

# **ALASKA WORKERS' COMPENSATION MEDICAL SERVICES REVIEW COMMITTEE MEETING**



**June 21, 2019**

# TABLE OF CONTENTS

<b><u>TAB 1</u></b> Page 2	<b>Agenda</b>
<b><u>TAB 2</u></b> Page 3	<b>Approved Meeting Minutes July 27, 2018</b>
<b><u>TAB 3</u></b> Page 5	<b>Alaska Medical Fee Schedule Action Items</b>
<b><u>TAB 4</u></b> Page 6	<b>MSRC Member Roster June 2019</b>
<b><u>TAB 5</u></b> Page 7	<b>Reed Group Presentation – Evidence Based Treatment Guidelines</b>
<b><u>TAB 6</u></b> Page 35	<b>2019 Adopted Medical Fee Schedule</b>
<b><u>TAB 7</u></b> Page 89 Page 94 Page 100 Page 106	<b>NCCI Analysis of Fee Schedule Impact on WC Market 2016-2019</b> 2019 2018 2017 2016
<b><u>TAB 8</u></b> Page 115	<b>Hearing Aid/Services Data</b>

**TAB 1**

**ALASKA WORKERS' COMPENSATION**  
**MEDICAL SERVICES REVIEW COMMITTEE MEETING**

**June 21, 2019**

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

**AGENDA**

**June 21, 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 August 10, 2014 meeting
- 10:15 am** Public Comment Period
- 11:15 am** Break
- 11:30 am** Overview of MSRC Fee Schedule Issues
- 11:45 am** Presentation – Medical Treatment Guidelines and Utilization Standards
- 1:00 pm** Lunch Break
- 2:00 pm** Fee Schedule Guidelines Development
- Items for consideration
    - Conversion factor determinations/consolidation options
    - Physical Therapist and other non-physician providers reimbursement/utilization/frequency determination
    - Hearing aid dispensing, fitting, and other fees
    - Non-FDA approved procedures standards for payment
    - Chiropractic Injections
    - Narrative cosmetic issues
  - Goals
- 3:00 pm** Break
- 3:15 pm** Fee Schedule Guidelines Development (cont.)
- 5:00 pm** Adjournment

# TAB 2

***Workers' Compensation  
Medical Services Review Committee  
Meeting Minutes  
July 27, 2018***

**I. Call to order**

Director Marx, acting as Chair of the Medical Services Review Committee, called the Committee to order at 10:02 am on Friday, July 27, 2018, in Anchorage, Alaska.

**II. Roll call**

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

Vince Beltrami  
Tammi Lindsey

Dr. Mary Ann Foland  
Misty Steed

Jennifer House  
Dr. Christopher Twiford

Members Pamla Scott and Dr. Robert Hall were excused.

**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**

The July 13, 2018 minutes were unanimously adopted by the committee.

**V. Fee Schedule Guidelines Development Discussion**

The committee reviewed the Draft MSRC July 27, 2018 Report. One grammatical error was noted and will be corrected. A motion to approve the draft report as corrected was made by member Beltrami and seconded by member Foland. A vote was held and the motion passed unanimously.

**VI. Public Comment**

Christopher Frost - United Physical Therapy

- Requested that the committee revisit Physical Therapy billing codes.
- Reiterated that physical therapy codes are primarily used by physical therapists.
- Stated that Alaska does not conform to CMS Guidelines for these codes.

**VII. Fee Schedule Guidelines Development Discussion**

The committee reviewed additional changes that had been made to the Alaska Workers' Compensation Medical Fee Schedule since the previous meeting.

The committee revisited the issue of hearing aid hardware payment rules. A note will be added to clarify that hearing aid hardware should be billed at 130% of the manufacturer or suppliers invoice, rather than the provider invoice.

A Motion to approve the Alaska Workers' Compensation Medical Fee Schedule with the one change noted above was made by member Beltrami, and seconded by member Foland. A vote was held and the motion passed unanimously.

The committee discussed the schedule and agenda items for 2019. The MSRC has tentatively scheduled the following meetings in 2019: June 14, July 12, August 2, and August 16.

The next meeting is scheduled for August 10, 2018. This will be a joint meeting of the MSRC and Workers' Compensation Board, and will be held in-person.

*Meeting Adjourned 11:10am*

**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 non-FDA approved procedures
5. Determine payment standards for chiropractic injections
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 June 15, 2019

<b>Seat</b>	<b>Last Name</b>	<b>First Name</b>	<b>Affiliation</b>
Chairperson	Mitchell	Grey	Director, Division of Workers' Compensation
Alaska State Medical Association	Hall, MD	Robert J.	Orthopedic Physicians Anchorage, Inc.
Alaska Chiropractic Society	Kanady, DC	Timothy	Kanady Chiropractic Center, Inc.
Alaska State Hospital & Nursing Home Association	Newcombe	William "Ross"	Providence Alaska Medical Center
Medical Care Provider	Foland, MD	Mary Ann	Primary Care Associates
Lay Member - Industry	Steed	Misty	PACBLU
Lay Member - Industry	Scott	Pam	Alaska Timber Insurance Exchange
Lay Member - Labor	Beltrami	Vince	AFL-CIO
Lay Member - Industry	Lindsey	Tammi	Industry

**TAB 5**



ReedGroup<sup>®</sup>  
**MDGuidelines<sup>®</sup>**

007

# ACOEM GUIDELINES AND FORMULARY

June 21, 2019



# AGENDA

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1. Baker and Welsh: The California Experience
2. MDGuidelines Overview
3. ACOEM Guidelines
4. ACOEM-based Formulary



# ENSURING THE HIGHEST QUALITY HEALTHCARE IN WORKERS' COMPENSATION

009

## ACCESS TO THE BEST MEDICAL TREATMENT REFERENCE MATERIAL IS KEY

# The California Experience

- SB 863 took effect in 2013. Strategy:
  - ▶ > Improve medical care delivery
  - ▶ > Remove Waste and Friction
  - ▶ > Use the savings to **increase benefits** for employees and **reduce workers' comp rates** for employers.
  - ▶ > **Win – Win**



# How Was This Done?

- ▶ Improve healthcare quality and delivery.
- ▶ Use evidence-based guidelines for presumptive first-level treatment decisions.
- ▶ Establish protocol (hierarchy of decision making) for escalating to other treatment regimens based on individual circumstances.
- ▶ Reduce over-care, i.e., provide evidenced based care first before surgery is considered.
- ▶ Eliminate litigation over issues that belong to the healthcare experts, not lawyers and judges.

# The Foundation of Effective Reform

- > Improving healthcare quality and delivery.
- > Access to quality medical care through medical provider networks and ombudsman.
- > Standardized reference material for first level, evidence-based treatment.

*History: DIR  
contracted Rand  
Corp to conduct  
a comprehensive  
study of existing  
medical  
treatment  
guidelines,  
applying the  
following criteria  
to rate their  
acceptability—  
Are they/Do they:*

- (1) Evidence-based,
- (2) Peer reviewed and nationally recognized,
- (3) Address the full range of tests and therapies commonly utilized particularly for injuries of spine, arm, and leg,
- (4) Reviewed or updated at least every three years,
- (5) Developed by a multidisciplinary clinical team,
- (6) Cost less than \$500 per individual user to subscribe

# Rand Study Evaluation:

- ▶ ACOEM stands out overwhelmingly as the best choice, particularly with its adherence to the principle of evidence-based validation.
- ▶ ACOEM subsequently addresses recommendations of Rand Study for continuous improvement.
- ▶ ACOEM Guidelines become the legal standard in California.

# What are guidelines and why use them?

- ▶ It is a set of regulations that provide the clinician with an analytical framework for the evaluation and treatment of injured workers in the workers' compensation system.
- ▶ It is the primary source of guidance for treating physicians and physician reviewers in workers' compensation.
- ▶ It provides the pathway to providing appropriate patient care and getting treatment requests approved.
- ▶ Good for workers: guidelines are presumed correct.
- ▶ Formulary is a component of the medical treatment guideline.
- ▶ The drug list is not stand alone it needs to be in conjunction with treatment guideline.

# Remaining Challenges

- Resistance to change.
- Broadening user base, i.e., all levels of healthcare professionals, claims adjusters, etc.

# MDGUIDELINES OVERVIEW

# ABOUT MDGUIDELINES

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- Founded 40 years ago by Dr. Presley Reed.
- Owned by *Guardian Life Insurance*, one of the largest mutual life insurance companies in the United States.
- Serves over 3,000 clients around the world.
- The industry's only clinical decision support tool that provides patient recovery time estimates.





# MDGUIDELINES PRODUCT FEATURES

## MDGUIDELINES HELPS PATIENTS GET BACK TO ACTIVITY

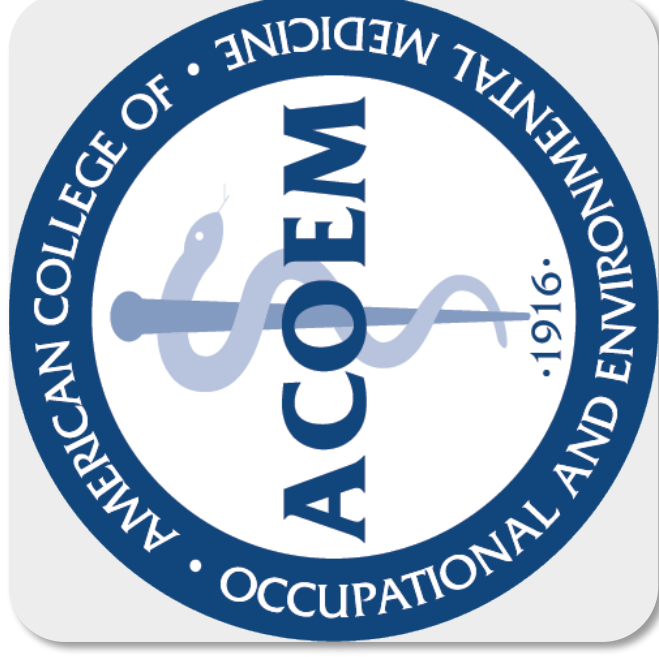
- Illness and Injury Recovery Duration Estimates
- Evidence-Based Clinical Guidelines
- Predictive Model to estimate illness timeframes
- Diagnosis and Related Treatments Tool
- Drug Formulary Tool
- Industry's largest database of disability cases (15 million)
- Full integration into EMR/EHR

The screenshot displays the MDGuidelines web application interface. At the top, there is a search bar with the text "Search for a topic or medical code...". Below the search bar, there are navigation tabs: "DURATION VIEW", "ICD MAPPING", "CROSSWALKS", "DART", "FORMULARY", and "ATM". The main content area shows a search for "J45.30 Mild persistent asthma, uncomplicated". There are several filter sections: "Physiological View" with "Age" set to 44 and "Sex" set to Female; "Case View" with "Job Class" set to Any and "Program Type" set to Any; and "Comorbid Conditions" with a list of checkboxes for various conditions. The "Total Predicted Duration" is shown as 53. At the bottom, there is a footer with contact information: "1-800-445-4519 | solutions\_support@mdguidelines.com | 10355 Westwood Drive, Westminster, CO 80021".

# MDGUIDELINES-ACOEM PRACTICE GUIDELINES

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- In 2013, Reed Group purchased the ACOEM Practice Guidelines
- ACOEM research team remains in place
- ACOEM content team has complete editorial independence
- ACOEM Practice Guidelines methodology is rigorously maintained
- Guidelines developed under supervision of Dr. Kurt Hegmann, MD, MPH, Professor and Center Director of the Rocky Mountain Center for Occupational and Environmental Health at the University of Utah



# GUIDELINES METHODOLOGY



- ACOEM's Practice Guidelines are developed in accordance with a meticulous strength-of-evidence rating methodology, incorporating the latest IOM, GRADE, AGREE and AMSTAR criteria.
- The goal behind the methodology and development process is to produce the most *rigorous*, *reproducible*, and *transparent* guidelines available.

