

The emergency repeal of 8 AAC 45.082(l)(2) is made permanent:

(2) repealed 12/1/2015;

The emergency amendment of 8 AAC 45.082(m) is made permanent to read:

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

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

The emergency adoption of 8 AAC 45.083 is made permanent and that section is further amended to read:

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

(b) For medical services provided by physicians under **AS 23.30** [THE] (Alaska Workers' Compensation Act), the following conversion factors shall be applied to the total facility or non-facility **relative value unit** [RELATIVE VALUE UNIT] in the *Resource-Based*

Relative Value Scale, **adopted by reference in (m) of this section** [ESTABLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AS AMENDED, IN EFFECT AT THE TIME OF TREATMENT OR SERVICE]. Medical service or treatment shall be identified by a code assigned to that treatment or service in [THE LATEST EDITION OF] the *Current Procedural Terminology*, **adopted by reference in (m) of this section**: [PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION, AS AMENDED.]

(1) **the** [THE] conversion factor for evaluation and management is **\$80**; [80.]

(2) **the** [THE] conversion factor for medicine, [(excluding anesthesiology,)] is **\$80**; [80.]

(3) **the** [THE] conversion factor for surgery is **\$205**; [205.]

(4) **the** [THE] conversion factor for radiology is **\$257**; [257.]

(5) **the** [THE] conversion factor for pathology and laboratory is **\$142**; [142.]

(6) **the** [THE] relative value for *Current Procedural Terminology* code 97545 **is** [SHALL BE] 3.41, and the relative value for *Current Procedural Terminology* code 97546 **is** [SHALL BE] 1.36.

(c) The conversion factor for anesthesiology is **\$121.82** [121.82], which is to be multiplied by the base and time units for each *Current Procedural Terminology* code established in the *Relative Value Guide*, **adopted by reference in (m) of this section** [AS AMENDED, PUBLISHED BY THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS].

(d) For supplies, materials, injections, and other services and procedures coded under the *Healthcare Common Procedure Coding System*, **adopted by reference in (m) of this section**, the following multipliers shall be applied to the following fee schedules established by the

Centers for Medicare and Medicaid Services **and** [, AS AMENDED,] in effect at the time of treatment or service; [.]

(1) [PATHOLOGY AND] Clinical **Diagnostic Laboratory services, multiplied by** [LAB, CENTERS FOR MEDICARE AND MEDICAID SERVICES] 6.33; [.]

(2) Durable Medical Equipment, **Prosthetics, Orthotics, and Supplies (DMEPOS), multiplied by** [CENTERS FOR MEDICARE AND MEDICAID SERVICES] 1.84; [.]

(3) **Payment Allowance Limits for Medicare Part B Drugs,** Average Sale Price, **multiplied by** [CENTERS FOR MEDICARE AND MEDICAID SERVICES] 3.375.

(e) For medical services provided by inpatient hospitals under **AS 23.30** [THE] (Alaska Workers' Compensation Act), the conversion factor of 328.2 **percent of the hospital specific total base rate** shall be applied to the *Medicare Severity Diagnosis Related Groups* weight **adopted by reference in (m) of this section, except that** [ESTABLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AS AMENDED, IN EFFECT AT THE TIME OF TREATMENT OR SERVICE,]

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

(2) **the** [THE] base rate for Providence Alaska Medical Center is **\$23,383.10;** [23,383.10.]

(3) **the** [THE] base rate for Mat-Su Regional Medical Center is **\$20,976.66;**

[20,976.66.]

(4) **the** [THE] base rate for Bartlett Regional Hospital is **\$20,002.93;** [20,002.93.]

(5) **the** [THE] base rate for Fairbanks Memorial Hospital is **\$21,860.73;**

[21,860.73.]

(6) **the** [THE] base rate for Alaska Regional Hospital is **\$21,095.72;** [21,095.72.]

