APRIL 2022
MEDICAL SERVICES REVIEW COMMITTEE MEETING

August 5, 2022
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TAB 1</th>
<th>Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAB 2</th>
<th>MSRC Member Roster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAB 3</th>
<th>MSRC Meeting Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAB 4</th>
<th>Draft 2023 Alaska Medical Fee Schedule – Track Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 11</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAB 5</th>
<th>Draft 2023 Alaska Medical Fee Schedule – Clean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 72</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAB 6</th>
<th>Draft MSRC Working Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 131</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAB 7</th>
<th>Public Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 136</td>
<td></td>
</tr>
</tbody>
</table>
TAB 1
AGENDA

August 5, 2022
9:00 am Call to order
  • Roll call - establishment of quorum
  • Approval of Agenda
  • Previous meeting minutes
10:00 am Break
10:15 am Public Comment Period
11:15 am Break
11:30 am Overview/Discussion of 2023 MSRC Fee Schedule Issues
  • Update notes
  • Motion to Approve 2023 Alaska Medical Fee Schedule recommendation

12:00 pm Lunch Break

1:30 pm Roll Call
1:35 pm 2023 Fee Schedule Conclusion
3:00 pm Break
3:15 pm 2023 Fee Schedule Guidelines Development (cont.)
5:00 pm Adjournment
TAB 2
Alaska Workers’ Compensation Medical Services Review Committee, AS 23.30.095(j)

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

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

Committee Membership as of May 25, 2022

<table>
<thead>
<tr>
<th>Seat</th>
<th>Last Name</th>
<th>First Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairperson</td>
<td>Collins</td>
<td>Charles</td>
<td>Director, Division of Workers’ Compensation</td>
</tr>
<tr>
<td>Alaska State Medical</td>
<td>Moore, MD</td>
<td>Jeffery</td>
<td>Orthopedic Physicians Anchorage, Inc.</td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska Chiropractic</td>
<td>McCloskey, DC</td>
<td>Mason</td>
<td>Kanady Chiropractic Center</td>
</tr>
<tr>
<td>Society</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska State Hospital</td>
<td>Gilbert</td>
<td>Jeff</td>
<td>St. Elias Specialty Hospital</td>
</tr>
<tr>
<td>&amp; Nursing Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Care Provider</td>
<td>Poland, MD</td>
<td>Mary Ann</td>
<td>Primary Care Associates</td>
</tr>
<tr>
<td>Lay Member – Industry</td>
<td>Steed</td>
<td>Misty</td>
<td>PACBLU</td>
</tr>
<tr>
<td>Lay Member – Industry</td>
<td>Scott</td>
<td>Pam</td>
<td>Northern Adjusters, Inc.</td>
</tr>
<tr>
<td>Lay Member – Labor</td>
<td>Mittelstead</td>
<td>Valerie</td>
<td>IBEW</td>
</tr>
<tr>
<td>Lay Member – Industry</td>
<td>Kosinski</td>
<td>Susan</td>
<td>ARECA Insurance Exchange</td>
</tr>
</tbody>
</table>
TAB 3
I. Call to order  
Director of Workers’ Compensation Charles Collins, Chair of the Medical Services Review Committee, called the Committee to order at 9:04 am on Friday, July 15, 2022. The meeting was held by telephone and video conference.

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

Dr. Mary Ann Foland Jeffery Gilbert Susan Kosinski Mason McCloskey  
Valerie Mittelstead Jeffery Moore Misty Steed  

Member Pam Scott was excused. Director Collins introduced senior staff present, and Carla Gee and Nan Orme with Optum.

III. Approval of Agenda  
A motion to adopt the agenda was made by member Gilbert and seconded by member Foland. The agenda was adopted unanimously.

IV. Review of Minutes  
A motion to approve the May 25, 2022 and June 24, 2022 meeting minutes was made by member Foland and seconded by member Kosinski. The motion passed unanimously.

V. Fee Schedule Guidelines Development Discussion  
Director Collins presented the draft MSRC recommendation report.

Carla Gee of Optum presented physical therapy utilization guidelines by state. The committee discussed utilization guidelines for Alaska. Member Steed reported that she spoke with Physical Therapy Group regarding utilization and they provided recommendations.

Break 10:11 am – 10:15 am

VI. Public Comment  
Written public comment was received from the Alaska Hospital & Healthcare Association (AHHA), regarding inflation of labor and non-labor costs. Member Gilbert presented the comments.

VII. Fee Schedule Guidelines Development Discussion, continued  
The committee discussed conversion factors. Director Collins presented data from the September 2021 NCCI Alaska Medical Data Report. Member Foland moved to make no changes to the existing conversion factors for calendar year 2023 and member McCloskey seconded. The motion passed unanimously.
The committee continued discussion of guidelines for physical therapy and other ongoing treatments and discussed injured worker non-compliance. Optum will provide draft language for discussion at the next meeting.

A motion to adjourn was made by Member Kosinski and seconded by Member Gilbert. The motion passed unanimously.

*Meeting Adjourned 12:10 pm*
TAB 4
Summary of Comments on Alaska State Fee Schedule 2023 edits_tracking_cg1_080222.pdf

Kimberly, the state really didn’t state a color -- but let’s maybe do a gold/marigold color ?

Change: Effective January 1, 2023

Author: KiS4211 Subject: Sticky Note Date: 6/15/2022 3:53:35 PM
STATE OF ALASKA DISCLAIMER
The Official Alaska Workers' Compensation Medical Fee Schedule is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

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

NOTICE
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 American Medical Association (AMA) according to CPT® (Current Procedural Terminology) 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.

QUESTIONS ABOUT THE OFFICIAL WORKERS’ COMPENSATION MEDICAL FEE SCHEDULE
Division staff are unable to provide advisory opinions on specific questions about billing, calculations, clarifications, or interpretations of the medical fee schedule. Readers should use their own judgment and interpretation and apply the medical fee schedule accordingly. If a provider is dissatisfied with payment, they may file a "Claim for Workers' Compensation Benefits," which is found on the division’s website under "Quick Links" and "Forms." If a provider needs assistance in completing the claim, requesting a prehearing conference or scheduling a hearing on their claim, they may contact a Workers’ Compensation Technician at 907-465-2790.

GENERAL QUESTIONS ABOUT WORKERS’ COMPENSATION
General questions regarding the statutes, regulations, or claims process should be addressed to the State of Alaska Workers’ Compensation Division at 907-465-2790.

AMERICAN MEDICAL ASSOCIATION NOTICE
CPT © 2021 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS NOTICE
Relative Value Guide © 2021, American Society of Anesthesiologists. All Rights Reserved.

Relative Value Guide is a relative value study and not a fee schedule. It is intended only as a guide. ASA does not directly or indirectly practice medicine or dispense medical services. ASA assumes no liability for data contained or not contained herein.

Relative Value Guide is a registered trademark of the American Society of Anesthesiologists.

COPYRIGHT
Copyright © 2021, State of Alaska, Department of Labor, Division of Workers’ Compensation

All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or storage in a database or retrieval system, without the prior written permission of the publisher.

Made in the USA
This page contains no comments
Introduction

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

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

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

An employee shall not be required to pay a fee or charge for medical treatment or service provided under this chapter including prepayment, deposit, or balance billing for services (Alaska Statute 23.30.097(f)).

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

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

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

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

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

• 85 percent of billed charges,
• The charge for the treatment or service when provided to the general public, or
• The charge for the treatment or service negotiated by the provider and the employer

SCOPE OF PRACTICE LIMITS

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

ORGANIZATION OF THE FEE SCHEDULE

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

• Introduction
• General Information and Guidelines
• Evaluation and Management
• Anesthesia
• Surgery
• Radiology
• Pathology and Laboratory
Drugs and pharmaceuticals are considered an integral component of the comprehensive surgical outpatient fee schedule. 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. Compounded and/or mixed drugs shall be limited to the manufacturer’s average wholesale price plus a $10 dispensing fee.

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.

Changes to the Evaluation and Management (E/M) section of codes effective January 1, 2021 are discussed in more detail in the Evaluation and Management section of this fee schedule.

Familiarity with the Introduction and General Information and Guidelines sections as well as general guidelines within each subsequent section is necessary for all who use the schedule. It is extremely important that these be read before the schedule is used.
to medical necessity and must be U.S. Food and Drug Administration (FDA)-approved combinations. Reimbursement for compounded or mixed drugs will be at the lowest generic National Drug Code (NDC) for each specific or over the counter drug.

HCPCS LEVEL II

Durable Medical Equipment

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

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

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

Ambulance Services

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

OUTPATIENT FACILITY

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB-04 (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.


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

Procedure — a unit of health service.

Procedure code — a five-digit numerical or alphanumeric 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, eyeglasses, 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.
This page contains no comments
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 Resource-Based Relative Value Scale (RBRVS) relative value units (RVU) produced by the Centers for Medicare and Medicaid Services (CMS) and the Geographic Practice Cost Index (GPCI) for Alaska based on the following formula:

Total RVU = Work RVU x Work GPCI + Practice Expense RVUs x Practice Expense GPCI + Malpractice RVUs x Malpractice GPCI

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

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

<table>
<thead>
<tr>
<th>RVUs</th>
<th>GPCI</th>
<th>SUBTOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVU x Work GPCI</td>
<td>1.03</td>
<td>1.54</td>
</tr>
<tr>
<td>Practice Expense RVUs x Practice Expense GPCI</td>
<td>1.118</td>
<td>1.500</td>
</tr>
<tr>
<td>Malpractice RVUs x Malpractice GPCI</td>
<td>0.08596</td>
<td>0.0864</td>
</tr>
<tr>
<td>Total RVU</td>
<td>3.69926</td>
<td></td>
</tr>
</tbody>
</table>

Calculation using example data:

1.03 x 1,500 = 1,545

1.85 x 1,118 = 2,062.3

0.14 x 0.614 = 0.0864

3.69926 x $119.00 (CF) = 440.21

Payment is rounded to $440.21

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

Services by out-of-state providers shall be reimbursed at the lower of the Alaska Workers’ Compensation Medical Fee Schedule or the workers compensation fee schedule of the state where the service is rendered. See Alaska Statute 23.30.079(k).

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICE</th>
<th>CPT CODE RANGE</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>10201–10299</td>
<td>$118.00</td>
</tr>
<tr>
<td>Radiology</td>
<td>72010–75999</td>
<td>$121.00</td>
</tr>
<tr>
<td>Pathology and Lab</td>
<td>80047–89398</td>
<td>$122.00</td>
</tr>
<tr>
<td>Medicine (excluding anesthesia)</td>
<td>90291–90482 and 93131–99189 and 99500–99607</td>
<td>$80.00</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>95001–95222–99489</td>
<td>$80.00</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>00110–00199 and 99120–00140</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

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

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

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

**RBRVS Status Codes**

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

<table>
<thead>
<tr>
<th>STATUS CODE</th>
<th>THE CENTERS FOR MEDICARE AND MEDICARE SERVICES (CMS) DEFINITION</th>
<th>OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Active Code: These codes are paid separately under the physician fee schedule, if covered. These will be RVUs for codes with this status. The maximum fee for this service is calculated as described in Fees for Medical Treatment.</td>
<td>The service may be a covered service of the Official Alaska Workers’ Compensation Medical Fee Schedule. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</td>
</tr>
<tr>
<td>A2</td>
<td>Active Code: Payment for 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.</td>
<td>The service may be a covered service of the Official Alaska Workers’ Compensation Medical Fee Schedule. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</td>
</tr>
<tr>
<td>B1</td>
<td>Deleted/Discontinued Codes. These codes are deleted effective with the beginning of the applicable year. No separate payment is made for these services even if an RVU is listed.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>C1</td>
<td>Deleted/Discontinued Codes. These codes are deleted effective with the beginning of the applicable year. No separate payment is made for these services even if an RVU is listed.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>D1</td>
<td>Deleted/Discontinued Codes. These codes are deleted effective with the beginning of the applicable year. No separate payment is made for these services even if an RVU is listed.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>E1</td>
<td>Deleted/Discontinued Codes. These codes are deleted effective with the beginning of the applicable year. No separate payment is made for these services even if an RVU is listed.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>F1</td>
<td>Deleted/Discontinued Codes. These codes are deleted effective with the beginning of the applicable year. No separate payment is made for these services even if an RVU is listed.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>H1</td>
<td>Deleted/Discontinued Codes. These codes are deleted effective with the beginning of the applicable year. No separate payment is made for these services even if an RVU is listed.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
</tbody>
</table>

This page contains no comments
### General Information and Guidelines

#### 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), neuromorphy(s), vertebral segment(s), tendon(s), joint(s)).

---

<table>
<thead>
<tr>
<th>STATUS CODE</th>
<th>DEFINITION</th>
<th>CODE</th>
<th>ADDITIONAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Anesthesia Services</td>
<td>There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.</td>
<td>Alaska recognizes the anesthesia base units in the Relative Value Guide published by the American Society of Anesthesiologists. See the Relative Value Guide or Anesthesia Section.</td>
</tr>
<tr>
<td>M</td>
<td>Measurement Codes</td>
<td>Used for reporting purposes only.</td>
<td>These codes are supplemental to other covered services and for informational purposes only.</td>
</tr>
<tr>
<td>N</td>
<td>Non-covered Services</td>
<td>These services are not covered by Medicare.</td>
<td>The service may be a covered service of the Official Alaska Workers' Compensation Medical Fee Schedule.</td>
</tr>
</tbody>
</table>

#### Add-on Procedures Description

- **Add-on Procedures**: These codes are reported secondarily in addition to the primary procedure. They represent work that is performed in addition to the primary service/procedure.