## HOW CAN YOU TELL IF GUIDELINES ARE EVIDENCE-BASED?

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1. Is there a published, detailed, and understandable **methodology**?
2. Are the conclusions **scientifically verifiable**?
3. Were the reviews and recommendations developed by professionals with **appropriate training and credentials**?
4. Were findings made by **individuals or by broad-based physician panels**?

# DEVELOPMENT / REVISION PROCESS SUMMARY

Step	Purpose	Individual(s) Responsible	Educational Credentials
<b>Pose Answerable Clinical Questions</b>	Direct search, following format in Attachment 9.	Editor, EBPPs	MD, DO
<b>Literature Search</b>	Comprehensive search of the literature focusing on highest level of evidence in Attachment 7. Pull articles using inclusion criteria shown in Table A.C5	Research Assistant(s)	Undergrad/ MS/MPH/MD (resident)
<b>Article Abstraction / Preliminary Development of Evidence tables</b>	Read articles Initial construction of evidence tables for topic, for example Attachment 10.	Research Assistant(s), Study Coordinator(s)	MS/MPH/PhD
<b>Article Abstraction / Semi-Final Development of Evidence Tables</b>	Read articles Semi-final construction of evidence tables for topic, including critiquing of study design and data.	Study Coordinator(s), Research Associate	MS/MPH/PhD
<b>Evidence Table Review and Finalization</b>	Over-read evidence tables to ensure that all important aspects of articles are included. QA/QC	Physician(s)	MD/DO with MPH (or equivalent)
<b>Rate Articles</b>	Rate the articles based on defined criteria, for example Table B for RCTs	Physician(s)	MD/DO with MPH (or equivalent)
<b>Rate Strength of Evidence</b>	Determine strength of evidence rating for topic based on the quality of the articles as shown in Table C.	Physician(s)	MD/DO with MPH (or equivalent)
<b>Draft Summaries</b>	Draft text summaries of the evidence on each topic citing design, results and quality.	Physician(s)	MD/DO with MPH (or equivalent)
<b>Draft Recommendations</b>	Draft recommendations	Physician(s)	MD/DO with MPH (or equivalent)
<b>Panel Process</b>	Review evidence tables and strength of evidence ratings. Revise recommendations based on discussion, application of clinical judgment and first principles or new evidence.	Multi-disciplinary health professionals	MD/DO/MPH, MS, PT, etc.

# EXHAUSTIVE LITERATURE SEARCH

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**All MeSH terms documented for database searches. Including:**

1. The National Library of Medicine's MEDLARS database (Medline)
2. EMB Online
3. The Cochrane Central Register of Controlled Trials
4. TRIP Database
5. CINAHL (Nursing, allied health, physical therapy, occupational therapy, social services)
6. EMBASE
7. PEDro: Physiotherapy Evidence Database

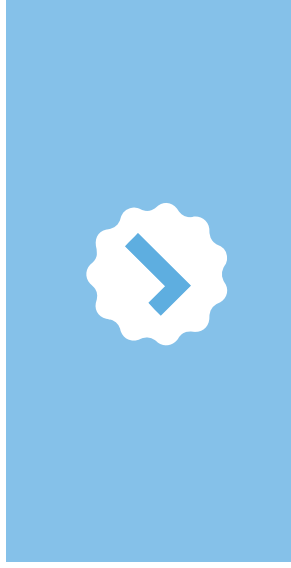
# MDGUIDELINES' ACOEM-BASED FORMULARY

# FORMULARY: PURPOSE AND PRINCIPLES

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**Evidence-based** formulary  
for workers' compensation  
treatment



Use the strength of the  
**ACOEM** Occupational  
Medicine Practice  
Guidelines



State of the art **guidance:**

- physicians
- injured workers
- claims professionals
- legal and regulatory community
- all other stakeholders in WC treatment



# FORMULARY: DEVELOPMENT TEAM

---

ROBERT GOLDBERG, MD,  
MPH  
Project Leader  
“Editor-in-chief”



CHERYL ELTON,  
PHARMD, Lead  
Pharmacist

REGINA MEARS,  
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BRITTEN FEATHERSTON,  
PHARMD

# FORMULARY: EXTERNAL REVIEWERS

---

WILL GAINES, MD  
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MARCOS IGLESIAS, MD  
Broadspire

MELISSA BURKE, PHARM D  
Travelers

ADAM SEIDNER, MD  
Travelers

KURT HEGMANN, MD  
ACOEM, University of  
Utah



# FORMULARY: METHODOLOGY

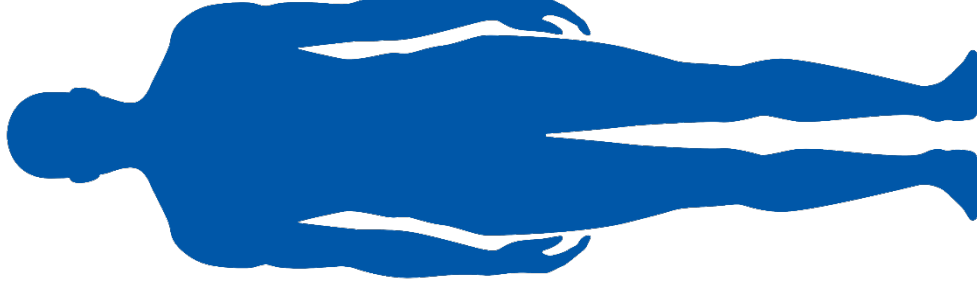
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<b>Guidelines</b>	<b>Recommendations</b>	<b>Supplement</b>	<b>Leading Sources</b>
ACOEM Practice Guidelines as primary source	ACOEM recommendations <ul style="list-style-type: none"><li>• Based on literature review and evaluation for bias and strength</li><li>• Class of medications, e.g. Opioids, NSAIDs</li><li>• Specific medications</li></ul>	Other leading sources as needed	Healthsystems' recommendations based on leading sources as well as P&T decisions <ul style="list-style-type: none"><li>• Pharmacy and medical literature, safety, cost</li></ul>

# FORMULARY: METHODOLOGY

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- Specific Conditions by body part
- ICD9/10 codes attached
- Phase of treatment - acute and chronic
- Class of medications
- Specific medications - generic listing
- ACOEM Recommendations:
  - Recommended
  - Not recommended
  - No recommendation- insufficient evidence
- Healthsystems' recommendations for specific medications within a class:
  - Yes
  - No
- National cost data for relative comparisons



# FORMULARY: METHODOLOGY

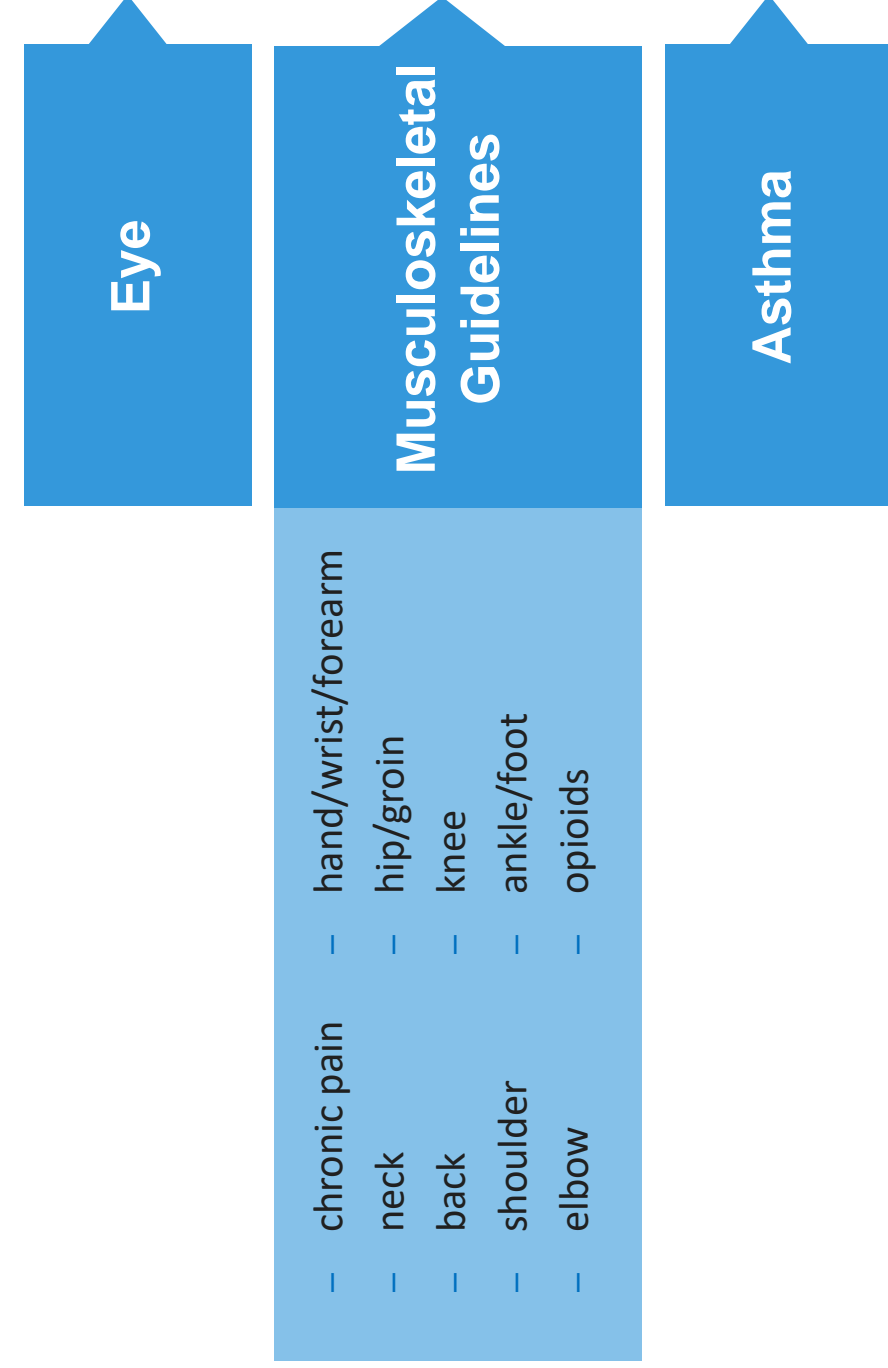
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- Initial reading of ACOEM Guidelines
- ACOEM recommendations reviewed
  - Most accepted
- Some updated or greater specificity required
  - Additional sources identified as evidence
- Comments added to guide physicians and claims professionals
- Editor (RG) reviewed work by PharmD - an iterative approach
- External reviews conducted
- Input considered and adopted if justified
- Updated and sent for ACOEM review
- Input considered and discussed if needed, adopted if justified
- Final decisions by Robert Goldberg, MD & Kurt Hegmann, MD



# FORMULARY: CONTENT

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# FORMULARY: STRENGTHS OF FORMULARY

Primary source:  
**ACOEM**  
Occupational  
Medicine  
Guidelines

Additional sources to complete formulary only as needed

Regular guideline updates by **ACOEM/Reed**

Pharmacy and Medical expertise are **combined**

 Transparent literature review and guideline development process are the foundation

 Iterative development and review process

**EVIDENCE - BASED**

ReedGroup®  
**MDGuidelines®** | The measure  
of health



**TAB 6**

*Official*

# ALASKA

WORKERS' COMPENSATION

◆ ————— *MEDICAL FEE SCHEDULE*

*Effective January 1, 2019*



## **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.

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## **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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# Contents