(7) **the** [THE] base rate for Yukon Kuskokwim Delta Regional Hospital is

\$38,753.21; [38,753.21.]

(8) **the** [THE] base rate for Central Peninsula General Hospital is **\$19,688.56;**

[19,688.56.]

(9) **the** [THE] base rate for Alaska Native Medical Center is **\$31,042.20;**

[31,042.20.]

(10) **the** [THE] base rate for Mt. Edgecumbe Hospital is **\$26,854.53;** [26,854.53.]

(11) **on** [ON] outlier cases, implants shall be paid at invoice plus 10 percent.

(f) For medical services provided by **hospital** outpatient clinics or ambulatory surgical centers under **AS 23.30** [THE] (Alaska Workers' Compensation Act), an outpatient conversion factor of **\$221.79** [221.79] shall be applied to the relative weights established for each *Current Procedural Terminology* or *Ambulatory Payment Classifications* code **adopted by reference in (m) of this section** [BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AS AMENDED, IN EFFECT AT THE TIME OF TREATMENT OR SERVICE]. For procedures performed in an outpatient setting, implants shall be paid at invoice plus 10 percent.

(g) The maximum allowable reimbursement for medical services that do not have current Centers for Medicare and Medicaid Services, *Current Procedural Terminology*, or *Healthcare*

Common Procedure Coding System codes, a currently assigned Centers for Medicare and Medicaid Services relative value, or an established conversion factor **is** [SHALL BE] the **lowest** [LOWER] of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

(h) The maximum allowable reimbursement for prescription drugs is as follows:

(1) **brand** [BRAND] name drugs shall be reimbursed at the manufacturer's **average wholesale price** [AVERAGE WHOLESAL PRICE] plus a \$5 dispensing fee; [.]

(2) **generic** [GENERIC] drugs shall be reimbursed at manufacturer's **average wholesale price** [AVERAGE WHOLESAL PRICE] plus a \$10 dispensing fee; [.]

(3) **reimbursement** [REIMBURSEMENT] for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's **average wholesale price** [AVERAGE WHOLESAL PRICE] for each drug included in the compound, [(] listed separately by National Drug Code, [)] plus a \$10 compounding fee.

(i) The maximum allowable reimbursement for lift off fees and air mile rates for air ambulance services rendered under **AS 23.30** [THE] (Alaska Workers' Compensation Act), is as follows:

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

(A) **a** [A] fixed wing lift off fee **may** [MUST] not exceed \$11,500; [.]

(B) a [A] fixed wing air mile rate may [MUST] not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate [, AS AMENDED,] in effect at the time of service; [.]

(C) a [A] rotary wing lift off fee may [MUST] not exceed \$13,500; [.]

(D) a [A] rotary wing air mile rate may [MUST] not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate [, AS AMENDED,] in effect at the time of service; [.]

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

(j) The following billing and payment rules [SHALL] apply for medical treatment or services provided by physicians. [(1)] Providers and payers shall follow the billing and coding rules adopted by reference in (m) of this section [, AS AMENDED, IN EFFECT AT THE TIME OF TREATMENT,] as established by the Centers for Medicare and Medicaid Services and the American Medical Association, including the use of modifiers. The procedure with the largest relative value unit [RELATIVE VALUE UNIT] will be the primary procedure and shall [WILL] be listed first on the claim form. Specific modifiers shall be reimbursed as follows:

(1) [(2)] Modifier 50: reimbursement is the lowest of [REIMBURSEMENT SHALL BE] 100 percent of the fee schedule amount or [THE LESSER OF] the billed charge for the procedure with the highest relative value unit; reimbursement is the lowest of [RELATIVE VALUE UNIT. REIMBURSEMENT SHALL BE] 50 percent of the fee schedule amount or [THE LESSER OF] the billed charge for the procedure for the second and all subsequent procedures; [.]

