY III MODIFIERS

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

HCPCS Level II

GENERAL INFORMATION AND GUIDELINES

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

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

MEDICARE PART B DRUGS

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

DURABLE MEDICAL EQUIPMENT

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

Hearing Aids

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

The codes below are reimbursed according to the listed fees.

CODE	FEE
92591	
92593	
92594	
92595	
92633	
V5014	
V5020	
V5267	
V5275	
V5299	

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.

Ground ambulance services are reported using the appropriate HCPCS codes. The maximum allowable reimbursement (MAR) for medical services that do not have

valid Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) codes, a currently assigned CMS relative value, or an established conversion factor is the lowest of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

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

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

A revenue code is defined by CMS as a code that identifies a specific accommodation, ancillary service or billing calculation. Revenue codes are used by outpatient facilities to specify the type and place of service being billed and to reflect charges for items and services provided. A substantial number of outpatient facilities use both CPT codes and revenue codes to bill private payers for outpatient facility services. The outpatient facility fees are driven by CPT code rather than revenue code. Common revenue codes are

reported for components of the comprehensive surgical outpatient facility charge, as well as pathology and laboratory services, radiology services, and medicine services. The CMS guidelines applicable to status indicators are followed unless otherwise superseded by Alaska state guidelines. The following billing and payment rules apply for medical treatment or services provided by hospital outpatient clinics, and ambulatory surgical centers:

- (1) medical services for which there is no *Ambulatory Payment Classifications* weight listed are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (2) status indicator codes C, E, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (3) two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;
- (4) a payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.

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

2020 Alaska Workers' Compensation Medical Fee Schedule—Outpatient Facility

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPSS, for example: <ul style="list-style-type: none"> Ambulance services Separately payable clinical diagnostic laboratory services Separately payable non-implantable prosthetic and orthotic devices Physical, occupational, and speech therapy Diagnostic mammography Screening mammography 	Not paid under OPSS. See the appropriate section under the provider fee schedule.
B	Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPSS. An alternate code that is recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPSS. <i>Alaska Specific Guideline: May be performed in the outpatient or ASC setting if beneficial to the patient and as negotiated by the payer and providers. Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i>
D	Discontinued codes	Not paid under OPSS.
E1	Items, codes and services: <ul style="list-style-type: none"> Not covered by any Medicare outpatient benefit category Statutorily excluded by Medicare Not reasonable and necessary 	Not paid under OPSS. <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>

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
E2	Items and services for which pricing information and claims data are not available	Not paid under OPSS. Status may change as data is received by CMS. <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>
F	Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines	Not paid under OPSS. Paid at reasonable cost.
G	Pass-through drugs and biologicals	Paid under OPSS; separate APC payment includes pass-through amount.
H	Pass-through device categories	Separate cost-based pass-through payment. <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>
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPSS; 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	Paid under OPSS; addendum B displays APC assignments when services are separately payable. <ol style="list-style-type: none"> Comprehensive APC payment based on OPSS 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. Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1. In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radio-pharmaceuticals	Paid under OPSS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine	Not paid under OPSS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPSS.
N	Items and services packaged into APC rates	Paid under OPSS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. <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	Partial hospitalization	Paid under OPSS; per diem APC payment. <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>
Q1	STV packaged codes	Paid under OPSS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI of S, T, or V. (2) Composite APC payment if billed with specific combinations of services based on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
Q2	T packaged codes	Paid under OPSS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
Q3	Codes that may be paid through a composite APC	Paid under OPSS; addendum B displays APC assignments when services are separately payable. (1) Composite APC payment on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPSS or Clinical Laboratory Fee Schedule (CLFS). (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. (2) In other circumstances, laboratory tests should have an SI = A and payment is made under the CLFS.
R	Blood and blood products	Paid under OPSS; separate APC payment.
S	Procedure or service, not discounted when multiple	Paid under OPSS; separate APC payment.
T	Procedure or service, multiple reduction applies	Paid under OPSS; separate APC payment. <i>Alaska Specific Guideline: Two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classification's calculated amount and all other status indicator code T items paid at 50 percent.</i>
U	Brachytherapy sources	Paid under OPSS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPSS; separate APC payment.
Y	Non-implantable durable medical equipment	Not paid under OPSS. 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 110%
Implant reimbursement	= \$ 3,300

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

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

EXEMPT FROM THE MS-DRG

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

SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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

PREPARING TO DETERMINE A PAYMENT

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

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

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

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

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

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

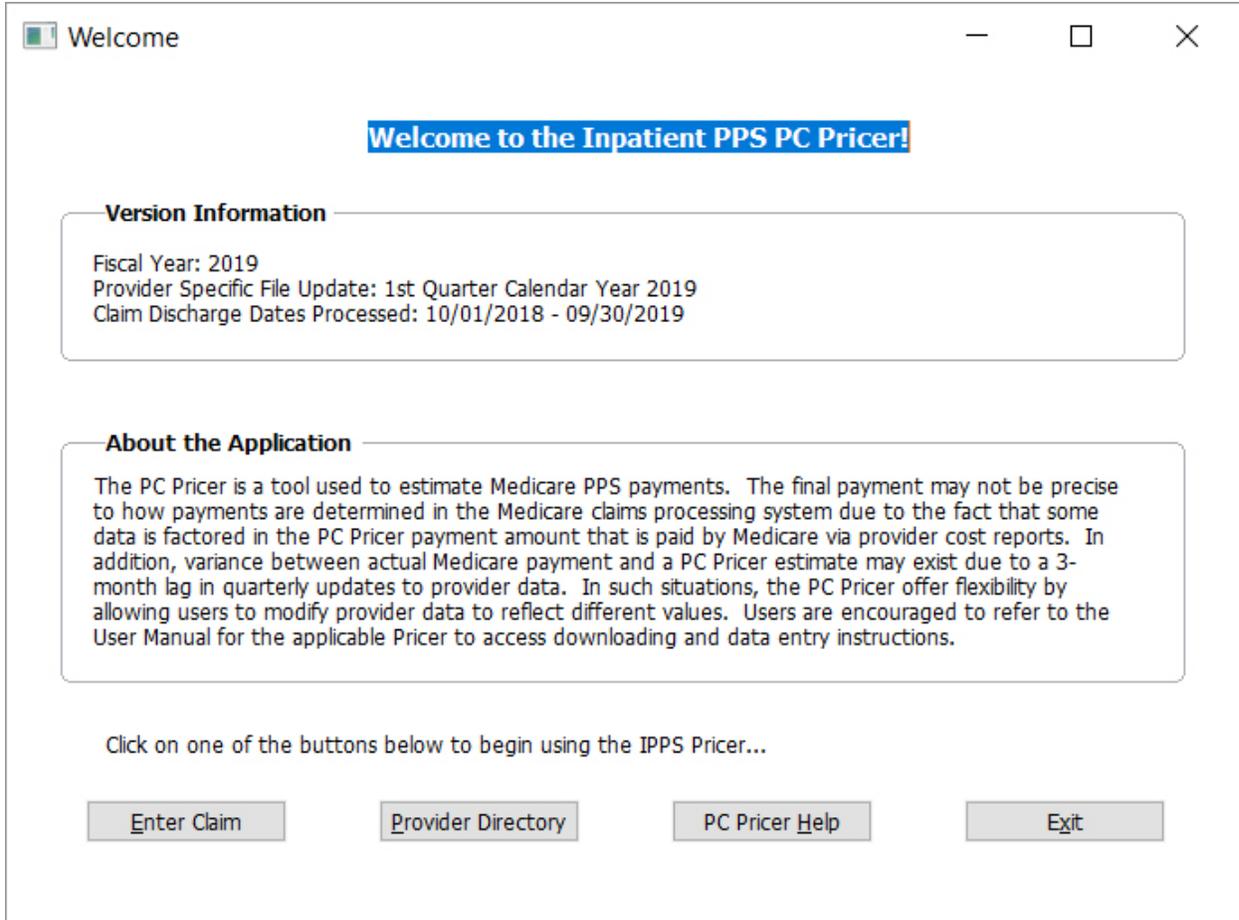
The current version of the PC Pricer tool may be downloaded here:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html>

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.

All screenshots have been updated.



The PC Pricer instructions are included below:

Data Entry and Calculation Steps for the Inpatient PPS

PC Pricer—From the welcome screen above (top image), select Enter Claim. The IPSS Claim Entry Form will appear.

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

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

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

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

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

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

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

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

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

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

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

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

IPPS Payment Results
— □ ×

FY 2019 Inpatient Prospective Payment (IPPS) Payment Results

Calculator Version: C19.0

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

PROVIDER DETAILS	CLAIM DETAILS	PPS FACTORS & ADJUSTMENTS
Provider #: 020001	Patient Id: 1111111	OP/CAP CCR: 0.2050 / 0.0160
PSF Record Eff Date: 10/01/2018	DRG: 460	OP/CAP DSH: 0.3077 / 0.1074
Provider Type: 00	Discharge Date: 10/22/2018	Operating IME: 000000.028533292
GEO/STD CBSA: 11260 /	Length of Stay: 12 Days	Capital IME: 000000.021967351
Reclass CBSA:	Charges: \$75,000.00	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	OPERATING AMOUNTS	
C-FSP: \$2,284.40	O-FSP: \$27,918.98	
C-Outlier: \$0.00	O-HSP: \$0.00	
C-DSH: \$245.34	O-Outlier: \$0.00	
C-IME: \$50.18	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

Print
Enter Claim
Provider Directory
PC Pricer Help
Exit

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
Multiplied by Providence Alaska Medical Center multiplier	x 2.38
Alaska Workers' Compensation Payment	\$86,310.49

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

GENERAL INFORMATION AND GUIDELINES

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

for the treatment or service negotiated by the provider and the employer.

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

TAB 6

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.

DURABLE MEDICAL EQUIPMENT

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

HEARING AIDS

The dispensing of hearing aids is reported with the appropriate HCPCS Level II codes and a copy of the manufacturer/supplier’s invoice. Reimbursement is the lower of the manufacturer/supplier’s invoice cost plus 30 percent or billed charges.

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 carrier¹, 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.

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.

¹ 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.

TAB 7

See at: <https://wcd.oregon.gov/medical/billing/Pages/excluded.aspx>



Contact

855-350-4636 (toll-free)
503-947-7606
Fax: 503-947-7629
wcd.medicalquestions@oregon.gov

Para información en español
1-800-452-0288

[Receive updates on health care provider information](#)

Treatment you won't be paid for

The Department of Consumer and Business Services has excluded the following treatments from compensability. The insurer does not have to pay you for the following:

- **Dimethyl sulfoxide (DMSO)**, except for treatment of compensable interstitial cystitis
- **Intradiscal electrothermal therapy (IDET)**
- **Surface EMG (electromyography) tests**
- **Rolfing**
- **Platelet-rich plasma (PRP) injections**
- **Prolotherapy**
- **Thermography**
- **Lumbar artificial disc replacement**, unless it is a single-level replacement with an unconstrained or semi-constrained metal on polymer device and all of the following are true:
 - The single level artificial disc replacement is between L3 and S1
 - The injured worker is 16 to 60 years old
 - The injured worker underwent a minimum of six months unsuccessful exercise based rehabilitation
 - The procedure is not found inappropriate under OAR 436-010-0230(15)
- **Cervical artificial disc replacement**, unless it is a single-level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and all of the following are true:
 - The single level artificial disc replacement is between C3 and C7
 - The injured worker is 16 to 60 years old
 - The injured worker underwent unsuccessful conservative treatment
 - There is intraoperative visualization of the surgical implant level
 - The procedure is not found inappropriate under OAR 436-010-0230(16)

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Workers' Compensation Division
350 Winter Street NE

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About Oregon

Oregon.gov

TAB 8

See at→ <https://wcd.oregon.gov/medical/mac/Documents/prprec.pdf>

Oregon Workers' Compensation Division Medical Advisory Committee Recommendation Regarding Platelet Rich Plasma (PRP) Injection

April 19, 2019

Summary:

The Medical Advisory Committee for the Workers' Compensation Division researched and analyzed whether PRP injections should continue to be a non-compensable medical service. After conducting a thorough literature review and determining the most persuasive studies, the Committee concluded that PRP injections should continue to be a **non-compensable** medical service.

Since there is considerable research still ongoing, the MAC expects to re-evaluate PRP injections in the fall of 2020.

Findings:

Plasma Rich Platelet injections are not compensable because they are:

- Unproven - The evidence does **not** demonstrate efficacy
- Experimental - There is **insufficient** evidence to reasonably assess

outcome

Recommendation:

Platelet Rich Plasma injection is *not* a compensable medical service.

TAB 9



**Payment Policies for Healthcare Services
 Provided to Injured Workers and Crime Victims**

Chapter 5: Audiology and Hearing Services

Effective July 1, 2019



Link: Look for possible **updates and corrections** to these payment policies at:

<http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2019/MARFS/Chapter12/default.asp>



Note: The policies and requirements in this chapter apply to all hearing aid services and devices except for CPT® codes.



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Definitions

- ▶ **Bundled codes:** Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.



Link: For the legal definition of **Bundled codes**, see [WAC 296-20-01002](#).

- ▶ **By report (BR):** A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.



Link: For the legal definition of **By report**, see [WAC 296-20-01002](#).

- ▶ **Restocking fees:** The Washington State Department of Health statute ([RCW 18.35.185](#)) and rule ([WAC 246-828-290](#)) allow hearing instrument fitter/dispensers and licensed audiologists to retain **\$150.00** or **15%** of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee sometimes is called a "restocking fee."

Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds the purchase agreement.



Links: For more information, see [WAC 246-828-290](#) and [RCW 18.35.185](#).



Payment policy: Audiology services

▶ Worker responsibilities

Worker responsible for devices that aren't medically necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given and wants to purchase different hearing aids, **the worker** then becomes completely responsible for the purchase of:

- The hearing aid,
- Any future repairs.

Worker responsible for some repairs, losses, damages

Workers are responsible to pay for repairs of hearing aids that aren't authorized by the insurer.

The worker is also responsible for non-work related losses or damages to their hearing aids (for example, the worker's pet eats/chews the hearing aid, etc...). In no case will the insurer cover this type of loss or damage. In these instances, the worker will be required to buy a new (not used) hearing aid consistent with current L&I guidelines outlined in this chapter.

After the worker's purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

▶ Services that can be billed

The insurer will only purchase hearing aids, devices, supplies, parts, and services described in the fee schedule (see Additional information: Audiology fee schedule, below.)

A physician or ARNP may be paid for a narrative assessment of work-relatedness to the hearing loss condition.

When filing a Report of Accident, Otolaryngologists or Occupational Medicine physicians should also bill 1190M if they perform a Comprehensive Hearing Loss Exam (see [Chapter 12: Impairment Ratings](#) for more information). If auditory testing is performed, the person performing the test will bill the appropriate procedure codes.

▶ **Services that aren't covered**

The insurer doesn't pay any provider or worker to fill out the:

- **Occupational Disease Employment History Hearing Loss form** (F262-013-000), or
- **Occupational Hearing Loss Questionnaire** (F262-016-000).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period.

The insurer won't pay for the reprogramming of hearing aids.

The insurer won't cover disposable shells ("ear molds" in HCPCS codes).

The insurer won't cover services and supplies included in the purchase of hearing aids that are advertised and offered to the general public at no cost,



Links: The **Occupational Disease Employment History Hearing Loss form** is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1695.

The **Occupational Hearing Loss Questionnaire** is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1697.

▶ **Requirements for billing**



Note: Also see the Documentation and record keeping requirements section of this chapter.

Hearing aid parts and supplies paid at acquisition cost

Parts and supplies must be billed and will be paid at acquisition cost including volume discounts (manufacturers' wholesale invoice). Acquisition cost and the amount on the invoice must reflect the cost of the item being dispensed to the worker, not the invoice of the replacement to stock.

Don't bill your usual and customary fee. (See specific billing instructions for these items in the following table.)

If you are billing for...	Then these can be:
Supply items for hearing aids, including:	Billed within the warranty period.