- **Add-on Procedures Example**: If a primary procedure is performed, an add-on code may be reported for additional work performed on the same day. Examples include additional digits, lesions, neuromorphies, vertebral segments, tendons, joints, etc.

---

CPT © 2021 American Medical Association. All Rights Reserved.
Add-on codes are not subject to reduction and should be reimbursed at the lower of the billed charges or 100 percent of MAR. Do not append modifier 51 to a code identified as an add-on procedure. Designated add-on codes are identified in Appendix D of the CPT book. Please reference the CPT book for the most current list of add-on codes.

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

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

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

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

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

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

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

Telehealth Services
Telehealth services are covered and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star ⭐ icon in the CPT book. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the appropriate telephone codes (99441–99443). Telehealth services should be reported with modifier 26 appended.

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

Medical Reports
A medical provider may not charge any fee for completing a medical report form required by the Workers’ Compensation Division. A medical provider may not charge a separate fee for medical reports that are requested to substantiate the medical necessity of a service. CPT code 99080 is not to be used for signing affidavits or certifying medical records forms. CPT code 99080 is appropriate for billing only after receiving a request for a special report from the employer or payer.
In all cases of accepted compensable injury or illness, the injured worker is not liable for payment for any services for the injury or illness.

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

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

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

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

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

Board Forms
All board bulletins and forms can be downloaded from the Alaska Workers’ Compensation Division website: www.labor.stat.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 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.

Alaska Specific Guidelines: Reimbursement is the lower of the billed charge or 5 percent of the MAR for the surgical 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 | ($1,350.00 x .15) + (($1,100.00 x .15) x .50) = $285.00 |

Data for the purpose of example only

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 code. Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure code with modifier TC.

Modifier QZ—CRNA without medical direction by a physician
Reimbursement is the lower of the billed charge or 85 percent of the MAR for the anesthesia procedure. Modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.

State-Specific Modifiers

Modifier 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 code. A physician assistant must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided. An advanced practice registered nurse (APRN) must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. 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 | ($150.00 x .85) + (($130.00 x .85) x .50) = $182.75 |

Data for the purpose of example only
Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

When exact text of the AMA 2021 CPT guidelines is used, the text is either in quotations or is preceded by a reference to the CPT book, CPT instructional notes, or other references.

BILLYING AND PAYMENT GUIDELINES

Telehealth Services

Telehealth services are covered and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star icon and in CPT Appendix I. In addition, the Centers for Medicare and Medicaid Services (CMS) has designated lists of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Note that many of the services identified by CMS for telehealth have temporary approval during the calendar year of the public health emergency (PHE) and may not be approved services in the next calendar year. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephonic only should be reported using the appropriate telephone codes (99441–99443). Telehealth services should be reported with modifier 95 appended.

New and Established Patient Service

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

E/M Component Guidelines for CPT Codes 99202-99215

CMS has announced that the CPT E/M code changes and guidelines developed by the American Medical Association (AMA) effective January 1, 2021 will be adopted. This includes deletion of CPT code 99201, changes to the code descriptions of codes 99202–99215 to place emphasis on code selection based on time or a revised medical decision making (MDM) table. History and exam should still be documented but will be commensurate with the level required by the practitioner to evaluate and treat the patient. Prolonged E/M visit will be a covered service with new CPT code 99417 or HCPCS code G2214.
The MDM for codes 99202-99215 is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2021 MDM table are:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

The new MDM guidelines table includes new definitions and descriptions of the qualifying activities in each element to assist users in appropriate code selection. The four levels of MDM for these services are as follows:

**Straightforward:** minimal number and complexity of problems addressed, minimal or no amount and/or complexity of data reviewed and analyzed, and minimal risk of complication and/or morbidity or mortality.

**Low:** Low number and complexity of problems addressed, limited amount and/or complexity of data reviewed and analyzed, and low risk of complications and/or morbidity or mortality.

**Moderate:** Moderate number and complexity of problems addressed, moderate amount and/or complexity of data reviewed and analyzed, and moderate risk of complications and/or morbidity or mortality.

**High:** High number and complexity of problems addressed, extensive amount and/or complexity of data reviewed and analyzed, and high risk of complications and/or morbidity or mortality.

Note that the 2021 E/M MDM table found on CPT pages 16-17 is to be used only for codes 99202-99215. All other E/M codes use the table found on CPT page 12.

**Time Element for Codes 99202-99215:** CPT codes 99202-99205 and 99214-99215 may be selected based upon the duration (face-to-face) and indirect time spent on the date of service. Counseling and/or coordination of care are not required elements. Revised code descriptions include a range of time for each code 99202-99205 and 99214-99215. Documentation should include notation of the times spent on the date of service.

When time is utilized to select a level of E/M for codes other than 99202–99215, only the face-to-face time is considered, and the counseling/coordination of care must be documented.
### Evaluation and Management

<table>
<thead>
<tr>
<th>The CPT book identifies the following body areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Head, including the face</td>
</tr>
<tr>
<td>• Neck</td>
</tr>
<tr>
<td>• Chest, including breasts and axilla</td>
</tr>
<tr>
<td>• Abdomen</td>
</tr>
<tr>
<td>• Genitalia, groin, buttocks</td>
</tr>
<tr>
<td>• Back</td>
</tr>
<tr>
<td>• Each extremity</td>
</tr>
</tbody>
</table>

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**

### Contributory Components

Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters. They generally provide information in support of other services. However, in some cases, when counseling or coordination of care dominates the encounter (more than 50 percent of the time spent), 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:
- **Diagnosis**, indications, and/or recommendations for 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 (99202–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary. Support the claim with documentation. The description and comments for office and other outpatient services should begin with “See more detailed information above.”

Office or Other Outpatient Consultations (99202–99215)

Subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations.

Office or Other Outpatient Consultations (99202–99215)

Use these codes to report an initial encounter with a patient who has not undergone a procedure for which a global surgical service was provided on the same day. The global surgical service is not reportable separately.

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

- Use these codes to report the encounter with the supervising or attending physician when the patient is designated inpatient hospital "observation status.”
- These codes include initiation of observation status, supervision of the health care plan for observation, and performance of diagnostic assessments. To report observation encounters by other physicians, see Office or Other Outpatient Consultation codes (99202–99215) or Subsequent Observation Care codes (99216–99221).
- 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 hospital observation services. Do not use these observation care codes for postoperative or follow-up care that is considered a global surgical service.

Office or Other Outpatient Consultations (99202–99215)

Use these codes to report an initial encounter with a patient who has not undergone a procedure for which a global surgical service was provided on the same day. The global surgical service is not reportable separately.

Consultations (99241–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations. For follow-up consultations...
Inpatient Consultations, see Subsequent Hospital Care codes 99231–99233 and Subsequent Nursing Facility Care codes 99370–99391. 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 (99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations [99241–99245] or 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 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 (99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations [99241–99245] or 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, or subsequent to, the date of the initial consultation.

- When the consultant assumes responsibility for the management or continuity of care subsequent to the encounter, the site of the encounter, either time or the location, identifies the correct code.

- 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 for a calendar day if medically necessary.

- Critical Care Services (99291–99292)

  The CPT book defines 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.
The total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

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.

The total duration of critical care is reported. For example, 25 minutes is not reportable, and 50 minutes is reported as one unit (99360 x 1).

Critically ill patient requiring the presence of medical staff on a routine basis who may provide services to other patients or be proctoring a surgical package, the standby is not separately reportable. If the standby physician ultimately provides services to another physician for the time to be reportable. Also, if the standby physician ultimately provides services to a surgical package, the standby is not separately reportable.

Code 99292 reports each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

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).

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.

The total duration of critical care is reported. For example, 25 minutes is not reportable, and 50 minutes is reported as one unit (99360 x 1).

Critically ill patient requiring the presence of medical staff on a routine basis who may provide services to other patients or be proctoring a surgical package, the standby is not separately reportable. If the standby physician ultimately provides services to another physician for the time to be reportable. Also, if the standby physician ultimately provides services to a surgical package, the standby is not separately reportable.

Code 99292 reports each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

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).

The total duration of critical care is reported. For example, 25 minutes is not reportable, and 50 minutes is reported as one unit (99360 x 1).

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.

The total duration of critical care is reported. For example, 25 minutes is not reportable, and 50 minutes is reported as one unit (99360 x 1).

Critically ill patient requiring the presence of medical staff on a routine basis who may provide services to other patients or be proctoring a surgical package, the standby is not separately reportable. If the standby physician ultimately provides services to another physician for the time to be reportable. Also, if the standby physician ultimately provides services to a surgical package, the standby is not separately reportable.

Code 99292 reports each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

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.

Telephone Services (99441–99443, 99446–99449, 99451–99452)
Telephone services are reported for telehealth services where only audio communication is available. Usually initiated by the patient or guardian, these codes are not reported if the telephone call results in a face-to-face encounter within 24 hours or the next available visit. Telephone services are not reported if provided within seven days of a face-to-face encounter or during the follow-up time associated with a surgical procedure.

Special Evaluation and Management Services (99450, 99455–99456)
This series of codes reports physician evaluations in order to establish baseline information for insurance certification and/or work related or medical disability evaluation. Services for work related or disability evaluation are covered at the following total RVU values:

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.
This page contains no comments
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 $100.00. Relative values for anesthesia procedures (00100–01999, 99100–99140) are as specified in the current Relative Value Guide published by the American Society of Anesthesiologists.

Time for Anesthesia Procedures

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

Calculating Anesthesia Charges

The following scenario is for the purpose of example only:

01382 Anesthesia for arthroscopic procedure of knee joint
Dollar Conversion Unit = $100.00
Base Unit Value = 3
Time Unit Value = 8 (4 units per hr x 2 hrs)
Physical Status Modifier Value = 0
Qualifying Circumstances Value = 0
Anesthesia Fee = $100.00 x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = $1,100.00

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.

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

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

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

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

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

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

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

Modifier G8 Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure—Modifier G8 is appended only to anesthesia service codes to identify those circumstances in which monitored anesthesia care (MAC) is provided and the service is a deeply complex, complicated, or markedly invasive surgical procedure.
Modifier G9 Monitored anesthesia care for patient who has history of severe cardiopulmonary condition.—Modifier G9 is appended only to anesthesia service codes to identify those circumstances in which a patient with a history of severe cardio-pulmonary conditions has a surgical procedure with monitored anesthesia care (MAC).

