Workers' Compensation Medical Fee Schedule Recommendations

Medical Services Review Committee

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To: Heidi Drygas, Commissioner of the Department of Labor and Workforce Development

The Medical Services Review Committee (MSRC) is pleased to present the following report outlining its workers' compensation medical fee schedule recommendations. The Committee is an advisory body established by the Alaska Legislature in 2005 to assist and advise the Department of Labor and Workforce Development and the Alaska Workers' Compensation Board (Board) in matters involving the appropriateness, necessity, and cost of medical and related services provided under the Alaska Workers' Compensation Act.

On April 23, 2014, the Alaska Legislature passed HB316, chapter 63 SLA 2014, which became effective September 20, 2014. This legislation required the MSRC to develop new workers' compensation medical fee schedules, and submit their recommendations to you for review prior to transmission to the Board for adoption by regulation.

In this report the committee presents its analysis, its findings, and its recommendations for your review. It is the committee's belief that these recommendations will maintain employee access to medical care while improving medical cost stability and predictability to the employers who are required by law to pay for those benefits.

Sincerely,
Michael P. Monagle
Chair, Medical Services Review Committee
Director, Division of Workers' Compensation

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ACKNOWLEDGEMENTS

As Chair of the Medical Services Review Committee (MSRC), I'd like to acknowledge the tremendous amount of time the committee members have dedicated to this task. Beginning in July 2014, the committee held eleven public meetings analyzing data, reviewing reports, listening to testimony, and learning the complex rules of medical billing and payment formulas. As full-time professionals, the time these committee members took away from their practices and professions is deeply appreciated.

I would also like to acknowledge the following professionals whose input and subject matter expertise was invaluable to the committee's work:

- Eric Anderson, Optum
- Kevin Barry, Alaska Surgery Center
- Kira Boyd, Automated Healthcare Solutions
- Stephanie Brewer, Optum
- Raji Chadarevian, National Council on Compensation Insurance
- Lisa Anne Forsythe, Coventry Health
- Juliann McCabe, Guardian Flight
- Carla Gee, Optum
- Dr. Anthony Hamm, DC, FACO, President of the American Chiropractic Association and co-chair of the American Medical Association Specialty Society RVS HCPAC
- Sheila Hansen, Corvel
- Scott Kirby, LifeMed Alaska
- Don Lipsy, Coventry Health
- Matt Mayfield, FAIR Health
- Chris Rappleye, Guardian Flight
- Susan Schulte, National Council on Compensation Insurance
- Misty Steed, PacBlu
- Cathy Wilson, Automated Healthcare Solutions

Any errors or omissions contained in this report are my responsibility.

Michael P. Monagle, Chair

EXECUTIVE SUMMARY

PURPOSE OF THIS REPORT

The purpose of this report is to convey the findings and recommendations of the MSRC to the Commissioner of Labor and Workforce Development and the Alaska Workers' Compensation Board, as required by Alaska Statute 23.30.097, as amended in 2014 by HB316.

BACKGROUND

Beginning in 2000, Alaska's workers' compensation premium rates started rising rapidly. Between 2000 and 2006, premium rates rose 61.8%. In 2000, Alaska's workers' compensation premium rates ranked 28th in the nation. By 2006, Alaska had risen to the top of the premium rate rankings, having the dubious distinction of having the highest premium rates in the nation.

Analysis showed that the primary cost driver was medical costs, which had risen from 52% of claim costs in 1988 to 76% of claim costs by 2006. From 2000 to 2006, total medical benefit costs rose 50.9%, from $81.1 million to $122.4 million.

As part of the legislative reforms in 2005, SB130 (chapter 10 FSSLA 2005), AS 23.30.095(j), the Alaska Legislature established the Medical Services Review Committee (MSRC) to "to assist and advise the department and the board in matters involving the appropriateness, necessity, and cost of medical and related services provided under this chapter."

The MSRC is composed of

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

The members are appointed by the Commissioner of Labor and Workforce Development. No terms for the members are set out in statute or regulation - they serve at will of the Commissioner.

