Official

ALASKA

WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2020

State of Alaska Disclaimer

This document establishes professional medical fee reimbursement amounts for covered services rendered to injured employees in the State of Alaska and provides general guidelines for the appropriate coding and administration of workers' medical claims. Generally, the reimbursement guidelines are in accordance with, and recommended adherence to, the commercial guidelines established by the AMA according to CPT guidelines. However, certain exceptions to these general rules are proscribed in this document. Providers and payers are instructed to adhere to any and all special rules that follow.

Notice

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Introduction

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

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

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

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

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

The **maximum allowable reimbursement (MAR)** is the maximum 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 Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes, a currently assigned CMS relative value, or an established conversion factor is the lowest of:

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

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

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- Category II
- Category III
- HCPCS Level II
- Outpatient Facility
- Inpatient Hospital

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

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

Provider Schedule

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

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

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

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

Drugs and Pharmaceuticals

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

The maximum allowable reimbursement for prescription drugs is as follows:

1. Brand name drugs shall be reimbursed at the manufacturer's average wholesale price plus a $5 dispensing fee;

2. Generic drugs shall be reimbursed at the manufacturer's average wholesale price plus a $10 dispensing fee;

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

HCPCS Level II

Durable Medical Equipment

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

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

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

Ambulance Services

Ambulance services are reported using HCPCS Level II codes. Guidelines for ambulance services are separate from

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other services provided within the boundaries of the State of Alaska. See the HCPCS section for more information.

Outpatient Facility

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. This includes, but is not limited to, ambulatory surgical centers (ASC), hospitals, and freestanding clinics within hospital property. Only the types of facilities described above will be reimbursed using outpatient facility fees. Only those charges that apply to the facility services—not the professional—are included in the Outpatient Facility section.

Inpatient Hospital

The Inpatient Hospital section represents services performed in an inpatient setting and billed on a UB-04 (CMS 1450) or 837i electronic claim form. Base rates and amounts to be applied to the Medicare Severity Diagnosis Related Groups (MS-DRG) are explained in more detail in the Inpatient Hospital section.

Definitions

Act — the Alaska Workers' Compensation Act; Alaska Statutes, Title 23, Chapter 30.

Bill — a request submitted by a provider to an insurer for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment — a reduction of a fee on a provider's bill.

Board — the Alaska Workers' Compensation Board.

Case — a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

Consultation — a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

Covered injury — accidental injury, an occupational disease or infection, or death arising out of and in the course of employment or which unavoidably results from an accidental injury. Injury includes one that is caused by the willful act of a third person directed against an employee because of the employment. Injury further includes breakage or damage to eyeglasses, hearing aids, dentures, or any prosthetic devices which function as part of the body. Injury does not include mental injury caused by stress unless it is established that the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, or the work stress was the predominant cause of the mental injury. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

Critical care — care rendered in a medical emergency that requires the constant attention of the provider, such as cardiac arrest, shock, bleeding, respiratory failure, and postoperative complications, and is usually provided in a critical care unit or an emergency care department.

Day — a continuous 24-hour period.

Diagnostic procedure — a service that helps determine the nature and causes of a disease or injury.

Drugs — a controlled substance as defined by law.

Durable medical equipment (DME) — specialized equipment that is designed to stand repeated use, is appropriate for home use, and is used solely for medical purposes.

Employer — the state or its political subdivision or a person or entity employing one or more persons in connection with a business or industry carried on within the state.

Expendable medical supply — a disposable article that is needed in quantity on a daily or monthly basis.

Follow-up care — care related to recovery from a specific procedure that is considered part of the procedure's maximum allowable fee, but does not include care for complications.

Follow-up days — the days of care following a surgical procedure that are included in the procedure's maximum allowable fee, but does not include care for complications. Follow-up days for Alaska include the day of surgery through termination of the postoperative period.

Incidental surgery — a surgery performed through the same incision, on the same day and by the same physician, that does not increase the difficulty or follow-up of the main procedure, or is not related to the diagnosis (e.g., appendectomy during hernia surgery).

Independent procedure — a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

Insurer — an entity authorized to insure under Alaska Statute 23.30.030 and includes self-insured employers.

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Maximum allowable reimbursement (MAR) — the maximum amount for a procedure established by these rules, or the provider's usual and customary or billed charge, whichever is less, and except as otherwise specified.

Medical record — an electronic or paper record in which the medical service provider records the subjective and objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and improvement rating as applicable.

Medical supply — either a piece of durable medical equipment or an expendable medical supply.

Modifier — a two-digit number used in conjunction with the procedure code to describe any unusual circumstances arising in the treatment of an injured or ill employee.