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

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

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

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

Modifier QZ CRNA service: without medical direction by a physician.—Reimbursement is the lower of the billed charge or 85 percent of the MAR for the anesthesia procedure. Modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist. When a CRNA performs the anesthesia procedure without any direction by a physician, modifier QZ should be appended to the code for the anesthesia service.
This page contains no comments
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, 50) | $1,100.00 |
| Reimbursement | $285.00 [($1,350.00 x .15) + ((1,100.00 x .15) x .50)] |

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

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. 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)] |

Anesthesia by Surgeon

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

Multiple or Bilateral Procedures

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

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

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

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

Note: CPT codes listed in Appendix D of the CPT book and designated as add-on codes have already been reduced in RBRVS and are not subject to the 50 percent reimbursement reductions listed above. CPT codes listed in Appendix E of the CPT book and designated as exempt from modifier 51 are also not subject to the above multiple procedure reduction rule. They are reimbursed at the lower of the billed charge or MAR.
**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 claviculectomy were both performed arthroscopically, the value for code 29824, the second procedure, would be reduced by the amount of code 29805.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>MAR</th>
<th>Adjusted amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>29827</td>
<td>$5,167.92</td>
<td>$5,167.92 [100%]</td>
</tr>
<tr>
<td>29824</td>
<td>$3,222.09</td>
<td>$988.35 [the value of 29824 minus the value of 29805]</td>
</tr>
<tr>
<td>29805</td>
<td>$2,233.74</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$6,156.27</td>
</tr>
</tbody>
</table>

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**

**Modifier 50**—Reimbursement is the lower of the billed charge or 50 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.

**Applicable HCPCS 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.

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended.

**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 [$1,350.00 x .15] + [$.15 x $1,100.00] |

Data for the purpose of example only
State-specific Modifiers
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:

<table>
<thead>
<tr>
<th>Procedure 1 (Modifier PE)</th>
<th>$150.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure 2 (Modifier PE, 51)</td>
<td>$130.00</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$182.75</td>
</tr>
</tbody>
</table>

Data for the purpose of example only
RADIOLoGY

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

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

BILLING AND PAYMENT GUIDELINES

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

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

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

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

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

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

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

See example below under Reimbursement Guidelines for CPT Modifiers.

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

A complete list of the applicable CPT modifiers is available in Appendix A of the CPT book.
Reimbursement Guidelines for CPT Modifiers
Specific CPT modifiers shall be reimbursed as follows:

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

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

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

Alaska MAR:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>TC</th>
<th>PC</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142</td>
<td>$1,448.61</td>
<td></td>
</tr>
<tr>
<td>72142-TC</td>
<td>$998.14</td>
<td></td>
</tr>
<tr>
<td>72142-26</td>
<td>$490.48</td>
<td></td>
</tr>
<tr>
<td>72147</td>
<td>$1,479.15</td>
<td></td>
</tr>
<tr>
<td>72147-TC</td>
<td>$990.25</td>
<td></td>
</tr>
<tr>
<td>72147-26</td>
<td>$488.90</td>
<td></td>
</tr>
</tbody>
</table>

Data for the purpose of example only

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

**Technical Component**:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142-TC</td>
<td>$998.14</td>
</tr>
<tr>
<td>72142-26</td>
<td>$490.48</td>
</tr>
<tr>
<td>Total</td>
<td>$1,493.27</td>
</tr>
</tbody>
</table>

**Professional Component**:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142-26</td>
<td>$488.90</td>
</tr>
<tr>
<td>Total</td>
<td>$954.94</td>
</tr>
</tbody>
</table>

**Global Reimbursement**:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142</td>
<td>$1,488.61</td>
</tr>
<tr>
<td>72147</td>
<td>$959.59</td>
</tr>
<tr>
<td>$495.13 x 464.46 TC and 26 above</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$2,448.20</td>
</tr>
</tbody>
</table>

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

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

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

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

Example data for CPT code 80500 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.

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

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

For example, if CPT code 81001 has a payment rate of $3.17 in the CLAB file, this is multiplied by 4.43 for a MAR of $13.94.

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 personnel, material, space, equipment, and other personnel, materials, space, equipment, and other professional services necessary to perform the pathology service. Reimbursement is the lower of the billed charge or the MAR (RBRVS or CLAB) for the pathology 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.

Technical Component
The technical component includes the charges for personnel, materials, space, equipment, and other personnel, materials, space, equipment, and professional services necessary to perform the pathology service. Reimbursement is the lower of the billed charge or the MAR (RBRVS or CLAB) for the pathology 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.

Organ or Disease Oriented Panels
The billing for panel tests must include documentation that the tests in the panel. When billing for panel tests (CPT codes 88047–88081), use the code number corresponding to the appropriate panel test. The individual tests performed should not be reimbursed separately. Refer to the CPT book for information about which tests are included in each panel test.
Drug Screening

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

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

Applicable HCPCS Modifiers

- TC Technical Component
  Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.
  Reimbursement is the lower of the billed charge or the MAR for the code with modifier TC.
GENERAL INFORMATION AND GUIDELINES

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

BILLING AND PAYMENT GUIDELINES

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

Multiple Procedures

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

Separate Procedures

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

Materials Supplied by Physician

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes and the Alaska value in effect at the time of treatment in the Medicare DMEPOS fee schedule multiplied by 1.75.

Telehealth Services

Telehealth services are covered and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star icon and in HCPCS Level II codes with modifier 93 or 95 appended. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audiovisual methods where available. Telehealth services, offering relief only should be reported using the appropriate telephone codes (99441–99443). Telehealth services should be reported with modifier 95 appended.

Physical Medicine

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

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

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

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

TENS Units
TENS (transcutaneous electrical nerve stimulation) must be FDA-approved and provided under the attending or treating physician’s prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published in Medicare multiplied by 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

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

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

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

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

97545  3.41
97546  1.36

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

• Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

• Evaluation and management services may be reported separately if, the patient’s condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the OMT. Different diagnoses are not required for the reporting of the OMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.

• Recognized body regions are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

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

• Chiropractic manipulative treatment (CMT) is a form of manual treatment using a variety of techniques for treatment of joint and neurophysiological function. The chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

• Evaluation and management services may be reported separately if, the patient’s condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the CMT. Different diagnoses are not required for the reporting of the CMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.

• There are five spinal regions recognized in the CPT book for CMT: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacroiliac joint) region. There are also five recognized extraspinal regions: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities;
Data for the purpose of example only

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 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 “9” in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee 1</th>
<th>Fee 2</th>
<th>Fee 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>92132</td>
<td></td>
<td>$90.65</td>
<td>$116.38</td>
<td>$197.96</td>
</tr>
<tr>
<td>92132-26</td>
<td></td>
<td>$50.80</td>
<td>$68.47</td>
<td>$116.38</td>
</tr>
<tr>
<td>92132-TC</td>
<td></td>
<td>$39.84</td>
<td>$53.19</td>
<td>$88.32</td>
</tr>
<tr>
<td>93303</td>
<td></td>
<td>$673.25</td>
<td>$933.51</td>
<td>$1,399.76</td>
</tr>
<tr>
<td>93303-26</td>
<td></td>
<td>$267.91</td>
<td>$394.68</td>
<td>$571.92</td>
</tr>
<tr>
<td>93303-TC</td>
<td></td>
<td>$405.34</td>
<td>$571.92</td>
<td>$838.47</td>
</tr>
<tr>
<td>93351</td>
<td></td>
<td>$68.47</td>
<td>$90.65</td>
<td>$130.80</td>
</tr>
<tr>
<td>93351-26</td>
<td></td>
<td>$293.78</td>
<td>$394.68</td>
<td>$571.92</td>
</tr>
<tr>
<td>93351-TC</td>
<td></td>
<td>$405.34</td>
<td>$571.92</td>
<td>$838.47</td>
</tr>
</tbody>
</table>

Data for the purpose of example only
Technical Component:

<table>
<thead>
<tr>
<th>Code</th>
<th>TC</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>92060-TC</td>
<td>$68.47</td>
<td>100% of the TC</td>
</tr>
<tr>
<td>92132-TC</td>
<td>$31.87</td>
<td>80% of the TC for the second procedure</td>
</tr>
<tr>
<td>Total</td>
<td>$100.34</td>
<td></td>
</tr>
</tbody>
</table>

Global Reimbursement:

<table>
<thead>
<tr>
<th>Code</th>
<th>TC</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>92060</td>
<td>$184.85</td>
<td>100% of the global</td>
</tr>
<tr>
<td>92132</td>
<td>$82.67</td>
<td>(80% of the TC for the second procedure + 100% of the second procedure)</td>
</tr>
<tr>
<td>Total</td>
<td>$267.52</td>
<td></td>
</tr>
</tbody>
</table>

**Therapy services**—For the practitioner and the office or institutional setting, all therapy services are subject to MMPR. 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:**

<table>
<thead>
<tr>
<th>Code</th>
<th>TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>97016</td>
<td>$36.40</td>
</tr>
<tr>
<td>97016 (2nd unit same date)</td>
<td>$26.25</td>
</tr>
<tr>
<td>97024 (additional therapy same visit)</td>
<td>$13.95</td>
</tr>
</tbody>
</table>

The reduced MAR for multiple procedure rule:

<table>
<thead>
<tr>
<th>Code</th>
<th>TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>97016</td>
<td>$29.25</td>
</tr>
<tr>
<td>97024</td>
<td>$13.95</td>
</tr>
</tbody>
</table>

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>97016</td>
<td>$36.40</td>
</tr>
<tr>
<td>97016 (2nd unit same date)</td>
<td>$29.25</td>
</tr>
<tr>
<td>97024 (additional therapy same visit)</td>
<td>$13.95</td>
</tr>
</tbody>
</table>

**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 the physician. Reimbursement is the lower of the billed charge or the MAR for the code with modifier TC.
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.
This page contains no comments
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.
This page contains no comments
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 HCPCS the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges. Note: The corresponding National Drug Code (NDC) number should be included in the records for the submitted HCPCS codes.

Durable Medical Equipment
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value for Alaska in effect at the time of treatment or service multiplied by 1.75 or billed charges. If no code identifies the supply, bill using the appropriate unlisted HCPCS code or CPT code 99070. An invoice is required and reimbursement shall be the lower of the manufacturer/supplier’s invoice plus 20 percent or billed charges.

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician’s prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

Hearing Aids
The patient must be referred by a physician for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes one year of follow-up care including all evaluations, tests, adjustments, repairs, or reprogramming of the hearing aids. New hearing aids may be dispensed 1) once every four years or 2) when new medical evaluation by a physician and testing documents changes necessitate a new device prescription as related to the work-related injury or 3) replacement of a nonworking device that is no longer covered by warranty. Repairs will not be paid when a device is still under the manufacturer’s warranty. An evaluation and management service shall not be billed at the time of any hearing aid evaluations or testing. The dispensing of hearing aids is reported with the appropriate HCPCS Level II codes and a copy of the manufacturer/supplier’s invoice. Reimbursement for hearing aids is the lower of the manufacturer/supplier’s invoice cost plus 30 percent or billed charges including testing, dispensing and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V510, V5160, VS240, and VS241 are not separately reimbursed services.
Hearing Aid Services
The codes below are reimbursed according to the listed maximum allowable reimbursement (MAR) or the actual fee, whichever is less.

<table>
<thead>
<tr>
<th>CODE</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>92591</td>
<td>$193.62</td>
</tr>
<tr>
<td>92593</td>
<td>$99.64</td>
</tr>
<tr>
<td>92594</td>
<td>$57.89</td>
</tr>
<tr>
<td>92595</td>
<td>$124.11</td>
</tr>
<tr>
<td>V5014</td>
<td>$249.31</td>
</tr>
<tr>
<td>V5020</td>
<td>$116.17</td>
</tr>
</tbody>
</table>

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:

(A) a fixed wing lift off fee may not exceed $11,500;
(B) a fixed wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;
(C) a rotary wing lift off fee may not exceed $13,500;
(D) a rotary wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;

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

Charter Air Carrier Note: The limitations on allowable reimbursements apply to air carriers who have on-demand, emergent, and unscheduled flights, including, but not limited to, intra-state air services responding to “911” emergency calls. The employer may require the air carrier to provide the carrier’s operating certificate along with the initial billing for services under this section.