<b>Introduction</b> .....	<b>1</b>	<b>Medicine</b> .....	<b>29</b>
Organization of the Fee Schedule .....	1	General Information and Guidelines .....	29
Provider Schedule .....	2	Billing and Payment Guidelines .....	29
Drugs and Pharmaceuticals .....	2	Modifiers .....	30
HCPCS Level II .....	2	<b>Category II</b> .....	<b>33</b>
Outpatient Facility .....	2	<b>Category III</b> .....	<b>35</b>
Inpatient Hospital .....	2	Category III Modifiers .....	35
Definitions .....	2	<b>HCPCS Level II</b> .....	<b>37</b>
<b>General Information and Guidelines</b> .....	<b>5</b>	General Information and Guidelines .....	37
Billing and Payment Guidelines .....	5	Medicare Part B Drugs .....	37
Modifiers .....	8	Durable Medical Equipment .....	37
<b>Evaluation and Management</b> .....	<b>11</b>	Modifiers .....	37
General Information and Guidelines .....	11	Ambulance Services .....	37
Billing and Payment Guidelines .....	11	<b>Outpatient Facility</b> .....	<b>39</b>
Modifiers .....	15	General Information and Guidelines .....	39
<b>Anesthesia</b> .....	<b>17</b>	Surgical Services .....	41
General Information and Guidelines .....	17	Drugs and Biologicals .....	42
Billing and Payment Guidelines .....	17	Equipment, Devices, Appliances, and Supplies .....	42
Anesthesia Modifiers .....	18	Specialty and Limited-Supply Items .....	42
<b>Surgery</b> .....	<b>21</b>	Durable Medical Equipment (DME) .....	42
General Information and Guidelines .....	21	Use of Outpatient Facility and Ancillary Services .....	42
Billing and Payment Guidelines .....	21	Nursing and Related Technical Personnel Services .....	42
Modifiers .....	23	Surgical Dressings, Splinting, and Casting Materials .....	42
<b>Radiology</b> .....	<b>25</b>	<b>Inpatient Hospital</b> .....	<b>43</b>
General Information and Guidelines .....	25	General Information and Guidelines .....	43
Billing and Payment Guidelines .....	25	Exempt from the MS-DRG .....	43
Modifiers .....	25	Services and Supplies in the Facility Setting .....	43
<b>Pathology and Laboratory</b> .....	<b>27</b>	Preparing to Determine a Payment .....	44
General Information and Guidelines .....	27	<b>Critical Access Hospital, Rehabilitation Hospital,</b>	
Billing and Payment Guidelines .....	27	<b>Long-term Acute Care Hospital</b> .....	<b>49</b>
Modifiers .....	28	General Information and Guidelines .....	49



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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.

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

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

## 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:

- Unna 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.

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.27	1.500	1.905
Practice Expense RVU x Practice Expense GPCI	2.03	1.117	2.26751
Malpractice RVU x Malpractice GPCI	0.17	0.708	0.12036
Total RVU			4.29287

**Data for the purpose of example only**

Calculation using example data:

$$\begin{aligned}
 &1.27 \times 1.500 = 1.905 \\
 &+ 2.03 \times 1.117 = 2.26751 \\
 &+ 0.17 \times 0.708 = 0.12036 \\
 &= 4.29287
 \end{aligned}$$

$$4.29287 \times \$165.00 \text{ (CF)} = 708.32355$$

Payment is rounded to \$708.32

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

MEDICAL SERVICE	CPT CODE RANGE	CONVERSION FACTOR
Surgery	(10021–69990)	\$165.00
Radiology	(70010–79999)	\$196.00
Pathology and Lab	(80047–89398)	\$135.00
Medicine (excluding anesthesia)	(90281–99091 and 99151–99199 and 99500–99607)	\$80.00
Evaluation and Management	(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.

**2019 Alaska Workers' Compensation Medical Fee Schedule—General Information and Guidelines**

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	<b>Active Code.</b> 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	<b>Bundled Code.</b> Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.	No separate payment is made for these services even if an RVU is listed.
C	<b>Contractors price the code.</b> 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	<b>Deleted Codes.</b> 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	<b>Excluded from Physician Fee Schedule by regulation.</b> 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	<b>Deleted/Discontinued Codes.</b> (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	<b>Not valid for Medicare purposes.</b> Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.	Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
H	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	<b>Not valid for Medicare purposes.</b> 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	<b>Anesthesia Services.</b> 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	<b>Measurement Codes.</b> Used for reporting purposes only.	These codes are supplemental to other covered services and for informational purposes only.
N	<b>Non-covered Services.</b> 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	<b>Bundled/Excluded Codes.</b> 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"> <li>• 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.)</li> <li>• 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.</li> </ul>	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
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 is 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.
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 <u>any</u> 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.

### 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](http://www.labor.state.ak.us/wc).

### MODIFIERS

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

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

### Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

**Applicable HCPCS Modifiers**

**Modifier TC—Technical Component**

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

**Modifier QZ—CRNA without medical direction by a physician**

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

**State-Specific Modifiers**

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

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

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

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

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

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

**Data for the purpose of example only**

**Modifier PE—Physician Assistants and Advanced Practice Registered Nurses**

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

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

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

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

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

**Data for the purpose of example only**



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# 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 2018 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.

**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). 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. In these instances, CRNA or AA payment is based on the lower of billed charges or 100 percent of the MAR.





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# 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 $[(\$1,350.00 \times .15) + ((\$1,100.00 \times .15) \times .50)]$

**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:

Procedures 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**

### 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 $(\$1000 + (.50 \times \$600))$

**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.

## 2019 Alaska Workers' Compensation Medical Fee Schedule—Surgery

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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:

Procedures 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**

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# 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). As of January 1, 2018, 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	\$2,149.12
72142-TC	\$1,465.24
72142-26	\$683.88
72147	\$2,133.80
72147-TC	\$1,452.11
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	\$1,465.24	100% of the TC
72147-TC	\$726.06	(50% of the TC for the second procedure)
Total	\$2,191.30	

Professional Component:

72142-26	\$683.88	100% of the 26
72147-26	\$647.61	(95% of the 26 for the second procedure)
Total	\$1,331.49	

Global Reimbursement:

72142	\$2,149.12	100% of the global
72147-51	\$1,373.67	(\$726.06 + \$647.61 TC and 26 above)
Total	\$3,522.79	

**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	0.27	1.117	0.30159
Malpractice RVU x Malpractice GPCI	0.02	0.708	0.01416
Total RVU			0.87075

**Data for the purpose of example only**

Calculation using example data:

$$\begin{aligned}
 &0.37 \times 1.500 = 0.555 \\
 &+ 0.27 \times 1.117 = 0.30159 \\
 &+ 0.02 \times 0.708 = 0.01416 \\
 &= 0.87075 \\
 &0.87075 \times \$135.00 \text{ (CF)} = 117.55125 \\
 &\text{Payment is rounded to } \$117.55
 \end{aligned}$$

Laboratory services not found in the RBRVS but found 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.

For example, if CPT code 81001 has a payment rate of \$3.92 in the CLAB file, this is multiplied by 6.33 for a MAR of \$24.81.

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.

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# 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 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.

### 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, 98940, 98941, 98942, 98943, 97810, 97811, 97813, 97814.

### MODIFIERS

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

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

#### Reimbursement Guidelines for CPT Modifiers

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

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

Alaska MAR:

93303	\$649.66
93303-TC	\$449.72
93303-26	\$199.94
93351	\$644.03
93351-TC	\$376.12
93351-26	\$267.91

**Data for the purpose of example only**

Technical Component:

93303-TC	\$449.72	100% of the TC
93351-TC	\$282.09	(75% of the TC for the second procedure)
Total	\$731.81	

Global Reimbursement:

93303	\$649.66	100%
93351	\$550.00	(75% of the TC for the second procedure + 100% of the 26) (\$282.09 + \$267.91 = \$550.00)
Total	\$1,199.66	

*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	\$184.91
92060-TC	\$66.69
92060-26	\$118.22
92132	\$88.07
92132-TC	\$37.20
92132-26	\$50.86

**Data for the purpose of example only**

Technical Component:

92060-TC	\$66.69	100% of the TC
92132-TC	\$29.76	(80% of the TC for the second procedure)
Total	\$96.45	

Global Reimbursement:

92060	\$184.91	100% of the global
92132	\$80.62	(80% of the TC for the second procedure + 100% of the 26) (\$29.76 + \$50.86 = \$80.62)
Total	\$265.53	

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

Alaska MAR:

97016	\$45.40
[(.18 x 1.5) + (.26 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	\$33.78
[(.18 x 1.5) + ((.26 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	\$45.40
97016 (2nd unit same date)	\$33.78
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.



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# 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.



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# 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.

## 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 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.



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# 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 OPPTS methodology for hospital outpatient and ambulatory surgical centers (ASCs). For procedures performed in an outpatient setting, implants shall be paid at 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.

2019 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"> <li>Ambulance services</li> <li>Separately payable clinical diagnostic laboratory services</li> <li>Separately payable non-implantable prosthetic and orthotic devices</li> <li>Physical, occupational, and speech therapy</li> <li>Diagnostic mammography</li> <li>Screening mammography</li> </ul>	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"> <li>Not covered by any Medicare outpatient benefit category</li> <li>That are not covered by Medicare based on statutory exclusion</li> <li>Not reasonable and necessary</li> </ul>	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"> <li>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.</li> <li>Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1.</li> <li>In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.</li> </ol>

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals	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 outliners. 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. <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. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI of S, T, or V. (2) In other circumstances, payment is made through a separate APC payment.
Q2	T packaged codes	Paid under OPSS. (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.
Q3	Codes that may be paid through a composite APC	Paid under OPSS. (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.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
Q4	Conditionally packaged laboratory tests	(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 Clinical Laboratory Fee Schedule (CLFS)
R	Blood and blood products	Paid under OPSS.
S	Significant procedure, not discounted when multiple	Paid under OPSS.
T	Significant procedure, multiple reduction applies	Paid under OPSS. <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.
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 an invoice from the supplier showing the actual cost incurred by the outpatient facility for the purchase of the supply items or devices.

## DURABLE MEDICAL EQUIPMENT (DME)

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

Example:

- 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 invoice cost of the device or devices was more than \$25,000. Invoices are required to be submitted for payment. Payment will be the invoice cost minus \$25,000 plus 10 percent of the difference.