If you are billing for...	Then these can be:
<ul style="list-style-type: none"> • Tubing, • Wax guards, <i>and</i> • Ear hooks. 	
Parts for hearing aids, including: <ul style="list-style-type: none"> • Switches, • Controls, • Filters, • Battery doors, <i>and</i> • Volume control covers. 	Billed as replacement parts only, but not within the warranty period.
Shells (“ear molds” in HCPCS codes)	Billed separately at acquisition cost (the insurer doesn’t cover disposable shells).
Hearing aid extra parts, options, circuits, and switches (for example, T-coil and noise reduction switches)	Only billed when the manufacturer doesn’t include these in the base invoice for the hearing aid.

► Payment limits

Batteries

The insurer will pay the cost of battery replacement for the life of an authorized hearing aid.

Only a maximum of 60 batteries are authorized within each 90 day period. Providers must document the request for batteries by the worker and maintain proof that the worker actually received the batteries.

Wax Guards

The insurer will pay the cost of wax guards for the life of the authorized hearing aid.

Wax guards are reimbursed up to a maximum of 104 per calendar year. Wax guards are billed using code 5095V. This service can't be billed as part of a repair.

Tubes and Domes

Tubes and domes are used with some hearing aids. Replacement of tubes and domes is considered maintenance.

The insurer will reimburse service for in office replacement of tubes and domes. This amount includes binaural replacement. This service:

- can be billed a maximum 18 times per calendar year,
- can be billed in conjunction with a quarterly cleaning visit,

- can't be billed as part of a repair
- can't bill more than 1 unit per date of service.

Tubes and domes are billed using code 5094V.



Note: Sending workers batteries that they haven't requested and for which they don't have an immediate need violates L&I's rules and payment policies.

► **Additional information: Audiology fee schedule**



Notes: The insurer will only purchase the hearing aids, devices, supplies, parts, and services described in the fee schedule.

Also, see definitions of **By report** and **Bundled** in Definitions at the beginning of this chapter.

HCPCS code	Description	Maximum fee
V5008	Hearing screening	\$83.13
V5010	Assessment for hearing aid	Bundled
V5011	Fitting/orientation/checking of hearing aid	Bundled
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V)	\$55.42
V5020	Conformity evaluation	Bundled
V5030	Hearing aid, monaural, body worn, air conduction	Acquisition cost
V5040	Body-worn hearing aid, bone	Acquisition cost
V5050	Hearing aid, monaural, in the ear	Acquisition cost
V5060	Hearing aid, monaural, behind the ear	Acquisition cost

HCPCS code	Description	Maximum fee
V5070	Glasses air conduction	Acquisition cost
V5080	Glasses bone conduction	Acquisition cost
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	Acquisition cost
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	Acquisition cost
V5130	Binaural, in the ear	Acquisition cost
V5140	Binaural, behind the ear	Acquisition cost
V5150	Binaural, glasses	Acquisition cost
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$1,573.95
V5171	Hearing aid, contralateral routing device, monaural, in the ear (ite)	Acquisition cost
V5172	Hearing aid, contralateral routing device, monaural, in the canal (itc)	Acquisition cost
V5181	Hearing aid, contralateral routing device, monaural, behind the ear (bte)	Acquisition cost
V5190	Hearing aid, cros, glasses	Acquisition cost
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$943.39

HCPCS code	Description	Maximum fee
V5211	Hearing aid, contralateral routing system, binaural, ite/ite	Acquisition cost
V5212	Hearing aid, contralateral routing system, binaural, ite/itc	Acquisition cost
V5213	Hearing aid, contralateral routing system, binaural, ite/bte	Acquisition cost
V5214	Hearing aid, contralateral routing system, binaural, itc/itc	Acquisition cost
V5215	Hearing aid, contralateral routing system, binaural, itc/bte	Acquisition cost
V5221	Hearing aid, contralateral routing system, binaural, bte/bte	Acquisition cost
V5230	Hearing aid, bicros, glasses	Acquisition cost
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$943.39
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$786.98
V5242	Hearing aid, analog, monaural, CIC (completely in the ear canal)	Acquisition cost
V5243	Hearing aid, monaural, ITC (in the canal)	Acquisition cost
V5244	Hearing aid, digitally programmable analog, monaural, CIC	Acquisition cost
V5245	Hearing aid, digitally programmable, analog, monaural, ITC	Acquisition cost

HCPSC code	Description	Maximum fee
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)	Acquisition cost
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)	Acquisition cost
V5248	Hearing aid, analog, binaural, CIC	Acquisition cost
V5249	Hearing aid, analog, binaural, ITC	Acquisition cost
V5250	Hearing aid, digitally programmable analog, binaural, CIC	Acquisition cost
V5251	Hearing aid, digitally programmable analog, binaural, ITC	Acquisition cost
V5252	Hearing aid, digitally programmable, binaural, ITE	Acquisition cost
V5253	Hearing aid, digitally programmable, binaural, BTE	Acquisition cost
V5254	Hearing aid, digital, monaural, CIC	Acquisition cost
V5255	Hearing aid, digital, monaural, ITC	Acquisition cost
V5256	Hearing aid, digital, monaural, ITE	Acquisition cost
V5257	Hearing aid, digital, monaural, BTE	Acquisition cost
V5258	Hearing aid, digital, binaural, CIC	Acquisition cost
V5259	Hearing aid, digital, binaural, ITC	Acquisition cost
V5260	Hearing aid, digital, binaural, ITE	Acquisition cost
V5261	Hearing aid, digital, binaural, BTE	Acquisition cost
V5262	Hearing aid, disposable, any type, monaural	Not covered

HCPCS code	Description	Maximum fee
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	Acquisition cost
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	\$0.97
V5267	Hearing aid supply/accessory	Acquisition cost
5091V	Hearing aid restocking fee (the lesser of 15% of the hearing aid total purchase price or \$150.00 per hearing aid)	By report
5092V	Hearing aid cleaning visit per ear (1 every 90 days, after the first year)	\$25.85
5093V	Hearing aid repair fee. Invoice required	By report
5094V	Bilateral in office tubes/dome replacement (maximum of 18 times per calendar year)	\$25.00 per unit (limited to 1 unit per date of service)
5095V	Wax guards (maximum of 104 per calendar year)	\$1.25 each



Payment policy: Advertising limits

▶ False, misleading, or deceptive advertising or representations

L&I can deny a provider's application to provide services, or suspend or revoke an existing provider account if the provider participates in:

- False, misleading, or deceptive advertising, *or*
- Misrepresentations of industrial insurance benefits.

False advertising includes mailers and advertisements that:

- Suggest a worker's hearing aids are obsolete and need replacement, *or*
- Don't clearly document a specific hearing aid's failure, *or*
- Make promises of monetary gain without proof of disability or consideration of current law.



Link: For more information, see [RCW 51.36.130](#) and [WAC 296-20-015](#).



Payment policy: Dispensing fees

▶ Services that can be billed

Dispensing fees cover a 30 day trial period during which all aids may be returned. Also included:

- Up to four follow up visits (ongoing checks of the aid as the wearer adjusts to it), *and*
- One hearing aid cleaning kit, *and*
- Routine cleaning during the first year, *and*
- All shipping, handling, delivery, and miscellaneous fees.



Payment policy: Documentation and record keeping requirements

▶ Documentation to support initial authorization

The provider must keep **all of the following** information in the worker's medical records and submit a copy of each to the insurer:

- Name and title of referring practitioner, if applicable, *and*
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual, *and*
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea, and fever, *and*
- A record of whether the worker has been treated for recent or frequent ear infections, *and*
- Results of the ear examination, *and*
- Results of all hearing and speech tests from initial examination, *and*
- Review and comment on historical hearing tests, if applicable, *and*
- All applicable manufacturers' warranties (length and coverage) plus the make, model and serial number of any hearing aid device(s) supplied to the worker as original or as a replacement, *and*
- Original or unaltered copies of manufacturers' invoices, *and*
- Copy of the **Hearing Services Worker Information** form (F245-049-000) signed by the worker and provider, *and*
- Invoices and/or records of all repairs.



Link: The **Hearing Services Worker Information** form is available at:
www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032.

▶ Documentation to support repair

The provider who arranges for repairs to hearing aid(s) authorized and purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period. Repair requests for State Fund claims must be sent to the Provider Hotline. A copy of the warranty must be on file with the insurer to ensure payment. Documentation to support replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement:

- The name and credential of the person who inspected the hearing aid, *and*
- Serial number of the aids to be replaced, *and*
- Date of the inspection, *and*
- Observations (for example, a description of the damage, and specific reasons why the device can't be repaired).

▶ Requirements for billing

Correspondence with the insurer

The insurer may deny payment of the provider's bill if the following information hasn't been received:

- Original or unaltered wholesale invoices from the manufacturer are required to show the acquisition cost, serial numbers, and warranty information, and must be retained in the provider's office records for a minimum of 5 years, *and*
- A copy of the original or unaltered manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part, or supply costs \$150.00 or more, or upon the insurer's request, *and*
- Documentation of the repair and who performed it must be submitted to the insurer.



Note: Electronic billing providers must submit a copy of the original or unaltered manufacturer's wholesale invoice with the make, model, and serial number for individual hearing aids within 5 days of bill submission.

To avoid delays in processing, all correspondence to the insurer must indicate the worker's name and claim number in the upper right hand corner of each page of the document.

Providers are required to send warranty information for:

- **State Fund** claims to:
Department of Labor and Industries
PO Box 44291
Olympia, WA 98504-4291
- **Self-insured** claims to the SIE/TPA. Contact list available at:
www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.



Payment policy: Hearing aids, devices, supplies, parts, and services

▶ General requirements

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards.

All manufacturers and assemblers must hold a valid FDA certificate.

▶ Self-insurers with purchasing contracts for hearing aids

SIEs that have entered into contracts for purchasing hearing aid related services and devices may continue to use them.



Link: For more information, see [WAC 296-23-165\(1b\)](#).

SIEs that don't have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this chapter.

▶ Types of hearing aids authorized

Types of hearing aids authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). The decision will be based on recommendations from:

- Physicians, *or*
- ARNPs, *or*
- Licensed audiologists, *or*
- Fitter/dispensers.

The insurer covers the following types of hearing aids:

- Behind the ear (BTE),
- Digital or programmable in the ear (ITE),
- In the canal (ITC),
- Completely in the canal (CIC), *and*
- Receiver in Canal (RIC)

Any other types of hearing aids needed for medical conditions will be considered based on justifications from the physician, ARNP, licensed audiologist or fitter/dispenser.

- L&I won't purchase used or repaired equipment.
- The insurer won't purchase hearing devices intended for safety protection.

The following table indicates which services and devices are covered by provider type:

If the provider is a...	Then the services or devices that can be billed are:
Fitter/dispenser	HCPCS codes for all hearing related services and devices.
Durable medical equipment (DME) provider	<ul style="list-style-type: none"> • Supply codes, <i>and</i> • Battery codes.
Physician, ARNP, licensed audiologist	<ul style="list-style-type: none"> • HCPCS codes for hearing related services and devices, <i>and</i> • CPT® codes for hearing-related testing and office calls.

► Prior authorization

Initial and subsequent hearing related services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies, and accessories.

The insurer won't pay for hearing devices provided prior to authorization.

To initiate the authorization process for:

- **State Fund** claims, call the claim manager or the State Fund's Provider Hotline at **1-800-848-0811** (in Olympia call **360-902-6500**).

- **Self-insured** claims, the provider should obtain prior authorization from the SIE or its TPA.

The insurer will notify the worker in writing when the claim is accepted or denied.



Link: For more information, see [WAC 296-20-03001](#) and [WAC 296-20-1101](#).

Cases of special need

In cases of special need, such as when the worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted.

Special authorization for hearing aids and masking devices over \$900.00 per ear

If the manufacturer's invoice cost of any hearing aid or masking device exceeds **\$900.00** per ear, special authorization is required from the claim manager.



Notes: The cost of ear molds doesn't count toward the **\$900.00** for special authorization. Initial ear molds may be billed using **V5264** and replacements may be billed using **V5014** with **V5264**.

The cost of any external electronic device, such as a remote control or Bluetooth, counts towards the **\$900.00** limit per hearing aid.

Masking devices for tinnitus

In cases of accepted tinnitus, the insurer may authorize masking devices. (Also see Requirements for billing, below.)

Required documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work related hearing loss.

An SIE/TPA may use these or similar forms to gather information:

- **Report of Accident** ([F242-130-000](#)),
- **Occupational Disease Employment History Hearing Loss form** ([F262-013-000](#)),
- **Occupational Hearing Loss Questionnaire** ([F262-016-000](#)),
- Valid audiogram,
- Medical report, *and*
- **Hearing Services Worker Information form** ([F245-049-000](#)).



Link: The forms are available on L&I's website, at: www.Lni.wa.gov/FormPub/.

► **Who must perform these services to qualify for payment**

Authorized testing

Testing to fit a hearing aid may be done by a:

- Licensed audiologist,
- Fitter/dispenser,
- Qualified physician, *or*
- Qualified ARNP.

The provider must obtain prior authorization for subsequent testing.



Note: Fitter/ dispensers aren't reimbursed for audiograms. The provider performing the service must do the billing.

► **Requirements for billing**



Note: Also see the Documentation and record keeping requirements section of this chapter.

All hearing aids, parts, and supplies

All hearing aids, parts, and supplies must be billed using HCPCS codes.

Hearing aids and devices are considered durable medical equipment (DME) and must be billed at their acquisition cost.



Link: For more details, refer to the Acquisition Cost Policy in: Chapter 28: Supplies, Materials, and Bundled Services.

Binaural hearing aids

When billing the insurer for hearing aids **for both ears**, providers must indicate on the **CMS- 1500 (F245 127 000)** or **Statement for Miscellaneous Services form (F245-072-000)** the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left), *and*
- The appropriate HCPCS code for binaural aids.

Only bill one unit of service even though two hearing aids (binaural aids) are dispensed.



Note: Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.



Link: The forms are available on L&I's website, at: www.Lni.wa.gov/FormPub/.

Monaural hearing aids

When billing the insurer for **one hearing aid**, providers must indicate on the **CMS-1500 (F245-127-000)** or **Statement for Miscellaneous Services form (F245-072-000)** the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected, *and*
- The appropriate HCPCS code for monaural aid.

Only bill one unit of service.



Note: Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

Tinnitus masking devices



Note: Also see Prior authorization, above.

If masking devices are dispensed without hearing aids, providers will bill using code **E1399**.

When dispensed as a component of a hearing aid, providers will bill using code **V5267**.

If masking devices are dispensed without hearing aids, the provider may also bill the appropriate dispensing fee code for monaural or binaural devices.

▶ Payment limits

Authorized testing

The insurer doesn't pay for testing after a claim has closed unless related to fitting of replacement hearing aids.

The insurer will pay for hearing screening (**V5008**) only when performed and billed by an audiologist.

The insurer doesn't cover annual hearing tests.

If free initial hearing screenings are offered to the public, the insurer won't pay for these services.

▶ 30 day trial period

A 30 day trial period is the standard established by [RCW 18.35.185](#). During this time:

- The provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids aren't damaged),
- Follow up hearing aid adjustments are bundled into the dispensing fee, *and*
- If hearing aids are returned within the 30 day trial period, the provider must refund the hearing aid and dispensing fees.



Link: For more information, see [RCW 18.35.185](#).



Payment policy: Repairs and replacements

▶ Warranties

Hearing aid industry standards provide a minimum of a one year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than one year, the manufacturer's warranty will apply.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is covered under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid according to the warranty. The worker is responsible for any charges outlined in the manufacturer's warranty.

The insurer doesn't purchase or provide additional manufacturers' or extended warranties beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period. The warranty period begins:

- On the date the hearing aid is dispensed to the worker, *or*
- For repairs, when the hearing aid is returned to the worker.

▶ Prior authorization

Repairs

Prior authorization is required for all billed repairs. The insurer will repair hearing aids and devices when needed due to normal wear and tear. Also note that:

- At its discretion, the insurer may repair hearing aids and devices under other circumstances, *and*
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased, *and*
- If the aid is damaged in a work related incident, the worker must file a new claim to repair or replace the damaged hearing aid.

Providers must submit a written estimate of the repair cost to the State Fund Provider Hotline or the self-insured employer (SIE) claim manager to get prior authorization for:

- In office repairs, *or*
- Repairs by the manufacturer, *or*
- Repairs by an all make repair company.