Seat	Lname	Fname	Affiliation
Chairperson	Monagle	Michael	Director, Division of Workers' Compensation
Ak State Medical Assn	Hall, MD	Robert J.	Orthopedic Physicians Anchorage, Inc.
Ak Chiropractic Society	Pfeifer, DC	William	Family Chiropractic Clinic
Ak State Hospital & Nursing Home Assn	Griffith	Jane	Providence Alaska Medical Center
Medical Care Provider	Foland, MD	Mary Ann	Primary Care Associates
Public Member	Smith	Kevin	Ak Municipal League Joint Insurance Association
Public Member	Scott	Pam	Ak Timber Insurance Exchange
Public Member	Beltrami	Vince	AFL-CIO
Public Member	Lindsey	Tammi	Ak National Insurance Co

In 2014, the Alaska Legislature passed HB316, Chapter 63, SLA 2014. The bill became effective September 20, 2014. HB316 tasked the Workers' Compensation Medical Services Review Committee with proposing new fee schedules founded on resource based relative value scale (RBRVS) methodology to the Workers' Compensation Board, through the Commissioner, for adoption by regulation.

SUMMARY OF MSRC ACTIVITY

The MSRC held 11 meetings between July 2014 and April 2015: July 7, 2014; September 5, 2014; September 19, 2014; October 24, 2014; November 7, 2014; December 12, 2014; January 15-16, 2015; January 29, 2015; February 23, 2015; March 16, 2015; and April 20, 2015. All of these meetings were open to the public, and public comment was taken at each meeting. The agenda and minutes of those meetings are posted online at http://labor.alaska.gov/wc/med-serv-comm.htm.

At its July 2014 meeting, the committee adopted the following action plan:

1. Collect data.
2. Select a third party vendor to assist the Division and the MSRC in developing fee schedules.
3. Analyze data and establish conversion factors, transitioning maximum allowable reimbursement rates (MAR) from the 2010 usual customary and reasonable (UCR) workers' compensation fee schedule to MAR rates based on the Centers for Medicare and Medicaid Services (CMS) resource based relative value system (RBRVS).
4. Obtain feedback on the proposed conversion factors from the MSRC member constituency groups, i.e. the State Medical Association (member Hall), the Alaska Chiropractic Society (member Pfeifer), the Hospital and Nursing Home Association (member Griffith), at large health care providers (member Foland), and the general public (members Smith, Scott, Lindsey, and Beltrami).
5. Submit adopted conversion factors to the Commission for review, and referral to the Workers' Compensation Board for adoption in regulation.

MILESTONES

- In August 2014, Optum was chosen as the vendor for fee schedule development. Optum has over 20 years' experience assisting state development of workers' compensation fee schedules, including Alaska, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Maine, Minnesota, Mississippi, Montana, Nebraska, New York, North Carolina, South Carolina, Texas, Utah, and Vermont. A contract with Optum was finalized in late September, 2014.
- FAIR Health was selected to provide medical billing data. FAIR Health is a national, independent nonprofit corporation who collects medical billing data and provides data products to clients. A contract with FAIR Health was finalized in October 2014.
- The National Council on Compensation Insurance (NCCI) was selected to provide medical data from workers' compensation insurers. NCCI is contracted by the Alaska Division of Insurance (DOI) as the rate setting organization for the State of Alaska. NCCI collects data from all workers' compensation insurers doing business in Alaska, excluding self-insured employers, analyzes that data, and makes premium rate recommendations to DOI for the coming calendar year. Recognizing the rising influence of medical costs on workers' compensation rates, NCCI began collecting medical data in 2010. NCCI is the rating organization for 38 states.
- On September 19, 2014, the committee was briefed by Dr. Anthony Hamm, DC, FACO, President of the American Chiropractic Association and co-chair of the AMA Specialty Society RVS Health Care Professionals Advisory Committee. Dr. Hamm presented an overview of how relative values are determined and the work of RVS Update Committees in collaboration with the AMA.
- Nondisclosure agreements were finalized between FAIR Health, Optum, and NCCI in October 2014.
- Data from NCCI was received in October 2014 and provided to Optum for analysis.
- Data from FAIR Health was received in November 2014, and provided to Optum for analysis.
- The first physician data analysis was received from Optum in December 2014.
- The committee received presentations on air ambulance services from Guardian Flight and LifeMed Alaska at the December 12, 2014 meeting.
- The first facility (inpatient and outpatient) data analysis was received from Optum in January 2015.
- The first draft recommendations were produced by the committee at its January 29, 2015 meeting.
- Final recommendations were approved by the committee at its April 20, 2015 meeting.