Operative report — the provider's written or dictated description of the surgery and includes all of the following:

- Preoperative diagnosis
- Postoperative diagnosis
- A step-by-step description of the surgery
- Identification of problems that occurred during surgery
- Condition of the patient when leaving the operating room, the provider's office, or the health care organization.

Optometrist — an individual licensed to practice optometry.

Orthotic equipment — orthopedic apparatus designed to support, align, prevent or correct deformities, or improve the function of a moveable body part.

Orthotist — a person skilled and certified in the construction and application of orthotic equipment.

Outpatient service — services provided to patients who do not require hospitalization as inpatients. This includes outpatient ambulatory services, hospital-based emergency room services, or outpatient ancillary services that are based on the hospital premises. Refer to the Inpatient Hospital section of this fee schedule for reimbursement of hospital services.

Payer — the employer/insurer or self-insured employer, or third-party administrator (TPA) who pays the provider billings.

Pharmacy — the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Physician — under AS 23.30.395(32) and *Thoeni v. Consumer Electronic Services,* 151 P.3d 1249, 1258 (Alaska 2007), "physician" includes doctors of medicine, surgeons, chiropractors, osteopaths, dentists, optometrists, and psychologists.

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

Procedure — a unit of health service.

Procedure code — a five-digit numerical or alpha-numerical sequence that identifies the service performed and billed.

Properly submitted bill — a request by a provider for payment of health care services submitted to an insurer on the appropriate forms, with appropriate documentation, and within the time frame established in Alaska Statute 23.30.097.

Prosthetic devices — include, but are not limited to, eye glasses, hearing aids, dentures, and such other devices and appliances, and the repair or replacement of the devices necessitated by ordinary wear and arising out of an injury.

Prosthesis — an artificial substitute for a missing body part.

Prosthetist — a person skilled and certified in the construction and application of a prosthesis.

Provider — any person or facility as defined in 8 AAC 45.900(a)(15) and licensed under AS 08 to furnish medical or dental services, and includes an out-of-state person or facility that meets the requirements of 8 AAC 45.900(a)(15) and is otherwise qualified to be licensed under AS 08.

Second opinion — when a physician consultation is requested or required for the purpose of substantiating the necessity or appropriateness of a previously recommended medical treatment or surgical opinion. A physician providing a second opinion shall provide a written opinion of the findings.

Secondary procedure — a surgical procedure performed during the same operative session as the primary and, for billing purposes, is valued less than the first billed procedure.

Special report — a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

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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:

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.03	1.500	1.545
Practice Expense RVU x Practice Expense GPCI	1.61	1.117	1.79837
Malpractice RVU x Malpractice GPCI	0.14	0.708	0.09912
Total RVU			3.44249

Data for the purpose of example only

Calculation using example data:

1.03 x 1.500 = 1.545

+ 1.61 x 1.117 = 1.79837

+ 0.14 x 0.708 = 0.09912

= 3.44249

3.44249 x $132.00 (CF) = 454.40868

Payment is rounded to $454.41

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.

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.

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

MEDICAL SERVICE	CPT CODE RANGE	CONVERSION FACTOR
Surgery	10004–69990	$132.00
Radiology	70010–79999	$141.00
Pathology and Lab	80047–89398	$122.00
Medicine (excluding anesthesia)	90281–99082 and 99151–99199 and 99500–99607	$80.00
Evaluation and Management	99091, 99201–99499	$80.00
Anesthesia	00100–01999 and 99100–99140	$110.00

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

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

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

RBRVS Status Codes

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

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
A	Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status.	The maximum fee for this service is calculated as described in Fees for Medical Treatment.
B	Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.	No separate payment is made for these services even if an RVU is listed.
C	Contractors price the code. Contractors will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.	The service may be a covered service of the *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.
D	Deleted Codes. These codes are deleted effective with the beginning of the applicable year.	Not in current RBRVS. Not payable under the *Official Alaska Workers' Compensation Medical Fee Schedule.*
E	Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes.	The service may be a covered service of the *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.
F	Deleted/Discontinued Codes. (Code not subject to a 90 day grace period).	Not in current RBRVS. Not payable under the *Official Alaska Workers' Compensation Medical Fee Schedule.*
G	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.)	Not in current RBRVS. Not payable under the *Official Alaska Workers' Compensation Medical Fee Schedule.*
H	Deleted Modifier. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H."	Not in current RBRVS. Not payable with modifiers TC and/or 26 under the *Official Alaska Workers' Compensation Medical Fee Schedule.*
I	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)	The service may be a covered service of the *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.
J	Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.	Alaska recognizes the anesthesia base units in the *Relative Value Guide®* published by the American Society of Anesthesiologists. See the *Relative Value Guide* or Anesthesia Section.
M	Measurement Codes. Used for reporting purposes only.	These codes are supplemental to other covered services and for informational purposes only.