Note: Tubes, domes and wax guards aren't considered repairs.

Replacements

- Replacement is defined as purchasing a new hearing aid for the worker according to L&I's current guidelines.
- Insurer authorized hearing aids will be replaced upon request 5 years or more after their Issue date, *or*
- For hearing aids less than 5 years from the issue date of the current aids, the insurer will replace hearing aids when they aren't repairable due to normal wear and tear.
 - The insurer will require detailed documentation supporting why hearing aids aren't repairable and should be replaced.

Also note that for hearing aids less than 5 years from their current issue date:

- At its discretion, the insurer may replace hearing aids in other circumstances, *and*
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer won't pay for new hearing aids when only new ear shell(s) are needed, *and*
- The insurer won't replace a hearing aid when the hearing aid is working up to the manufacturer's original specifications, *and*
- The insurer won't replace a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on the job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident, *and*
- The insurer won't replace hearing aids based solely on changes in technology, *and*
- The insurer won't pay for new hearing aids for hearing loss resulting from:

- Noise exposure that occurs outside the workplace, *or*
- Further coverage exposure, *or*
- Non-work related diseases, *or*
- The natural aging process.

Replacement requests may be sent directly to the insurer using the Hearing Aid Repair/Replacement Durable Medical Equipment Provider Hotline Service Authorization Request form (F245-418-000). If this form isn't used, any request must be in writing and include all information required on the form.

State fund replacement requests are made directly to the claim manager. Requests may be mailed or faxed to **360-902-6490**.

Documentation that a hearing aid isn't repairable may be submitted by:

- Licensed audiologists, *or*
- Fitter/dispensers, *or*
- All make repair companies, *or*
- FDA certified manufacturers.

The provider must submit written, logical rationale for the claim manager's consideration if:

- Only one of the binaural hearing aids isn't repairable, *and*
- In the professional's opinion, both hearing aids need to be replaced.



Note: The condition of the other hearing aid must be documented.

▶ **Who must perform these services to qualify for payment**

Repairs

Audiologists and fitters/dispensers may be paid for providing authorized in office repairs.

▶ **Requirements for billing**

Repairs

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Authorized in-office repairs must be billed using **V5014** and **V5267**. These billings require an invoice and description.

Additional information

- Separate charges for accessories are paid at acquisition cost and aren't to be billed with repair codes.
- The insurer won't cover repairs, services and supplies that are offered to the general public at no cost.
- If a repair is done in the office and no warranty is available, this information must be included in the written description of the repair.

Replacements

The worker must sign and be given a copy of the **Hearing Services Worker Information** form (F245-049-000). The provider must submit a copy of the signed form with the replacement request.

A copy of the manufacturer's warranty and a copy of any additional provider warranty must be submitted to the insurer for all hearing devices and hearing aid repairs. The warranty should include the individual hearing aids:

- Make, *and*
- Model, *and*
- Serial number.

The provider must inform the insurer of the type of hearing aid dispensed and the codes they are billing.



Link: The **Hearing Services Worker Information** form (F245-049-000) and the **Hearing Aid Replacement** form (F242-414-000) are available on L&I's website, at: <http://www.lni.wa.gov/FormPub/>



Payment policy: Replacement of linear nonprogrammable analog hearing aids

▶ When these hearing aids may be replaced

Linear nonprogrammable analog hearing aids may be replaced with nonlinear digital or analog hearing aid when the worker returns a linear analog hearing aid to their dispenser or audiologist because:

- The hearing aid is inoperable, *or*
- The worker is experiencing an inability to hear, *and*
- The insurer has given prior authorization to replace the hearing aid.

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with nonlinear digital or analog hearing aid is authorized (see Prior authorization, below).

▶ Prior authorization

Prior authorization must be obtained from the insurer **before** replacing linear analog hearing aids. The insurer **won't pay** for replacement hearing aids issued prior to authorization.

Authorization documentation and record keeping requirements

Before authorizing replacement, the insurer will require and request the following documentation from the provider:

- **Required:** A separate statement (signed by both the provider and the injured worker): *This linear analog replacement request is sent in accordance with L&I's linear analog hearing aid replacement policy, and*
- **Required for State Fund claims:** Completed **Hearing Services Worker Information** form (F245-049-000), available at: <http://www.lni.wa.gov/FormPub/>, *and*
- Serial number(s) of the current linear analog aid(s), if available, *and*
- Make/model of the current linear analog aid(s), if available, *and*
- Date original hearing aid(s) issued to worker, if available.

For State Fund claims prior authorization:

- Call the claim manager, *or*
- Fax the request to the Provider Hotline at **360-902-6252**.

For self-insured claims prior authorization, contact the SIE/TPA for prior authorization.



Link: For a list of SIEs/TPAs, see:

www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/

▶ **Who must perform these services to qualify for payment**

Audiologists, physicians, ARNPs, and fitter/dispensers who have current L&I provider account numbers may bill for hearing aid replacement. These providers may bill for the acquisition cost of the nonlinear aids and the associated professional fitting fee (dispensing fee).



Payment policy: Restocking fees

(See definition of **restocking fees** in Definitions at the beginning of this chapter.)

► Requirements for billing

The insurer must receive a **Termination of Agreement (Rescission)** form (F245-050-000) or a statement signed and dated by the provider and the worker.



Note: The form must be faxed to L&I at **360-902-6252** or forwarded to the SIE/TPA within two business days of receipt of the signatures.



Link: The form is available on L&I's website, at: <http://www.lni.wa.gov/FormPub/>.

The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer:

- Either for the restocking fee of **\$150.00** or **15%** of the total purchase price, whichever is less, *and*
- Using billing code **5091V**.



Note: Restocking fees can't be paid until the insurer has received the refund.



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules and Washington state laws for audiology and hearing services	Washington Administrative Code (WAC) 246-828-290: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-828-290 WAC 296-20-015: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-015 WAC 296-23-165: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-165 Revised Code of Washington (RCW) 18.35.185: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.35.185 RCW 51.36.130: http://apps.leg.wa.gov/RCW/default.aspx?cite=51.36.130
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including audiology)	L&I's website: http://www.lni.wa.gov/apps/FeeSchedules/
Hearing Services Worker Information form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032
Occupational Disease Employment History Hearing Loss form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1695
Occupational Hearing Loss Questionnaire	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1697
Payment policies for acquisition cost	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for durable medical equipment (DME)	Chapter 9: Durable Medical Equipment

If you're looking for more information about...	Then go here:
Payment policies for supplies	Chapter 28: Supplies, Materials, and Bundled Services
Report of Accident form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599
Statement for Miscellaneous Services form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627
Termination of Agreement (Rescission) form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2033

▶ **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**

TAB 10



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

STATE OF ALASKA

DIVISION OF WORKERS' COMPENSATION

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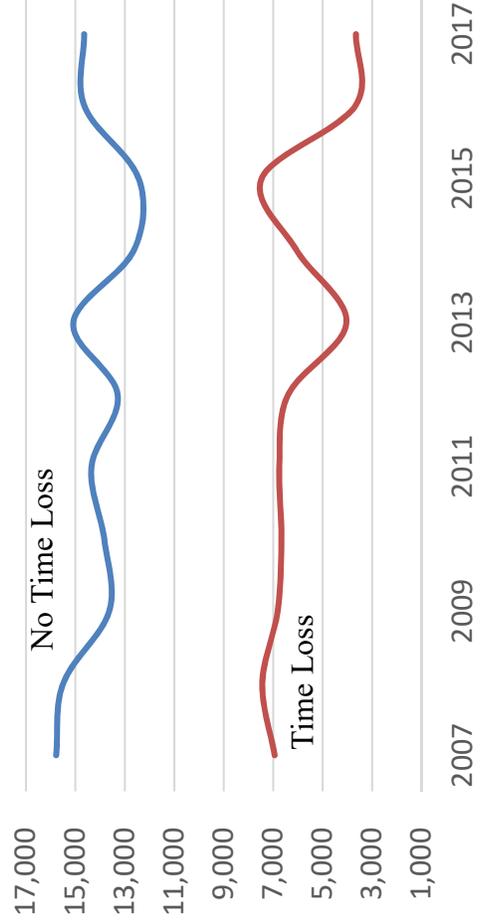
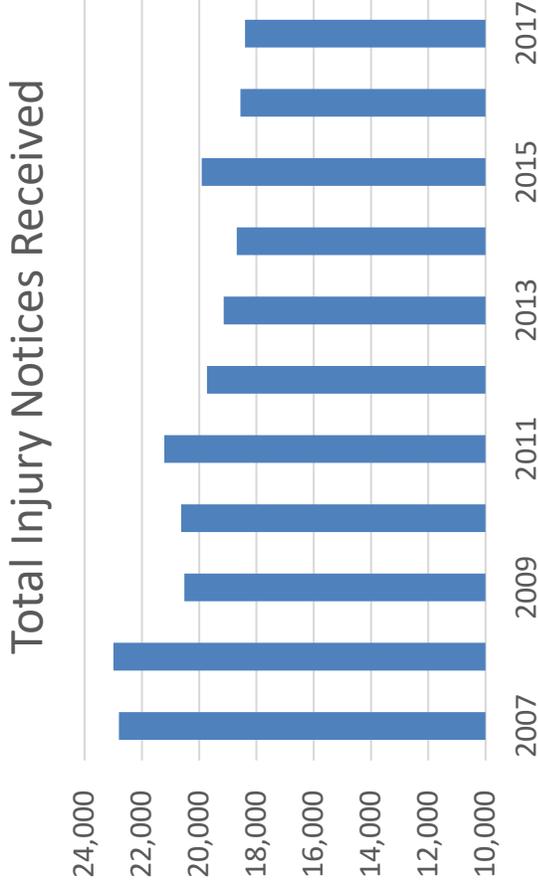


2017 ANNUAL REPORT

Analysis of Workers' Compensation Claims Data

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

In 2017, there were 18,396 reports of injury and occupational illness filed with the Workers' Compensation Division, a 0.9% decrease from 18,555 reports filed in 2016.



Of the case files established in 2017:

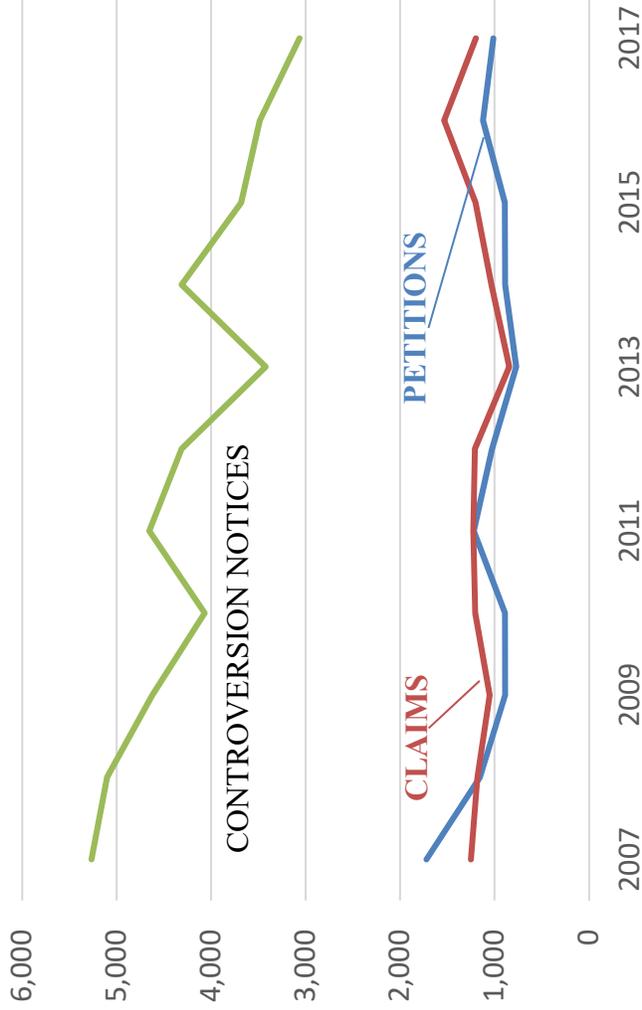
- No-time-loss cases: 14,646 cases, 80%
- Time-loss cases: 3,652 cases, 20%
- Notification only cases: 4,198 cases
- Fatalities: 18 cases, 0.10%
- Jurisdictional claims: 80 cases, 0.43%



2017 ANNUAL REPORT

Analysis of Workers' Compensation Claims Data

CLAIMS & PETITIONS



In 2017, there were 1,198 claims filed, a 21.9% decrease from 1,533 claims filed in 2016.

There were 1,012 petitions filed, a 9.8% decrease from 1,122 petitions filed in 2016.

3,064 controversy notices were filed, a 5.4% decrease from 3,485 in 2016. The number of cases converted in 2017 totaled 2,281, an 11.6% decrease from 2,579 cases in 2016.



2017 ANNUAL REPORT

ANNUAL TOTAL COMPENSATION REPORTING

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 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 uninsured employers and self-insured employers.

Along with the annual report, each insurer, adjuster, uninsured employer, or self insured employer must submit payment of their Second Injury Fund (SIF) contribution and their Workers' Compensation Fund fee. 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, 2017 to December 31, 2017
 - FY = Fiscal Period from July 1 to June 30

Notes:

Other Costs Totals include the following Medical Costs: Physical Therapy, Chiropractic Fees, Durable Medical expenses, Medical Travel, Employee Medical-Legal Costs. This is a significant change in reporting medical expenses from previous medical expense data captured prior to 2014.



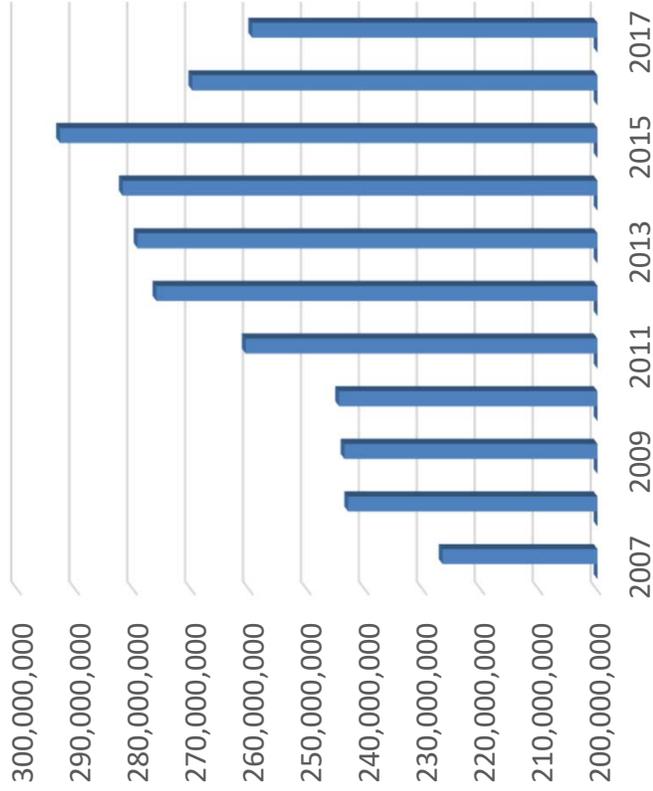
2017 ANNUAL REPORT

Total Compensation Payments

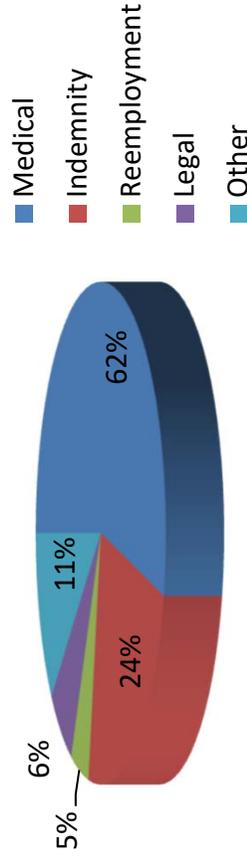
A total of \$259.5 million was paid in workers' compensation benefits during calendar year 2017 by 200 market-insured employers and self-insured employers. This is a decrease of 3.8% from \$269.9 million in 2016.

Of this amount, \$192.8 was paid by market-insured employers (74.3%), and \$66.7 million was paid by self-insured employers (25.7%).