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

GENERAL INFORMATION AND GUIDELINES

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers’ Compensation Act), a conversion factor shall be applied to the hospital outpatient relative weights established for each CPT or Ambulatory Payment Classifications (APC) code adopted by reference in 8 AAC 45.085(m). The outpatient facility conversion factor will be $221.79 and the ambulatory surgical center (ASC) conversion factor will be $168.00. Payment determination, packaging, and discounting methodology shall follow the CMS OPPS methodology for hospital outpatient and ambulatory surgical centers (ASCs). For procedures performed in an outpatient setting, implants shall be paid at manufacturer/supplier’s invoice plus 10 percent.

The maximum allowable reimbursement (MAR) for medical services that do not have valid CPT or 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 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.

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 APC 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, E1, E2, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
3. two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;
4. a payer shall subtract implantable hardware from a hospital outpatient clinic’s or ambulatory surgical center’s billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent;
5. procedures without a relative weight in Addendum B shall use a payment rate where available with the multiplier of 2.08 for ASCs and 2.75 for outpatient facilities.

Status indicators determine how payments are calculated, whether items are paid, and which reimbursement methodology is used. The Official Alaska Workers’ Compensation Medical Fee Schedule guidelines supersede the CMS guidelines as described below.
### 2022 Alaska Workers’ Compensation Medical Fee Schedule

#### Outpatient Facility

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>ITEM CODE/SERVICE</th>
<th>OP PAYMENT STATUS/ALASKA SPECIFIC GUIDELINE</th>
<th>OP PAYMENT STATUS/ALASKA SPECIFIC GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Services furnished to a hospital outpatient that are paid under a fee schedule other than OPPS, for example:</td>
<td>Not paid under OPPS. See the appropriate section under the provider fee schedule.</td>
<td>Not paid under OPPS. Status may change as data is received OPPS displays APC assignments when at a cost of 5 percent of billed charges. If billed charges are divided by 20 percent of billed charges, the lower amount is used to change the treatment or service when provided to the general public; the fee or charge for the treatment or service negotiated by the provider and the employer.</td>
</tr>
<tr>
<td>B</td>
<td>Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (2x and 3x)</td>
<td>Not paid under OPPS. An alternative code is recognized by OPPS when submitted on an outpatient hospital Part B bill type (2x and 3x) may be available.</td>
<td>Not paid under OPPS. Paid at reasonable cost.</td>
</tr>
<tr>
<td>C</td>
<td>Inpatient Procedures</td>
<td>Not paid under OPPS.</td>
<td>Paid under OPPS; separate APC payment included pass-through amount.</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued Codes</td>
<td>Not paid under OPPS.</td>
<td>Paid under OPPS; separate APC payment included pass-through amount.</td>
</tr>
<tr>
<td>E</td>
<td>Items and services for which pricing information and claims data are not available</td>
<td>Not paid under OPPS. Status may change as data is received OPPS displays APC assignments when at a cost of 5 percent of billed charges. If billed charges are divided by 20 percent of billed charges, the lower amount is used to change the treatment or service when provided to the general public; the fee or charge for the treatment or service negotiated by the provider and the employer.</td>
<td>Paid under OPPS; all covered Part B services paid through a comprehensive APC.</td>
</tr>
<tr>
<td>F</td>
<td>Hospital Part B services paid through a comprehensive APC</td>
<td>Paid under OPPS; additional APC payment included pass-through amount.</td>
<td>Paid under OPPS; additional APC payment included pass-through amount.</td>
</tr>
<tr>
<td>G</td>
<td>Hospital Part B services that may be paid through a comprehensive APC</td>
<td>Paid under OPPS; all covered Part B services paid through a comprehensive APC.</td>
<td>Paid under OPPS; all covered Part B services paid through a comprehensive APC.</td>
</tr>
</tbody>
</table>

**Examples:**

- **Example 1:**
  - Items and services for which pricing information and claims data are not available
  - Paid under OPPS; separate APC payment included pass-through amount.

- **Example 2:**
  - Hospital Part B services that may be paid through a comprehensive APC
  - Paid under OPPS; all covered Part B services paid through a comprehensive APC.
### Outpatient Facility

#### 2022 Alaska Workers' Compensation Medical Fee Schedule

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>ITEM/CODE/SERVICE</th>
<th>OP PAYMENT STATUS/ALASKA SPECIFIC GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Not paid under OPPS. Paid for reasonable cost.</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>Not paid under OPPS. Paid at reasonable cost.</td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td>Partial hospitalization</td>
<td>Paid under OPPS; separate APC payment. Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, daily capitation, or employee limit; therefore, there is no separate APC payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4)</td>
<td>Conditionally packaged laboratory tests</td>
<td>Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS). (1) Paid or paid as a separate APC payment if billed on the same date of service 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 OPSI = A and payment is made under the CLFS.</td>
</tr>
</tbody>
</table>

#### Addendum B

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>ITEM/CODE/SERVICE</th>
<th>OP PAYMENT STATUS/ALASKA SPECIFIC GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Not paid under OPPS. Paid at reasonable cost.</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(3)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(4)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(5)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(6)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(7)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(8)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>(9)</td>
<td>Paid under OPPS; separate APC payment.</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
</tbody>
</table>

#### Addendum M

- All institutional providers other than home health agencies bill to a DME MAC.
SURGICAL SERVICES
Outpatient facility services directly related to the procedure on the day of an outpatient surgery comprise the comprehensive, or all-inclusive, surgical outpatient facility charge. The comprehensive outpatient surgical facility charge usually includes the following services:

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

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

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

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

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

Example:
- Syringe for drug administration
- Patient gown
- IV pump

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

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

DURABLE MEDICAL EQUIPMENT (DME)
The sale, lease, or rental of durable medical equipment for use in a patient’s home is not included in the comprehensive surgical outpatient facility fee allowance.

Example:
- Surgical boot for a postoperative podiatric 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.
This page contains no comments
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 Prospective Payment System (IPPS) Web Pricer 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 IPPS Web Pricer amount by the applicable multiplier to obtain the Alaska MAR payment. Software solutions other than the CMS IPPS Web Pricer are acceptable as long as they produce the same results.

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

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

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

Example of Implant Outlier:
If the implant was $28,000 the calculation would be:

- Implant invoice: $28,000
- Less threshold: ($25,000)
- Outlier amount = $3,000

Implant reimbursement = $3,300

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

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

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

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

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

The CMS IPPS Web Pricer is normally available on the CMS web site 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, 2022, remains in effect, unless the Alaska Workers’ Compensation Division publishes a notice that a new version is in effect. Besides the IPPS Web Pricer, two additional elements are required to determine a payment:

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

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

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

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

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

   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

   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 IPPS Web Pricer application may be accessed here:

   https://webpricer.cms.gov/#/pricer/ipps

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

   **NOTE:** These illustrations and calculations are for example purposes only and do not reflect current reimbursement.
The IPPS Web Pricer instructions are included below:

**Data Entry and Calculation Steps for the IPPS Web Pricer**—Claim Entry Form

**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 IPPS Web Pricer cannot process using an NPI.

**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).

**COVERED CHARGES** – Enter the total covered charges on the claim.

**COVERED DAYS** – The number of days of inpatient stay in this facility that Medicare would reimburse.

**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.

**NATIONAL DRUG CODE (NDC)** – Enter NDC codes when appropriate.

**PROCEDURE CODE** – Enter the appropriate ICD-10-PCS codes for procedures performed.

**DIAGNOSIS CODE** – Enter the patient’s principle and other diagnoses using the appropriate ICD-10-CM codes.

**CONDITION CODE** – Enter the condition code when required.

**LIFETIME RESERVE DAYS** – Not required to be entered.

**TRANSFER STATUS** – Select the correct option from:
- No transfer
- Short-term acute transfer
- Post-acute transfer

Pricer will apply a transfer payment if the length of stay is less than the average length of stay for this DRG.

**REQUIRES COST OUTLIER THRESHOLD** – Enter ‘Y’ if the cost outlier threshold is not applicable for the claim. For the cost outlier threshold, enter ‘N’. 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.
### Inpatient Hospital

#### 2022 Alaska Workers' Compensation Medical Fee Schedule

- **Key claim information**
  - Provider number: [Redacted]
  - Effective date: [Redacted]
  - Diagnosis related group (DRG): [Redacted]

- **Claim estimate**
  - Claim estimate with provider adjustments: [Redacted]
  - Outlier calculation: [Redacted]
  - Grand total amount: $35,534.13

---

#### Provider details

- Provider type: [Redacted]
- Geographic CPEA: [Redacted]
- Reassignment CPEA: [Redacted]

#### Capital amounts

- Capital federal specific portion: $2,290.07
- Capital outlier: $0.00
- Capital disproportionate share hospital: $225.34
- Capital indirect medical education: $51.43

#### Operating amounts

- Operating federal specific portion: $29,117.71
- Operating hospital specific payment: $0.00
- Operating outlier: $0.00
- Operating disproportionate share hospital: $1,958.23
- Operating indirect medical education: $644.72
- Uncompensated care: $1,387.07
- Medicaid adjustment: $0.00
- Value-based purchasing adjustment: $17.28
- FQHC adjustment: $0.00

#### Other PPS amounts

- Hospital acquired condition adjustment: $758.93
- Low volume: $0.00
- Induced-labor adjustment: $0.00
- Electronic health record adjustment: $0.00
- Bundle adjustment: $0.00
- Medicare Advantage hospital specific payment: $0.00

**Total pass through & miscellaneous**: $156.97

- Pass through amount capital: $0.00
- Pass through amount direct: $156.97
- Pass through amount organs: $0.00
A Note on Pass-through Payments in the IPPS Web 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 IPPS Web 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 Grand Total Amount result above by the hospital specific multiplier listed above to calculate the payment. In the above example, the Grand Total Amount is reported as:

CMS IPPS Web Pricer Grand Total Amount: $35,534.13
Multiplied by Providence Alaska Medical Center multiplier x 2.38
Alaska Workers’ Compensation Payment: $84,571.23
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 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.
This page contains no comments
Official

ALASKA
WORKERS’ COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2023

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

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

NOTICE
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 American Medical Association (AMA) according to CPT® (Current Procedural Terminology) 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.

QUESTIONS ABOUT THE OFFICIAL WORKERS’ COMPENSATION MEDICAL FEE SCHEDULE
Division staff are unable to provide advisory opinions on specific questions about billing, calculations, clarifications, or interpretations of the medical fee schedule. Readers should use their own judgment and interpretation and apply the medical fee schedule accordingly. If a provider is dissatisfied with payment, they may file a “Claim for Workers’ Compensation Benefits,” which is found on the division’s website under “Quick Links” and “Forms.” If a provider needs assistance in completing the claim, requesting a prehearing conference or scheduling a hearing on their claim, they may contact a Workers’ Compensation Technician at 907-465-2790.

GENERAL QUESTIONS ABOUT WORKERS’ COMPENSATION
General questions regarding the statutes, regulations, or claims process should be addressed to the State of Alaska Workers’ Compensation Division at 907-465-2790.

AMERICAN MEDICAL ASSOCIATION NOTICE
CPT © 2022 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS NOTICE
Relative Value Guide © 2022 American Society of Anesthesiologists. All Rights Reserved.

Relative Value Guide is a relative value study and not a fee schedule. It is intended only as a guide. ASA does not directly or indirectly practice medicine or dispense medical services. ASA assumes no liability for data contained or not contained herein.

Relative Value Guide is a registered trademark of the American Society of Anesthesiologists.

COPYRIGHT
Copyright 2022 State of Alaska, Department of Labor, Division of Workers’ Compensation

All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or storage in a database or retrieval system, without the prior written permission of the publisher.