METHODOLOGY USED BY THE MSRC

Optum consulted with the Medical Services Committee to create a proposed fee schedule which would transition Alaska's current workers' compensation fee schedule that is reflective of the 90th percentile of usual, customary, and reasonable (UCR) charges, to a resource based relative value system (RBRVS).

Optum's analysis was based on data from NCCI's 2013 medical data call, FAIR Health's Spring 2014 billing data, CMS 2015 relative values and fee schedules, CMS Medicare Provider Analysis and Review (MEDPAR) data, CMS Outpatient Standard Analytical File (OPSAF), and the existing 2010 workers' compensation medical fee schedule.

Optum's analysis was based on billed charges for professional fees and paid charges for facility fees. Conversion factors were selected which would produce values between the 75th and 80th percentile of FAIR Health data.

Physician Fee Schedule

Optum obtained summary information from NCCI of carrier submitted claims data with calendar year 2013 dates of service. For each Common Procedure Terminology (CPT) code, Anesthesiology (ANES) code, and Healthcare Common Procedure Coding System (HCPCS) code evaluated, data fields included procedure code, modifier, second modifier, place of service, billed charge amount, paid amount, number of transactions and number of units for professional services. Total transactions and frequencies in the NCCI data were 219,237 and 1,642,896 respectively.

The data was then run through a validation process. Such validation included checking for old or invalid procedure codes and inappropriate procedure code/modifier combinations. Records with modifiers representing assistant surgeon were eliminated as not to inflate the occurrences of procedures (as the surgeon's record should have also been submitted). HCPCS transactions classified under 'other' place of service (not provider, not facility) were also excluded. Final numbers used in the analysis were 213,282 transactions and 1,603,008 units.

Occurrences per code, applicable modifiers and place of service were then determined and analyzed with the current fee schedule to create total dollar amounts by service area (surgery, radiology, laboratory/pathology, medicine, evaluation and management, and HCPCS). Corresponding geographic adjusted 'non-facility' and 'facility' relative values from RBRVS were used to determine total relative value units. The total dollar amounts were divided by total relative value units to calculate fee schedule neutral conversion factors to use as a baseline.

Codes that were not valued in RBRVS used, when available, associated Alaska information from the Clinical Diagnostic Laboratory (CLAB), Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS), Average Sale Price (ASP), and Parenteral and Enteral Nutrition Items and Services (PEN) fee schedules.

FAIR Health's total dollars (based on occurrences) were also calculated to see how the current fee schedule and the proposed fee schedule compared to commercial data. The 75th percentile to 80th percentile range was used as a guideline for determining conversion factors (RBRVS) and multipliers (other CMS files) for the data.

Inpatient Fee Schedule

Optum used the appropriate relative weights for each federal fiscal year in its analysis (i.e., FFY 2012 for 2012 data, FFY 2013 for 2013 data), and summed the relative weights and total payments for each year's inpatient claims. For 2013 data this was 357.72 and $8,719,881.99. Dividing the total payments by the total relative weights produces an effective Medicare base rate of $21,449.74. As a cross-check, this produced a workers' compensation case mix index of 1.873 which is in line with Optum's national calculations and what the company has observed in other states.

The 2015 total "all in" base rates ranged from $7,498.69 for Central Peninsula General Hospital to $12,991.50 for Yukon Kuskokwim Delta Regional Hospital. The average base rate was $8,944.40. Because Optum did not have volumes by hospital, the rate could not be adjusted to reflect different

utilization patterns. Optum used the 2015 average rate for the 2012 analysis in order to keep relativity between the 2012/2013 data.

Optum did not include the disproportionate (DSH) per claim amount in the calculated conversion factor. Some Alaska hospitals qualify for DSH per claim payments; some do not. The average DSH per claim amount in Alaska is $973.25. (Including the DSH per claim payment would increase the total payments by $185,891 for 2013 data.)

Based on this, Optum estimated current payments as 239.8% compared with Medicare. For 2012, the percentage to Medicare was 255.7%.

Outpatient Fee Schedule

Hospital Outpatient followed a similar process except that Optum used the 2015 Medicare weights for both the 2012 and 2013 data. This is because Medicare has been moving various CPT/HCPCS codes into differing Ambulatory Payment Classifications (APCs) and changing their weight, sometimes substantially. Optum wanted to keep relativity between the data years for accurate comparison.