Total Compensation Payments



Benefit Distribution





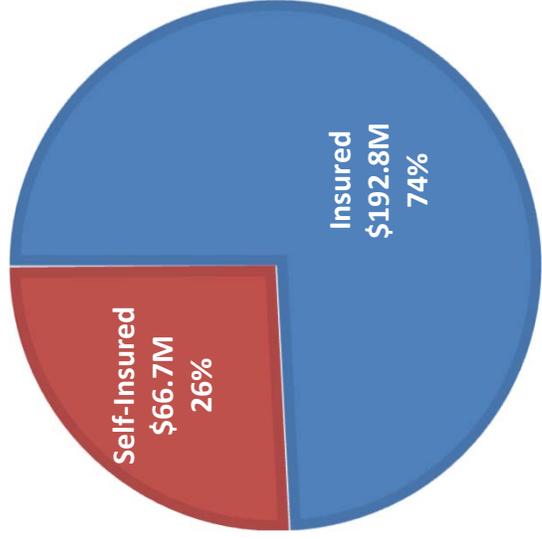
2017 ANNUAL REPORT

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

Of the \$259.5 million in total benefits paid in 2017, 192.8 million was paid by market-insured employers (74.3%), and \$66.7 million was paid by self-insured employers (25.7%). The top twenty insurers/self-insured employers paid \$176.2 million, or 68% of total workers' compensation benefits paid in 2017. This compares to \$186.7 million, or 69%, in 2016.

Rank	Self-Insurer	Total Benefits Paid
1	ALASKA NATIONAL INS CO	40,130,335.07
2	ALASKA, STATE OF	20,062,149.00
3	LIBERTY NORTHWEST INSURANCE CO	10,713,560.20
4	COMMERCE AND INDUSTRY INS CO	10,078,187.38
5	LIBERTY INSURANCE CORP	8,755,173.05
6	ANCHORAGE, MUNICIPALITY OF	8,276,151.64
7	ACE AMERICAN INSURANCE COMPANY	6,957,147.09
8	AMERICAN INTERSTATE INSURANCE CO	6,919,970.70
9	INDEMNITY INS CO OF NORTH AMERICA	6,671,901.26
10	AMERICAN ZURICH INS CO	6,372,994.97
11	ALASKA INS GUARANTY ASSN	6,154,365.47
12	REPUBLIC INDEMNITY CO OF AMERICA	5,999,379.48
13	ARCTIC SLOPE REGIONAL CORP	5,932,103.45
14	NEW HAMPSHIRE INSURANCE CO	5,332,737.24
15	ANCHORAGE SCHOOL DISTRICT	4,996,577.40
16	BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY	4,846,023.21
17	ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOC	4,703,201.52
18	TRAVELERS PROPERTY CASUALTY CO OF AMERICA	4,656,939.10
19	EMPLOYERS INS CO OF WAUSAU	4,642,200.15
20	FEDERAL INS CO	4,083,061.86
Total		176,284,159.24

Insurers	186,366,341
Self-Insured Employers	66,695,390
Guaranty Associations	6,212,175
AK Benefits Guaranty Fund	316,825
Total	259,590,730





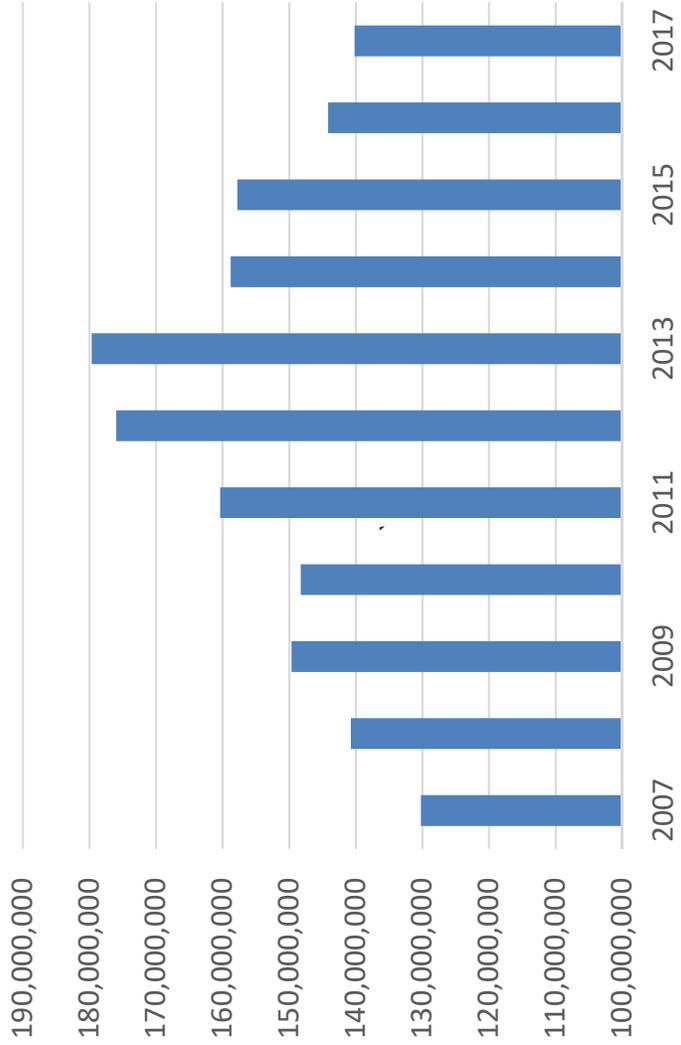
2017 ANNUAL REPORT

Medical Benefits

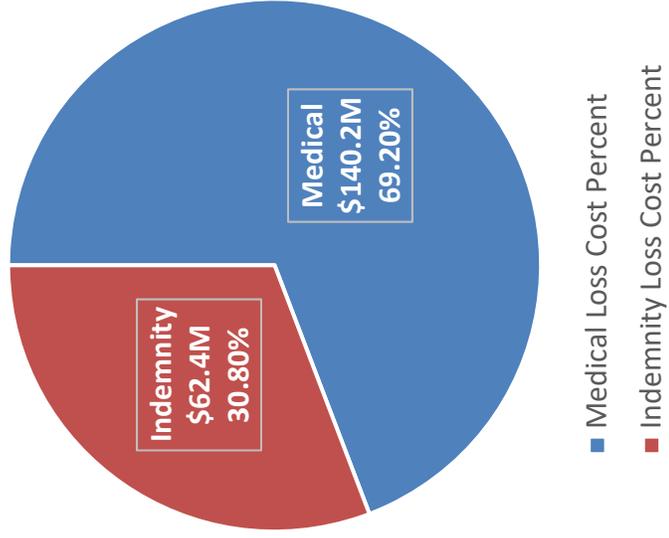
In the calendar year 2017, medical benefits totaled \$140.2 million, a 2.75% decrease from \$144.2 million in 2016.

Medical benefits were 54% of total benefits paid and 69.2% of loss costs in 2017, compared to 53.41% of total benefits paid and 67.3% of loss costs in 2016.

Medical Payments



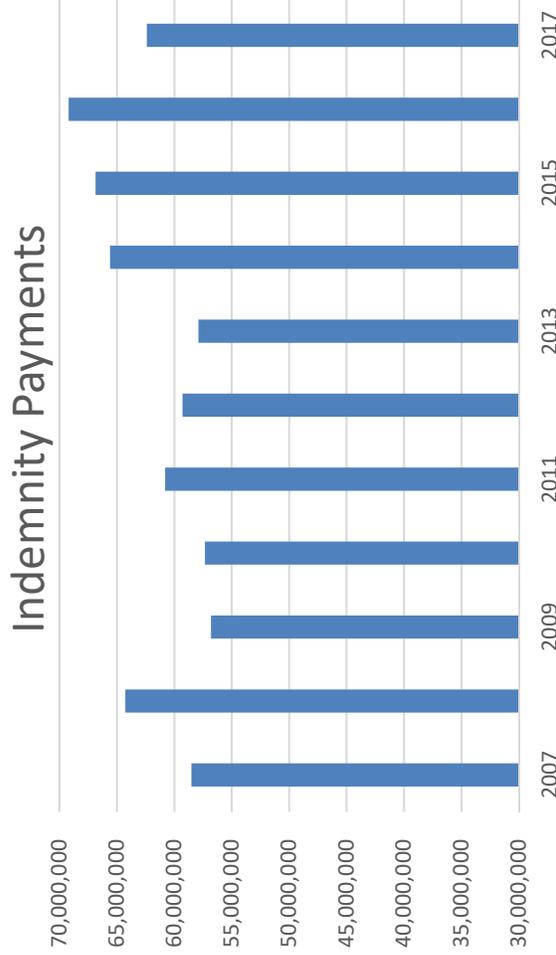
Loss Cost Distribution





2017 ANNUAL REPORT

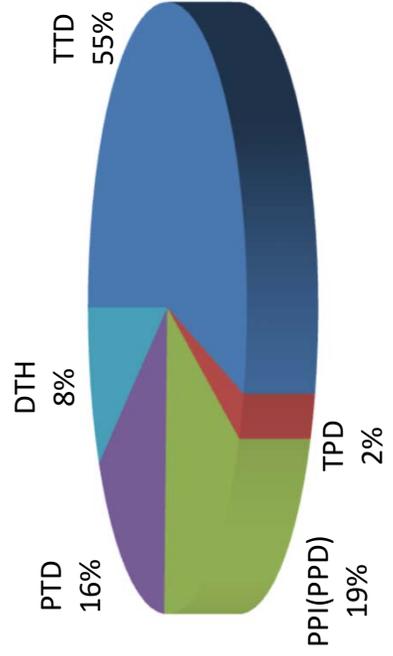
Indemnity Benefits



For calendar year 2017 indemnity benefits (TTD, TPD, PPI, PTB & Death Benefits) totaled \$62.4 million, a 9.84% decrease from \$69.2 million in 2016.

- TTD benefits totaled \$34.0 million in 2017, a 0.43% decrease from \$34.2 million in 2016.
- TPD benefits totaled \$1.5 million in 2017, a 36.33% increase from \$1.1 million in 2016.
- PPI benefits totaled \$11.6 million in 2017, an 8.9% decrease from \$12.7 million in 2016.
- PTB benefits totaled \$9.9 million in 2017, a 24% decrease from \$13 million in 2016.
- Death benefits totaled \$5.3 million in 2017, a 34.4% decrease from \$8.0 million in 2016.

Indemnity Benefit Distribution

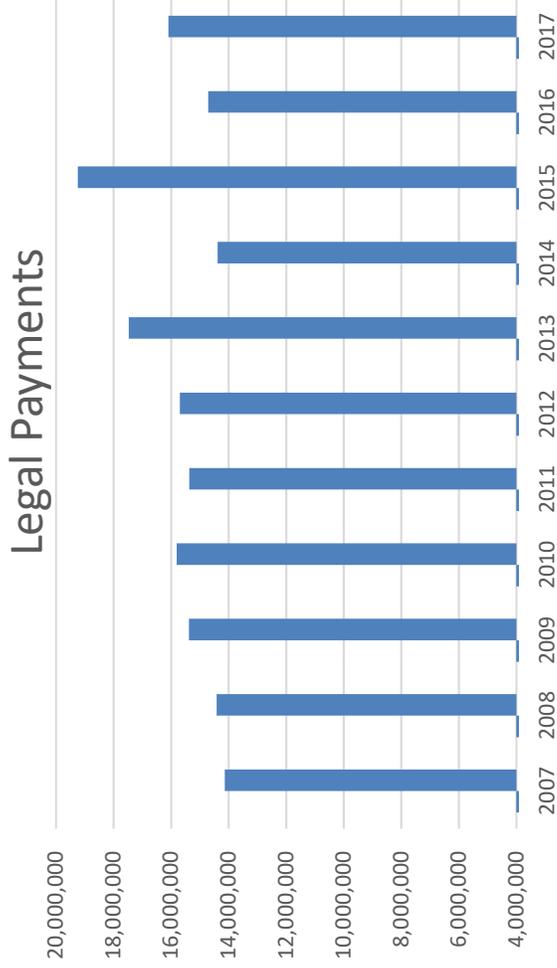




2017 ANNUAL REPORT

Legal Costs

- For calendar year 2017, legal expenses totaled \$16 million, a 9.4% increase from \$14.7 million in 2016.
- Employee attorney fees were \$6.1 million in 2017, a 13.4% increase from \$5.4 million in 2016.
- Employer attorney fees were \$9.5 million in 2017, a 9.14% increase from \$8.7 million in 2016.
- Litigation costs were \$486 thousand in 2017, a 21.5% decrease from \$619 thousand in 2016.



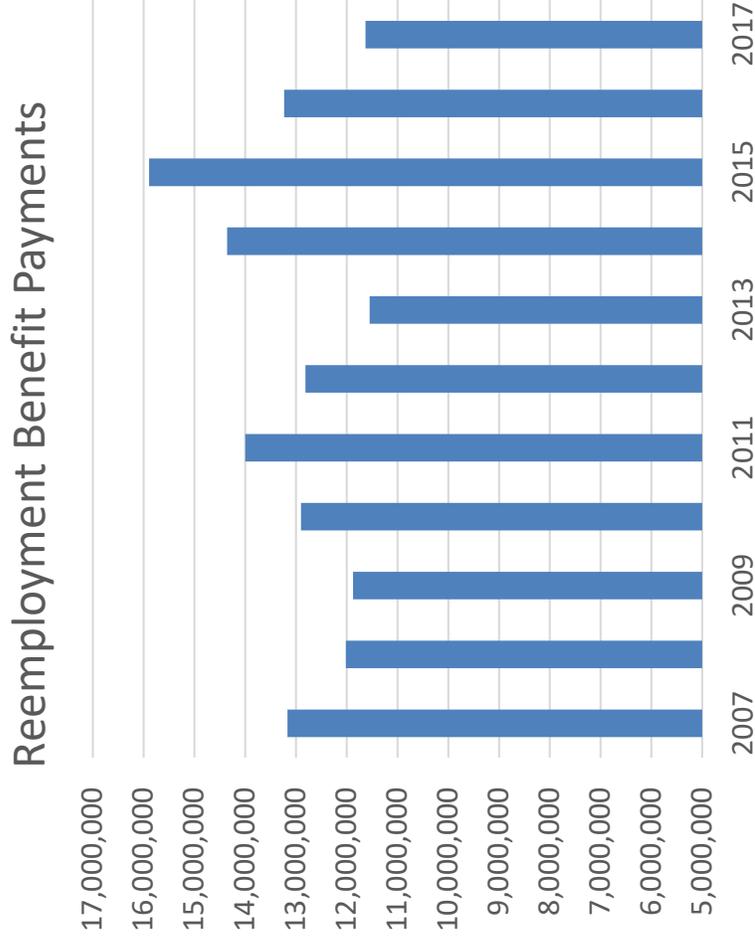


2017 ANNUAL REPORT

Reemployment Benefits

Total reemployment benefit payments totaled \$11.6 million in 2017, a 12.1% decrease from \$13.2 million in 2016.

