

State of Alaska Bill Walker Governor	Alaska Workers' Compensation Division PO Box 115512 Juneau, Alaska 99811-5512		
Department of Labor and Workforce Development	BULLETIN	Number 16-01 (Revised)	Date May 11, 2016
Heidi Drygas Commissioner	SUBJECT REFERENCE	Director's Interpretation of Issues Impacting the Alaska Workers' Compensation Medical Fee Schedule. AS 23.30.097 and 8 AAC 45.083	

The Department of Labor and Workforce Development and the Alaska Workers' Compensation Board adopted regulation changes by emergency regulation with an effective date of December 1, 2015, dealing with fees for medical treatment and services. Changes made to the emergency regulations when made permanent took effect March 11, 2016. Amended versions of material adopted by reference in 8 AAC 45.083(m) went into effect January 1, 2016.

The Division is publishing this interpretive bulletin in an effort to provide guidance on practical applications and interpretations of the Alaska Workers' Compensation Act and the newly effective regulations. This bulletin is not binding on the Department or the Board, and is not comprehensive, but is offered as a navigational tool. In the event of any discrepancy or conflict between 8 AAC 45.083 and the description of the regulation in this bulletin, 8 AAC 45.083 controls.

If you have questions regarding the information contained in this bulletin or would like to see additional issues addressed in future bulletins, please direct your inquiries to Marie Marx, Department of Labor and Workforce Development, Division of Workers' Compensation, at 1111 W 8th St., Suite 305, Juneau, Alaska 99811, (907) 465-2790, or email at marie.marx@alaska.gov.

Medical Services Provided by a Physician

For medical services provided by a physician, other than anesthesiology, the Alaska maximum allowable reimbursement (MAR) payment is calculated using the *Resource-Based Relative Value Scale*, produced by the Centers for Medicare and Medicaid Services (CMS). RVU is Relative Value Unit; GPCI is Geographic Practice Cost Index.

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

Then multiply the Total RVU by the applicable conversion factor set out in 8 AAC 45.083(b) to obtain the Alaska MAR payment. The Alaska MAR for anesthesiology is calculated as explained in 8 AAC 45.083(c).

The conversion factors found in 8 AAC 45.083(b) are listed here with their applicable *Current Procedural Terminology* (CPT®) code ranges for your convenience. (CPT is registered trademark of the American Medical Association.)

Medical service	CPT Code Range	CONVERSION FACTOR
Surgery	(10021-69990)	\$205
Radiology	(70010-79999)	\$257
Pathology and Lab	(80047-89398)	\$142
Medicine Excluding Anesthesiology	(90281-99099 and 99141-99199 and 99500-99607)	\$80
Evaluation & Management	(99201-99499)	\$80
Anesthesiology	(00100-01999 and 99100-99140)	\$121.82

8 AAC 45.083(b) applies to medical services provided by a 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.

8 AAC 45.083(b) also applies to certain medical services provided by physician assistants, advanced practice registered nurses, nurse practitioners, and certified registered nurse anesthetists, as set forth in 8 AAC 45.083(j)(4)-(6).

Under 8 AAC 45.083(j), for medical treatment or services provided by a physician, providers and payers shall follow CMS and AMA billing and coding rules, including the use of modifiers. If there is a billing rule discrepancy between National Correct Coding Initiative edits and the *AMA Current Procedural Terminology Assistant*, *AMA Current Procedural Terminology Assistant* guidance governs.

Under CMS billing and coding rules and CPT coding rules, chiropractic manipulation treatment codes include a pre-manipulation patient assessment; additional E&M services may be reported separately using modifier -25, but only if the patient’s condition requires a significant separately identifiable E&M service.

8 AAC 45.083(g) applies where a CPT code has a relative value of zero. For example, CPT code 99456 returns a relative value of zero, so the Alaska MAR is the lowest of 85% percent of billed charges, the charge for treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer. However, when a CPT code is modified with 26 or TC (technical component) and the relative value is zero and reflects 0% of the global, the MAR is zero.