## Example of Implant Outlier:

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

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

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

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

## EXEMPT FROM THE MS-DRG

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

## SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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



- Surgery, special procedures, or special treatment room services

### PREPARING TO DETERMINE A PAYMENT

The CMS Inpatient PC Pricer is normally posted by CMS one to two months after the Inpatient Prospective Payment System rule goes into effect each October 1. The version that is available on January 1, 2019 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/FY2018-IPPS-Final-Rule-Home-Page.html>

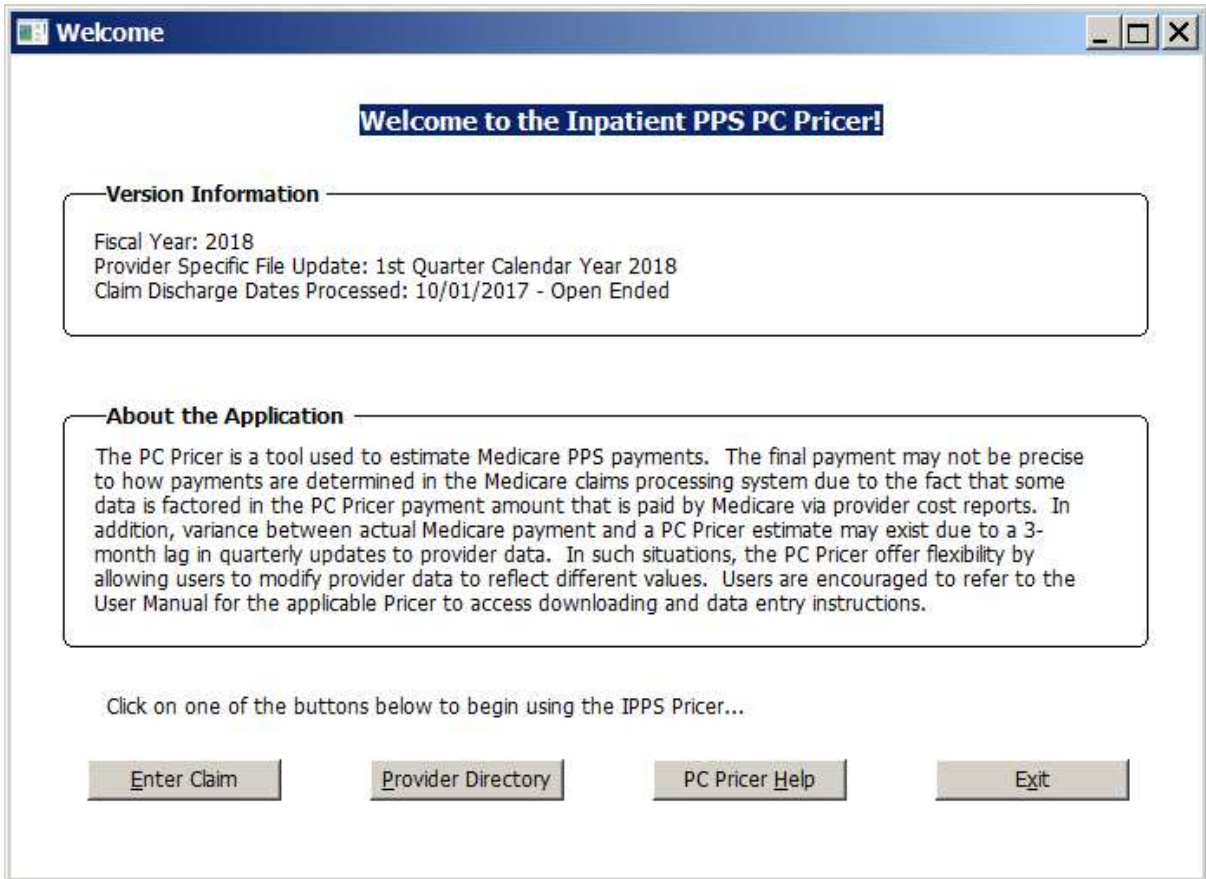
Third-party vendors such as Optum, 3M, and others also have software available which will assign the MS-DRG to the claim.

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.**



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
[-] [x]

### FY 2018 Inpatient Prospective Payment (IPPS) Payment Results

Calculator Version: C18.1

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

PROVIDER DETAILS	CLAIM DETAILS	PPS FACTORS & ADJUSTMENTS
<b>Provider #: 020001</b> PSF Record Eff Date: 10/01/2017 Provider Type: 00 GEO/STD CBSA: 11260 / Reclass CBSA:	Patient Id: 1111111 DRG: 460 Discharge Date: 10/22/2017 Length of Stay: 12 Days Charges: \$75,000.00	OP/CAP CCR: 0.2350 / 0.0180 OP/CAP DSH: 0.2662 / 0.0962 Operating IME: 000000.030440092 Capital IME: 000000.022919518 Nat Labor/Non-Labor %: 0.6830 / 0.3170 Nat Labor: 03806.04 Nat Non-Labor: 01766.49 Inp Wage Index: 01.3305 Inp PR Wage Index: 00.0000 Inp DRG Weight: 04.0149 Inp DRG GM ALOS: 02.9 Transfer Adj. Factor: 0.0000 Readmissions Adj. Factor: 1.0000 VBP Adj. Factor: 1.00073865970 Bundle %: 0.000 EHR Reduction Indicator: HAC Reduction Indicator: N Cost Outlier Threshold: \$0.00
<b>CAPITAL AMOUNTS</b> C-FSP: \$2,391.31 C-Outlier: \$0.00 C-DSH: \$230.04 C-IME: \$54.81	<b>OPERATING AMOUNTS</b> O-FSP: \$29,196.55 O-HSP: \$0.00 O-Outlier: \$0.00 O-DSH: \$1,943.03 O-IME: \$888.75 Uncomp Care: \$1,492.95 Readmissions Adj.: \$0.00 VBP Adjustment: \$21.57 New Tech: \$0.00	
<b>OTHER PPS AMOUNTS</b> HAC Adj.: \$0.00 Low Volume: \$0.00 Pass Thru + Misc: \$382.80 Islet Add-on: \$0.00 EHR Adj.: \$0.00 Bundle Adj.: \$0.00 MA-HSP: \$0.00	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <b>* TOTAL PAYMENT *</b>  <span style="font-size: 1.2em; font-weight: bold;">\$36,601.81</span> </div>	

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	\$36,601.81
Multiplied by Providence Alaska Medical Center multiplier	x <u>2.38</u>
Alaska Workers' Compensation Payment	\$87,112.31

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

## **GENERAL INFORMATION AND GUIDELINES**

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

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

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



**TAB 7**





## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2019

**NCCI estimates that the changes to the fee schedule in Alaska, effective January 1, 2019, will result in a negligible<sup>1</sup> impact on overall workers compensation system costs.**

### SUMMARY OF CHANGES

The major changes to the Alaska medical fee schedule (MFS) effective 1/1/2019 include:

- Update to the Physician Fee Schedule to incorporate 2019 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT<sup>2</sup> code and published by the Centers for Medicare and Medicaid Services (CMS). The prior Physician Fee Schedule was based on 2018 Medicare RBRVUs. The conversion factors established by the Department of Labor and Workforce Development (DLWD) for surgery, radiology, and pathology & lab services have been updated from \$174 to \$165, \$206 to \$196, and \$142 to \$135, respectively. All other conversion factors remain unchanged.
- Update to the Hospital Inpatient Fee Schedule to incorporate 2019 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior Hospital Inpatient Fee Schedule was based on 2018 MS-DRG weights and hospital specific base rates. The DLWD established multipliers for each hospital to be applied to the Medicare Maximum Allowable Reimbursement (MAR) amount. All multipliers remain unchanged, with the exception of Mt. Edgecumbe Hospital which is now a critical access hospital.
- Update to the Hospital Outpatient Fee Schedule and Ambulatory Surgical Center (ASC) Fee Schedule to incorporate 2019 Medicare Outpatient Prospective Payment System (OPPS) relative weights established for each CPT code and published by the CMS. The prior Hospital Outpatient Fee Schedule was based on 2018 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.
- Update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule to incorporate 2019 DMEPOS MARs established for each HCPCS<sup>3</sup> code published by the CMS. The prior DMEPOS fee schedule was based on 2018 MARs. As established by the DLWD, DMEPOS services will continue to be reimbursed at 184% of Medicare's DMEPOS fee schedule.
- Update to the intrastate air ambulance fees associated with wing air mile rates to incorporate the 2019 Ambulance Fee Schedule MARs established for each HCPCS code and published by the CMS. The prior intrastate air ambulance fee schedule was based on 2018 MARs. As established by the DLWD, intrastate air ambulance HCPCS codes associated with wing air mile rates will not

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<sup>1</sup> Negligible is defined in this document to be an impact of less than 0.1%.

<sup>2</sup> Current Procedural Terminology maintained by the American Medical Association

<sup>3</sup> Healthcare Common Procedure Coding System maintained by the CMS



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2019

exceed 400% of the Medicare fee schedule rate. The fixed wing lift-off fee will not exceed \$11,500 and the rotary wing lift-off fee will not exceed \$13,500.

### ACTUARIAL ANALYSIS

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

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

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Alaska for Service Year 2017.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from Policy Years 2014, 2015, and 2016 projected to the effective date of the benefit changes.

### *Physician Fee Schedule*

In Alaska, payments for physician services represent 46.8% of total medical costs. The overall change in maximums for physician services is a weighted average of the percentage change in MAR by procedure code (Revised MAR/Prior MAR). The weights are based on Service Year 2017 observed payments by procedure code for Alaska, as reported on NCCI's Medical Data Call. The overall weighted-average



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES  
EFFECTIVE JANUARY 1, 2019**

percentage change in maximums for physician services is -2.3%. The impact by category is shown in the following table.

<b>Physician Practice Category</b>	<b>Share of Physician Costs</b>	<b>Percentage Change in MAR</b>
Anesthesia	4.0%	0.0%
Surgery	28.1%	-5.2%
Radiology	13.2%	-5.4%
Pathology & Laboratory	0.7%	-8.8%
Evaluation & Management	18.2%	+0.5%
Medicine	32.2%	-0.5%
Other HCPCS	0.2%	0.0%
Physician Payments with no specific MAR	3.4%	-
<b>Total Physician Costs</b>	<b>100.0%</b>	<b>-2.3%</b>

A price realization factor of 80% was applied. The impact on physician payments after applying the price realization factor is -1.8% (= -2.3% x 0.80).

The above impact of -1.8% is then multiplied by the percentage of medical costs attributed to physician payments in Alaska (46.8%) to arrive at an impact of -0.8% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact on overall workers compensation costs of -0.6%.

*Hospital Inpatient Fee Schedule*

In Alaska, payments for hospital inpatient services represent 12.1% of total medical costs. Of these payments, 83.5% have a MAR. The overall change in maximums for hospital inpatient services is a weighted average of the percentage change in MAR by episode (Revised MAR/Prior MAR). The weights are based on Service Year 2017 observed payments by episode for Alaska, as reported on NCCI’s Medical Data Call. The overall weighted-average percentage change in maximums for hospital inpatient services is +3.1%<sup>4</sup>. A price realization factor of 80% was applied. The impact on hospital inpatient payments after applying the price realization factor is +2.5% (= +3.1% x 0.80).

The above impact of +2.5% is then multiplied by the percentage of medical costs attributed to hospital inpatient payments in Alaska (12.1%) to arrive at an impact of +0.3% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact of +0.2% on overall workers compensation costs.

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<sup>4</sup> This does not include the impact of any change in reimbursement levels due Mt. Edgecumbe’s transition to a critical access hospital. This impact is expected to be minimal.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2019

### *Hospital Outpatient Fee Schedule*

In Alaska, payments for hospital outpatient services represent 14.4% of total medical costs. Of these payments, 90.6% have a MAR. The impact on hospital outpatient services, which is calculated in an analogous manner to the physician fee schedule change, is +1.0%. A price realization factor of 80% was applied. The impact on hospital outpatient payments after applying the price realization factor is +0.8% ( $= +1.0\% \times 0.80$ ).

The above impact of +0.8% is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Alaska (14.4%) to arrive at an impact of +0.1% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact of +0.1% on overall workers compensation costs.

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

### *Ambulatory Surgical Centers (ASC) Fee Schedule*

In Alaska, payments for ASC services represent 11.4% of total medical costs. Of these payments, 90.5% have a MAR. The impact on ASC services, which is calculated in an analogous manner to the physician fee schedule change, is +3.1%. A price realization factor of 80% was applied. The impact on ASC payments after applying the price realization factor is +2.5% ( $= +3.1\% \times 0.80$ ).

The above impact of +2.5% is then multiplied by the percentage of medical costs attributed to ASC payments in Alaska (11.4%) to arrive at an impact of +0.3% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact of +0.2% on overall workers compensation costs.

### *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule*

In Alaska, payments for DMEPOS services represent 3.9% of total medical costs. The impact on DMEPOS services, which is calculated in an analogous manner to the physician fee schedule change, is +1.8%. A price realization factor of 80% was applied. The impact on DMEPOS service payments after applying the price realization factor is +1.4% ( $= +1.8\% \times 0.80$ ).