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STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
N	Non-covered Services. These services are not covered by Medicare.	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.
P	Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. • If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) • If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.	The service may be a covered service of the *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.
Q	Therapy functional information code (used for required reporting purposes only).	These codes are supplemental to other covered services and for informational purposes only.
R	Restricted Coverage. Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D." We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)	The service may be a covered service of the *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.
T	Injections. There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)	The service may be a covered service of the *Official Alaska Workers' Compensation Medical Fee Schedule.* For drugs and injections coded under the Healthcare Common Procedure Coding System (HCPCS) the payment allowance limits for drugs is the lower of average sale price multiplied by 3.375 or billed charges. See HCPCS Level II section of these guidelines.
X	Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)	The service may be a covered service of the *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. For ambulance services see HCPCS Level II section of this guideline.

Add-on Procedures

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

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

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Exempt from Modifier 51 Codes

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

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

Professional and Technical Components

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

Global Days

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

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

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

Supplies and Materials

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

Medical Reports

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

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

Off-label Use of Medical Services

All 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

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knew of the claim and knew that the claim related to employment.

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

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.

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

Applicable HCPCS Modifiers

Modifier TC—Technical Component

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

Modifier QZ—CRNA without medical direction by a physician

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

State-Specific Modifiers

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

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

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

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

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

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

Data for the purpose of example only

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Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

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

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

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

Data for the purpose of example only

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Evaluation and Management

General Information and Guidelines

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

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

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

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

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

Billing and Payment Guidelines

New and Established Patient Service

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

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

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

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

E/M Service Components

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

1. The history component is categorized by four levels:

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

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

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

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

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

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

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

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

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

The CPT book identifies the following body areas:

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

The CPT book identifies the following organ systems:

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

3. Medical decision making is the final piece of the E/M coding process, and is somewhat more complicated to determine than are the history and exam components. Three subcomponents must be evaluated to determine the overall complexity level of the medical decision.

   a. The number of possible diagnoses and/or the number of management options to be considered.

   b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed.

   c. The risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

Contributory Components

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

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

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

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

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

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Subcategories of Evaluation and Management

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

Office or Other Outpatient Services (99201–99215)
Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary. Support the claim with documentation.

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

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

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

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

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

Observation Care Discharge Services (99217)
This code reports observation care discharge services. Use this code only if discharge from observation status occurs on a date other than the initial date of observation status. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. If a patient is admitted to, and subsequently discharged from, observation status on the same date, see codes 99234–99236.

Hospital Inpatient Services (99221–99239)
The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge-day management. Per CPT guidelines for inpatient care, the time component includes not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals such as other physicians, nursing staff, respiratory therapists, and so on.

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

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

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

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

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

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

Emergency Department Services (99281–99288)
Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The CPT guidelines clearly define an emergency department as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." Care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Critical Care Services (99291–99292)
The CPT book clarifies critical services providing additional detail about these services. Critical care is defined as "the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." Carefully read the guidelines in the CPT book for detailed information about the reporting of critical care services. Critical care is usually, but not always, given in a critical care area such as a coronary care unit (CCU), intensive care unit (ICU), pediatric intensive care unit (PICU), respiratory care unit (RCU), or the emergency care facility.

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

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

Nursing Facility Services (99304–99318)
Nursing facility E/M services have been grouped into three subcategories: Comprehensive Nursing Facility Assessments, Subsequent Nursing Facility Care, and Nursing Facility Discharge Services. Included in these codes are E/M services provided to patients in psychiatric residential treatment centers. These facilities must provide a "24-hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

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Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (99324–99337)
These codes report care given to patients residing in a long-term care facility that provides room and board, as well as other personal assistance services. The facility's services do not include a medical component.

Home Services (99341–99350)
Services and care provided at the patient's home are coded from this subcategory.

Prolonged Services (99354–99360, 99415–99416)
This section of E/M codes includes three service categories:

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

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

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

Physician Standby Services
Code 99360 reports the circumstances of a physician who is requested by another physician to be on standby, and the standby physician has no direct patient contact. The standby physician may not provide services to other patients or be proctoring another physician for the time to be reportable. Also, if the standby physician ultimately provides services subject to a surgical package, the standby is not separately reportable.

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

Case Management Services (99366–99368)
Physician case management is the process of physician-directed care. This includes coordinating and controlling access to the patient or initiating and/or supervising other necessary health care services.

Care Plan Oversight Services (99374–99380)
These codes report the services of a physician providing ongoing review and revision of a patient's care plan involving complex or multidisciplinary care modalities. Only one physician may report this code per patient per 30-day period, and only if more than 30 minutes is spent during the 30 days. Do not use this code for supervision of patients in nursing facilities or under the care of home health agencies unless the patient requires recurrent supervision of therapy. Also, low intensity and infrequent supervision services are not reported separately.