Medical Services Provided by an Inpatient Hospital

For medical services provided by an inpatient hospital not described in 8 AAC 45.083(e)(1) or 8 AAC 45.083(k)(5), the Alaska MAR payment is calculated as follows:

$$\text{Medicare Severity Diagnosis Related Groups (DRG) Relative Weight} \times \text{Facility Base Rate} = \text{MAR}$$

The facility base rate for most Alaska inpatient hospitals are listed in 8 AAC 45.083(e)(2)-(10). To calculate the facility base rate for all other inpatient hospitals, multiply the CMS base rate by 328.2%.

8 AAC 45.083(k)(5) governs when and how an inpatient hospital outlier is triggered and calculated. The CMS outlier threshold is used to determine when an outlier is triggered. Under subsection (k)(5), implant charges, if any, are subtracted from the total amount charged and reimbursed at 110% of invoice cost. The non-implant charges are entered into the CMS PC Pricer tool and the Medicare price returned by CMS is then multiplied by 250%. The final reimbursement for outlier cases is therefore the sum of the implant reimbursement and the non-implant charges (run through the PC Pricer and multiplied by 250%).

Medical Services Provided by a Critical Access Hospital, Rehabilitation Hospital or Long Term Acute Care Hospital

Medical services provided by a critical access hospital, rehabilitation hospital or long term acute care hospital are governed by 8 AAC 45.083(e)(1), which provides the maximum allowable reimbursement is the lower of 100% of billed charges, the charge for the treatment or service when provided to the general public, or the charge negotiated by the provider and the employer.

Medical Services Provided by a Hospital Outpatient Clinic or Ambulatory Surgical Center

For medical services provided by a hospital outpatient clinic or an Ambulatory Surgical Center (ASC), the Alaska MAR payment is calculated as follows:

Ambulatory Payment Classifications Relative Weight for each CPT code x 221.79 = MAR

Outpatient Prospective Payment System (OPPS) Addendum B is used to establish the Relative Weight for both hospital outpatient clinic and ASC reimbursement.

Medical Services Provided by a Provider Other than a Physician

Unless the Alaska Workers' Compensation Act and regulations specify otherwise, and pursuant to 8 AAC 45.083(l), the Alaska MAR for medical services provided by a provider other than a physician, hospital, or ASC is the lowest of 85% billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge negotiated by the provider and employer.

Supplies, Materials, Injections, and Other Services and Procedures Coded under the Healthcare Common Procedure Coding System

For supplies, materials, injections, and other services and procedures coded under the *Healthcare Common Procedure Coding System*, produced by the American Medical Association, the Alaska MAR payment is calculated under 8 AAC 45.083(d) as follows:

CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee specific to Alaska (DMEPOS) x 1.84 = MAR

CMS Clinical Diagnostic Laboratory services fee specific to Alaska (CLAB) x 6.33 = MAR

CMS Payment Allowance Limits for Medicare Part B Drugs, Average Sale Price fee (ASP) x 3.375 = MAR

Other MAR Payments

Under 8 AAC 45.083(k)(1), for medical services for which there is no Ambulatory Payment Classifications weight listed, the MAR is the lowest of 85% percent of billed charges, the charge for treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

Versions of Reference Material

The division will publish a notice when amended versions of the material adopted by reference in 8 AAC 45.083(m) take effect. The ASP, CLAB, and DMEPOS fee schedules that apply are the schedules “in effect at the time of treatment or service” under 8 AAC 45.083(d).

Note: This revised bulletin replaces the bulletin previously published on April 8, 2016. The changes clarify a critical access hospital, rehabilitation hospital or long term acute care hospital are governed by 8 AAC 45.083(e)(1). It also addresses reimbursement of certain chiropractic treatment codes. It clarifies if a CPT code has a relative value of zero, 8 AAC 45.083(g) applies in certain cases, and also clarifies if there is a billing rule discrepancy between National Correct Coding Initiative edits and the AMA Current Procedural Terminology Assistant, AMA Current Procedural Terminology Assistant guidance governs.