The above impact of +1.4% is then multiplied by the percentage of medical costs attributed to DMEPOS payments in Alaska (3.9%) to arrive at an impact of +0.1% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70%) to arrive at an impact of +0.1% on overall workers compensation costs.



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES  
EFFECTIVE JANUARY 1, 2019**

*Intrastate Air Ambulance Fee Schedule*

In Alaska, payments for air ambulance services represent 2.4% of total medical payments, and 37.4% of air ambulance payments are for intrastate flights. Therefore, the payments for intrastate air ambulance services represent 0.9% (= 2.4% x 37.4%) of total medical payments. The impact on intrastate air ambulance services, which is calculated in an analogous manner to the physician fee schedule change, is +1.4%. The impact on intrastate air ambulance payments after applying the price realization factor is +1.1% (= +1.4% x 0.80).

The above impact of +1.1% is then multiplied by the percentage of medical costs attributed to intrastate air ambulance payments in Alaska (0.9%) to arrive at a negligible increase on medical costs and on overall workers compensation costs.

**SUMMARY OF IMPACTS**

The impacts from the fee schedule changes in Alaska, effective January 1, 2019, are summarized in the following table:

Type of Service	(A) Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Impact on Medical Costs
Physician	-1.8%	46.8%	-0.8%
Hospital Inpatient	+2.5%	12.1%	+0.3%
Hospital Outpatient	+0.8%	14.4%	+0.1%
ASC	+2.5%	11.4%	+0.3%
DMEPOS	+1.4%	3.9%	+0.1%
Intrastate Air Ambulance	+1.1%	0.9%	Negligible Increase
<b>Combined Impact on Medical Costs (D) = Total of (C)</b>			<b>Negligible</b>
Medical Costs as a Share of Overall Costs (E)			70%
<b>Combined Impact on Overall Costs (F) = (D) x (E)</b>			<b>Negligible</b>

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



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES  
EFFECTIVE JANUARY 1, 2018**

**NCCI estimates that the changes to the fee schedule in Alaska, effective January 1, 2018, will result in an impact of -1.0% on overall workers compensation system costs in Alaska.**

**Summary of Changes**

The major changes to the Alaska medical fee schedule (MFS) effective 1/1/2018 include:

- Update to the Physician Fee Schedule to incorporate 2018 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT<sup>1</sup> code and published by the Centers for Medicare and Medicaid Services (CMS). The prior Physician Fee Schedule was based on 2017 Medicare RBRVUs. The conversion factors established by the Department of Labor and Workforce Development (DLWD) for surgery and radiology services have been updated from \$205 and \$257 to \$174 and \$206, respectively. All other conversion factors remain unchanged. The revised conversion factors are listed below.

• Evaluation and Management	\$ 80.00
• Medicine [excluding anesthesiology]	\$ 80.00
• Surgery	\$174.00
• Radiology	\$206.00
• Pathology and Laboratory	\$142.00
• Anesthesia	\$121.82

- Update to the Hospital Inpatient Fee Schedule to incorporate 2018 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior Hospital Inpatient Fee Schedule was based on 2017 MS-DRG weights and hospital specific base rates. This year the DLWD established multipliers for each hospital to be applied to the Medicare Maximum Allowable Reimbursement (MAR) amount. The multipliers are listed below.

• Providence Alaska Medical Center	2.38
• Mat-Su Regional Medical Center	1.84
• Bartlett Regional Hospital	1.79
• Fairbanks Memorial Hospital	1.48
• Alaska Regional Hospital	2.32
• Yukon Kuskokwim Delta Regional Hospital	2.63
• Central Peninsula General Hospital	1.38
• Alaska Native Medical Center	2.53
• Mt. Edgecumbe Hospital	1.83
• All Other Hospitals	2.02

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<sup>1</sup> Current Procedural Terminology maintained by the American Medical Association



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2018

- Update to the Hospital Outpatient Fee Schedule to incorporate 2018 Medicare Outpatient Prospective Payment System (OPPS) relative weights established for each CPT code and published by the CMS. The prior Hospital Outpatient Fee Schedule was based on 2017 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.
- Update to the Ambulatory Surgical Center (ASC) Fee Schedule to incorporate 2018 Medicare OPPS relative weights established for each procedure code and published by the CMS. The prior ASC fee schedule was based on 2017 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.
- Update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule to incorporate 2018 DMEPOS MARs established for each HCPCS<sup>2</sup> code published by the CMS. The prior DMEPOS fee schedule was based on 2017 MARs. As established by the DLWD, DMEPOS services will continue to be reimbursed at 184% of Medicare's DMEPOS fee schedule.
- Update to the intrastate air ambulance fees associated with wing air mile rates to incorporate the 2018 Ambulance Fee Schedule MARs established for each HCPCS code and published by the CMS. The prior intrastate air ambulance fee schedule was based on 2017 MARs. As established by the DLWD, intrastate air ambulance HCPCS codes associated with wing air mile rates will not exceed 400% of the Medicare fee schedule rate. The fixed wing lift-off fee will not exceed \$11,500 and the rotary wing lift off fee will not exceed \$13,500.

### Actuarial Analysis

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

1. Calculate the percentage change in maximum reimbursements
  - Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code.
  - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the revised fee schedule
  - NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
    - In response to a fee schedule decrease, NCCI research indicates that physician payments decline by approximately 50% of the fee schedule change.

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<sup>2</sup> Healthcare Common Procedure Coding System maintained by the CMS



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2018

- In response to a fee schedule increase, NCCI research indicates that physician payments increase by approximately 80% of the fee schedule change. The magnitude of the response for physician fee schedules depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure). Consequently, the formula used to determine the percent realized for physician fee schedule changes is  $80\% \times (1.10 + 1.20 \times (\text{price departure}))$ . For non-physician fee schedule changes, a price realization factor of 80% is assumed.
3. Determine the share of costs that are subject to the fee schedule
- The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.
  - The share is calculated as the greater of the percent of observed payments with a MAR or 75%. NCCI assumes no change for the share of costs not subject to the fee schedule.

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Alaska for Service Year 2016.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from the latest three policy years projected to the effective date of the benefit changes.

### Physician Fee Schedule

In Alaska, payments for physician services represent 47.1% of total medical costs. Of these payments, 91.1% have a MAR. The overall change in maximums for physician services is a weighted average of the percentage change in MAR by procedure code (Revised MAR/Prior MAR). The weights are based on Service Year 2016 observed payments by procedure code for Alaska, as reported on NCCI's Medical Data Call. The overall weighted-average percentage change in maximums for physician services is -7.1%. The impact by category is shown in the following table.





**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES  
EFFECTIVE JANUARY 1, 2018**

Physician Practice Category	Share of Physician Costs	Percentage Change in MAR
Anesthesia	3.8%	-
Surgery	27.1%	-14.9%
Radiology	13.1%	-19.1%
Pathology and Laboratory	0.5%	-7.9%
Evaluation and Management	15.1%	+0.3%
Medicine	31.3%	-1.8%
Other HCPCS	0.2%	-2.7%
Physician Payments with no specific MAR	8.9%	-
<b>Total Physician Costs</b>	<b>100.0%</b>	<b>-7.1%</b>

Since the overall average maximum reimbursement for physician services decreased, the percentage expected to be realized from the fee schedule change is 50%. The impact on physician payments after applying the price realization factor is -3.6% ( $= -7.1\% \times 0.50$ ).

The above impact of -3.6% is then multiplied by the percentage of medical costs attributed to physician payments in Alaska (47.1%) to arrive at an impact of -1.7% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70.0%) to arrive at an impact of -1.2% on overall workers compensation costs.

#### Hospital Inpatient Fee Schedule

In Alaska, payments for hospital inpatient services represent 11.8% of total medical costs. Of these payments, 74.2% have a MAR. The impact on hospital inpatient services, which is calculated in an analogous manner to the physician fee schedule change, is -3.2%. For hospital inpatient services, the experience is aggregated by episode when calculating the impact. A price realization factor of 50% was applied. The impact on hospital inpatient payments after applying the price realization factor is -1.6% ( $= -3.2\% \times 0.50$ ).

The above impact of -1.6% is then multiplied by the percentage of medical costs attributed to hospital inpatient payments in Alaska (11.8%) to arrive at an impact of -0.2% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70.0%) to arrive at an impact of -0.1% on overall workers compensation costs.

#### Hospital Outpatient Fee Schedule

In Alaska, payments for hospital outpatient services represent 12.7% of total medical costs. Of these payments, 90.1% have a MAR. The impact on hospital outpatient services, which is calculated in an analogous manner to the physician fee schedule change, is +1.9%. A price realization factor of 80% was applied. The impact on hospital outpatient payments after applying the price realization factor is +1.5% ( $= +1.9\% \times 0.80$ ).



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES EFFECTIVE JANUARY 1, 2018

The above impact of +1.5% is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Alaska (12.7%) to arrive at an impact of +0.2% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70.0%) to arrive at an impact of +0.1% on overall workers compensation costs.

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

### Ambulatory Surgical Centers (ASC) Fee Schedule

In Alaska, payments for ASC services represent 11.6% of total medical costs. Of these payments, 90.2% have a MAR. The impact on ASC services, which is calculated in an analogous manner to the physician fee schedule change, is +2.8%. A price realization factor of 80% was applied. The impact on ASC payments after applying the price realization factor is +2.2% ( $= +2.8\% \times 0.80$ ).

The above impact of +2.2% is then multiplied by the percentage of medical costs attributed to ASC payments in Alaska (11.6%) to arrive at an impact of +0.3% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (70.0%) to arrive at an impact of +0.2% on overall workers compensation costs.

### Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

In Alaska, payments for DMEPOS services represent 4.7% of total medical costs. The impact on DMEPOS services, which is calculated in an analogous manner to the physician fee schedule change, is +0.3%. A price realization factor of 80% was applied. The impact on DMEPOS payments after applying the price realization factor is +0.2% ( $= +0.3\% \times 0.80$ ).

The above impact of +0.2% is then multiplied by the percentage of medical costs attributed to DMEPOS payments in Alaska (4.7%) to arrive at a negligible<sup>3</sup> increase on medical costs and on overall workers compensation costs.

### Intrastate Air Ambulance Fee Schedule

In Alaska, payments for air ambulance services represent 2.7% of total medical payments and 39.3% of air ambulance payments are for intrastate flights. Therefore, the payments for intrastate air ambulance services represent 1.1% ( $= 2.7\% \times 39.3\%$ ) of total medical payments. The impact on intrastate air ambulance services, which is calculated in an analogous manner to the physician fee schedule change, is +0.6%. The impact on intrastate air ambulance payments after applying the price realization factor is +0.5% ( $= +0.6\% \times 0.80$ ).

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<sup>3</sup> Negligible is defined in this document to be an impact of less than 0.1%.



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES  
EFFECTIVE JANUARY 1, 2018**

The above impact of +0.5% is then multiplied by the percentage of medical costs attributed to intrastate air ambulance payments in Alaska (1.1%) to arrive at a negligible increase on medical costs and on overall workers compensation costs.