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

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

99455	10.63
99456	21.25

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

MODIFIERS

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

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

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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.

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Anesthesia

General Information and Guidelines

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

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

Billing and Payment Guidelines

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

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

Anesthesia values consist of the sum of anesthesia base units, time units, physical status modifiers, and the value of qualifying circumstances multiplied by the specific anesthesia conversion factor $110.00. 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 = $110.00

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 = $110.00 x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = $1,210.00

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

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

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

Anesthesia Modifiers

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

Physical Status Modifiers

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

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

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

Qualifying Circumstances

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

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

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

Modifiers

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

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

Applicable HCPCS Modifiers

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

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

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

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

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

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

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

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

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

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Surgery

General Information and Guidelines

Definitions of Surgical Repair

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

Billing and Payment Guidelines

Global Reimbursement

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

In addition to the surgical procedure, global reimbursement includes:

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

Follow-up Care for Diagnostic Procedures

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

Follow-up Care for Therapeutic Surgical Procedures

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

Additional Surgical Procedure(s)

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

Incidental Procedure(s)

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

Suture Removal

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

Aspirations and Injections

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

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Surgical Assistants

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

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

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

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

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

Data for the purpose of example only

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

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

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

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

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

Data for the purpose of example only

Anesthesia by Surgeon

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

Multiple or Bilateral Procedures

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

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

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

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

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

Example:

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

Data for the purpose of example only

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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:

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

Data for the purpose of example only

Arthroscopy

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

State-Specific Modifiers

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

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

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

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

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

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

Data for the purpose of example only

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

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

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

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

Data for the purpose of example only

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Radiology

General Information and Guidelines

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

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

Billing and Payment Guidelines

Professional Component

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

Technical Component

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

Review of Diagnostic Studies

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

Written Reports

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

Multiple Radiology Procedures

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

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

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

Modifiers

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

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

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Reimbursement Guidelines for CPT Modifiers

Specific CPT modifiers shall be reimbursed as follows:

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

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

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

Alaska MAR:

72142	$1,510.83
72142-TC	$1,019.43
72142-26	$491.40
72147	$1,503.53
72147-TC	$1,013.13
72147-26	$490.40

Data for the purpose of example only

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

Technical Component:

72142-TC	$1,019.43	100% of the TC
72147-TC	$506.57	(50% of the TC for the second procedure)
Total	$1,526.00	

Professional Component:

72142-26	$491.40	100% of the 26
72147-26	$465.88	(95% of the 26 for the second procedure)
Total	$957.28	

Global Reimbursement:

72142	$1,510.83	100% of the global
72147-51	$972.45	($506.57+ $465.88 TC and 26 above)
Total	$2,483.28	

Applicable HCPCS Modifiers

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

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

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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 80500 in the RBRVS with the Alaska GPCI using the non-facility RVUs:

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	0.37	1.500	0.555
Practice Expense RVU x Practice Expense GPCI	0.26	1.117	0.29042
Malpractice RVU x Malpractice GPCI	0.02	0.708	0.01416
Total RVU			0.85958

Data for the purpose of example only

Calculation using example data:

0.37 x 1.500 = 0.555

+ 0.26 x 1.117 = 0.29042

+ 0.02 x 0.708 = 0.01416

= 0.85958

0.85958 x $122.00 (CF) = 104.86876

Payment is rounded to $104.87

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 $3.52 in the CLAB file, this is multiplied by 4.43 for a MAR of $15.59.

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.

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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.

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Medicine

General Information and Guidelines

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

Billing and Payment Guidelines

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

Multiple Procedures

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

Separate Procedures

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

Materials Supplied by Physician

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

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

Physical Medicine

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

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

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

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

TENS Units

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

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

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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 premanipulation patient assessment.
- Evaluation and management services may be reported separately if, the patient's condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the CMT. Different diagnoses are not required for the reporting of the CMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.
- There are five spinal regions recognized in the CPT book for CMT: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacroiliac joint) region. There are also five recognized extraspinal regions: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.
- Chiropractors may report codes 97014, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943.

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

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

Specific modifiers shall be reimbursed as follows:

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

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

The multiple procedure payment reduction (MPPR) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same

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patient on the same day. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services and to the TC of global services. The MPPRs are as follows:

Cardiovascular services—Full payment is made for the TC service with the highest MAR. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a "6" in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

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

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

Ophthalmology services—Full payment is made for the TC service with the highest MAR. Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a "7" in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

92060	$183.12
92060-TC	$65.80
92060-26	$117.32
92132	$88.07
92132-TC	$37.20
92132-26	$50.86

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

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

Alaska MAR:

97016	$37.36
[(.18 x 1.5) + (.17 x 1.117) + (0.01 x .708)] x 80	
97024	$19.38
[(.06 x 1.5) + (.13 x 1.117) + (0.01 x .708)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

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

Example:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

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Category II

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

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

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

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Category III

Category III codes are temporary codes identifying emerging technology and should be reported when available. These codes are alphanumeric with and 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.