Made in the USA
## Contents

**Introduction** ................................................................. 1  
  Scope of Practice Limits ............................................. 1  
  Organization of the Fee Schedule ................................. 1  
  Provider Schedule ....................................................... 2  
  Drugs and Pharmaceuticals ........................................... 2  
  HCPCS Level II ................................................................ 3  
  Outpatient Facility ....................................................... 3  
  Inpatient Hospital .......................................................... 3  
  Definitions ....................................................................... 3  

**General Information and Guidelines** .............................. 7  
  Billing and Payment Guidelines ....................................... 7  
  Modifiers ......................................................................... 11  

**Evaluation and Management** ......................................... 13  
  General Information and Guidelines ............................... 13  
  Billing and Payment Guidelines ....................................... 13  
  Modifiers ......................................................................... 17  

**Anesthesia** ................................................................. 19  
  General Information and Guidelines ............................... 19  
  Billing and Payment Guidelines ....................................... 19  
  Anesthesia Modifiers ...................................................... 20  

**Surgery** ................................................................. 23  
  General Information and Guidelines ............................... 23  
  Billing and Payment Guidelines ....................................... 23  
  Modifiers ......................................................................... 25  

**Radiology** ................................................................. 27  
  General Information and Guidelines ............................... 27  
  Billing and Payment Guidelines ....................................... 27  
  Modifiers ......................................................................... 27  

**Pathology and Laboratory** .............................................. 29  
  General Information and Guidelines ............................... 29  
  Billing and Payment Guidelines ....................................... 29  
  Modifiers ......................................................................... 30  

**Medicine** ................................................................... 31  
  General Information and Guidelines ............................... 31  
  Billing and Payment Guidelines ....................................... 31  
  Modifiers ......................................................................... 33  

**Category II** ............................................................... 35  

**Category III** ............................................................... 37  
  Category III Modifiers .................................................... 37  

**HCPCS Level II** ........................................................... 39  
  General Information and Guidelines ............................... 39  
  Medicare Part B Drugs .................................................. 39  
  Durable Medical Equipment .......................................... 39  
  Modifiers ......................................................................... 40  
  Ambulance Services ....................................................... 40  

**Outpatient Facility** ..................................................... 41  
  General Information and Guidelines ............................... 41  
  Surgical Services .......................................................... 44  
  Drugs and Biologicals ..................................................... 44  
  Equipment, Devices, Appliances and Supplies ............... 44  
  Specialty and Limited Supply Items ............................... 44  
  Durable Medical Equipment .......................................... 44  
  Use of Outpatient Facility and Ancillary Services .......... 45  
  Nursing & Related Technical Personnel Services .......... 45  
  Surgical Dressings, Splinting and Casting Materials ....... 45  

**Inpatient Hospital** ....................................................... 47  
  General Information and Guidelines ............................... 47  
  Exempt from the MS-DRG .............................................. 47  
  Services and Supplies in the Facility Setting ................... 47  
  Preparing to Determine a Payment ............................... 48  

**Critical Access Hospital, Rehabilitation Hospital,**  
**Long-term Acute Care Hospital** ................................... 53  
  General Information and Guidelines ............................... 53
Introduction

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

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

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

An employee shall not be required to pay a fee or charge for medical treatment or service provided under this chapter including prepayment, deposit, or balance billing for services (Alaska Statute 23.30.097(f)).

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

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

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

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

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

• 85 percent of billed charges,
• The charge for the treatment or service when provided to the general public, or
• The charge for the treatment or service negotiated by the provider and the employer

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

ORGANIZATION OF THE FEE SCHEDULE
The Official Alaska Workers’ Compensation Medical Fee Schedule is comprised of the following sections and subsections:

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

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

Changes to the Evaluation and Management (E/M) section of codes effective January 1, 2021 are discussed in more detail in the Evaluation and Management section of this fee schedule. Additional changes that are similar to codes 99202-99215 were made to the E/M codes for 2023.

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 RBRVS.

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

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

SERVICES BY OUT-OF-STATE PROVIDERS
Services by out-of-state providers shall be reimbursed at the lower of the Alaska Workers’ Compensation Medical Fee Schedule or the workers compensation fee schedule of the state where the service is rendered. See Alaska Statute 28.30.097(k).

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

The maximum allowable reimbursement for prescription drugs is as follows:

1. Brand name drugs shall be reimbursed at the manufacturer’s average wholesale price plus a $5 dispensing fee;
2. Generic drugs shall be reimbursed at the manufacturer’s average wholesale price plus a $10 dispensing fee;
3. Compounded and/or mixed drugs shall be limited to medical necessity and must be U.S. Food and Drug Administration (FDA)-approved combinations. Reimbursement for compounded or mixed drugs will be at the lowest generic National Drug Code (NDC) for each specific or over the counter drug.

**HCPCS LEVEL II**

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

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

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

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

**OUTPATIENT FACILITY**
The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB-04 (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.


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 alphanumeric 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, eyeglasses, 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.

**Telehealth** — remote healthcare services provided using audiovisual or audioonly communication technology. Only services identified by CPT or the Centers for Medicare and Medicaid Services (CMS) as appropriate telehealth services and rendered by the treating physician may be reported.
General Information and Guidelines

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

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

**BILLING AND PAYMENT GUIDELINES**

**Fees for Medical Treatment**

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

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

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

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

<table>
<thead>
<tr>
<th>RVUs</th>
<th>GPCI</th>
<th>SUBTOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVU x Work GPCI</td>
<td>1.03</td>
<td>1.500</td>
</tr>
<tr>
<td>Practice Expense RVU x Practice Expense GPCI</td>
<td>1.87</td>
<td>1.118</td>
</tr>
<tr>
<td>Malpractice RVU x Malpractice GPCI</td>
<td>0.12</td>
<td>0.614</td>
</tr>
<tr>
<td><strong>Total RVU</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Data for the purpose of example only*

**Calculation using example data:**

\[
1.03 \times 1.500 = 1.545 \\
+ 1.87 \times 1.118 = 2.09066 \\
+ 0.12 \times 0.614 = 0.07368 \\
= 3.70934
\]

\[
3.70934 \times $119.00 \text{ (CF)} = 441.4115
\]

Payment is rounded to $441.41

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

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

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICE</th>
<th>CPT CODE RANGE</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>10004–69990</td>
<td>$119.00</td>
</tr>
<tr>
<td>Radiology</td>
<td>70010–79999</td>
<td>$121.00</td>
</tr>
<tr>
<td>Pathology and Lab</td>
<td>80047–89398</td>
<td>$122.00</td>
</tr>
<tr>
<td>Medicine (excluding anesthesia)</td>
<td>90281–99082 and 99151–99199 and 99500–99607</td>
<td>$80.00</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>99091, 99202–99499</td>
<td>$80.00</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>00100–01999 and 99100–99140</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th>STATUS CODE</th>
<th>THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION</th>
<th>OFFICIAL ALASKA WORKERS’ COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status.</td>
<td>The maximum fee for this service is calculated as described in Fees for Medical Treatment.</td>
</tr>
<tr>
<td>B</td>
<td>Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.</td>
<td>No separate payment is made for these services even if an RVU is listed.</td>
</tr>
<tr>
<td>C</td>
<td>Carriers price the code. Contractors will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.</td>
<td>The service may be a covered service of the Official Alaska Workers’ Compensation Medical Fee Schedule. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</td>
</tr>
<tr>
<td>D</td>
<td>Deleted Codes. These codes are deleted effective with the beginning of the applicable year.</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>E</td>
<td>Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes.</td>
<td>The service may be a covered service of the Official Alaska Workers’ Compensation Medical Fee Schedule. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</td>
</tr>
<tr>
<td>F</td>
<td>Deleted/Discontinued Codes. (Code not subject to a 90 day grace period).</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>G</td>
<td>Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.)</td>
<td>Not in current RBRVS. Not payable under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>H</td>
<td>Deleted Modifier. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of “H.”</td>
<td>Not in current RBRVS. Not payable with modifiers TC and/or 26 under the Official Alaska Workers’ Compensation Medical Fee Schedule.</td>
</tr>
<tr>
<td>I</td>
<td>Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)</td>
<td>The service may be a covered service of the Official Alaska Workers’ Compensation Medical Fee Schedule. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.</td>
</tr>
</tbody>
</table>
Add-on Procedures

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

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

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

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

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

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

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

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

**Telehealth Services**
Telehealth services are covered and reimbursed at the lower of the billed amount or non-facility MAR. Telehealth services are identified in CPT with a star icon for audiovisual services and with the icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

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

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

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

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

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

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

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

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

**Board Forms**
All board bulletins and forms can be downloaded from the Alaska Workers’ Compensation Division website: [www.labor.state.ak.us/wc](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 on 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 rendered during the same session. Other procedures performed at the same operative session are reimbursed at the lower of the billed charge or the appropriate percentage of the MAR.
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 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.

*Alaska Specific Guidelines: 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:

<table>
<thead>
<tr>
<th>Procedure 1 (Modifier AS)</th>
<th>$1,350.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure 2 (Modifier AS, 51)</td>
<td>$1,100.00</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$285.00 [($1,350.00 \times .15) + ((1,100.00 \times .15) \times .50)]</td>
</tr>
</tbody>
</table>

*Data for the purpose of example only*

**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 code. Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure code with modifier TC.

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

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

**State-Specific Modifiers**

**Modifier 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 code. A physician assistant must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided. An advanced practice registered nurse (APRN) must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. 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:

<table>
<thead>
<tr>
<th>Procedure 1 (Modifier PE)</th>
<th>$150.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure 2 (Modifier PE, 51)</td>
<td>$130.00</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$182.75 [($150.00 \times .85) + ((130.00 \times .85) \times .50)]</td>
</tr>
</tbody>
</table>

*Data for the purpose of example only*
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 2021 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

Telehealth Services
Telehealth services are covered and reimbursed at the lower of the billed amount or non-facility MAR. Telehealth services are identified in CPT with a star ★ icon for audiovisual services and with the icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Note that many of the services identified by CMS for telehealth have temporary approval during the calendar year of the public health emergency (PHE) and may not be approved services in the next calendar year. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

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

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

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

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

E/M Service Components

E/M Component Guidelines for CPT Codes 99202-99215
CMS has announced that the CPT E/M code changes and guidelines developed by the American Medical Association (AMA) effective January 1, 2021 will be adopted. This includes deletion of CPT code 99201, changes to the code descriptions of codes 99202–99215 to place emphasis on code selection based on time or a revised medical decision making (MDM) table.
History and exam should still be documented but will be commensurate with the level required by the practitioner to evaluate and treat the patient. Prolonged E/M visit will be a covered service with new CPT code 99417 or HCPCS code G2212.

The MDM for codes 99202-99215 is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2021/2023 MDM table are:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

The new MDM guidelines table includes new definitions and descriptions of the qualifying activities in each element to assist users in appropriate code selection. The four levels of MDM for these services are as follows:

**Straightforward:** minimal number and complexity of problems addressed, minimal or no amount and/or complexity of data reviewed and analyzed, and minimal risk of complication and/or morbidity or mortality.

**Low:** Low number and complexity of problems addressed, limited amount and/or complexity of data reviewed and analyzed, and low risk of complications and/or morbidity or mortality.

**Moderate:** Moderate number and complexity of problems addressed, moderate amount and/or complexity of data reviewed and analyzed, and moderate risk of complications and/or morbidity or mortality.

**High:** High number and complexity of problems addressed, extensive amount and/or complexity of data reviewed and analyzed, and high risk of complications and/or morbidity or mortality.

Note that the 2021 E/M MDM table found on CPT pages 16-17 is to be used only for codes 99202-99215. All other E/M codes use the table found on CPT page 12.

**Time Element.** CPT E/M codes may be selected based upon the total direct (face-to-face) and indirect time spent on the date of service. Counseling and/or coordination of care are not required elements. Revised code descriptions include a range of time for each code. Documentation should include notation of the times spent on the date of service.

**Presenting Problem**
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 (99202–99215)**
Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary. Support the claim with documentation.

**Hospital Inpatient and Observation Care Services (99221–99223, 99231–99239)**
The codes for hospital inpatient and observation care 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 and observation 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 and Observation Care code.

Codes 99238 and 99239 report hospital discharge day management including discharge of a patient from observation status. When concurrent care is provided...
Consultations (99242–99245 and 99252–99255)
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 (99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99242–99245 or Initial Inpatient Consultations 99252–99255). The general rules and requirements of a consultation are defined by the CPT book as follows:

• A consultation is “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 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 99242–99245 or Initial Inpatient Consultations 99252–99255).

• 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. ED services are selected based upon medical decision making and are not time based.

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 (99304–99316)

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.

Home or Residence Services (99341–99350)

Services and care provided at the patient’s home or residence are coded from this subcategory. Code selection is based upon new or established patient status and the time or MDM provided.