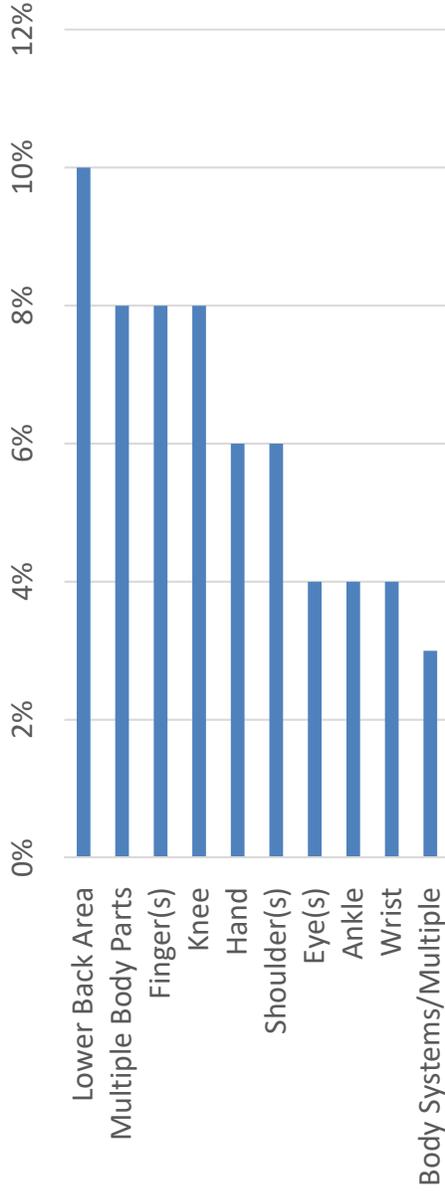
- Compensation paid for rehabilitation AS 23.30.041(k) benefits totaled \$4.4 million in 2017, a 1.4% decrease from \$4.48 million in 2016.
- Employee evaluation costs totaled \$1.9 million in 2017, a 16.1% decrease from \$2.3 million in 2016.
- Rehabilitation specialist fees/plan monitoring fees totaled \$637 thousand in 2017, a 33.3% decrease from \$945 thousand in 2016.
- Plan development costs totaled \$1.5 million in 2017, a 6.1% decrease from \$1.6 million in 2016.
- Rehabilitation AS 23.30.041(g) benefits totaled \$3.1 million in 2017, a 19.4% decrease from \$3.8 million in 2016.





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Top Ten Injuries by Body Part Injured



Body Part Injured	Cases	%
1. Lower Back	1756	10%
2. Multiple Body Parts	1474	8%
3. Finger(s)	1465	8%
4. Knee	1357	8%
5. Hand	1086	6%

	Body Part Injured	Cases	%
6.	Shoulder(s)	1052	6%
7.	Eye(s)	674	4%
8.	Ankle	634	4%
9.	Wrist	613	4%
10.	Body Systems / Multiple	561	3%



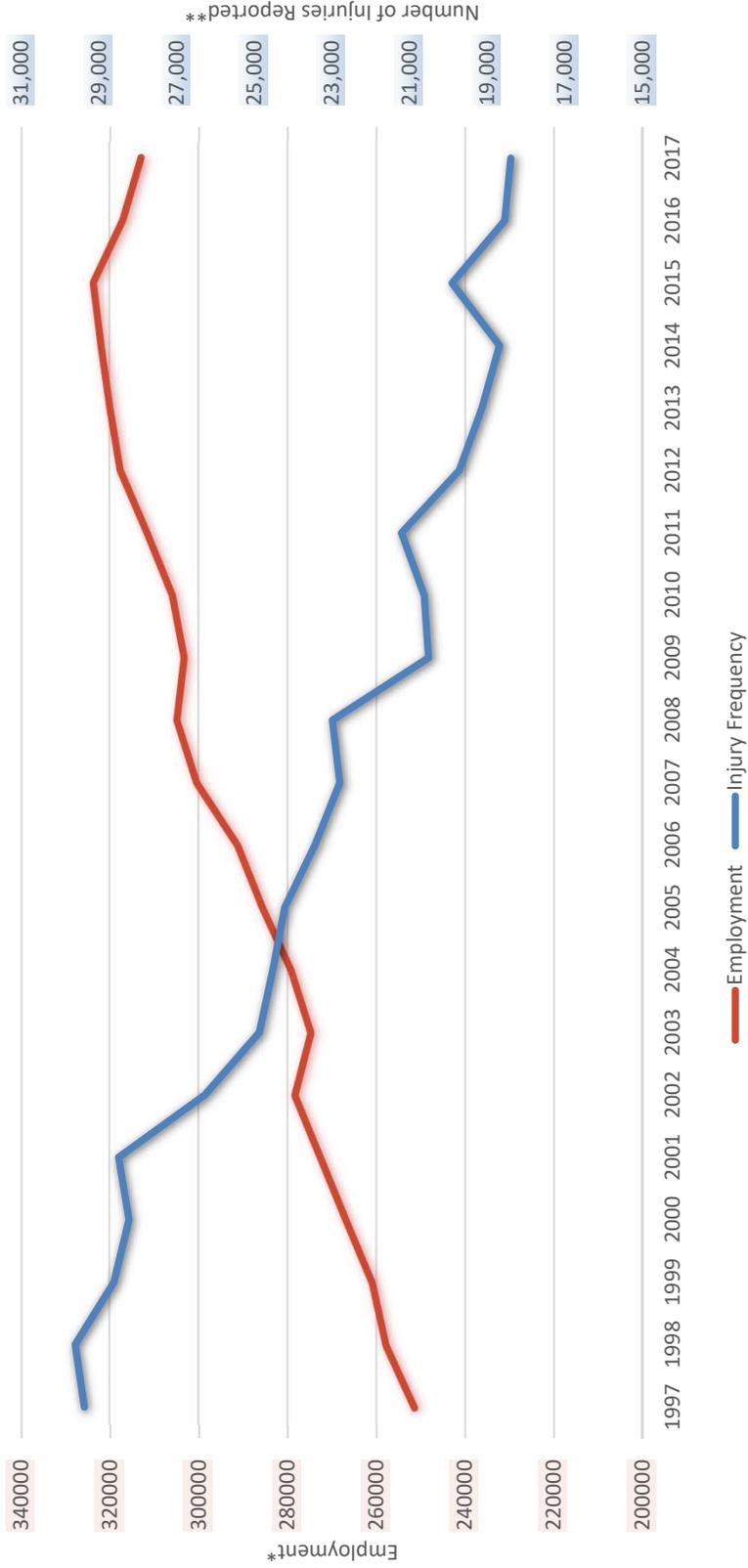
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Alaska Injury Frequency

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment, employment totaled 327,963 in 2017, a 1.27% decrease from 332,177 in 2016. Excluding 15,077 federal employees, the number of workers covered under the Alaska Workers' Compensation Act in 2017 was approximately 312,886, a 1.29% decrease from 316,979 in 2016.

Employment in Alaska ↑

Alaska Injury Frequency ↓



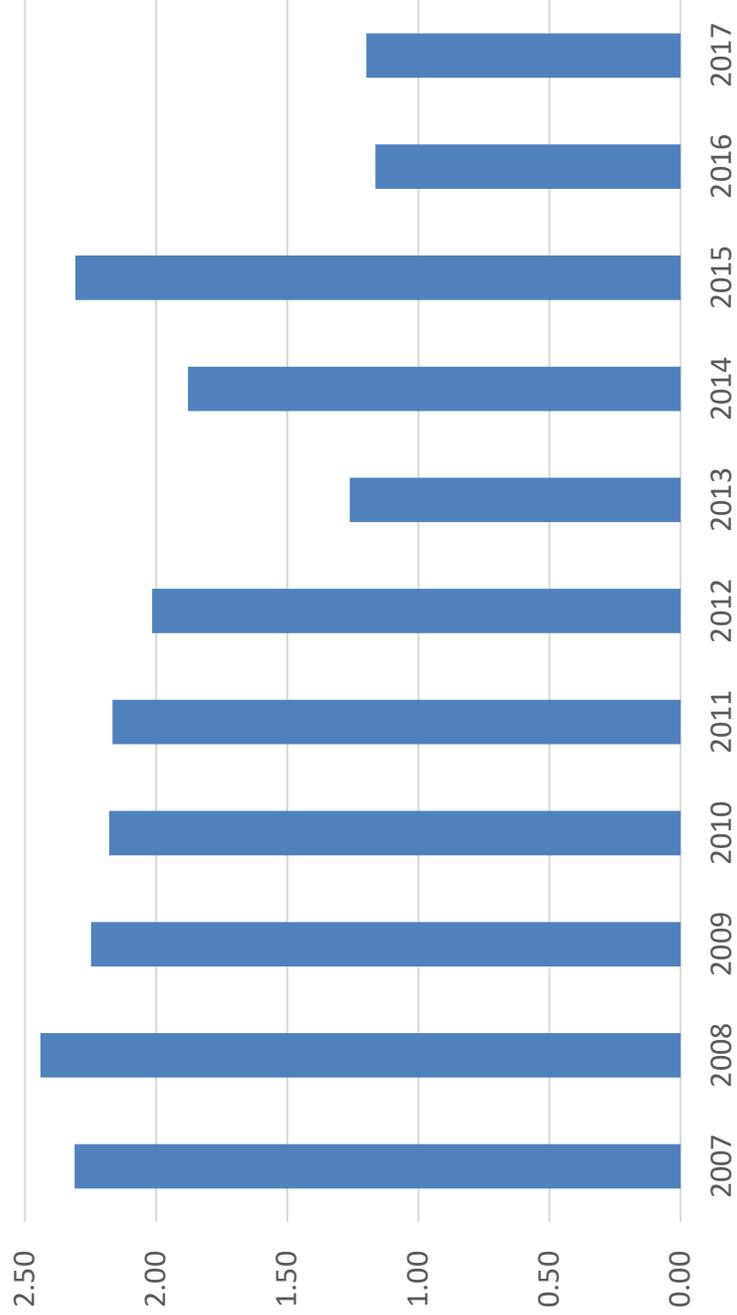


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Time Loss Rate

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

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 2017 was 1.20, a 3% increase from a time loss rate of 1.16 in 2016.

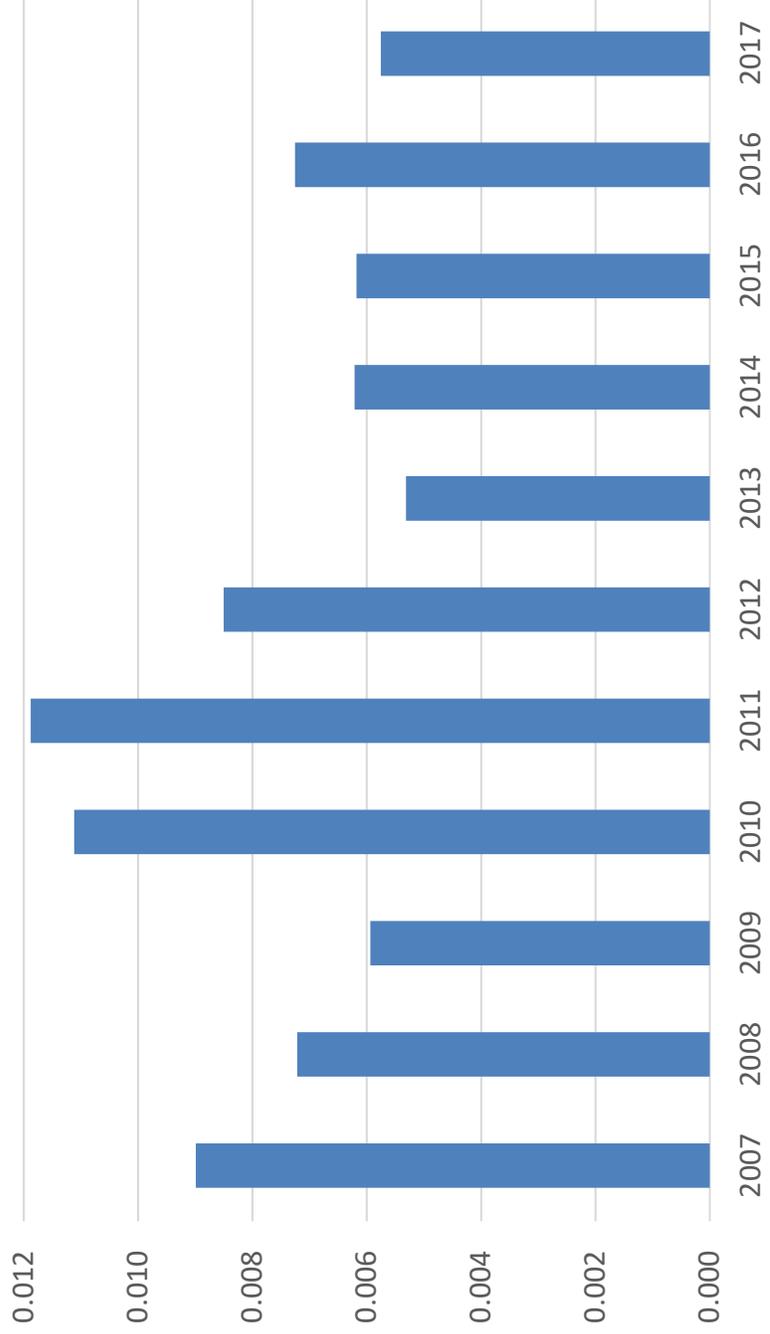




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Fatality Rate

There were 18 fatalities reported in 2017, a 21.74% decrease from 23 in 2016. Using the number of fatalities established by the Workers' Compensation Division, the fatality rate per 100 employees in 2017 was .006, compared to .007 in 2016.





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Direct Written Premium

Calendar Year	Direct Written Premium (000s)
2017	\$251,109*
2016	\$268,052
2015	\$281,738
2014	\$279,615

*Estimate based on The Division of Insurance Calendar Year 2017 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 2015, the 7,942 assigned risk policies made up 52.2% of all workers' compensation policies. The \$34.8 million in premium was approximately 13.9% of total workers' compensation premium. Of the 7,942 assigned risk policies, 5,099 had premiums of less than \$2,500.

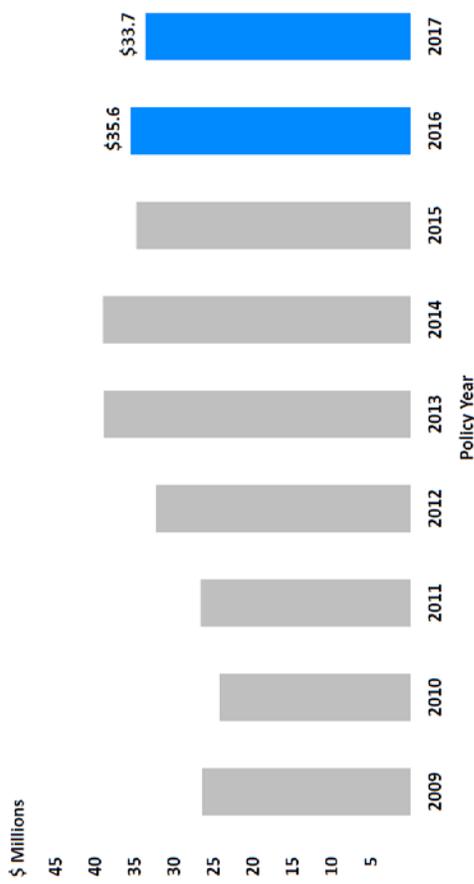


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Alaska Residual Market

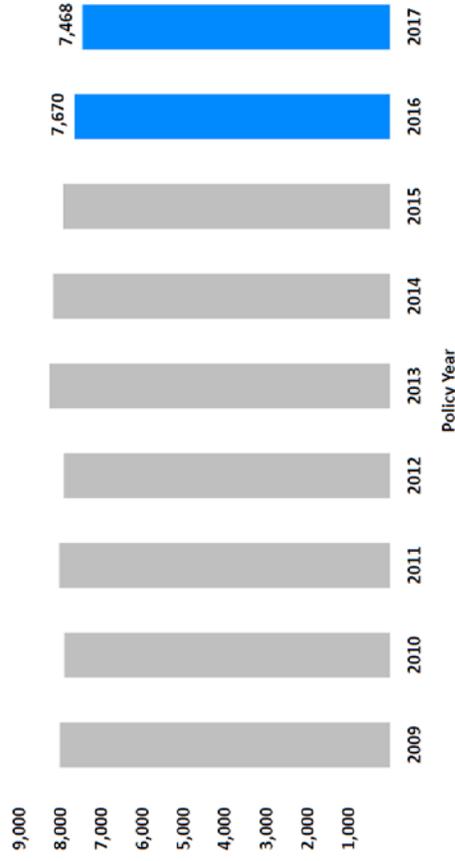
Department of Labor and Workforce Development
 DIVISION OF WORKERS' COMPENSATION
 Web: <http://labor.state.ak.us/wc>

Alaska Residual Market Plan Premium
 As of 12/31/2017



Premium data is on a policy year basis as reported to NCCI, for policies effective from January 1, 2017, to December 31, 2017, including prorated cancellations, with all policies' premium associated to the dominant state

Alaska Residual Market Plan Policy Counts
 As of 12/31/2017



Policy count data is on a policy year basis as reported to NCCI, for policies effective from January 1, 2017, to December 31, 2017, including prorated cancellations, with all policies' premium associated to the dominant state



