EMERGENCY REGULATION

Register 216, January 2016 LABOR AND WORKFORCE DEV.

8 AAC 45.082(*l*)(2) is repealed:

(2) repealed 12 / 1 / 2015 ;

8 AAC 45.082(m) is amended to read:

(m) A fee or other charge for medical treatment or service provided on or after December 31, 2010, **but before December 1, 2015,** may not exceed the board's fees established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective December 31, 2010, and adopted by reference. (Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 7/1/88, Register 107; am 10/28/88, Register 108; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 2/3/2001, Register 157; am 7/31/2010, Register 195; am 12/31/2010, Register 196; am 6/27/2011, Register 199; am 7/9/2011, Register 199; am 11/20/2011, Register 200; am 3/28/2012, Register 201; am 12 / 1 / 2015, Register 216)

Authority: AS 23.30.005 AS 23.30.045 AS 23.30.097
AS 23.30.030 AS 23.30.095

8 AAC 45 is amended by adding a new section to read:

8 AAC 45.083. Fees for medical treatment and services. (a) A fee or other charge for medical treatment or service provided on or after December 1, 2015, may not exceed the fee schedules set out in this section.

(b) For medical services provided by physicians under the Alaska Workers' Compensation Act, the following conversion factors shall be applied to the total facility or non-facility Relative Value Unit in the *Resource-Based Relative Value Scale*, established by the

Centers for Medicare and Medicaid Services, as amended, in effect at the time of treatment or service. Medical service or treatment shall be identified by a code assigned to that treatment or service in the latest edition of the *Current Procedural Terminology*, published by the American Medical Association, as amended.

(1) The conversion factor for evaluation & management is 80.

(2) The conversion factor for medicine (excluding anesthesiology) is 80.

(3) The conversion factor for surgery is 205.

(4) The conversion factor for radiology is 257.

(5) The conversion factor for pathology and laboratory is 142.

(6) The relative value for *Current Procedural Terminology* code 97545 shall be 3.41, and the relative value for *Current Procedural Terminology* code 97546 shall be 1.36.

(c) The conversion factor for anesthesiology is 121.82, which is to be multiplied by the base and time units for each *Current Procedural Terminology* code established in the *Relative Value Guide*, as amended, published by the American Society of Anesthesiologists.

(d) For supplies, materials, injections, and other services and procedures coded under the *Healthcare Common Procedure Coding System*, the following multipliers shall be applied to the fee schedules established by the Centers for Medicare and Medicaid Services, as amended, in effect at the time of treatment or service.

(1) Pathology & Clinical Lab, Centers for Medicare and Medicaid Services x 6.33.

(2) Durable Medical Equipment Centers for Medicare and Medicaid Services x 1.84.

(3) Average Sale Price Centers for Medicare and Medicaid Services x 3.375.

(e) For medical services provided by inpatient hospitals under the Alaska Workers' Compensation Act, the conversion factor of 328.2 shall be applied to the *Medicare Severity Diagnosis Related Groups* weight established by the Centers for Medicare and Medicaid Services, as amended, in effect at the time of treatment or service.

(1) The maximum allowable reimbursement for medical services provided by a critical access hospital, rehabilitation hospital, or long term acute care hospital is the lower 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.

(2) The base rate for Providence Alaska Medical Center is 23,383.10.

(3) The base rate for Mat-Su Regional Medical Center is 20,976.66.

(4) The base rate for Bartlett Regional Hospital is 20,002.93.

(5) The base rate for Fairbanks Memorial Hospital is 21,860.73.

(6) The base rate for Alaska Regional Hospital is 21,095.72.

(7) The base rate for Yukon Kuskokwim Delta Regional Hospital is 38,753.21.

(8) The base rate for Central Peninsula General Hospital is 19,688.56.

(9) The base rate for Alaska Native Medical Center is 31,042.20.

(10) The base rate for Mt. Edgecumbe Hospital is 26,854.53.

(11) On outlier cases, implants shall be paid at invoice plus 10 percent.

(f) For medical services provided by outpatient clinics or ambulatory surgical centers under the Alaska Workers' Compensation Act, an outpatient conversion factor of 221.79 shall be

applied to the relative weights established for each *Current Procedural Terminology* or *Ambulatory Payment Classifications* code by the Centers for Medicare and Medicaid Services, as amended, in effect at the time of treatment or service. For procedures performed in an outpatient setting, implants shall be paid at invoice plus 10 percent.

(g) The maximum allowable reimbursement for medical services that do not have current Centers for Medicare and Medicaid Services, *Current Procedural Terminology*, or *Healthcare Common Procedure Coding System* codes, a currently assigned Centers for Medicare and Medicaid Services relative value, or an established conversion factor shall be the lower 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.

(h) 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 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.

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

(1) For air ambulance services provided entirely in Alaska 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:

(A) A fixed wing lift off fee must not exceed $11,500.

(B) A fixed wing air mile rate must not exceed 400 percent of the Centers for Medicare and Medicaid Services fee schedule rate, as amended, in effect at the time of service.

(C) A rotary wing lift off fee must not exceed $13,500.

(D) A rotary wing air mile rate must not exceed 400 percent of the Centers for Medicare and Medicaid Services fee schedule rate, as amended, in effect at the time of service.

(2) For air ambulance services in circumstances not covered by (1) in this subsection, the maximum allowable reimbursement is 100 percent of the billed charges.