Prolonged Services (99358–99360, 99415-99417)

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

- Prolonged Physician Service with Direct (Face-to-Face) Patient Contact
  These codes report services involving direct (face-to-face) patient contact beyond the usual service. 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.

  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 codes 99205 and 99215 prolonged services are reported with CPT code 99417 or HCPCS code G2212.

- 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.

**Telephone Services (99441–99443, 99446–99449, 99451–99452)**
Telephone services are reported for telehealth services where only audio communication is available. Usually initiated by the patient or guardian, these codes are not reported if the telephone call results in a face-to-face encounter within 24 hours or the next available visit. Telephone services are not reported if provided within seven days of a face-to-face encounter or during the follow-up time associated with a surgical procedure.

**Special Evaluation and Management Services (99450, 99455–99456)**
This series of codes reports physician evaluations in order to establish baseline information for insurance certification and/or work related or medical disability.

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

- 99455 10.63
- 99456 21.25

**Other Evaluation and Management Services (99499)**
This is an unlisted code to report services not specifically defined in the CPT book.

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

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

**State-Specific Modifier**

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

Reimbursement is the lower of the billed charges or 85 percent of the MAR for the procedure; modifier PE shall be used when services and procedures are provided by a physician assistant or an advanced practice registered nurse.
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 $100.00. Relative values for anesthesia procedures (00100–01999, 99100–99140) are as specified in the current Relative Value Guide published by the American Society of Anesthesiologists.

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

Calculating Anesthesia Charges
The following scenario is for the purpose of example only:

01382 Anesthesia for arthroscopic procedure of knee joint

Dollar Conversion Unit = $100.00
Base Unit Value = 3
Time Unit Value = 8 (4 units per hr x 2 hrs)
Physical Status Modifier Value = 0
Qualifying Circumstances Value = 0
Anesthesia Fee = $100.00 x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = $1,100.00

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.

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

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.

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

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

**Modifiers**

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

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

**Applicable HCPCS Modifiers**

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

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

Modifier G8 Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure—Modifier G8 is appended only to anesthesia service codes to identify those circumstances in which monitored anesthesia care (MAC) is provided and the service is a deeply complex, complicated, or markedly invasive surgical procedure.
Modifier G9 Monitored anesthesia care for patient who has history of severe cardiopulmonary condition—Modifier G9 is appended only to anesthesia service codes to identify those circumstances in which a patient with a history of severe cardio-pulmonary conditions has a surgical procedure with monitored anesthesia care (MAC).

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (AS)</td>
<td>$1,350.00</td>
</tr>
<tr>
<td>2 (AS, 51)</td>
<td>$1,100.00</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$285.00</td>
</tr>
</tbody>
</table>

Data for the purpose of example only

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

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. 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:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (PE)</td>
<td>$150.00</td>
</tr>
<tr>
<td>2 (PE, 51)</td>
<td>$130.00</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$182.75</td>
</tr>
</tbody>
</table>

Data for the purpose of example only

**Anesthesia by Surgeon**

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

**Multiple or Bilateral Procedures**

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

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

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

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

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

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

Data for the purpose of example only

Endoscopic Procedures

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

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>MAR</th>
<th>Adjusted amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>29827</td>
<td>$5,167.92</td>
<td>$5,167.92 (100%)</td>
</tr>
<tr>
<td>29824</td>
<td>$3,222.09</td>
<td>$988.35 (the value of 29824 minus the value of 29805)</td>
</tr>
<tr>
<td>29805</td>
<td>$2,233.74</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$6,156.27</td>
</tr>
</tbody>
</table>

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 50 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.

Applicable HCPCS 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.

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended.

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
State-specific Modifiers

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:

<table>
<thead>
<tr>
<th>Procedure 1 (Modifier PE)</th>
<th>Procedure 2 (Modifiers PE, 51)</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150.00</td>
<td>$130.00</td>
<td>$182.75</td>
</tr>
</tbody>
</table>

Reimbursement = $182.75 = ($150.00 x .85) + ($130.00 x .85) x .50

Data for the purpose of example only
GENERAL INFORMATION AND GUIDELINES
This section refers to radiology services, which includes nuclear medicine and diagnostic ultrasound. These rules apply when radiological services are performed by or under the responsible supervision of a physician.

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

BILLING AND PAYMENT GUIDELINES

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

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

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

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

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

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

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

See example below under Reimbursement Guidelines for CPT Modifiers.

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

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

Reimbursement Guidelines for CPT Modifiers
Specific CPT modifiers shall be reimbursed as follows:

Modifier 26—Reimbursement is the lower of the billed charge or the MAR for the code with modifier 26.
**Modifier 51**—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure.

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

Alaska MAR:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142</td>
<td>$1,448.61</td>
</tr>
<tr>
<td>72142-TC</td>
<td>$998.14</td>
</tr>
<tr>
<td>72142-26</td>
<td>$490.48</td>
</tr>
<tr>
<td>72147</td>
<td>$1,479.15</td>
</tr>
<tr>
<td>72147-TC</td>
<td>$990.25</td>
</tr>
<tr>
<td>72147-26</td>
<td>$488.90</td>
</tr>
</tbody>
</table>

*Data for the purpose of example only*

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

**Technical Component:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142-TC</td>
<td>$998.14</td>
<td>100% of the TC</td>
</tr>
<tr>
<td>72147-TC</td>
<td>$495.13</td>
<td>50% of the TC for the second procedure</td>
</tr>
<tr>
<td>Total</td>
<td>$1,493.27</td>
<td></td>
</tr>
</tbody>
</table>

**Professional Component:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142-26</td>
<td>$490.48</td>
<td>100% of the 26</td>
</tr>
<tr>
<td>72147-26</td>
<td>$464.46</td>
<td>95% of the 26 for the second procedure</td>
</tr>
<tr>
<td>Total</td>
<td>$954.94</td>
<td></td>
</tr>
</tbody>
</table>

**Global Reimbursement:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72142</td>
<td>$1,488.61</td>
<td>100% of the global</td>
</tr>
<tr>
<td>72147-51</td>
<td>$959.59</td>
<td>($495.13 + $464.46 TC and 26 above)</td>
</tr>
<tr>
<td>Total</td>
<td>$2,448.20</td>
<td></td>
</tr>
</tbody>
</table>

**Applicable HCPCS Modifiers**

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

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

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

Example data for CPT code 80503 in the RBRVS with the Alaska GPCI using the non-facility RVUs:

<table>
<thead>
<tr>
<th>RVUS</th>
<th>GPCI</th>
<th>SUBTOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVU x Work GPCI</td>
<td>0.43</td>
<td>1.500</td>
</tr>
<tr>
<td>Practice Expense RVU x Practice Expense GPCI</td>
<td>0.32</td>
<td>1.118</td>
</tr>
<tr>
<td>Malpractice RVU x Malpractice GPCI</td>
<td>0.02</td>
<td>0.614</td>
</tr>
<tr>
<td>Total RVU</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data for the purpose of example only

Calculation using example data:

\[
0.43 \times 1.500 = 0.645 \\
+ 0.32 \times 1.118 = 0.35776 \\
+ 0.02 \times 0.614 = 0.01228 \\
= 1.01504 \\
1.01504 \times $122.00 \text{ (CF)} = 123.8349 \\
\text{Payment is rounded to $123.83}
\]

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

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

For example, if CPT code 81001 has a payment rate of $3.17 in the CLAB file, this is multiplied by 4.43 for a MAR of $14.04.

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Organ or Disease Oriented Panels

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (CPT codes 80047–80081), use the code number corresponding to the appropriate panel test. The individual tests performed should not be reimbursed separately. Refer to the CPT book for information about which tests are included in each panel test.
**Drug Screening**
Drug screening is reported with CPT codes 80305–80307. These services are reported once per patient encounter. These codes are used to report urine, blood, serum, or other appropriate specimen. Drug confirmation is reported with codes G0480–G0483 dependent upon the number of drug tests performed. These codes are valued in the CLAB schedule and the multiplier is 4.43.

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

**Applicable HCPCS Modifiers**

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

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

BILLING AND PAYMENT GUIDELINES
All providers may report and be reimbursed for codes 97014 and 97810–97814.

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

See modifier section below for examples of the reduction calculations.

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

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes and the Alaska value in effect at the time of treatment in the Medicare DMEPOS fee schedule multiplied by 1.75.

Telehealth Services
Telehealth services are covered and reimbursed at the lower of the billed amount or non facility MAR. Telehealth services are identified in CPT with a star ⭐ icon for audiovisual services and with the ¶ icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

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

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

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

A limited number of physical medicine services have been identified as appropriate for telehealth. See CPT Appendix P, T or CMS for identification of approved codes.

For statutes and regulations addressing billing for medical care requiring continuing and multiple treatments of a similar nature, please refer to AS 23.30.095(c) and 8 AAC 45.086(a)(14).

**TENS Units**

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician's prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

**Publications, Books, and Videos**

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

**Functional Capacity Evaluation**

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

**Work Hardening**

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

- 97545  3.41
- 97546  1.36

**Osteopathic Manipulative Treatment**

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

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

**Chiropractic Manipulative Treatment**

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

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

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

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

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

Reimbursement Guidelines for CPT Modifiers

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

Specific modifiers shall be reimbursed as follows:

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued, 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>93303</td>
<td>$634.77</td>
</tr>
<tr>
<td>93303-TC</td>
<td>$434.77</td>
</tr>
<tr>
<td>93303-26</td>
<td>$200.00</td>
</tr>
<tr>
<td>93351</td>
<td>$673.34</td>
</tr>
<tr>
<td>93351-TC</td>
<td>$404.44</td>
</tr>
<tr>
<td>93351-26</td>
<td>$268.89</td>
</tr>
</tbody>
</table>

Data for the purpose of example only

Technical Component:

<table>
<thead>
<tr>
<th>Code</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>93303-TC</td>
<td>$434.77</td>
</tr>
<tr>
<td>93351-TC</td>
<td>$303.33</td>
</tr>
<tr>
<td>Total</td>
<td>$738.10</td>
</tr>
</tbody>
</table>

Global Reimbursement:

<table>
<thead>
<tr>
<th>Code</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>93303</td>
<td>$634.77</td>
</tr>
<tr>
<td>93351</td>
<td>$572.22</td>
</tr>
<tr>
<td>Total</td>
<td>$1,206.99</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>92060</td>
<td>$184.85</td>
</tr>
<tr>
<td>92060-TC</td>
<td>$68.47</td>
</tr>
<tr>
<td>92060-26</td>
<td>$116.38</td>
</tr>
<tr>
<td>92132</td>
<td>$90.65</td>
</tr>
<tr>
<td>92132-TC</td>
<td>$39.84</td>
</tr>
<tr>
<td>92132-26</td>
<td>$50.80</td>
</tr>
</tbody>
</table>

Data for the purpose of example only
Technical Component:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>92060-TC</td>
<td>$68.47</td>
<td>100% of the TC</td>
</tr>
<tr>
<td>92132-TC</td>
<td>$31.87</td>
<td>80% of the TC for the second procedure</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$100.34</strong></td>
<td></td>
</tr>
</tbody>
</table>

Global Reimbursement:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>92060</td>
<td>$184.85</td>
<td>100% of the global</td>
</tr>
<tr>
<td>92132</td>
<td>$82.67</td>
<td>80% of the TC for the second procedure + 100% of the $26.27 ($31.87 + $50.80 = $82.67)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$267.52</strong></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>97016</td>
<td>$36.40</td>
<td>[.18 \times 1.5 + (0.16 \times 1.118) + (0.01 \times .614)] x 80</td>
</tr>
<tr>
<td>97024</td>
<td>$20.21</td>
<td>[.06 \times 1.5 + (0.14 \times 1.118) + (0.01 \times .614)] x 80</td>
</tr>
</tbody>
</table>

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>97016</td>
<td>$29.25</td>
<td>[.18 \times 1.5 + (0.16 \times 1.118) \times 0.5 + (0.01 \times .614)] x 80</td>
</tr>
<tr>
<td>97024</td>
<td>$13.95</td>
<td>[.06 \times 1.5 + (0.14 \times 1.118) \times 0.5 + (0.01 \times .614)] x 80</td>
</tr>
</tbody>
</table>

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>97016</td>
<td>$36.40</td>
<td>[.18 \times 1.5 \times 1.5 + (0.16 \times 1.118) + (0.01 \times .614)] x 80</td>
</tr>
<tr>
<td>97016 (2nd unit same date)</td>
<td>$29.25</td>
<td>[.18 \times 1.5 \times 1.5 + (0.16 \times 1.118) \times 0.5 + (0.01 \times .614)] x 80</td>
</tr>
<tr>
<td>97024 (additional therapy same date)</td>
<td>$13.95</td>
<td>[.06 \times 1.5 \times 1.5 + (0.14 \times 1.118) \times 0.5 + (0.01 \times .614)] x 80</td>
</tr>
</tbody>
</table>

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 the physician.