Optum summed the relative weights and total payments for each year's outpatient claims. For 2013 data this was 31,750.6 and $7,042,049.83. Dividing the total payments by the total relative weights produced an effective Medicare base rate of $221.79.

Under the APC system, Medicare bundles some items together and only establishes a payment for the primary service. Optum used all payments reported so bundled items were included in the calculation where they existed, which presumes a 1:1 correlation between bundled items and primary items that may not exist. The result may somewhat over- or under-state the payments because of this. Typically, bundled payment items represent relatively small amounts. Based on an analysis of national Medicare data, Optum estimate the margin of error is likely to be within 1-3% either way.

Hospital outpatient only has a single adjustment between hospitals, by wage index. The formula is

$$\text{Hospital rate} = (\text{national rate}) * 60\% * (\text{hospital wage index}) + (\text{national rate}) * 40\%$$

There are two 2015 wage indexes in Alaska (1.3042 and 1.9343) with a substantial difference between them. As with inpatient, because we did not have volumes by hospital, we used an average wage index of $1.3310 to determine the comparison base rate of $101.72.

Although the volumes differed between 2012 and 2013, the comparison to Medicare produced almost the same results for each year. The 2013 calculation estimated the percentage to Medicare as 218.0%.

FINDINGS OF THE MSRC

The MSRC's findings follow in this section. Recommendations are listed separately under the "Recommendations of the MSRC" section.

Medical Costs

The committee finds that workers' compensation medical costs continue to be the significant cost driver for workers' compensation premiums.

Information presented by NCCI at the October 22, 2014 Alaska State Advisory Forum showed that Alaska's workers' compensation medical costs are significantly higher than countrywide. In Alaska, medical benefits comprise 74% of total benefit costs, compared to 59% countrywide. Alaska's average medical claim severity on a time loss claim averaged $53,000 per claim, compared to $29,000 countrywide. Alaska's average medical claim severity on a permanent partial impairment case averaged $95,100, compared to $40,900 countrywide.

NCCI's September 2014 Medical Data Report shows that Alaska's average medical payments are significantly higher than regional and countrywide average medical payments.

- Surgical – 377% higher than regional and 302% higher than countrywide
- Radiology – 313 % higher than regional and 267% higher than countrywide
- Physical/General Medicine – 179% higher than regional and 213% higher than countrywide
- Evaluation & Management – 186% higher than regional and 202% higher than countrywide
- Hospital Inpatient – 178% higher than regional and 166% higher than countrywide
- Hospital Outpatient – 160 % higher than regional and 131% higher than countrywide
- Ambulatory Surgical Centers – 250% higher than regional and 168% higher than countrywide

NCCI's January 2014 analysis of the impact of the 2010 workers' compensation medical fee schedule showed average medical payments increased 8.7% for physicians, 46.22% for hospital inpatient, 8.5% for hospital outpatient, and 19.0% for ambulatory surgical centers.

General

While HB316 only specifically tasked the committee with proposing conversion factors for physicians and facilities, the committee finds that it has subject matter expertise and statutory authority to make further fee schedule, billing, and payment recommendations that would be helpful and provide guidance to the Workers' Compensation Board in adopting regulations.

CMS does not produce relative values for all medical services, including pathology and clinical labs, durable medical equipment, parenteral and enteral nutrition items and services, some drug and pharmaceutical supplies. In addition, the committee acknowledged there will be some gaps for procedure codes not valued by CMS. The committee finds it needed to recommend payment rules for unvalued services and gaps where no CMS produces no relative values.

Physician Fee Schedule

Optum's analysis of the transition from UCR to RBRVS produced the following physician (non-facility) conversion values

- Surgery - $219.6829
- Radiology - $313.809
- Physical and General Medicine - $79.734
- Evaluation and Management - $77.0383
- Laboratory and Pathology - $230.1556
- Composite (combined non-facility service categories) - $126.714

The committee finds that implementing a single conversion factor ($126.714) would result in a significant increase or decrease in the MAR, depending on the medical specialty impacted. Therefore, the committee finds it in the best interest of all stakeholders that multiple conversion factors be established initially, with the goal of migrating toward a single physician schedule conversion factor over a four year period. The committee notes that a similar phased approach has also been recently used in Connecticut, Idaho, Montana, and California.