(2) [(3)] Modifier 51: **reimbursement is the lowest of** [REIMBURSEMENT SHALL BE] 100 percent of the fee schedule amount or [THE LESSER OF] the billed charge for the procedure with the highest **relative value unit** [RELATIVE VALUE UNIT] rendered during the same session as the primary procedure **reimbursement is the lowest of** [. REIMBURSEMENT SHALL BE] 50 percent of the fee schedule amount or [THE LESSER OF] the billed charge for the procedure with the second highest **relative value unit** [RELATIVE VALUE UNIT] and all subsequent procedures during the same session as the primary procedure; [.]

(3) [(4)] Modifiers 80, 81, and 82: **reimbursement is** [REIMBURSEMENT SHALL BE] 20 percent of the surgical procedure; [.]

(4) [(5)] Modifier PE: **(3) reimbursement is** [REIMBURSEMENT SHALL BE] 85 percent of the value of the procedure; **state** [. STATE] specific modifier PE shall be used when services and procedures are provided by **a** physician **assistant** [ASSISTANTS] or an advanced practice registered nurse; [.]

(5) [(6)] Modifier AS: **reimbursement is** [REIMBURSEMENT SHALL BE] 15 percent of the value of the procedure; **state** [. STATE] specific modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon; [.]

(6) [(7)] Modifier QZ: **reimbursement is** [REIMBURSEMENT SHALL BE] 85 percent of the value of the anesthesia procedure; **state** [. STATE] specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist; [.]

(7) providers [(8) Providers' and payers shall follow National Correct Coding Initiative edits established by the Centers for Medicare and Medicaid Services and the American Medical Association [, AS AMENDED,] in effect at the time of treatment; **if** [. When] there is a billing rule discrepancy between National **Correct Coding Initiative** [COUNCIL ON COMPENSATION INSURANCE] edits and the American Medical Association *Current Procedural Terminology* Assistant, American Medical Association *Current Procedural Terminology* Assistant guidance governs.

(k) The following billing and payment rules [SHALL] apply for medical treatment or services provided by inpatient hospitals, **hospital** outpatient clinics, and ambulatory surgical centers; [.]

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

(2) **status** [STATUS] codes C, E, and P **are** [SHALL BE] the **lowest** [LOWER] of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer; [.]

(3) **two** [TWO] or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the *Ambulatory Payment Classifications* calculated amount and all other status code T items paid at 50 percent; [.]

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

(5) **when** [WHEN] total costs for a hospital inpatient *Medicare Severity Diagnosis Related Groups* coded service exceeds the Centers for Medicare and Medicaid Services outlier threshold established at the time of service plus the *Medicare Severity Diagnosis Related Groups* payment, then the total payment for that service shall be calculated using the Centers for Medicare and Medicaid Services Inpatient PC Pricer tool as follows:

(A) **implantable** [IMPLANTABLE] charges, if applicable, are subtracted from the total amount charged; [.]

(B) **the** [THE] charged amount from **(A) of this paragraph** [(A)] is entered into the most recent version of the Centers for Medicare and Medicaid Services PC Pricer tool at the time of treatment; [.]

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

(D) **the** [THE] allowable implant reimbursement, if applicable, is the invoice cost of the **implant** [IMPLANT(S)] plus 10 percent, or 110 percent of invoice cost; [.]

(E) **the** [THE] amounts calculated in **(C)** [(C)] and **(D) of this paragraph** [(D)] are added together to determine the final reimbursement.

(I) For medical treatment or services provided by other providers, the maximum allowable reimbursement for medical services provided by providers other than physicians,

hospitals, outpatient clinics, or ambulatory surgical centers, **is** [SHALL BE] the **lowest** [LOWER] of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.

(m) The following material is **adopted** [INCORPORATED] by reference:

(1) *Current Procedural Terminology Codes*, **2015 edition**, produced by the American Medical Association, as may be amended; [.]

(2) *Healthcare Common Procedure Coding System*, **2015 edition**, produced by the American Medical Association, as may be amended; [.]