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Active Self-Insured Employers

There were 25 active self-insured employers in 2017

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	General Communication, Inc.	12/31/2005
Alyeska Pipeline Service Co.	7/1/1983	Harnish Group Inc.	5/1/2005
Anchorage School District	6/1/2004	Kenai Peninsula Borough & School District	2/16/1992
Arctic Slope Regional Corp.	6/1/2005	Matanuska-Susitna Borough	8/15/2008
Bristol Bay Area Health Corporation	2/1/2005	Matanuska-Susitna School District	7/1/1994
CH2M Hill Energy, LTD (formerly Veco)	4/1/2005	Municipality of Anchorage	1/1/2004
Chevron Corporation	5/12/1999	Nabors Alaska Drilling, Inc.	1/1/1987
Chugach Electric Assn. Inc.	1/1/2014	Providence Health System - WA	4/1/1995
City & Borough of Juneau	4/1/2004	Safeway Stores, Inc.	11/2/1998
Costco Wholesale Corp.	9/3/1999	State of Alaska	11/24/2003
Fairbanks North Star Borough & School District	7/1/1977	University of Alaska	2/1/2004
Federal Express Corp.	10/10/1990		



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Workers' Compensation Premium Rate Ranking

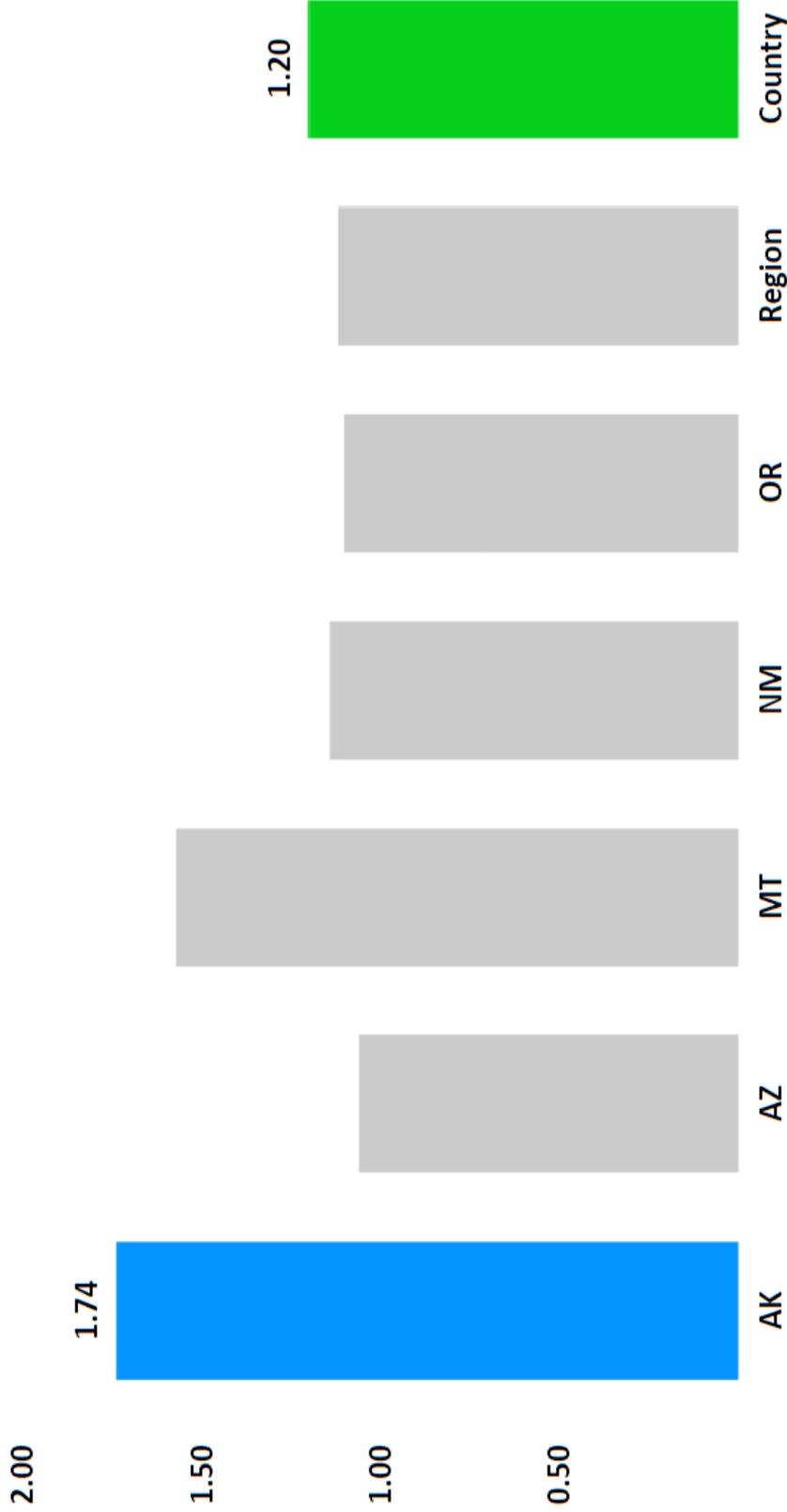
2018 Ranking	2016 Ranking	State	Index Rate	Percent of study median	Effective Date	Percent of 2016 study median
1	3	New York	3.08	181%	October 1, 2017	154%
2	1	California	2.87	169%	January 1, 2018	176%
3	2	New Jersey	2.84	167%	January 1, 2018	158%
4	5	Alaska	2.51	148%	January 1, 2018	149%
5	6	Delaware	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	100%
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



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Average Voluntary Pure Loss Costs Using Alaska Payroll Distribution



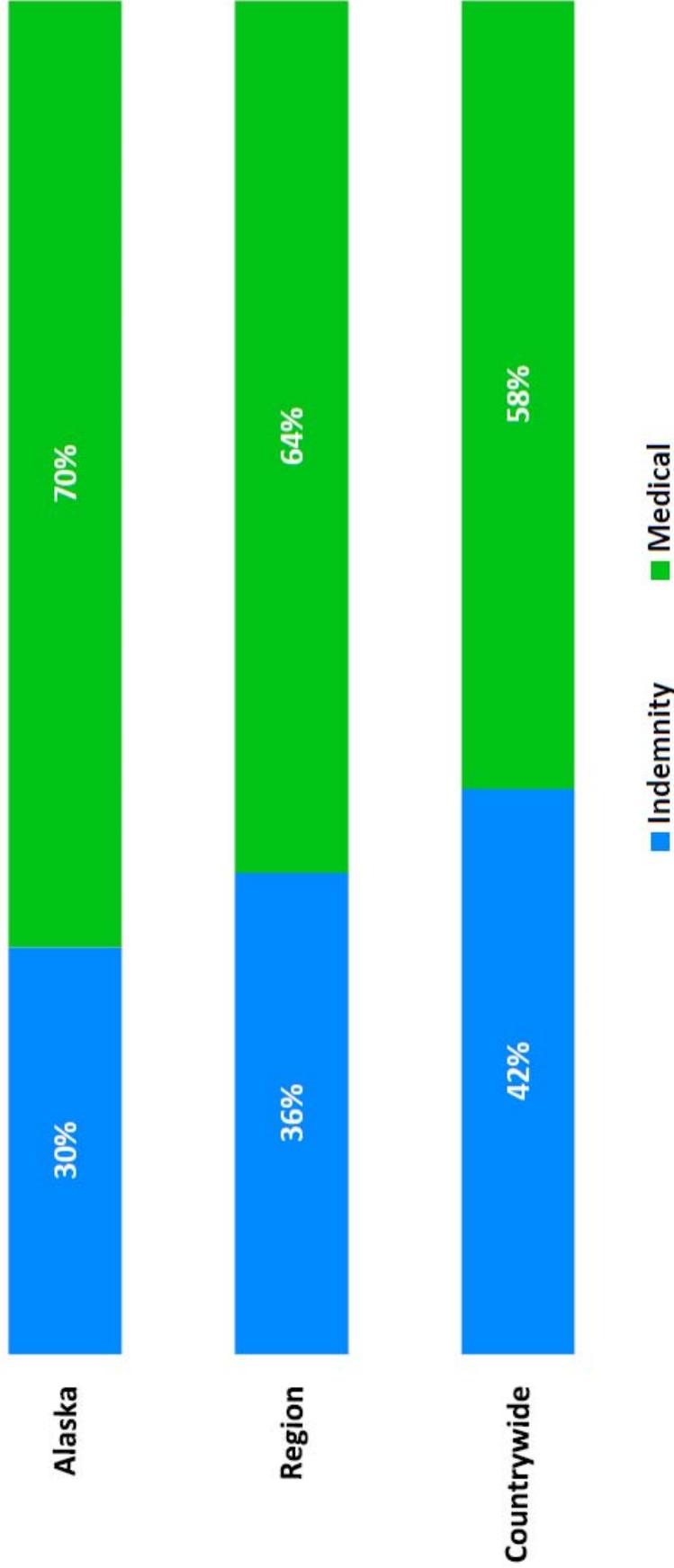
Based on approved rates and loss costs in various jurisdictions from filings using data valued as of 12/31/2016



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Total Benefit Costs in Alaska

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



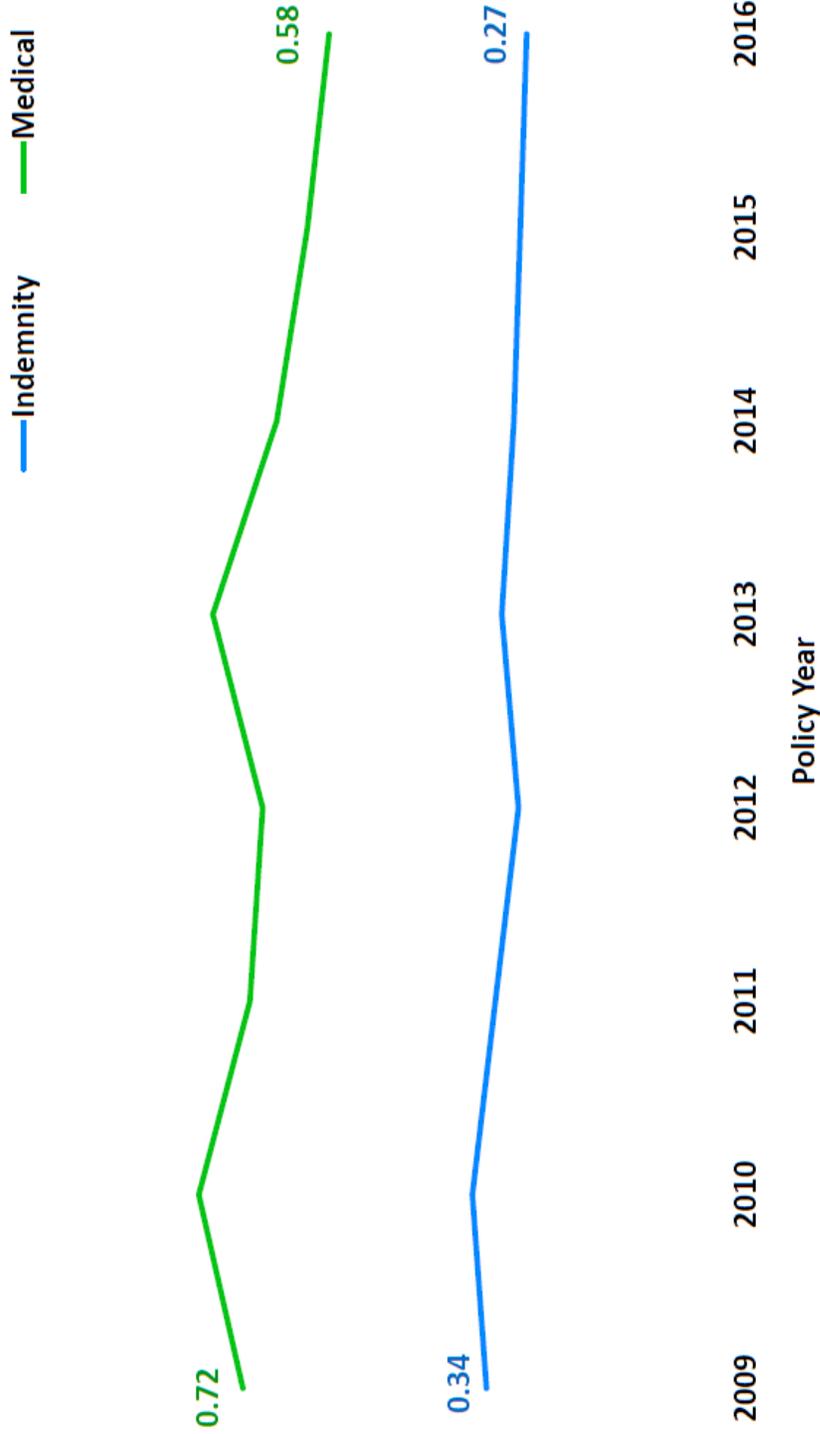
Regional states are AZ, MT, NM, and OR
Based on NCCI's financial data through 12/31/2017

Source: 2018 Alaska State Advisory Forum, National Council on Compensation Insurance



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Alaska Indemnity and Medical Loss Ratios



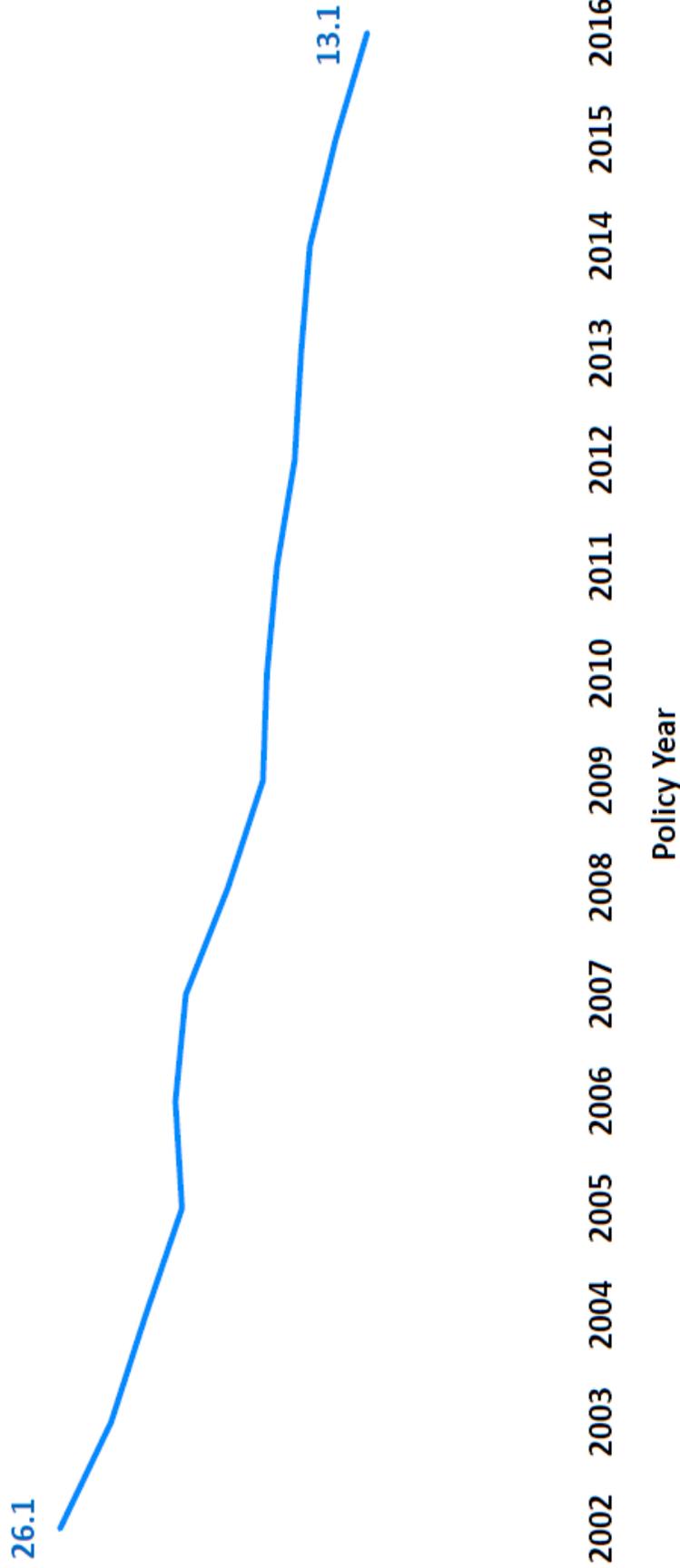
Based on NCCI's financial data through 12/31/2017 at current benefit level and developed to ultimate