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HCPCS Level II

General Information and Guidelines

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

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

Medicare Part B Drugs

For drugs and injections coded under the Healthcare Common Procedure Coding System (HCPCS) the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges. **Note:** The corresponding National Drug Code (NDC) number should be included in the 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 in effect at the time of treatment or service multiplied by 1.84 or billed charges. If no CPT code identifies the supply, bill using the appropriate HCPCS code with a copy of the manufacturer/supplier's invoice for supplies.

Hearing Aids

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

Hearing Aid Services

The codes below are reimbursed according to the listed maximum allowable reimbursement (MAR) or the actual fee, whichever is less.

CODE	MAR
92591	$193.62
92593	$99.64
92594	$57.89
92595	$124.11
V5014	$249.31
V5020	$116.17

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;

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

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Outpatient Facility

General Information and Guidelines

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers' Compensation Act), a conversion factor shall be applied to the hospital outpatient relative weights established for each *Current Procedural Terminology* (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 $177.00. 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 Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) codes, currently assigned Centers for Medicare and Medicaid Services (CMS) relative value, or an established conversion factor is the lowest of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

A revenue code is defined by CMS as a code that identifies a specific accommodation, ancillary service or billing calculation. Revenue codes are used by outpatient facilities to specify the type and place of service being billed and to reflect charges for items and services provided. A substantial number of outpatient facilities use both CPT codes and revenue codes to bill private payers for outpatient facility services. The outpatient facility fees are driven by CPT code rather than revenue code. Common revenue codes are reported for components of the comprehensive surgical outpatient facility charge, as well as pathology and laboratory services, radiology services, and medicine services. The CMS guidelines applicable to status indicators are followed unless otherwise superseded by Alaska state guidelines. The following billing and payment rules apply for medical treatment or services provided by hospital outpatient clinics, and ambulatory surgical centers:

(1) medical services for which there is no *Ambulatory Payment Classifications* weight listed are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;

(2) status indicator codes C, E, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;

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

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

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

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INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance services • Separately payable clinical diagnostic laboratory services • Separately payable non-implantable prosthetic and orthotic devices • Physical, occupational, and speech therapy • Diagnostic mammography • Screening mammography	Not paid under OPPS. See the appropriate section under the provider fee schedule.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	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.
C	Inpatient Procedures	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.*
D	Discontinued codes	Not paid under OPPS.
E1	Items, codes and services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary	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.*
E2	Items and services for which pricing information and claims data are not available	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.*
F	Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	Pass-through device categories	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.*
J1	Hospital Part B services paid through a comprehensive APC	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; all preventive services; and certain Part B inpatient services.
J2	Hospital Part B services that may be paid through a comprehensive APC	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; all preventive services; and certain Part B inpatient services. (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.

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INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
K	Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine	Not paid under OPPS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS.
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services, including outliers. 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.*
P	Partial hospitalization	Paid under OPPS; per diem APC payment. *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.*
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 though 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. (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 claim as a HCPCS code assigned published OPSI J1, J2, S, T, V, Q1, Q2, or Q3. (2) In other circumstances, laboratory tests should have an SI = A and payment is made under the CLFS.
R	Blood and blood products	Paid under OPPS; separate APC payment.
S	Procedure or service, not discounted when multiple	Paid under OPPS; separate APC payment.
T	Procedure or service, multiple reduction applies	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.*
U	Brachytherapy sources	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPPS; separate APC payment.
Y	Non-implantable durable medical equipment	Not paid under OPPS. 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.

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- 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 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.

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Inpatient Hospital

General Information and Guidelines

For medical services provided by inpatient acute care hospitals under AS 23.30 (Alaska Workers' Compensation Act), the Centers for Medicare and Medicaid Services (CMS) Inpatient PC Pricer Software shall be applied to the *Medicare Severity Diagnosis Related Groups* (MS-DRG) weight adopted by reference in 8 AAC 45.083(m). The MAR is determined by multiplying the CMS Inpatient PC Pricer amount by the applicable multiplier to obtain the Alaska MAR payment. ***Software solutions other than the CMS PC Pricer are acceptable as long as they produce the same results.***

(1) the PC Pricer amount for Providence Alaska Medical Center is multiplied by 2.38;

(2) the PC Pricer amount for Mat-Su Regional Medical Center is multiplied by 1.84;

(3) the PC Pricer amount for Bartlett Regional Hospital is multiplied by 1.79;