(3) *International Classification of Diseases*, **2016 edition, valid October 1, 2015 through September 30, 2016**, published by the American Medical Association, as may be amended; [.]

(4) *Relative Value Guide*, **2015 edition**, produced by the American Society of Anesthesiologists, as may be amended; [.]

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

(6) *Current Dental Terminology*, **2015 edition**, published by the American Dental Association, as may be amended; [.]

(7) *Resource-Based Relative Value Scale*, **effective January 1, 2015**, produced by the federal Centers for Medicare and Medicaid Services, as may be amended; [.]

(8) *Ambulatory Payment Classifications*, **effective January 1, 2015**, produced by the federal Centers for Medicare and Medicaid Services, as may be amended; [.]

(9) *Medicare Severity Diagnosis Related Groups*, **effective January 1, 2015**,

produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(n) In this section, “maximum allowable reimbursement” means the charge for medical treatment or services calculated in accordance with the fee schedule. (Eff. 12/1/2015, Register 216; am 3 / 11 / 2016, Register 217)

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

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

The emergency adoption of 8 AAC 45.900(a)(15) is made permanent to read:

(15) [UNLESS THE STATUTORY CONTEXT REQUIRES OTHERWISE,]

"provider", **unless the statutory context requires otherwise**,

(A) means any physician, pharmacist, dentist, or other health service worker or any hospital, clinic, or other facility licensed under AS 08 to furnish medical or dental services, including chiropractic, physical therapy, and mental health services;

(B) [, AND] includes an out-of-state person or facility that meets the requirements of this section and is otherwise qualified to be licensed under AS 08.

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

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.230
AS 23.30.030 AS 23.30.175 AS 23.30.240

AS 23.30.041 AS 23.30.220 AS 23.30.395
AS 23.30.090

Editor’s note: As of Register 151 (October 1999), the regulations attorney made technical revisions under AS 44.62.125(b)(6) to reflect the name change of the Department of Labor to the Department of Labor and Workforce Development made by ch. 58, SLA 1999 and the corresponding title change of the commissioner of labor.

An amendment to 8 AAC 45.900(a) to add a definition of “provider” took effect on December 1, 2015 as an emergency regulation and was first published in Register 216 (January 2016). In reviewing the permanent regulation in accordance with AS 44.62.060 and 44.62.125, the regulations attorney made technical changes to the definition of “provider” in 8 AAC 45.900(a). The technical changes appeared in the permanent regulations as published in Register 217 (April 2016). The history note for 8 ASAC 45.900 does not reflect the changes made by the regulations attorney.

THE REGULATIONS REPRODUCED HERE HAVE BEEN PROVIDED BY THE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT AS A PUBLIC COURTESY. WHILE EVERY EFFORT HAS BEEN MADE TO ASSURE THE ACCURACY OF THE REPRODUCED VERSION, THE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT CANNOT GUARANTEE ITS ABSOLUTE ACCURACY. A COPY OF THE REGULATIONS AS ORIGINALLY FILED BY THE LIEUTENANT GOVERNOR ARE AVAILABLE FROM THE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT, DIVISION OF WORKERS' COMPENSATION OR ON THE ALASKA ONLINE PUBLIC NOTICE SYSTEM.

THE EMERGENCY REGULATIONS HAVE AN EFFECTIVE DATE OF 12/01/2015, ARE IN REGISTER 216, AND WILL APPEAR IN OFFICIAL PUBLISHED FORM IN THE JANUARY 2016 SUPPLEMENT TO THE ALASKA ADMINISTRATIVE CODE.

THE PERMANENT REGULATIONS HAVE AN EFFECTIVE DATE OF 03/11/2016, ARE IN REGISTER 217, AND WILL APPEAR IN OFFICIAL PUBLISHED FORM IN THE APRIL 2016 SUPPLEMENT TO THE ALASKA ADMINISTRATIVE CODE.