Source: 2018 Alaska State Advisory Forum, National Council on Compensation Insurance



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Alaska Claim Frequency Per Million of On-Levelled Premium



Based on NCCI's financial data through 12/31/2017, adjusted to a common wage level

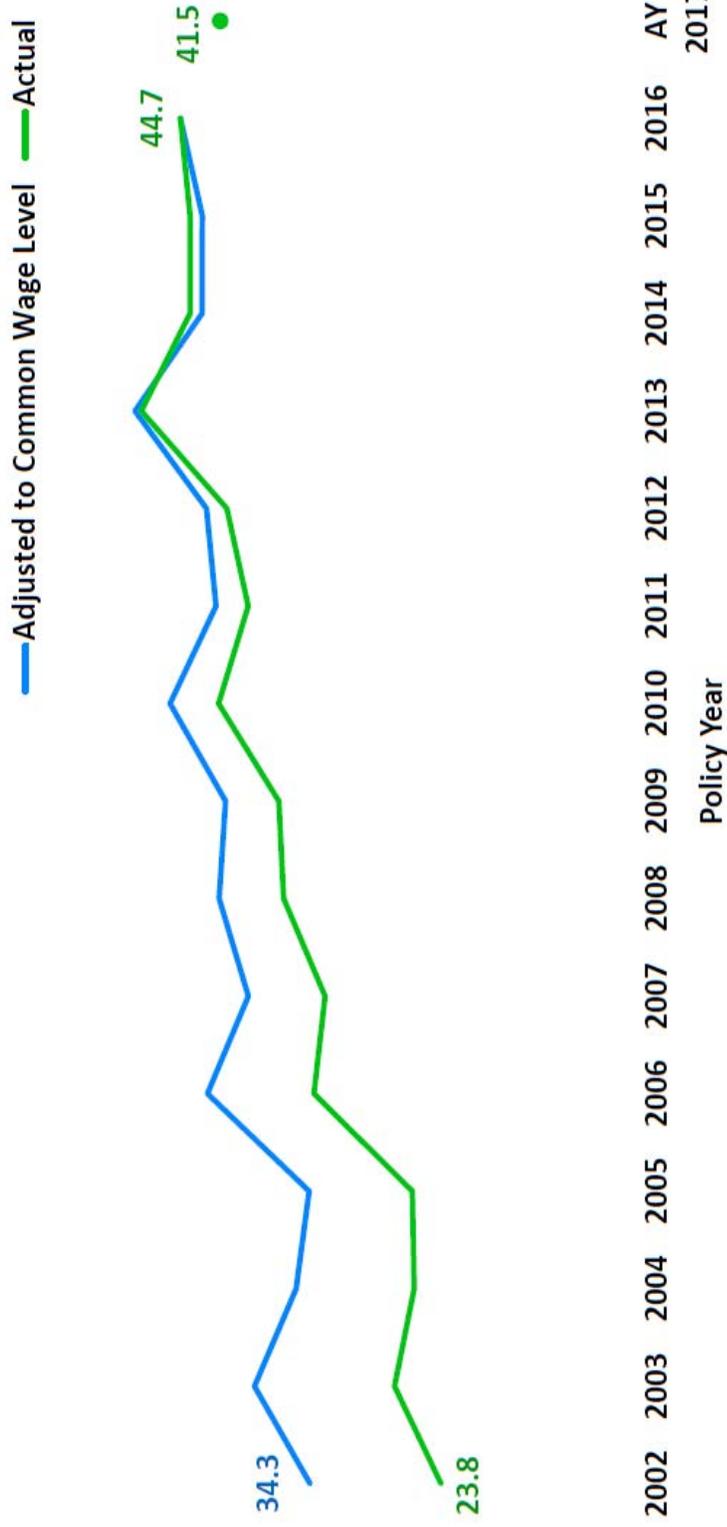
Source: 2018 Alaska State Advisory Forum, National Council on Compensation Insurance



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Alaska Average Medical Claim Severity

Average Medical Claim Severity in \$ Thousands

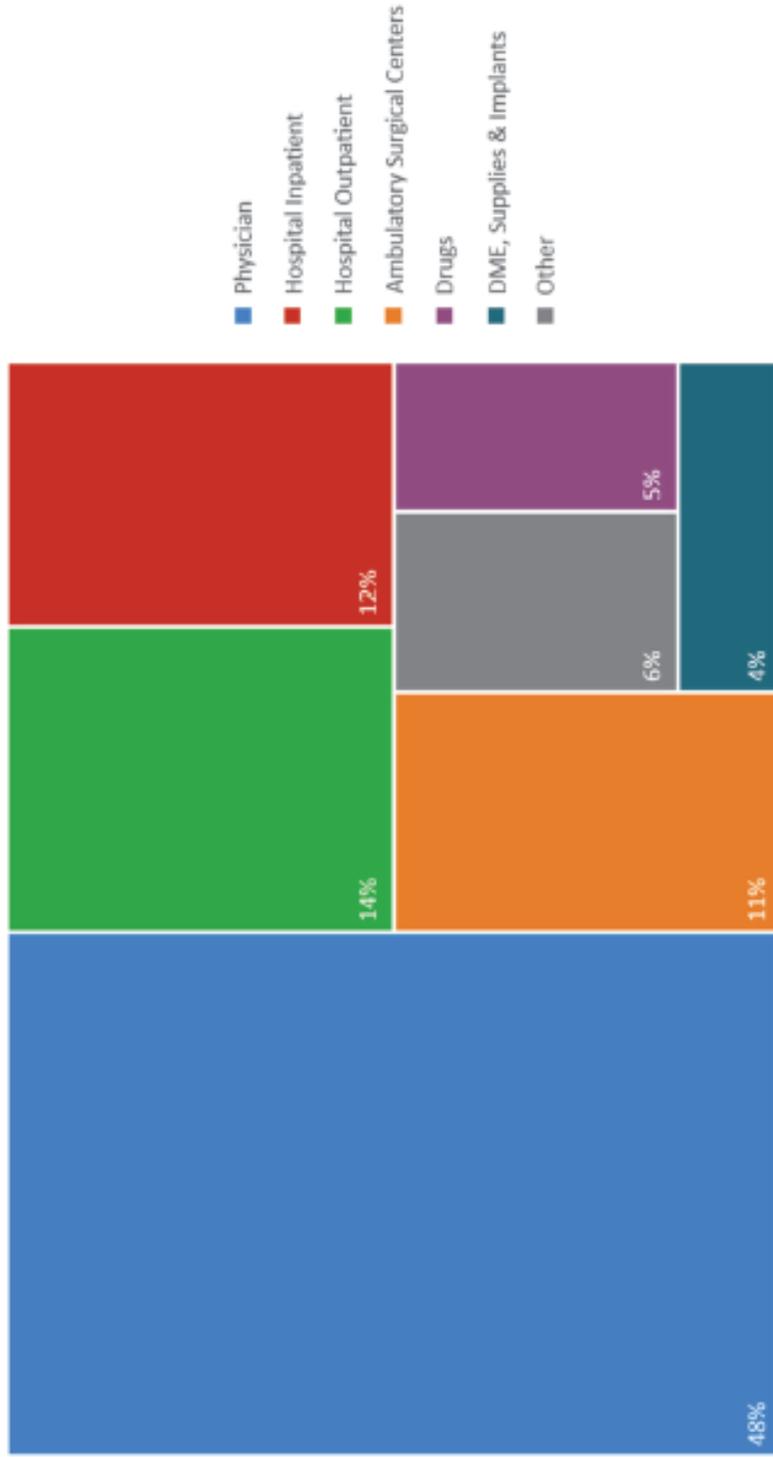


Based on NCCI's financial data through 12/31/2017 for lost-time claims at current benefit level and developed to ultimate



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Distribution of Medical Payments for Alaska



Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



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Payments as a Percentage of Medicare

Physician Service Category	Alaska	Region	Countrywide
Surgery	410%	207%	275%
Radiology	506%	215%	236%
General and Physical Medicine	164%	129%	131%
Evaluation and Management	184%	145%	141%
All Physician Services	239%	153%	167%

Medical Cost Category	Alaska	Region	Countrywide
Hospital Inpatient	187%	171%	191%
Hospital Outpatient	255%	206%	256%
Ambulatory Surgical Center	414%	212%	285%

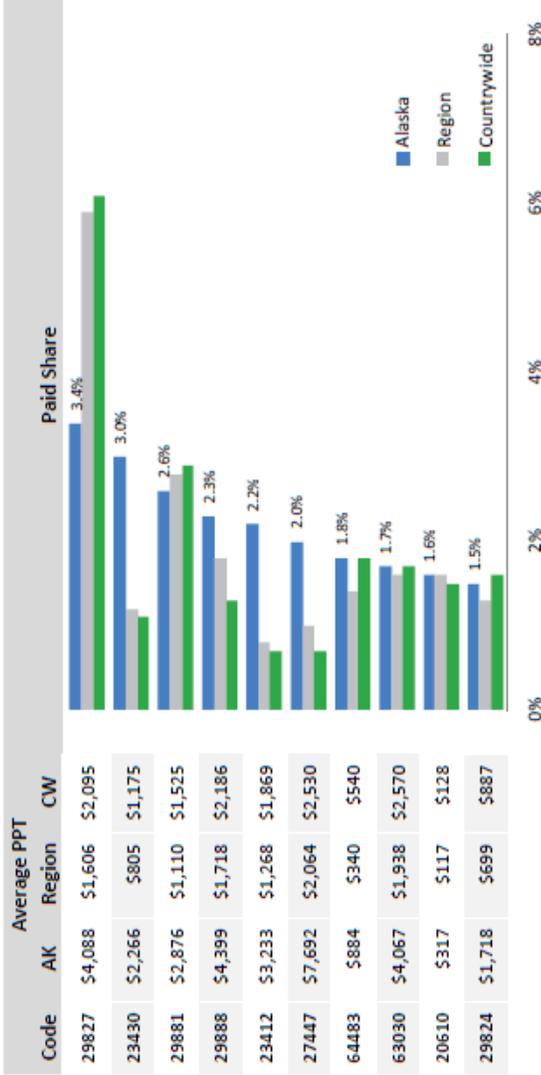
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



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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
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
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)

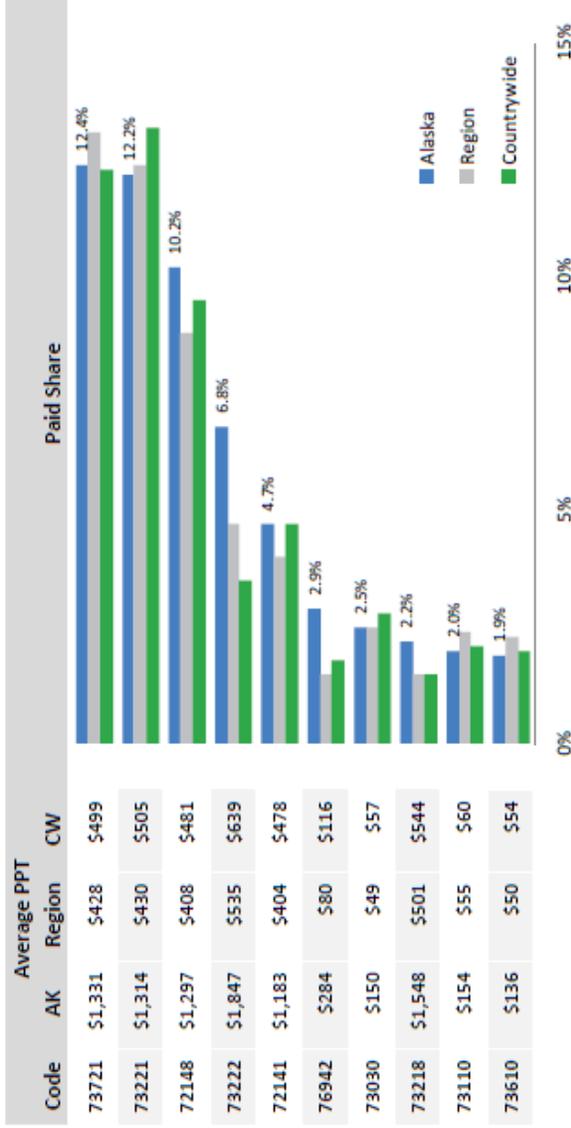
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



2017 ANNUAL 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
73218	Magnetic resonance (e.g., proton) imaging, upper extremity other than joint; without contrast material
73110	Radiologic examination, wrist; complete minimum of 3 views
73610	Radiologic examination, ankle; complete minimum of 3 views

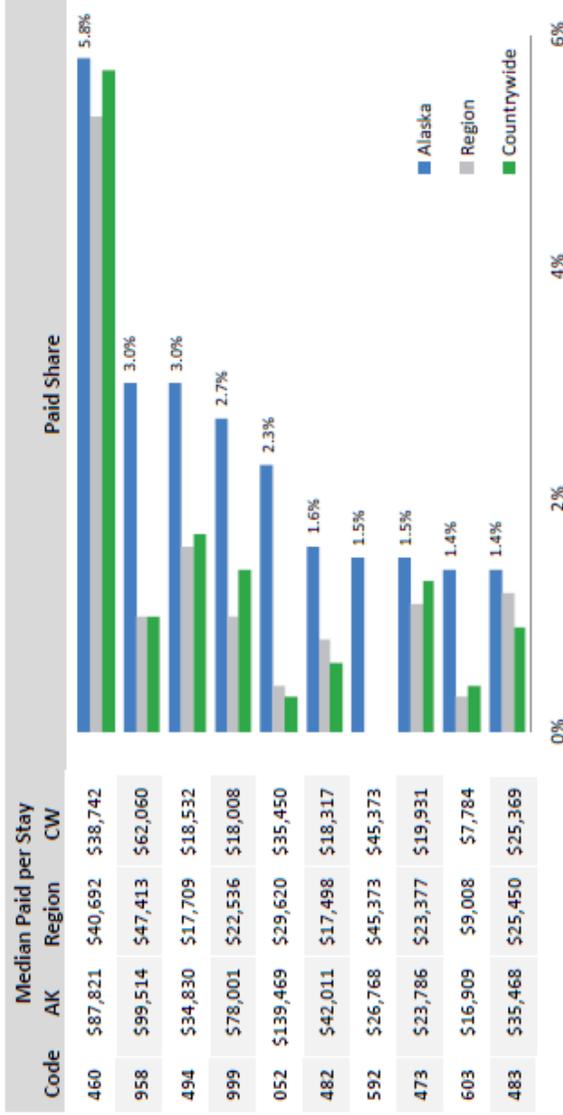
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



2017 ANNUAL REPORT

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services



Code	Description
460	Spinal fusion, except cervical, without major complications or comorbidities
958	Other operation room procedures for multiple significant trauma with complications or comorbidities
494	Lower extremity and humerus procedures except hip, foot, and femur without complications or comorbidities/major complications or comorbidities
999	Ungroupable
052	Spinal disorders and injuries with complications or comorbidities/major complications or comorbidities
482	Hip and femur procedures except major joint without complications or comorbidities/major complications or comorbidities
592	Skin ulcers with major complications or comorbidities
473	Cervical spinal fusion without complications or comorbidities/major complications or comorbidities
603	Cellulitis without major complications or comorbidities
483	Major joint/limb reattachment procedure of upper extremities