(4) the PC Pricer amount for Fairbanks Memorial Hospital is multiplied by 1.48;

(5) the PC Pricer amount for Alaska Regional Hospital is multiplied by 2.32;

(6) the PC Pricer amount for Yukon Kuskokwim Delta Regional Hospital is multiplied by 2.63;

(7) the PC Pricer amount for Central Peninsula General Hospital is multiplied by 1.38;

(8) the PC Pricer amount for Alaska Native Medical Center is multiplied by 2.53;

(9) except as otherwise provided by Alaska law, the PC Pricer amount for all other inpatient acute care hospitals is multiplied by 2.02;

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

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

Example of Implant Outlier:

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

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

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

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

Exempt from the MS-DRG

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

Services and Supplies in the Facility Setting

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

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

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Preparing to Determine a Payment

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

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

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

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

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

Payers (and others) who wish to verify the MS-DRG assignment for the claim will need an appropriate grouping software package. The current URL for the Medicare grouper software is: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html

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

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

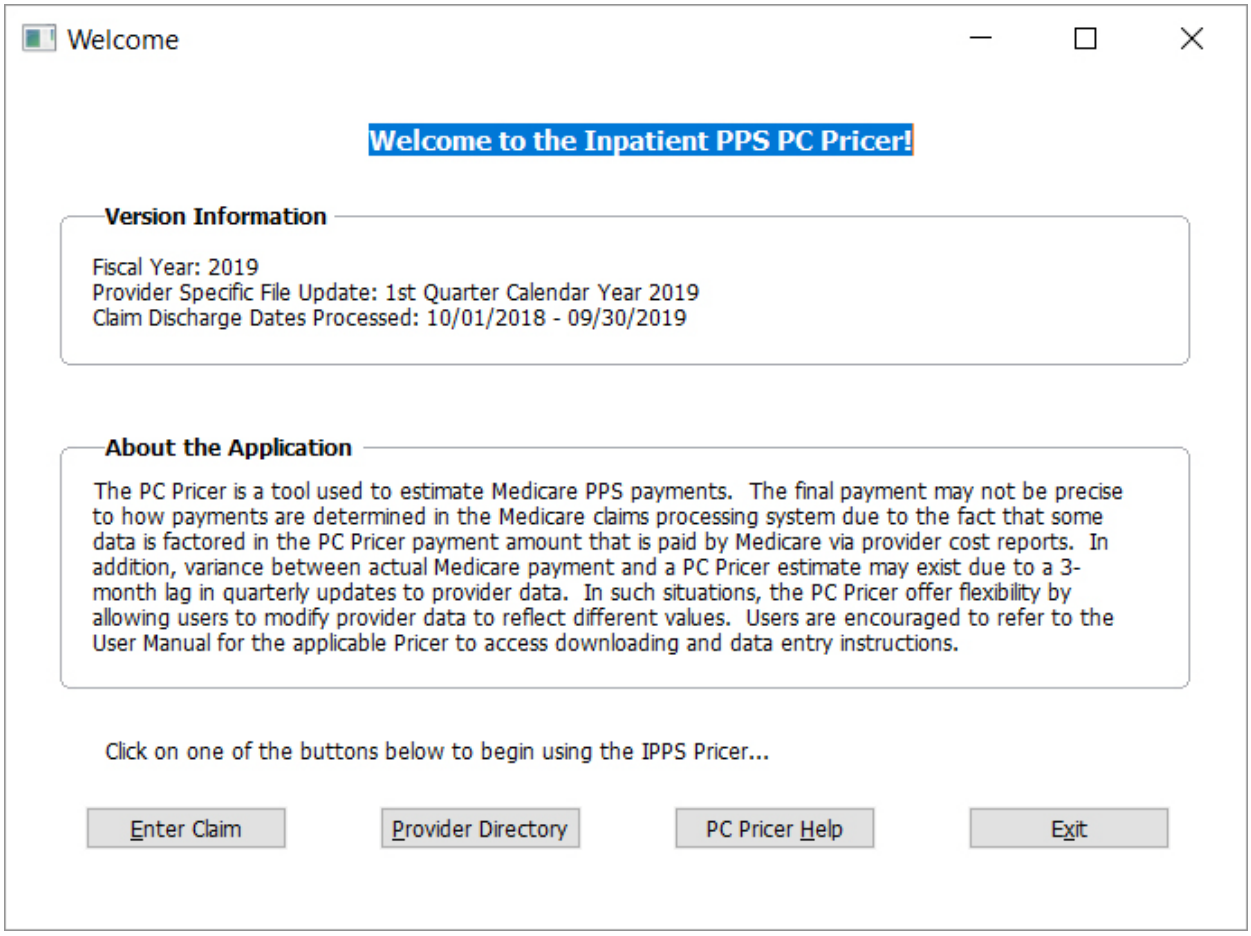
Guidelines for downloading and executing the PC Pricer can be downloaded here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/Guidelines.html