(j) The following billing and payment rules shall apply for medical treatment or services provided by physicians.

(1) Providers and payers shall follow the billing and coding rules, as amended, in effect at the time of treatment, as established by the Centers for Medicare and Medicaid Services and the American Medical Association, including the use of modifiers. The procedure with the largest Relative Value Unit will be the primary procedure and will be listed first on the claim form. Specific modifiers shall be reimbursed as follows:

(2) Modifier 50: Reimbursement shall be 100 percent of the fee schedule amount or the lesser of the billed charge for the procedure with the highest Relative Value Unit.

Reimbursement shall be 50 percent of the fee schedule amount or the lesser of the billed charge for the procedure for the second and all subsequent procedures.

(3) Modifier 51: Reimbursement shall be 100 percent of the fee schedule amount or the lesser of the billed charge for the procedure with the highest Relative Value Unit rendered during the same session as the primary procedure. Reimbursement shall be 50 percent of the fee schedule amount or the lesser of the billed charge for the procedure with the second highest Relative Value Unit and all subsequent procedures during the same session as the primary procedure.

(4) Modifiers 80, 81, and 82: Reimbursement shall be 20 percent of the surgical procedure.

(5) Modifier PE: Reimbursement shall be 85 percent of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants or an advanced practice registered nurse.

(6) Modifier AS: Reimbursement shall be 15percent of the value of the procedure. State specific modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.

(7) Modifier QZ: Reimbursement shall be 85 percent of the value of the anesthesia procedure. State specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.

(8) Providers and payers shall follow National Correct Coding Initiative edits established by the Centers Medicare and Medicaid Services and the American Medical Association, as amended, in effect at the time of treatment. When there is a billing rule

discrepancy between National Council on Compensation Insurance edits and the American Medical Association *Current Procedural Terminology* Assistant, American Medical Association *Current Procedural Terminology* Assistant guidance governs.

(k) The following billing and payment rules shall apply for medical treatment or services provided by inpatient hospitals, outpatient clinics, and ambulatory surgical centers.

(1) Medical services for which there is no *Ambulatory Payment Classifications* weight listed shall be the lower 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 codes C, E, and P shall be the lower 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 code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the *Ambulatory Payment Classifications* calculated amount and all other status code T items paid at 50 percent.

(4) A payer shall subtract implantable hardware from an outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.

(5) When total costs for a hospital inpatient *Medicare Severity Diagnosis Related Groups* coded service exceeds the Centers for Medicare and Medicaid Services outlier threshold established at the time of service plus the *Medicare Severity Diagnosis Related Groups* payment,

then the total payment for that service shall be calculated using the Centers for Medicare and Medicaid Services Inpatient PC Pricer tool as follows:

(A) Implantable charges, if applicable, are subtracted from the total amount charged.

(B) The charged amount from (a) is entered into the most recent version of the Centers for Medicare and Medicaid Services PC Pricer tool at the time of treatment.

(C) The Medicare price returned by the Centers for Medicare and Medicaid Services PC Pricer tool is multiplied by 2.5, or 250 percent of the Medicare price.

(D) The allowable implant reimbursement, if applicable, is the invoice cost of the implant(s) plus 10 percent, or 110 percent of invoice cost.

(E) The amounts calculated in (c) and (d) are added together to determine the final reimbursement.

(*l*) For medical treatment or services provided by other providers, the maximum allowable reimbursement for medical services provided by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers, shall be the lower 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.

(m) The following material is incorporated by reference:

(1) *Current Procedural Terminology Codes*, produced by the American Medical Association, as may be amended.

(2) *Healthcare Common Procedure Coding System*, produced by the American Medical Association, as may be amended.

(3) *International Classification of Diseases*, published by the American Medical Association, as may be amended.

(4) *Relative Value Guide*, produced by the American Society of Anesthesiologists, as may be amended.

(5) *Diagnostic and Statistical Manual of Mental Disorders*, produced by the American Psychiatric Association, as may be amended.

(6) *Current Dental Terminology*, published by the American Dental Association, as may be amended.

(7) *Resource-Based Relative Value Scale*, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(8) *Ambulatory Payment Classifications*, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(9) *Medicare Severity Diagnosis Related Groups*, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(n) In this section, "maximum allowable reimbursement" means the charge for medical treatment or services calculated in accordance with the fee schedule. (Eff. 12/1/2015, Register 216)

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

Editor's note: The above-referenced materials may be found at: Department of Labor and Workforce Development, Division of Workers' Compensation at 1111 W 8th St., Suite 305 Juneau, Alaska 99811

8 AAC 45.900(a) is amended by adding a new section to read:

(15) Unless the statutory context requires otherwise, "provider" means any physician, pharmacist, dentist, or other health service worker or any hospital, clinic, or other facility licensed under AS 08 to furnish medical or dental services, including chiropractic, physical therapy, and mental health services, and includes an out-of-state person or facility that meets the requirements of this section and is otherwise qualified to be licensed under AS 08.

(Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 7/1/88, Register 107; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 4/16/2010, Register 194; am 12/22/2011, Register 200; am 12/1/2015, Register 216)

Authority: AS 23.30.005 AS 23.30.090 AS 23.30.230
AS 23.30.030 AS 23.30.175 AS 23.30.240
AS 23.30.041 AS 23.30.220 AS 23.30.395
AS 23.30.097