**Summary of Impacts**

The impacts from the fee schedule change in Alaska, effective January 1, 2018, are summarized in the following table:

<b>Type of Service</b>	<b>(A) Impact on Type of Service</b>	<b>(B) Share of Medical Costs</b>	<b>(C) = (A) x (B) Impact on Medical Costs</b>	<b>(D) Medical Costs as a Share of Overall Costs</b>	<b>(E) = (C) x (D) Impact on Overall Costs</b>
Physician Services	-3.6%	47.1%	-1.7%	<b>70.0%</b>	-1.2%
Hospital Inpatient	-1.6%	11.8%	-0.2%		-0.1%
Hospital Outpatient	+1.5%	12.7%	+0.2%		+0.1%
ASC	+2.2%	11.6%	+0.3%		+0.2%
DMEPOS	+0.2%	4.7%	negligible increase		negligible increase
Intrastate Air Ambulance	+0.5%	1.1%	negligible increase		negligible increase
<b>Combined Impact Due to Fee Schedule Change</b>			<b>-1.4%</b>		



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE  
EFFECTIVE JANUARY 1, 2017**

**NCCI estimates that changes to the Alaska Medical Fee Schedule (MFS) due to the update of Medicare fee schedules by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2017<sup>1</sup> will result in an overall impact on Alaska’s workers compensation system costs of +0.2%.**

**Summary of Changes**

Alaska’s MFS was adopted by the Alaska Department of Labor and Workforce Development (DLWD) effective 1/1/2016. The major changes to the Alaska MFS effective 1/1/2017 include:

1. Update to the Physician Fee Schedule to incorporate 2017 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT<sup>2</sup> code and published by the CMS. The prior Physician Fee Schedule was based on 2016 Medicare RBRVUs. The conversion factors established by the DLWD are listed below and remain unchanged.

• Evaluation and Management	\$ 80.00
• Medicine [excluding anesthesiology]	\$ 80.00
• Surgery	\$205.00
• Radiology	\$257.00
• Pathology and Laboratory	\$142.00
• Anesthesia	\$121.82

2. Update to the Hospital Outpatient Fee Schedule to incorporate 2017 Medicare Outpatient Prospective Payment System (OPPS) relative weights established for each CPT code and published by the CMS. The prior Hospital Outpatient Fee Schedule was based on 2016 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.

3. Update to the Hospital Inpatient Fee Schedule to incorporate 2017 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior Hospital Inpatient Fee Schedule was based on 2016 MS-DRG weights. The base rates established by the DLWD for each hospital are listed below and remain unchanged.

• Providence Alaska Medical Center	\$23,383.10
• Mat-Su Regional Medical Center	\$20,976.66
• Bartlett Regional Hospital	\$20,002.93
• Fairbanks Memorial Hospital	\$21,860.73
• Alaska Regional Hospital	\$21,095.72
• Yukon Kuskokwim Delta Regional Hospital	\$38,753.21
• Central Peninsula General Hospital	\$19,688.56
• Alaska Native Medical Center	\$31,042.20
• Mt. Edgecumbe Hospital	\$26,854.53

4. Update to the Ambulatory Surgical Center (ASC) Fee Schedule to incorporate 2017 Medicare OPPS relative weights established for each procedure code and published by the CMS. The

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<sup>1</sup> A change to the rules effective April 1, 2017 clarifies rules regarding reimbursement for medical services, with no expected cost impact.

<sup>2</sup> Current Procedural Terminology maintained by the American Medical Association



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2017

prior ASC fee schedule was based on 2016 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.

5. Update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule to incorporate 2017 DMEPOS maximum allowable reimbursements (MARs) established for each HCPCS<sup>3</sup> code and published by the CMS. The prior DMEPOS fee schedule was based on 2016 MARs. As established by the DLWD, DMEPOS services will continue to be reimbursed at 184% of Medicare's DMEPOS fee schedule.
6. Update to the intrastate air ambulance fees associated with wing air mile rates to incorporate the 2017 Ambulance Fee Schedule MARs established for each HCPCS code and published by the CMS. The prior intrastate air ambulance fee schedule was based on 2016 MARs. As established by the DLWD, intrastate air ambulance HCPCS codes associated with wing air mile rates will not exceed 400% of the Medicare fee schedule rate. The fixed wing lift off fee will not exceed \$11,500 and the rotary wing lift off fee will not exceed \$13,500.

### **Actuarial Analysis**

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

1. Calculate the percentage change in maximum reimbursements
  - Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code.
  - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the revised fee schedule
  - NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
    - In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.
    - In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
    - The formula used to determine the percent realized for fee schedule increases is  $80\% \times (1.10 + 1.20 \times (\text{price departure}))$ .
3. Determine the share of costs that are subject to the fee schedule
  - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

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<sup>3</sup> Healthcare Common Procedure Coding System maintained by the CMS



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE  
EFFECTIVE JANUARY 1, 2017**

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI’s Medical Data Call for Alaska for Service Year (SY) 2015. For the hospital inpatient fee schedule analysis, Medical Data Call for Alaska for SY 2014 was used as well.
- The share of benefit costs attributed to medical benefits is based on NCCI’s Financial Call data for Alaska from the latest three policy years projected to the effective date of the benefit changes.

**Physician Fee Schedule**

In Alaska, payments for physician services represent 48.0% of total medical payments. To calculate the percentage change in MARs for physician services, NCCI calculates the percentage change in MAR for each procedure code. The overall change in MARs for physician services is a weighted average of the percentage change in MARs (revised MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI’s Medical Data Call, for Alaska for SY 2015. The overall, weighted-average percentage change in MARs is +0.4%. The impact by service category is shown in the table below:

Physician Practice Category	Share of Physician Costs	Percentage Change in MAR
Anesthesia	4.0%	0.0%
Surgery	30.7%	0.0%
Radiology	13.0%	+0.8%
Pathology and Laboratory	0.5%	+0.1%
Medicine (General and Physical)	29.7%	+0.8%
Evaluation and Management	14.0%	+0.5%
Physician Payments with no specific MAR	8.1%	-
<b>Total Physician Costs</b>	<b>100.0%</b>	<b>+0.4%</b>

Since the overall average MAR for physician services increased, the percent expected to be realized from the fee schedule increase is estimated according to the formula  $80\% \times (1.10 + 1.20 \times (\text{price departure}))$ . The observed price departure for physician payments in Alaska is -13%, which implies the ratio of actual payments to the prior fee schedule maximum is 0.87. The price realization factor is estimated to be 76% ( $= 80\% \times (1.10 + 1.20 \times (-0.13))$ ). The impact on physician payments after applying the price realization factor is +0.3% ( $= +0.4\% \times 0.76$ ).

The above impact of +0.3% is then multiplied by the percentage of medical costs attributed to physician payments (48.0%) to arrive at the impact on medical costs of +0.1%. This is then multiplied by the percentage of Alaska benefit costs attributed to medical benefits (72.9%) to arrive at an impact of +0.1% on overall workers compensation costs in Alaska.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2017

### Hospital Outpatient Fee Schedule

In Alaska, payments for hospital outpatient services represent 12.7% of total medical payments. To calculate the percentage change in MARs for hospital outpatient services, NCCI calculates the percentage change in MAR for each procedure. The overall change in MARs for hospital outpatient services is a weighted average of the percentage change in MARs (revised MAR / prior MAR) by procedure weighted by the observed payments by procedure as reported on NCCI's Medical Data Call, for Alaska for SY 2015.

The prior and revised MARs are based on the Calendar Year (CY) 2016 and CY 2017 version of Medicare's OPPOS relative weights, respectively, and a conversion factor of \$221.79. Note that Medicare rules for outpatient services contain a comprehensive payment policy that packages payment for adjunctive and secondary items, services, and procedures into the primary procedure under certain circumstances. For this analysis, the experience is aggregated according to the packaging rules reflected under Medicare, if applicable.

The overall, weighted-average percentage change in MAR for hospital outpatient services is -0.4%. Since the overall average MAR for outpatient services decreased, NCCI expects that 50% of the decrease will be realized on hospital outpatient price levels. The impact on hospital outpatient services payments after applying the price realization factor is -0.2% ( $= -0.4\% \times 0.50$ ).

The above impact of -0.2% is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Alaska (12.7%) to arrive at a negligible<sup>4</sup> decrease on both medical and overall workers compensation costs in Alaska.

### Hospital Inpatient Fee Schedule

In Alaska, payments for hospital inpatient services represent 10.6% of total medical payments for SY 2015. To calculate the percentage change in MARs for hospital inpatient services, NCCI calculates the percentage change in MAR for each inpatient hospital episode that is reported with a Medicare severity diagnosis related group (MS-DRG) code. The overall change in MARs for hospital inpatient services is a weighted average of the percentage change in MARs (revised MAR / prior MAR) for each episode weighted by the observed payments by episode as reported on NCCI's Medical Data Call, for Alaska for SYs 2014 and 2015. Two SYs are used to enhance the reliability of hospital inpatient experience.

The prior and revised MARs are based on the Fiscal Year (FY) 2016 and FY 2017 version of Medicare's MS-DRG relative weights, respectively, and a hospital-specific base rate. This analysis uses a weighted average of the hospital-specific conversion factors weighted by the number of admissions by hospital as reported to the CMS. The overall, weighted-average percentage change in MAR for hospital inpatient services is -0.2%.

Since the overall average MAR for hospital inpatient services decreased, NCCI expects that 50% of the decrease will be realized on hospital inpatient price levels. The impact on hospital inpatient payments after applying the price realization factor is -0.1% ( $= -0.2\% \times 0.5$ ).

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<sup>4</sup> Negligible is defined in this document to be an impact on overall system costs of less than 0.1%.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2017

The above impact of -0.1% is then multiplied by the percentage of medical costs attributed to hospital inpatient payments (10.6%) for Service Year 2015 to arrive at a negligible decrease on both medical and overall workers compensation costs in Alaska.

### **ASC Fee Schedule**

In Alaska, payments for ASC services represent 14.4% of total medical payments. The impact on ASC services due to the adoption of the 2017 Medicare OPSS relative weights is calculated in an analogous manner to the hospital outpatient fee schedule change. The overall, weighted-average percentage change in MAR for ASC services is +2.0%.

Since the overall average MAR for ASC services increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula  $80\% \times (1.1 + 1.2 \times (\text{price departure}))$ . Since a reliable price departure could not be determined, NCCI assumed a price realization factor of 80%. The impact on ASC payments after applying the price realization factor is +1.6% ( $= +2.0\% \times 0.80$ ).

The above impact of +1.6% is then multiplied by the percentage of medical costs attributed to ASC payments in Alaska (14.4%) to arrive at the impact on medical costs of +0.2%. This is then multiplied by the percentage of Alaska benefit costs attributed to medical benefits (72.9%) to arrive at an impact of +0.1% on overall workers compensation system costs in Alaska.

### **DMEPOS Fee Schedule**

In Alaska, payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services represent 4.4% of total medical payments. To calculate the percentage change in MARs for DMEPOS services, NCCI calculates the percentage change in MAR for each code. The overall change in MARs for DMEPOS services is a weighted average of the percentage change in MARs (revised MAR / prior MAR) by code weighted by the observed payments by code as reported on NCCI's Medical Data Call for Alaska for Service Year 2015. The overall, weighted-average percentage change in MAR for DMEPOS services is -1.1%.

Since the overall average MAR for DMEPOS services decreased, NCCI expects that 50% of the decrease will be realized on DMEPOS price levels. The impact on payments for DMEPOS services after applying the price realization factor is -0.6% ( $= -1.1\% \times 0.50$ ).

The above impact of -0.6% is then multiplied by the percentage of medical costs attributed to DMEPOS payments in Alaska (4.4%) to arrive at a negligible decrease on both medical and on overall workers compensation costs in Alaska.

### **Intrastate Air Ambulance Fee Schedule**

In Alaska, payments for air ambulance services represent 1.5% of total medical payments and 54.1% of air ambulance payments are for intrastate flights. Therefore, the payments for intrastate air ambulance





**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE  
EFFECTIVE JANUARY 1, 2017**

services represent 0.8% (= 1.5% x 54.1%) of total medical payments. To calculate the percentage change in MARs for intrastate air ambulance services, NCCI calculates the percentage change in MAR for each service. The overall change in MARs for air ambulance services is a weighted average of the percentage change in MARs (revised MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI’s Medical Data Call, for Alaska for Service Year 2015. The overall, weighted-average percentage change in MAR for intrastate air ambulance services is +0.4%.