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

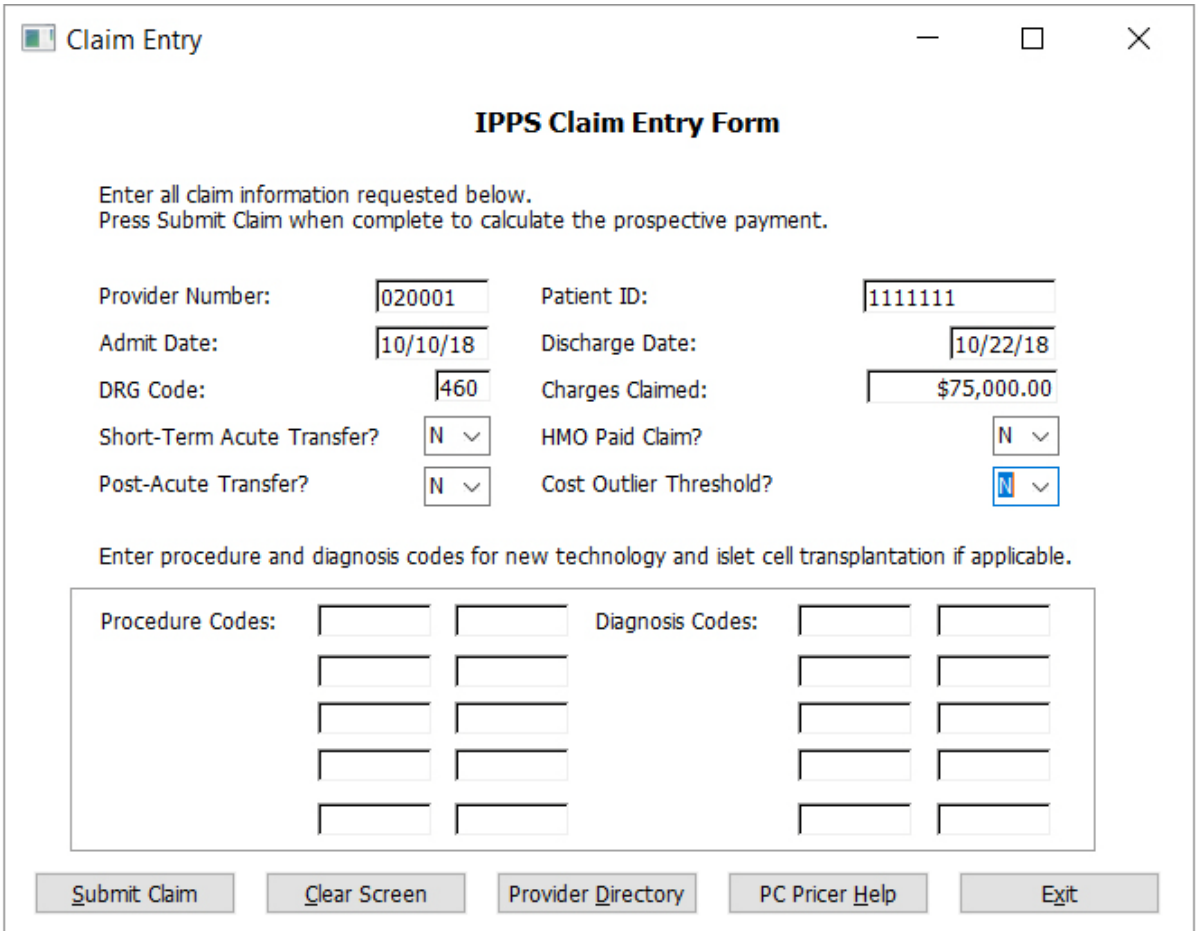
NOTE: These illustrations and calculations are for example purposes only and do not reflect current reimbursement.

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All screenshots have been updated.



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The PC Pricer instructions are included below:

Data Entry and Calculation Steps for the Inpatient PPS PC Pricer—From the welcome screen above (top image), select Enter Claim. The IPPS Claim Entry Form will appear.