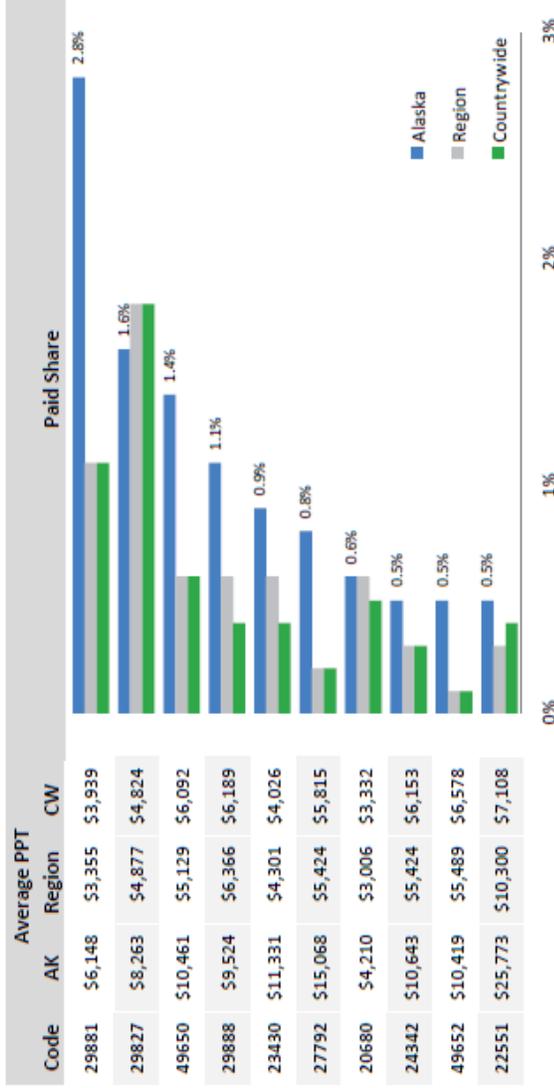
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



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Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services



Code	Description
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
49650	Laparoscopy, surgical; repair initial inguinal hernia
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23430	Tenodesis of long tendon of biceps
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
49652	Laparoscopy; surgical, to repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2

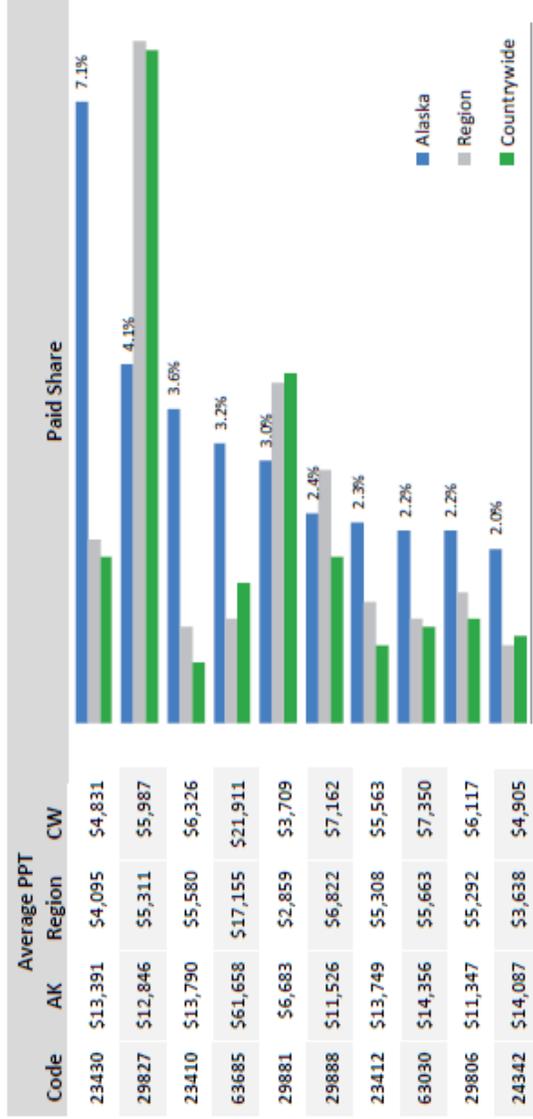
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



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Top 10 Surgery Procedure Codes by Amount Paid for Ambulatory Surgical Center (ASC) Services



Code	Description
23430	Tenodesis of long tendon of biceps
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft

Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



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Average Amount Paid Per Visit/Stay

Hospital Inpatient Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Stay	\$41,797	\$49,795	\$38,673	\$40,756	\$46,057
Number of Stays per 1,000 Active Claims	24	22	20	20	18

Hospital Outpatient Surgery Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Visit	\$5,723	\$5,260	\$5,154	\$4,826	\$5,242
Number of Visits per 1,000 Active Claims	92	82	78	84	79

ASC Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Visit	\$5,984	\$7,723	\$8,289	\$6,344	\$7,074
Number of Visits per 1,000 Active Claims	106	103	133	126	105

Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

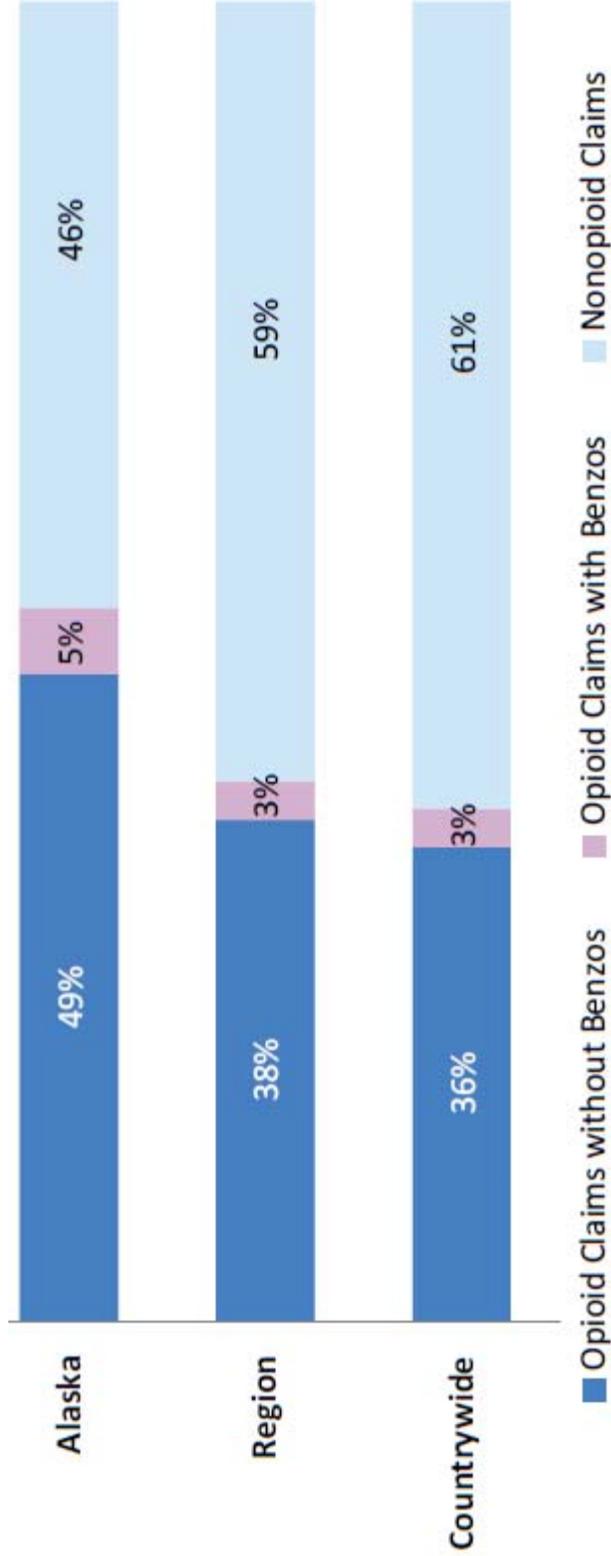
Source: 2018 Alaska Medical Data Report, National Council on Compensation Insurance



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Opioid Rx Claim Statistics

- **Rx claim**—A WC claim that had at least one prescription during the period
- **Opioid claim**—A WC claim that had at least one opioid prescription during the period
- **Nonopioid claim**—A WC claim that had at least one prescription but no opioids during the period
- **Opioid claim with benzos**—A WC claim that had at least one opioid prescription and at least one benzo prescription during the period
- **Opioid claim without benzos**—A WC claim that had at least one opioid prescription and no benzo prescriptions during the period



Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report Opioid Utilization Supplement, National Council on Compensation Insurance



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Oxycodone Pill Equivalents (OPE)

The CDC¹³ provides a way to convert daily—or hourly—doses of opioids to an equivalent daily dose of morphine by assigning a conversion factor to each type of drug, thus deriving the Morphine Milligram Equivalents (MME) for any opioid prescription, based on the number of units (pills for example) prescribed and the drug formulation. One milligram per day of oxycodone, for instance, is assigned an MME factor of 1.5; one milligram per day of codeine, on the other hand, is assigned an MME factor of 0.15.

NCCI converts milligrams of morphine to a number of oxycodone pills and calls it the Oxycodone Pill Equivalent (OPE). A 20mg oxycodone pill, which contains 30 MMEs, is exactly 1 OPE. Oxycodone is used as the standard of reference since it is the most prevalent opioid used in workers compensation. The chart below provides sample MME and OPE conversions for some commonly used opioids.



Morphine Milligram Equivalents (MME)

Vicodin® (10mg)	Oxycodone (20mg)	Butrans® (20mcg/hr)
10 MMEs	30 MMEs	36 MMEs/Day



Oxycodone Pill Equivalents (OPE)

Vicodin® (10mg)	Oxycodone (20mg)	Butrans® (20mcg/hr)
0.3 OPEs	1 OPE	1.2 OPEs/Day

¹³ www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

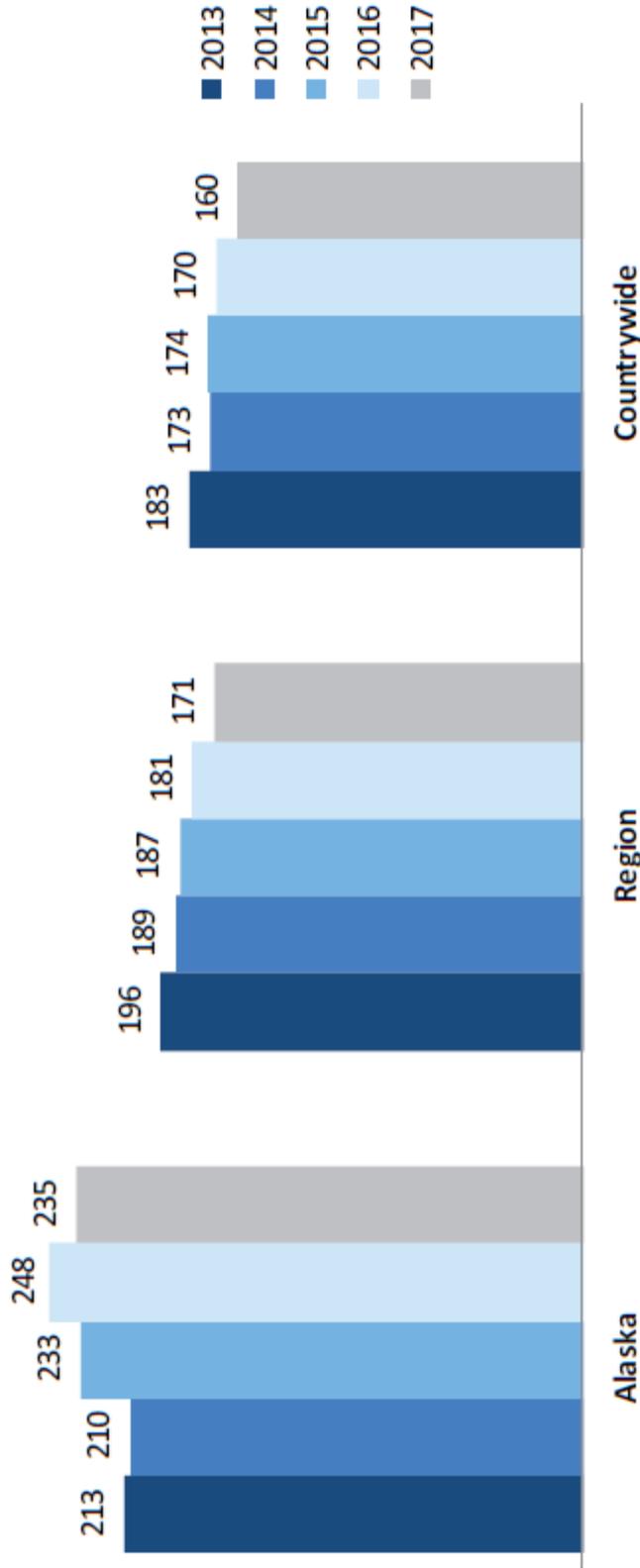
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report Opioid Utilization Supplement, National Council on Compensation Insurance



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Average Yearly OPE per Opioid Claim by Service Year



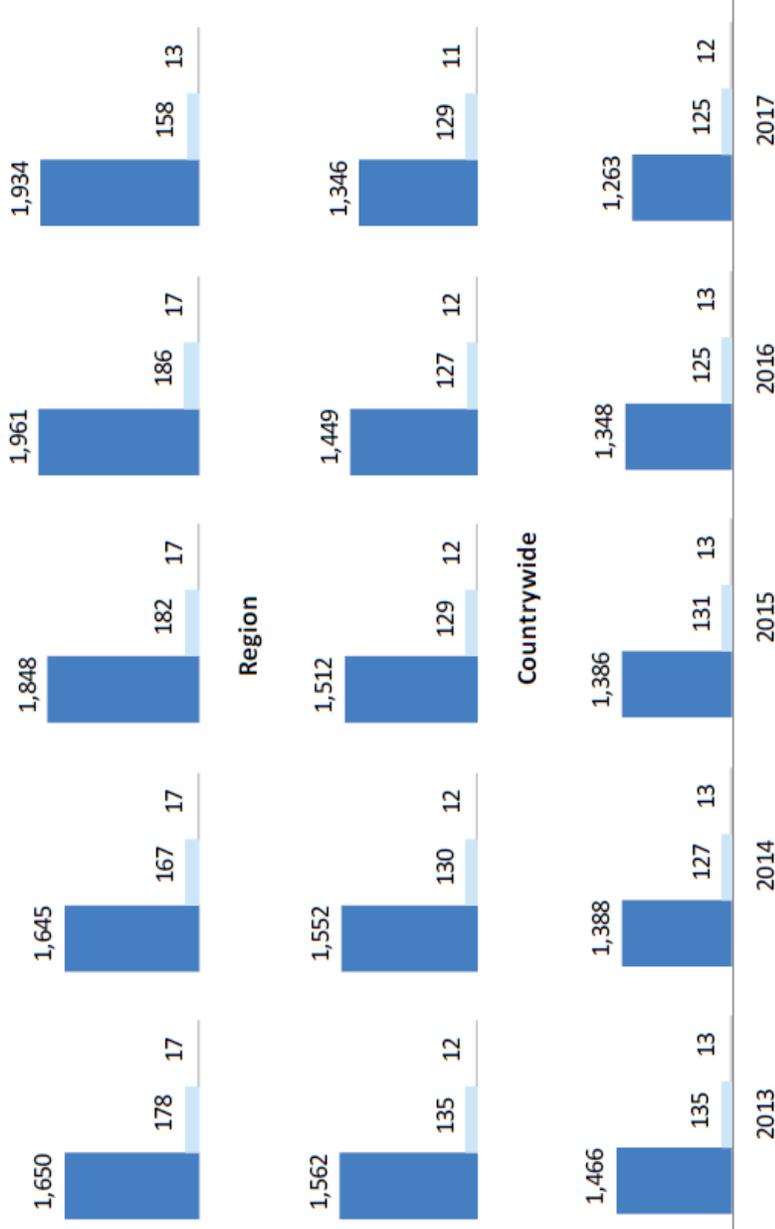
Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report Opioid Utilization Supplement, National Council on Compensation Insurance



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Average Yearly OPE per Opioid Claim by Service Year and Classification



- **Heavy Users** - top 10% of claims by OPE consumption
- **Moderate Users** - next 20% of claims by OPE consumption
- **Mild Users** - bottom 70% of claims by OPE consumption

Based on NCCI data for medical transactions for Service Year 2017; excludes lump-sum settlements and self-insured data.

Source: 2018 Alaska Medical Data Report Opioid Utilization Supplement, National Council on Compensation Insurance