Since the overall average MAR for intrastate air ambulance services increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula  $80\% \times (1.10 + 1.20 \times (\text{price departure}))$ . Since a reliable price departure could not be determined, NCCI assumed a price realization factor of 80%. The impact on intrastate air ambulance payments after applying the price realization factor is +0.3% (=+0.4% x 0.80).

The above impact of +0.3% is then multiplied by the percentage of medical costs subject to the intrastate air ambulance fee schedule in Alaska (0.8%) to arrive at a negligible increase on both medical and overall workers compensation system costs in Alaska.

**Summary of Impacts**

The impacts on Alaska’s workers compensation system costs due to the changes are summarized in the table below:

	<b>(A)</b> <b>Impact on Type of Service</b>	<b>(B)</b> <b>Share of Medical Costs</b>	<b>(C)</b> <b>Impact on Medical Costs</b> <b>(A) x (B)</b>	<b>(D)</b> <b>Impact on Overall Costs</b> <b>(C) x (2)</b>
<b>Physician</b>	+0.3%	48.0%	+0.1%	
<b>Hospital Outpatient</b>	-0.2%	12.7%	Negligible Decrease	
<b>Hospital Inpatient</b>	-0.1%	10.6%	Negligible Decrease	
<b>ASC</b>	+1.6%	14.4%	+0.2%	
<b>DMEPOS</b>	-0.6%	4.4%	Negligible Decrease	
<b>Intrastate Air Ambulance</b>	+0.3%	0.8%	Negligible Increase	
<b>(1) Total Impact on Alaska Medical Costs</b>			<b>+0.3%</b>	
<b>(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in Alaska</b>				<b>72.9%</b>
<b>(3) Total Impact on Overall Workers Compensation System Costs in Alaska = (1) x (2)</b>				<b>+0.2%</b>



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

**NCCI estimates that changes to the Alaska Medical Fee Schedule due to the update of Medicare fee schedules by the Centers for Medicare and Medicaid Services effective January 1, 2016 will result in an overall impact on Alaska's workers compensation system costs of +0.5%.**

### Summary of Changes

Alaska's Medical Fee Schedule was adopted by the Alaska Department of Labor and Workforce Development (DLWD) effective 12/1/2015. Changes to the Alaska Medical Fee Schedule effective 1/1/2016 include:

1. Update to the Physician Fee Schedule to incorporate 2016 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT<sup>1</sup> code and published by the Centers for Medicare and Medicaid Services (CMS). The prior Physician Fee Schedule was based on 2015 Medicare RBRVUs. The conversion factors established by the DLWD are listed below and remain unchanged.
  - Evaluation and Management \$80.00
  - Medicine [excluding anesthesiology] \$80.00
  - Surgery \$205.00
  - Radiology \$257.00
  - Pathology and Laboratory \$142.00
  - Anesthesia \$121.82
2. Update to the Hospital Outpatient Fee Schedule to incorporate 2016 Medicare Outpatient Prospective Payment System (OPPS) relative weights established for each CPT code and published by the CMS. The prior Hospital Outpatient Fee Schedule was based on 2015 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.
3. Update to the Hospital Inpatient Fee Schedule to incorporate 2016 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior Hospital Inpatient Fee Schedule was based on 2015 MS-DRG weights. The base rates established by the DLWD for each hospital are listed below and remain unchanged.
  - Providence Alaska Medical Center \$23,383.10
  - Mat-Su Regional Medical Center \$20,976.66
  - Bartlett Regional Hospital \$20,002.93
  - Fairbanks Memorial Hospital \$21,860.73
  - Alaska Regional Hospital \$21,095.72

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<sup>1</sup> Current Procedural Terminology maintained by the American Medical Association



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

- Yukon Kuskokwim Delta Regional Hospital \$38,753.21
  - Central Peninsula General Hospital \$19,688.56
  - Alaska Native Medical Center \$31,042.20
  - Mt. Edgecumbe Hospital \$26,854.53
4. Update to the Ambulatory Surgical Center (ASC) Fee Schedule to incorporate 2016 Medicare OPPS relative weights established for each CPT code and published by the CMS. The prior ASC fee schedule was based on 2015 OPPS relative weights. The conversion factor established by the DLWD remains at \$221.79.
  5. Update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule to incorporate 2016 DMEPOS maximum allowable reimbursements established for each HCPCS<sup>2</sup> code and published by the CMS. The prior DMEPOS fee schedule was based on 2015 maximum allowable reimbursements. As established by the DLWD, DMEPOS services will continue to be reimbursed at 184% of Medicare's DMEPOS fee schedule.
  6. Update to the intrastate air ambulance fees associated with wing air mile rates to incorporate the 2016 Ambulance Fee Schedule maximum allowable reimbursements established for each HCPCS code and published by the CMS. The prior intrastate air ambulance fee schedule was based on 2015 maximum allowable reimbursements. As established by the DLWD, intrastate air ambulance HCPCS codes associated with wing air mile rates will not exceed 400% of the Medicare fee schedule rate. The fixed wing lift off fee will not exceed \$11,500 and the rotary wing lift off fee will not exceed \$13,500.
  7. Update to the Medicare Part B Average Sales Price (ASP) Drug Fee Schedule to incorporate the 2016 ASP Drug Fee Schedule maximum allowable reimbursements established for each HCPCS code and published by the CMS. The prior ASP Drug Fee Schedule was based on 2015 maximum allowable reimbursements. As established by the DLWD, ASP services will continue to be reimbursed at 337.5% of Medicare's ASP fee schedule.

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<sup>2</sup> Healthcare Common Procedure Coding System maintained by the Centers for Medicare and Medicaid Services



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

### Actuarial Analysis

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

1. Calculate the percentage change in maximum reimbursements
  - a. Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code
  - b. Calculate the weighted average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights
2. Estimate the price level change as a result of the revised fee schedule
  - a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence From 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
    - i. In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.
    - ii. In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).

The formula used to determine the percent realized for fee schedule increases is  $80\% \times (1.10 + 1.20 \times (\text{price departure}))$ .
3. Determine the share of costs that are subject to the fee schedule
  - a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Alaska for Service Year 2014. For the hospital inpatient fee schedule analysis, Medical Data Call for Alaska for Service Year 2013 was used as well.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from the latest 3 policy years projected to the effective date of the benefit changes.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

### Physician Fee Schedule

In Alaska, payments for physician services represent 50.0% of total medical payments. To calculate the percentage change in maximums for physician services, NCCI calculates the percentage change in maximum allowable reimbursement (MAR) for each procedure code. The overall change in maximums for physician services is a weighted average of the percentage change in MAR (revised MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for Alaska for Service Year 2014.

The prior MARs are calculated as follows:

$$\text{Prior MAR} = \text{Prior Medicare RVUs} \times \text{Conversion Factors}$$

The revised MARs are calculated as follows:

$$\text{Revised MAR} = \text{Revised Medicare RVUs} \times \text{Conversion Factors}$$

Where Prior Medicare RVUs are based on the Calendar Year 2015 version of the Medicare RBRVS publication and the Revised Medicare RVUs are based on the Calendar Year 2016 version.

The Conversion Factors are

- Evaluation and Management \$80.00
- Medicine [excluding anesthesiology] \$80.00
- Surgery \$205.00
- Radiology \$257.00
- Pathology and Laboratory \$142.00
- Anesthesia \$121.82

Note: The relative values for work hardening CPT codes 97545 and 97546 are 3.41 and 1.36, respectively.

The overall weighted average percentage change in MARs is 0.0%. The impact by service category is shown in the table below:



**ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE  
EFFECTIVE JANUARY 1, 2016**

<b>Physician Practice Category</b>	<b>Share of Physician Costs</b>	<b>Percentage Change in MAR</b>
Anesthesia	3.7%	0.0%
Surgery	32.4%	+0.1%
Radiology	12.9%	+0.3%
Pathology and Laboratory	0.7%	0.0%
Medicine (General and Physical)	29.2%	-0.1%
Evaluation and Management	13.8%	-0.1%
Physician Payments with no specific MAR	7.3%	0.0%
<b>Total Physician Costs</b>	<b>100.0%</b>	<b>0.0%</b>

Given the above impact of 0.0% for physician services, the physician fee schedule changes will result in a negligible<sup>3</sup> change in both medical and overall workers compensation system costs in Alaska.

**Hospital Outpatient Fee Schedule**

In Alaska, payments for hospital outpatient services represent 12.8% of total medical payments. To calculate the percentage change in reimbursements for hospital outpatient services, NCCI calculates the percentage change in prior reimbursement to revised reimbursement for each procedure. The overall change in reimbursements for hospital outpatient services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI’s Medical Data Call, for Alaska for Service Year 2014. The prior reimbursements and revised reimbursements are calculated as follows:

**Prior Reimbursement**

For each relevant procedure,

$$\text{Prior Reimbursement} = [\text{Prior Relative Weight} \times \text{Alaska-Specific Conversion Factor} + \text{Prior Outlier Amount (if applicable)} - \text{Multiple Procedure Discounts (if applicable)}]$$

**Revised Reimbursement**

For each relevant procedure,

$$\text{Revised Reimbursement} = [\text{Revised Relative Weight} \times \text{Alaska-Specific Conversion Factor} + \text{Outlier Amount (if applicable)} - \text{Multiple Procedure Discounts (if applicable)}]$$

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<sup>3</sup> Negligible is defined in this document to be an impact on overall system costs of less than +/- 0.1%.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

Where Alaska-Specific Conversion Factor in both Prior and Revised Reimbursement Formulas = \$221.79

The prior reimbursement is based on the Calendar Year 2015 version of Medicare's OPPS publication while the revised reimbursement is based on the Calendar Year 2016 version.

The overall weighted-average percentage change in reimbursements for hospital outpatient services is +0.8%. Since the overall reimbursements for hospital outpatient services increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula  $80\% \times (1.1 + 1.2 \times (\text{price departure}))$ . Since a reliable price departure could not be determined, NCCI assumed a price realization factor of 80%. The impact on hospital outpatient services payments after applying the price realization factor of 80% is +0.6% ( $= +0.8\% \times 0.80$ ).

The above impact on hospital outpatient payments is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Alaska (12.8%) to arrive at the impact on medical costs of +0.1%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (76.1%) to arrive at the impact on overall workers compensation costs in Alaska of +0.1%.

### Hospital Inpatient Fee Schedule

In Alaska, payments for hospital inpatient services represent 12.7% of total medical payments for Service Year 2014. To calculate the percentage change in reimbursements for hospital inpatient services, NCCI calculates the percentage change in prior reimbursement to revised reimbursement for each inpatient hospital episode that is reported with a diagnosis related group (MS-DRG) procedure code. The overall change in reimbursements for hospital inpatient services is a weighted average of the percentage change in reimbursements for each episode weighted by the observed payments by episode as reported on NCCI's Medical Data Call, for Alaska for Service Years 2013 and 2014. Two service years are used in order to enhance the reliability of hospital inpatient experience. The prior and revised reimbursements are calculated as follows:

#### Prior Reimbursement

Prior Reimbursement = [Prior MS-DRG Weight x Conversion Factor<sup>4</sup> + Prior Outlier Amount (if applicable)]

#### Revised Reimbursement

Revised Reimbursement = [Revised MS-DRG Weight x Conversion Factor<sup>4</sup> + Revised Outlier Amount (if applicable)]

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<sup>4</sup> This analysis uses a weighted average of the hospital-specific conversion factors weighted by the number of admissions by hospital as reported to the Centers for Medicare and Medicaid Services.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

The Prior MS-DRG weight is based on the Fiscal Year 2015 version of Medicare's Inpatient Prospective Payment System publication. The Revised MS-DRG weight is based on the Fiscal Year 2016 version of the same Medicare publication.