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

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

Category II modifiers are used to report special circumstances such as Merit-based Incentive Payment System (MIPS) coding including why a quality measure was not completed.
Category III 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.
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 HCPCS the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges.

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

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value for Alaska in effect at the time of treatment or service multiplied by 1.75 or billed charges. If no code identifies the supply, bill using the appropriate unlisted HCPCS code or CPT code 99070. An invoice is required and reimbursement shall be the lower of the manufacturer/supplier’s invoice plus 20 percent or billed charges.

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician’s prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

HEARING AIDS

The patient must be referred by a physician for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes one year of follow-up care including all evaluations, tests, adjustments, repairs, or reprogramming of the hearing aids. New hearing aids may be dispensed 1) once every four years or 2) when new medical evaluation by a physician and testing documents changes necessitate a new device prescription as related to the work-related injury or 3) replacement of a nonworking device that is no longer covered by warranty. Repairs will not be paid when a device is still under the manufacturer’s warranty. An evaluation and management service shall not be billed at the time of any hearing aid evaluations or testing. The dispensing of hearing aids is reported with the appropriate HCPCS Level II codes and a copy of the manufacturer/supplier’s invoice. Reimbursement for hearing aids is the lower of the manufacturer/supplier’s invoice cost plus 30 percent or billed charges including testing, dispensing and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V5110, V5160, V5240, and V5241 are not separately reimbursed services.
Hearing Aid Services
The codes below are reimbursed according to the listed maximum allowable reimbursement (MAR) or the actual fee, whichever is less.

<table>
<thead>
<tr>
<th>CODE</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>92591</td>
<td>$193.62</td>
</tr>
<tr>
<td>92593</td>
<td>$99.64</td>
</tr>
<tr>
<td>92594</td>
<td>$57.89</td>
</tr>
<tr>
<td>92595</td>
<td>$124.11</td>
</tr>
<tr>
<td>V5014</td>
<td>$249.31</td>
</tr>
<tr>
<td>V5020</td>
<td>$116.17</td>
</tr>
</tbody>
</table>

MODIFIERS
Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

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

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

(1) for air ambulance services provided entirely in this state that are not provided under a certificate issued under 49 U.S.C. 41102 or that are provided under a certificate issued under 49 U.S.C. 41102 for charter air transportation by a charter air carrier, the maximum allowable reimbursements are as follows:

(A) a fixed wing lift off fee may not exceed $11,500;

(B) a fixed wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;

(C) a rotary wing lift off fee may not exceed $13,500;

(D) a rotary wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;

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

Charter Air Carrier Note: The limitations on allowable reimbursements apply to air carriers who have on-demand, emergent, and unscheduled flights, including but not limited to, intra-state air services responding to “911” emergency calls. The employer may require the air carrier to provide the carrier’s operating certificate along with the initial billing for services under this section.

Ground ambulance services are reported using the appropriate HCPCS codes. The maximum allowable reimbursement (MAR) for medical services that do not have valid CPT or 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.
GENERAL INFORMATION AND GUIDELINES
The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers’ Compensation Act), a conversion factor shall be applied to the hospital outpatient relative weights established for each CPT or Ambulatory Payment Classifications (APC) code adopted by reference in 8 AAC 45.083(m). The outpatient facility conversion factor will be $221.79 and the ambulatory surgical center (ASC) conversion factor will be $168.00. Payment determination, packaging, and discounting methodology shall follow the CMS OPPS methodology for hospital outpatient and ambulatory surgical centers (ASCs). For procedures performed in an outpatient setting, implants shall be paid at manufacturer/supplier's invoice plus 10 percent.

The maximum allowable reimbursement (MAR) for medical services that do not have valid CPT or 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 APC 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, E1, E2, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;

3. two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;

4. a payer shall subtract implantable hardware from a hospital outpatient clinic’s or ambulatory surgical center’s billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent;

5. procedures without a relative weight in Addendum B shall use a payment rate where available with the multiplier of 2.08 for ASCs and 2.75 for outpatient facilities.

Status indicators determine how payments are calculated, whether items are paid, and which reimbursement methodology is used. The Official Alaska Workers’ Compensation Medical Fee Schedule guidelines supersede the CMS guidelines as described below.
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>ITEM/CODE/SERVICE</th>
<th>OP PAYMENT STATUS/ALASKA SPECIFIC GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:</td>
<td>Not paid under OPPS. See the appropriate section under the provider fee schedule.</td>
</tr>
<tr>
<td></td>
<td>• Ambulance services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Separately payable clinical diagnostic laboratory services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Separately payable non-implantable prosthetic and orthotic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical, occupational, and speech therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic mammography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Screening mammography</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x)</td>
<td>Not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.</td>
</tr>
<tr>
<td>C</td>
<td>Inpatient Procedures</td>
<td>Not paid under OPPS. 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.</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued codes</td>
<td>Not paid under OPPS.</td>
</tr>
<tr>
<td>E1</td>
<td>Items, codes and services:</td>
<td>Not paid under OPPS. 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. 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.</td>
</tr>
<tr>
<td></td>
<td>• Not covered by any Medicare outpatient benefit category</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Statutorily excluded by Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not reasonable and necessary</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>ITEM/CODE/SERVICE</th>
<th>OP PAYMENT STATUS/ALASKA SPECIFIC GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2</td>
<td>Items and services for which pricing information and claims data are not available</td>
<td>Not paid under OPPS. Status may change as data is received by CMS. 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.</td>
</tr>
<tr>
<td>F</td>
<td>Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines</td>
<td>Not paid under OPPS. Paid at reasonable cost.</td>
</tr>
<tr>
<td>G</td>
<td>Pass-through drugs and biologics</td>
<td>Paid under OPPS, separate APC payment includes pass-through amount.</td>
</tr>
<tr>
<td>H</td>
<td>Pass-through device categories</td>
<td>Separate cost-based pass-through payment. 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.</td>
</tr>
<tr>
<td>J1</td>
<td>Hospital Part B services paid through a comprehensive APC</td>
<td>Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19.</td>
</tr>
<tr>
<td>INDICATOR</td>
<td>ITEM/CODE/SERVICE</td>
<td>OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>J2</td>
<td>Hospital Part B services that may be paid through a comprehensive APC</td>
<td>Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services, services assigned to a new technology APC, self-administered drugs, all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1. (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.</td>
</tr>
<tr>
<td>K</td>
<td>Non pass-through drugs and non-implantable biologicals, including therapeutic radio pharmaceuticals</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>L</td>
<td>Influenza vaccine; pneumococcal pneumonia vaccine; Covid-19 Vaccine, Monoclonal Antibody Therapy Product</td>
<td>Not paid under OPPS. Paid at reasonable cost.</td>
</tr>
<tr>
<td>M</td>
<td>Items and services not billable to the Medicare Administrative Contractor (MAC)</td>
<td>Not paid under OPPS.</td>
</tr>
<tr>
<td>N</td>
<td>Items and services packaged into APC rates</td>
<td>Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. 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.</td>
</tr>
</tbody>
</table>

**Q1** | STV packaged codes | Paid under OPPS, addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI of S, T, or V. (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment. |

**Q2** | T packaged codes | Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment. |

**Q3** | Codes that may be paid through a composite APC | Paid under OPPS; addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments. (1) Composite APC payment on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services. |

**Q4** | Conditionally packaged laboratory tests | Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS). (1) Packaged APC payment if billed on the same date of service 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 OPSI = A and payment is made under the CLFS.
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>ITEM/CODE/SERVICE</th>
<th>OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Blood and blood products</td>
<td>Paid under OPPS, separate APC payment.</td>
</tr>
<tr>
<td>S</td>
<td>Procedure or service, not discounted when multiple</td>
<td>Paid under OPPS, separate APC payment.</td>
</tr>
<tr>
<td>T</td>
<td>Procedure or service, multiple reduction applies</td>
<td>Paid under OPPS, separate APC payment. 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.</td>
</tr>
<tr>
<td>U</td>
<td>Brachytherapy sources</td>
<td>Paid under OPPS, separate APC payment.</td>
</tr>
<tr>
<td>V</td>
<td>Clinic or emergency department visit</td>
<td>Paid under OPPS, separate APC payment.</td>
</tr>
<tr>
<td>Y</td>
<td>Non-implantable durable medical equipment</td>
<td>Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC.</td>
</tr>
</tbody>
</table>

**DRUGS AND BIOLOGICALS**

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

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

**EQUIPMENT, DEVICES, APPLIANCES, AND SUPPLIES**

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

Example:
- Syringe for drug administration
- Patient gown
- IV pump

**SPECIALTY AND LIMITED-SUPPLY ITEMS**

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

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

**DURABLE MEDICAL EQUIPMENT (DME)**

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

**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.
Example:
- Surgical 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.
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 Prospective Payment System (IPPS) Web Pricer 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 IPPS Web Pricer amount by the applicable multiplier to obtain the Alaska MAR payment. Software solutions other than the CMS IPPS Web Pricer are acceptable as long as they produce the same results.

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

Note: Mt. Edgecumbe is now a critical access hospital.
(10) hospitals may seek additional payment for unusually expensive implantable devices if the manufacturer/supplier’s invoice cost of the device or devices was more than $25,000. Manufacturer/supplier’s invoices are required to be submitted for payment. Payment will be the manufacturer/supplier’s invoice cost minus $25,000 plus 10 percent of the difference.

Example of Implant Outlier:
If the implant was $28,000 the calculation would be:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant invoice</td>
<td>$28,000</td>
</tr>
<tr>
<td>Less threshold</td>
<td>($25,000)</td>
</tr>
<tr>
<td>Outlier amount</td>
<td>$3,000</td>
</tr>
<tr>
<td>Multiplied by 1.10%</td>
<td>$3,300</td>
</tr>
</tbody>
</table>

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

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

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

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

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

The CMS IPPS Web Pricer is normally available on the CMS web site 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, 2023 remains in effect, unless the Alaska Workers’ Compensation Division publishes a notice that a new version is in effect. Besides the IPPS Web Pricer, two additional elements are required to determine a payment:

1. The hospital’s provider certification number (often called the CCN or OSCAR number): Below is a current list of Alaska hospital provider numbers:
   - Providence Alaska Medical Center 020001
   - Mat-Su Regional Medical Center 020006
   - Bartlett Regional Hospital 020008
   - Fairbanks Memorial Hospital 020012
   - Alaska Regional Hospital 020017
   - Yukon Kuskokwim Delta Regional Hospital 020018
   - Central Peninsula General Hospital 020024
   - Alaska Native Medical Center 020026

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

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

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

   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

   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 IPPS Web Pricer application may be accessed here:

   https://webpricer.cms.gov/#/pricer/ipps

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

   *NOTE: These illustrations and calculations are for example purposes only and do not reflect current reimbursement.*
The IPPS Web Pricer instructions are included below:

**Data Entry and Calculation Steps for the IPPS Web Pricer**—Claim Entry Form

**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 IPPS Web Pricer cannot process using an NPI.

**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).

**COVERED CHARGES** – Enter the total covered charges on the claim.

**COVERED DAYS** – The number of days of inpatient stay in this facility that Medicare would reimburse

**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.

**NATIONAL DRUG CODE (NDC)** – Enter NDC codes when appropriate.

**PROCEDURE CODE** – Enter the appropriate ICD-10-PCS codes for procedures performed.

**DIAGNOSIS CODE** – Enter the patient’s principle and other diagnoses using the appropriate ICD-10-CM codes.

**CONDITION CODE** – Enter the condition code when required

**LIFETIME RESERVE DAYS** – not required to be entered.

**TRANSFER STATUS** – Select the correct option from

- No transfer
- Short-term acute transfer
- Post-acute transfer

Pricer will apply a transfer payment if the length of stay is less than the average length of stay for this DRG.