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

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

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

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

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

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

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

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

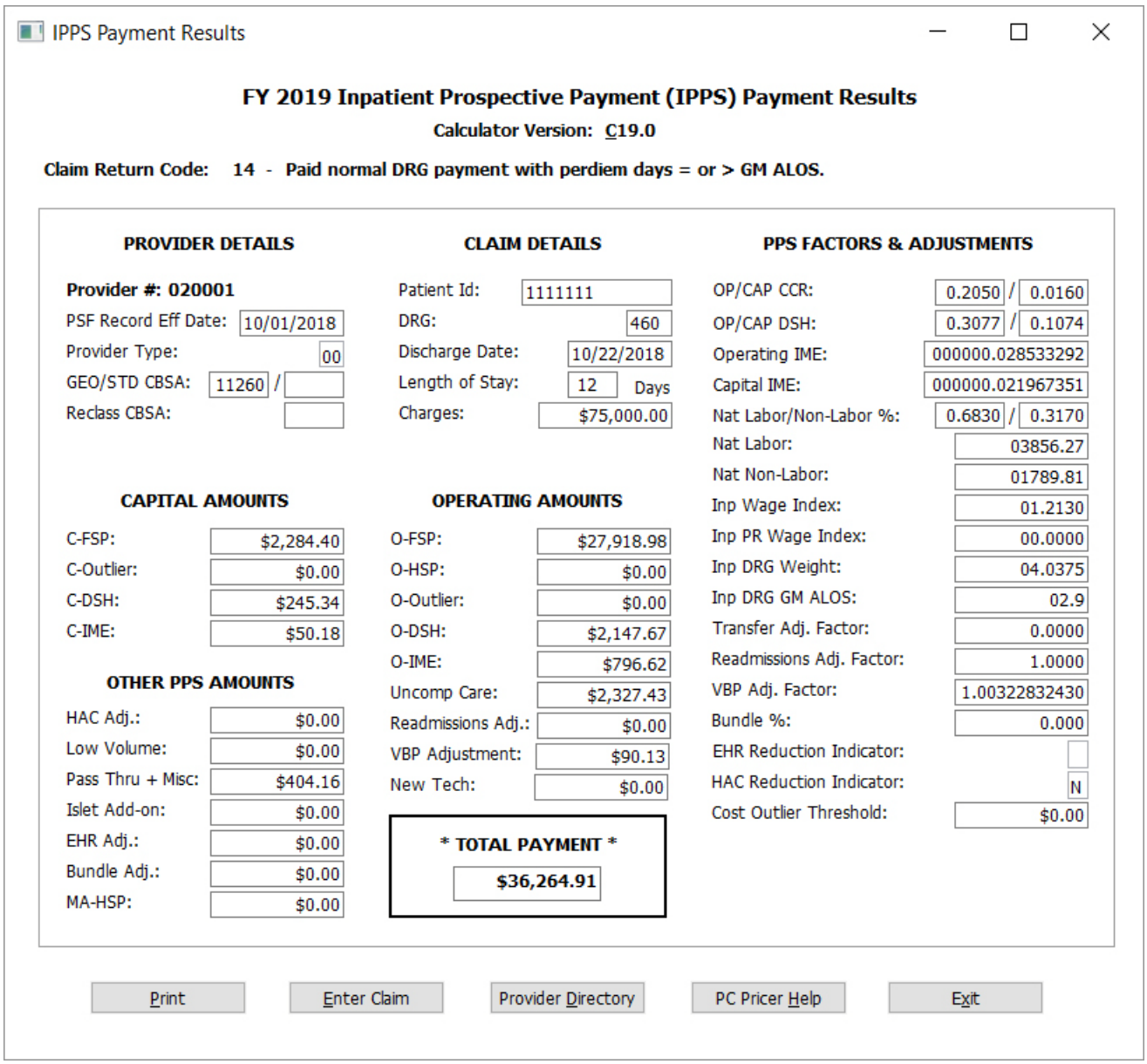
HMO PAID CLAIM—N/A for IHS/CHS. Enter 'N' (or tab). HMOs must enter 'Y.'

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

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

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



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A Note on Pass-through Payments in the PC Pricer

There are certain hospital costs that are excluded from the IPPS payment and are paid on a reasonable cost basis. Pass-through payments under Medicare FFS are usually paid on a bi-weekly interim basis based upon cost determined via the cost report (or data received prior to cost report filing). It is computed on the cost report based upon Medicare utilization (per diem cost for the routine and ancillary cost/charge ratios). In order for the PC Pricer user to estimate what the pass-through payments are, it uses the pass-through per diem fields that are outlined in the provider specific file.

Pass-through estimates should be included when determining the Alaska workers' compensation payment.

Determining the Final Maximum Allowable Reimbursement (MAR)

To determine the Alaska workers' compensation MAR, multiply the TOTAL PAYMENT field result above by the hospital specific multiplier listed above to calculate the payment. In the above example, the TOTAL PAYMENT is reported as:

CMS Inpatient PC Pricer Total Payment amount	$36,264.91
Multiplied by Providence Alaska Medical Center multiplier	x 2.38
Alaska Workers' Compensation Payment	$86,310.49

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

General Information and Guidelines

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

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

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