The overall weighted average percentage change in reimbursements for hospital inpatient services is -0.6%. Since the overall reimbursements for hospital inpatient services decreased, NCCI expects that 50% of the decrease will be realized on hospital inpatient price levels. The impact on hospital inpatient payments after applying the price realization factor of 50% is -0.3% (=  $-0.6\% \times 0.5$ ).

The above impact on hospital inpatient costs is then multiplied by the percentage of medical costs attributed to hospital inpatient payments (12.7%) for Service Year 2014 to arrive at a negligible change in both medical and overall workers compensation costs in Alaska.

### **ASC Fee Schedule**

In Alaska, payments for ASC services represent 10.4% of total medical payments. To calculate the percentage change in reimbursements for ASC services, NCCI calculates the percentage change in prior reimbursement to revised reimbursement for each procedure. The overall change in reimbursements for ASC services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for Alaska for Service Year 2014.

The prior and revised reimbursements are calculated in an analogous manner to the hospital outpatient analysis, except that Medicare has no outlier provision under the ASC fee schedule.

The overall weighted average percentage change in reimbursements for ASC services is +5.5%. Since the overall reimbursements for ASC services increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula  $80\% \times (1.1 + 1.2 \times (\text{price departure}))$ . Since a reliable price departure could not be determined, NCCI assumed a price realization factor of 80%. The impact on ASC payments after applying the price realization factor of 80% is +4.4% (=  $+5.5\% \times 0.80$ ).

The above impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in Alaska (10.4%) to arrive at the impact on medical costs of +0.5%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical benefits in Alaska (76.1%) to arrive at the impact on overall workers compensation system costs in Alaska of +0.4%.

### **DMEPOS Fee Schedule**

In Alaska, payments for DME services subject to the fee schedule represent 1.5% of total medical payments. To calculate the percentage change in maximums for DME, NCCI calculates the percentage change in maximum for each procedure code. The overall change in maximums





## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

for DMEPOS services is a weighted average of the percentage change in MAR (revised MAR / prior MAR) by procedure code weighted by the observed payments by procedure code. The overall weighted average percentage change in MARs for DMEPOS services is -3.2%.

Since the overall average maximum reimbursements for DMEPOS services decreased, NCCI expects that 50% of the decrease would be realized on DMEPOS price levels. The impact on DMEPOS payments after applying the price realization factor of 50% is -1.6% ( $= -3.2\% \times 0.50$ ).

The above impact is then multiplied by the percentage of medical costs subject to the fee schedule attributed to DMEPOS payments in Alaska (1.5%) to arrive at a negligible change in both medical and overall workers compensation system costs in Alaska.

### **Intrastate Air Ambulance Fee Schedule**

In Alaska, payments for air ambulance services represent 2.0% of total medical payments and 34.8% of air ambulance payments are for intrastate flights. Therefore, the payments for intrastate air ambulance services represent 0.7% ( $= 2.0\% \times 34.8\%$ ) of medical payments. To calculate the percentage change in reimbursements for intrastate air ambulance services, NCCI calculates the percentage change in prior reimbursement to revised reimbursement for each service. The overall change in reimbursements for air ambulance services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for Alaska for Service Year 2014.

The overall weighted-average percentage change in reimbursements for intrastate air ambulance services is -0.2%.

Since the overall reimbursements for intrastate air ambulance services decreased, NCCI expects that 50% of the decrease would be realized on air ambulance price levels. The impact on intrastate air ambulance payments after applying the price realization factor of 50% is -0.1% ( $= -0.2\% \times 0.50$ ).

The above impact on intrastate air ambulance payments is then multiplied by the percentage of medical costs subject to the fee schedule attributed to intrastate air ambulance payments in Alaska (0.7%) to arrive at a negligible change in both medical and overall workers compensation system costs in Alaska.

### **Average Sales Price (ASP) Drug Fee Schedule**

In Alaska, payments for drugs subject to the ASP fee schedule represent 0.2% of total medical payments. To calculate the percentage change in maximums for ASP, NCCI calculates the percentage change in maximum for each ASP drug code. The overall change in maximums for ASP services is a weighted average of the percentage change in MAR (revised MAR / prior MAR) by procedure code weighted by the observed payments by ASP drug code.



## ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE UPDATE EFFECTIVE JANUARY 1, 2016

The overall weighted average percentage change in reimbursements for ASP services is +3.4%.

Since the overall reimbursements for ASP services increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula  $80\% \times (1.1 + 1.2 \times (\text{price departure}))$ . Since a reliable price departure could not be determined, NCCI assumed a price realization factor of 80%. The impact on ASP payments after applying the price realization factor of 80% is +2.7% ( $= +3.4\% \times 0.80$ ).

The above impact on ASP payments is then multiplied by the percentage of medical costs subject to the fee schedule attributed to ASP payments in Alaska (0.2%) to arrive at a negligible change in both medical and overall workers compensation system costs in Alaska.

### Summary of Impacts

The impacts on Alaska's workers compensation system costs due to the changes are summarized in the table below:

	(A) Impact on Type of Service	(B) Share of Medical Costs	(C) Impact On Medical Costs  (A) x (B)	(D) Impact on Overall Costs  (C) x (2)
<b>Physician</b>	0.0%	50.0%	Negligible	
<b>Hospital Outpatient</b>	+0.6%	12.8%	+0.1%	
<b>Hospital Inpatient</b>	-0.3%	12.7%	Negligible	
<b>ASC</b>	+4.4%	10.4%	+0.5%	
<b>DMEPOS</b>	-1.6%	1.5%	Negligible	
<b>Intrastate Air Ambulance</b>	-0.1%	0.7%	Negligible	
<b>ASP</b>	+2.7%	0.2%	Negligible	
<b>(1) Total Impact on Alaska Medical Costs</b>			<b>+0.6%</b>	
<b>(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in Alaska</b>				<b>76.1%</b>
<b>(3) Total Impact on Overall Workers Compensation System Costs in Alaska = (1) x (2)</b>				<b>+0.5%</b>

**TAB 8**

**April 2, 2019 Email from Carla Gee at Optum regarding Hearing aid/services fees:**

Hi All,

Montana is silent on hearing aids/services but I've provided its fee schedule below along with Wyoming's per the list Misty provided. Wyoming's narrative of 'invoice +30%' is what the MSRC used as its basis last year for the hearing aid rule. I've also attached other state information on hearing aids; it is what I provided Marie last year (and is based on 2018 schedules).

Montana is able to value codes that Alaska does not as it adopts Optum's gap-fill values (Optum develops relative values for many of the codes that are not valued under RBRVS). Wyoming uses Relative Values for Physicians which also provides relative values for some of the codes listed below in which RBRVS does not.

I could check NCCI's data, however, it won't show shift from 2018 to 2019 as the most current full year information available is 2017.

Code	Description	Provided by PACBLU			2019 AK WC Allowance	2018 MT WC Allowance	2018 WY WC Allowance
		2018 Charge	2019 Charge				
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 + 92556)	\$270.00	\$272.00	\$113.91	\$67.95	\$87.01	
92567	Tympanometry (impedance testing)	\$132.00	\$134.00	\$44.23	\$26.04	\$19.78	
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation, w/ report	\$495.00	\$495.00	\$100.20	\$59.06	\$138.43	
92588-26				\$89.80	\$52.07	\$98.88	
92588-TC				\$10.40	\$6.99	\$39.55	
92591	Hearing aid examination and selection; binaural	\$371.00	\$378.00	85% of billed	\$125.73	\$130.52	

92593	Hearing aid check; binaural	\$191.00	\$200.00	85% of billed	\$64.14	\$47.46
92594	Electroacoustic evaluation for hearing aid; monaural	\$239.00	\$239.00	85% of billed	\$37.47	\$31.64
92595	Electroacoustic evaluation for hearing aid; binaural	\$111.00	\$111.00	85% of billed	\$80.65	\$47.46
92633	Auditory rehabilitation; postlingual hearing loss	\$405.00	\$405.00	85% of billed	by report	by report
V5011	Fitting/orientation/checking of hearing aid	\$465.00	<b>\$2,135.00</b>	85% of billed	\$146.69	\$283.19
V5014	Repair/modification of a hearing aid	\$561.89	\$561.89	85% of billed	\$177.17	\$341.04
V5020	Conformity evaluation	\$133.00	\$197.00	85% of billed	\$82.55	by report
V5160	Dispensing fee, binaural	\$1,836.00	<b>\$4,986.00</b>	85% of billed	\$578.49	\$300.00
V5267	Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	\$1,495.00	\$1,495.00	85% of billed	by report	by report
V5275	Ear impression, each	\$150.00	\$150.00	85% of billed	by report	by report
V5299	Hearing service, miscellaneous	\$1,495.00	\$1,495.00	85% of billed	by report	by report
CPT, Copyright 2018, American Medical Association						

Please let me know if you have questions or would like to discuss further.

Thanks

Carla

State	Notes
AK	by report
AL	silent
AR	by report
AZ	silent
CA	silent
CO	fee schedule; no specific language
CT	silent
DC	by report
DE	fee schedule, but no specific language
FL AUTO	by report
FL WC	by report
GA	by report
HI AUTO	silent
HI WC	silent
ID	silent
IL	fee schedule; no specific language
KS	silent
KY	fee schedule; no specific language
LA	fee schedule; no specific language
MA	adjusted acquisition cost + various markups depending on code
MD	by report
ME	by report
MI	Hearing aid suppliers shall use the appropriate procedure code V5008-V5230 listed in Medicare's National Level II Codes as referenced in 418.10107(2) to describe services provided. When requesting payment for hearing aids a minimum of 2 comparable written quotations shall be required for hearing aids which exceed \$1,500.00 per hearing aid, including related services such as orientation, fitting, ear molds, support, adjustment, conformity check, batteries, warranties and follow-up. Only a single price quotation shall be required for hearing aids, including related services that cost \$1,500.00 or less per hearing aid.
MN	by report
MS	fee schedule, employer shall provide injured employee
MT	fee schedule; no specific language
NC	dispensing fees, silent
ND	silent
NE	silent
NJ AUTO	silent
NM	silent
NV	silent
NY AUTO	silent
NY WC	silent
OH	fee schedule
OK	silent
OR AUTO	Hearing aids MUST BE prescribed by the attending physician, authorized nurse practitioner or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. The payment for hearing aids may not exceed \$7000 for a pair of hearing aids, or \$3500 for a single hearing aid.
OR WC	Hearing aids MUST BE prescribed by the attending physician, authorized nurse practitioner or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. The payment for hearing aids may not exceed \$7000 for a pair of hearing aids, or \$3500 for a single hearing aid.
PA AUTO	silent
PA WC	silent
RI	silent
SC	fee schedule with some individual consideration; no specific language
SD	silent
TN	silent
TX	silent
UT AUTO	silent
UT WC	silent
VA	silent (dispensing fees)
VT	Injury means any harmful work-related change in the body, whether occurring instantaneously or gradually, and includes a claimed or apparent injury or disease. The term also includes damage to and the cost of replacement of prosthetic devices, hearing aids and eyeglasses when the damage or need for replacement arises out of and in the course of employment. 21 V.S.A. §601(7). Depending on the circumstances, the term "injury" also includes "aggravation," "flare-up" or "recurrence" as those terms are defined in Rules 2.1200, 2.2300 and 2.3900.
WA	dispensing fees, the insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary
WI	fee schedule & by report
WV	prior authorization
WY	Dispensing fees; the Division shall pay 130% of the supplier's/manufacture's invoice price for hearing aids when the provider submits the invoice to the Division.

Prepared by Optum