**REQUIRED COST OUTLIER THRESHOLD** – Enter ‘No’ (or tab) if the cost outlier threshold is not applicable for the claim. For the cost outlier threshold, enter ‘Yes.’

**HMO PAID CLAIM** - Enter ‘No’ as this field is specific to Medicare Advantage claims.

Click the “Estimate” button at the top of the screen. The results will display on the right-hand side of the screen. 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.
### Inpatient Hospital

#### 2023 Alaska Workers' Compensation Medical Fee Schedule

**Review results**

**Summary**

- **Return code**: 14
- **Key claim information**
  - Provider number: [redacted]
  - Effective date: [redacted]
  - Diagnosis related group (DRG): 460
- **Claim estimate**
  - Claim estimate with provider adjustments: $35,218.14
  - Outlier calculation: $0.00
  - Grand total amount: $35,218.14

The estimate is based on submitted claim info.

**Provider details**

- **Provider type**: [redacted]
- **Geographic CBSA**: 11260
- **Reclassification CBSA**: [redacted]
- **Pass through amount allogeneic stem cell**: $0.00
- **Total pass through & miscellaneous**: $17.80
- **Pass through amount capital**: $0.00
- **Pass through amount direct**: $17.80
- **Pass through amount organ**: $0.00

**Capital amounts**

- **Capital federal specific portion**: $2,268.41
- **Capital outlier**: $0.00
- **Capital disproportionate share hospital**: $224.08
- **Capital indirect medical education**: $54.43

**Operating amounts**

- **Operating federal specific portion**: $29,203.19
- **Operating hospital specific payment**: $0.00
- **Operating outlier**: $0.00
- **Operating disproportionate share hospital**: $2,020.86
- **Operating indirect medical education**: $827.07
- **Uncompensated care**: $874.96
- **Readmission adjustment**: $-37.96
- **Value based purchasing adjustment**: $0.00
- **New technology**: $0.00

**Other PPS amounts**

- **Hospital acquired condition adjustment**: $354.30
- **Low volume**: $0.00
- **Islet add on**: $0.00
- **Electronic health record adjustment**: $0.00
- **Bundle adjustment**: $0.00
A Note on Pass-through Payments in the IPPS Web 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 IPPS Web 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 Grand Total Amount field result above by the hospital specific multiplier listed above to calculate the payment. In the above example, the Grand Total Amount is reported as:

- CMS IPPS Web Pricer Grand Total Amount: $35,218.14
- Multiplied by Providence Alaska Medical Center multiplier: $35,218.14 × 2.38
- Alaska Workers’ Compensation Payment: $83,819.17
GENERAL INFORMATION AND GUIDELINES
The maximum allowable reimbursement (MAR) for medical services provided by a critical access hospital, rehabilitation hospital, or long-term acute care hospital is the lowest of 100 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

For a list of critical access hospitals in Alaska, please contact the Alaska Department of Health and Social Services, Division of Health Care Services.
TAB 6
Workers’ Compensation Medical Services Review Committee

Medical Services Review Committee Members

Charles Collins, Chair
Jeff Moore, MD
Mason McCloskey, DC
Mary Ann Foland, MD
Jeff Gilbert
Misty Steed
Pam Scott
Valerie Mittlestad
Susan Kosinski
Recommendation for 2023 Fee Schedule

The MSRC unanimously voted to leave all conversion factors at the same level for 2023.

Discussion of medical treatments of continuing and multiple nature were ongoing. The committee had several valid arguments for tightening the language in the fee schedule and made this a priority. Language was added to the medical chapter in the Physical Medicine sub-heading to further guide providers on proper treatment schedules.

Alaska Statute 23.30.095 Medical treatments, services, and examinations. Paragraph (c):

c) A claim for medical or surgical treatment, or treatment requiring continuing and multiple treatments of a similar nature, is not valid and enforceable against the employer unless, within 14 days following treatment, the physician or health care provider giving the treatment or the employee receiving it furnishes to the employer and the board notice of the injury and treatment, preferably on a form prescribed by the board. The board shall, however, excuse the failure to furnish notice within 14 days when it finds it to be in the interest of justice to do so, and it may, upon application by a party in interest, make an award for the reasonable value of the medical or surgical treatment so obtained by the employee. When a claim is made for a course of treatment requiring continuing and multiple treatments of a similar nature, in addition to the notice, the physician or health care provider shall furnish a written treatment plan if the course of treatment will require more frequent outpatient visits than the standard treatment frequency for the nature and degree of the injury and the type of treatments. The treatment plan shall be furnished to the employee and the employer within 14 days after treatment begins. The treatment plan must include objectives, modalities, frequency of treatments, and reasons for the frequency of treatments. If the treatment plan is not furnished as required under this subsection, neither the employer nor the employee may be required to pay for treatments that exceed the frequency standard. The board shall adopt regulations establishing standards for frequency of treatment.

Alaska Workers’ Compensation Laws and Regulations Annotated, Rel. EB21-22E Sec. 23.30.095

Workers’ Compensation regulations address the frequency of treatments.

8 AAC 45.086(a)(14):

(14) a treatment plan, including the expected length and nature of treatment, the objectives, modalities, and frequency of treatment, and the justification for the frequency of treatments if the number of treatments

(A) during the first month exceeds three treatments per week;
(B) during the second and third months exceeds two treatments per week;

(C) during the fourth and fifth months exceeds one treatment per week; or

(D) during the sixth through twelfth months exceeds one treatment per month;

Alaska Workers’ Compensation Laws and Regulations Annotated, Rel. EB21-22E 8 AAC 45.086

These “guidelines” for frequency of treatment in both statute and regulation have withstood the judicial test and continue to be the prevailing law. In 1995 the law was challenged by a group of medical providers and the Alaska Supreme Court ruled in favor of Workers’ Compensation.

Chiropractors for Justice v State of Alaska and Alaska Workers’ Compensation Board S-5648

Stating in part:

Worker’s Compensation Act’s frequency of treatment statute and corresponding regulation bore a fair and substantial relationship to state’s objective of ensuring quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to employers and, therefore, did not violate equal protection. Const. Art. 1, § 1; AS 23.30.095(c); Alaska Admin.Code title 8, § 45.082(f, g).

Ruling by Summary Judgement:

For these reasons, we conclude that the superior court correctly denied summary judgment to CFJ and correctly granted summary judgment to the State upholding AS 23.30.095(c) and 8 AAC 45.082(f) and (g). We therefore AFFIRM the judgment of the superior court.

Issues with the Inpatient Hospital section were also discussed, upon research it was discovered that the CMS Web Pricer updates occasionally throughout the calendar year. This allows for the estimates Medicare reimbursement amounts to change over the course of the year. As our fee schedule and regulation directs that the “version” in place on January 1 of a given year is the authorized version for the entire period, usually a calendar year, this could pose a conflict. After exhaustive research by our legal team the Division offers this analysis:

Alaska Statute 23.30.097 Fees for medical treatment and services. Paragraph (j)

j) The board shall annually renew and adjust fees on the fee schedules established by the medical services review committee under (a)(1)(A) of this section by a conversion factor established by the medical services review committee and adopted by the board in regulation.
Workers’ Compensation regulation 8 AAC 45.083 Fees for medical treatment and services.

a) A fee or other charge for medical treatment or service may not exceed the maximums in AS 23.30.097. The fee or other charge for medical treatment or service

The annual fee schedule is adopted by reference in a subparagraph under (a) of this regulation normally adopted by the AWCB in the October annual meeting.

Research of legislative and past AWCB intent pointed to a consistent and easily defined parameter for billing of medical services. Several Alaska Supreme Court decisions have outlined this in case law. Notably:

AIG and VECO v Carriere and Gilmore v AWCB

Both decisions point to a legal “bright line” meeting the directive of 23.30.001 of “quick, efficient, fair, and predictable” provisions in the Act. The notes from Justice Matthews in the “Gilmore” case state this succinctly. Decision S-4765

This simplistic construction may result in a bright line for applying the statutory limitation, and a benefits system with quick, efficient, and predictable results that will not be "a fertile ground for litigation."

Telehealth in Alaska, HB 265 was signed into law on July 13, 2022, this bill allows for telehealth practices by licensed medical practitioners in the state of Alaska. This will include medical practice covered under workers compensation as allowed under the new law. Currently the Department of Law and the Workers’ Compensation Division are researching to ensure our statutes under the Act and regulations of those statutes do not conflict with this new law.

An explanation of telehealth as allowed by law will be added to the fee schedule to the definitions area in the introduction. Those codes that allow for telehealth are already addressed in the fee schedule and noted in the CMS guidelines.
TAB 7
July 27, 2022

Alaska Medical Services Review Committee
P.O. Box 115512
Juneau, AK 99811-5512
Email: workerscomp@alaska.gov

Re: 2023 Medical Fee Schedule | Physical Medicine

To Whom It May Concern,

Healthesystems is a Pharmacy and Ancillary Benefit Manager supporting workers’ compensation insurance carriers, third-party administrators, and self-insured employers in the state of Alaska. We want to thank the Medical Services Review Committee (MSRC) for allowing us the opportunity to provide feedback on recommendations made to the 2023 Medical Fee Schedule.

At the July 15th MSRC meeting, members discussed physical medicine utilization including concerns that therapy is billed excessively with no restrictions. To better manage these services, the committee recommended language in the fee schedule that would provide a limit of 6-weeks or maximum of 20 visits with exceptions before requiring a follow-up with physician to review patient’s condition. Members also suggested providers to submit progress notes every 30 days. Our comments below will focus on medical treatment guidelines and progress notes as it relates to physical medicine.

**Medical Treatment Guidelines**

The MSRC has previously discussed and considered medical treatment guidelines for the AK workers’ compensation system. Healthesystems would fully support the Committee’s decision to use evidence-based treatment guidelines as they are widely considered useful in the delivery of consistent and effective medical care for patients with injuries. According to a 12019 WCRI study, State Policies on Treatment Guidelines and Utilization Management, twenty-three (23) workers’ compensation jurisdictions have already adopted and implemented medical treatment guidelines to provide quality care in a cost-effective manner and limit inappropriate and unnecessary care.

More specifically, we recommend the Committee consider use of published Clinical Practice Guidelines, which rely upon evidence-based benchmarks for the number of visits with a therapist and the period during which these visits can take place. They are supported by relevant medical literature and actual experience data, combined with consensus review by experts. Comparing the limits recommended by MSRC with results against published guidelines may provide a better picture to see if the therapists and/or chiropractors are overutilizing. Twenty (20) visits might be reasonable for a knee diagnosis; however, it may be unreasonable for a low back diagnosis. Adopting a specific number of visits without considering the involved joint or severity of the injury could prove fruitless. Treatment guidelines will identify the maximum number of visits that can be justified by the evidence.

---

Progress Reports
To justify the medical necessity and continuation of treatment, the Committee also recommended the submission of progress reports every 30 days. In keeping with \textsuperscript{2}Medicare’s policy, we would like to recommend the Committee consider progress reports for therapy every 2 weeks. This frequency is parallel with what Medicare requires, and providers would already be familiar and compliant with this provision. A progress report does not mean the patient is re-evaluated. It means that the therapist provides a report that details the patient’s objective and functional gains or losses, how close the patient is to discharge, as well as information related to their attendance/absence from therapy. These reports provide valuable updates on the patient’s status at regular intervals throughout the course of care supporting the need for additional visits.

As always, thank you for considering our feedback and allowing Healthesystems the opportunity to comment on the 2023 Workers’ Compensation Medical Fee Schedule. Please feel free to contact me at the number or email below with any questions or comments you may have.

Sincerely,

\textbf{Tate Rice, PT, DPT, MBA}

Tate Rice, PT, DPT, MBA
Director, Product Management
Healthesystems, LLC
813-367-2651
trice@healthesystems.com

\textsuperscript{2} Medicare Benefit Policy Manual (cms.gov), Section 220.3