The current workers' compensation fee schedule does not distinguish between physician services provided in facility and non-facility settings. However since CMS does produce separate relative values for physician services provided in facility and non-facility settings, the committee finds that fee schedules should use relative values where they exist.

Optum analyzed CLAB, DMEPOS, ASP, PEN, and air ambulance billed charges, and compared these values to corresponding CMS fee schedules, proposing multipliers that would fall within the 75th to 80th percentile of the FAIR Health data. That analysis produced the following multiplier values

- CLAB – 6.33
- DMEPOS – 1.84
- ASP – 3.375
- PEN – 3.55

Optum reports that NCCI's data reflects a high frequency of work hardening codes, CPT 97545 and 97546. Since these codes are not valued by CMS, the committee finds that relative values should be established for these codes.

Hospital Inpatient Fee Schedule

There are 9 acute care hospitals subject to the inpatient hospital fee schedule: Alaska Regional Hospital, Bartlett Regional Hospital, Central Peninsula General Hospital, Fairbanks Memorial Hospital, Providence Alaska Medical Center, Mat-Su Regional Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Native Medical Center, and Mt. Edgecumbe Hospital. Each of these hospitals has their own operating and capital base rates, as determined by CMS.

Optum's analysis of NCCI and CMS data resulted in an inpatient base rate of $21,449.74, which is 239.8% of the average CMS FY15 base rate of $8,944.40 for the 9 Alaskan acute care hospitals. CMS base rates in Alaska vary from $7,498.69 for the Central Peninsula General Hospital to $12,991.50

for the Yukon Kuskokwim Delta Regional Hospital. The differences reflect the variances in each hospital's operating base rate, capital base rate, and wage index.

Because there are so few acute care hospitals in Alaska, rather than using a single conversion factor, the committee finds that it would be more equitable to use separate conversion factors for each hospital. The committee further finds that these conversion factors should be adjusted to account for CMS allowances for disproportionate share, and adjusted for outlier cases.

Hospital Outpatient Fee Schedule

Optum's analysis of the transition from UCR to RBRVS produced an outpatient conversion value of $221.79. Using an urban wage index of 1.3064 (95% of billed charges), the calculated base rate is $87.77, which is 252.7% of the 2015 CMS base rate.

CMS has developed status codes finding that certain procedures should not take place in an outpatient setting. The committee notes that CMS' patient mix trends to elderly patients or retirees whereas workers' compensation trends to younger workers. The committee finds that state specific rules should be recommended to address these status codes, notably status codes C, E, and P.

Ambulatory Surgical Centers

CMS' allowance for ASC's is 68% of the outpatient fee schedule. The 2010 workers' compensation medical fee schedule does not distinguish between outpatient services provided at hospital outpatient clinics or ambulatory surgical centers. Considering that ASC's are already taking a reduction in professional services, taking a further reduction on facility pricing would be problematic. The committee finds that ASC's should be paid at the same rate as other outpatient facilities.

Anesthesia

Optum's analysis of anesthesia billings reflects that the average unit charge is $145.5271 and the average unit payment is $121.4667. The 2010 workers' compensation fee schedule conversion factor is $121.82.

Prescription Drugs

There are multiple benchmarks utilized to determine prescription drug costs, such as average wholesale price (AWP), wholesale acquisition cost (WAC), actual acquisition cost (AAC), etc. However, AWP continues to be the most widely accepted price benchmark for both billers and payers. The committee finds that manufacturer's average wholesale price is the most widely accepted prescription drug price benchmark.

Air Ambulance Fee Schedule

The committee finds that establishing an air ambulance fee schedule is necessary to help contain air ambulance medivac costs.

The NCCI's November 2014 analysis of air ambulance payments shows that the fixed wing mileage rate in Alaska is 370% higher than regional payments and 211% higher than countrywide payments. Rotary wind air mileage rates are 103% higher than regional payments and 148% higher than countrywide payments.

Guardian Flight and LifeMed Alaska disclosed that public assistance programs, such as CMS and IHS, comprise the largest percentage of their payer mix, 75% and 64% respectively; and that

commercial payers comprise the smaller portion of their payer mix, 20% and 12% respectively. However, because public assistance program reimbursement rates are insufficient to cover costs, both carriers acknowledged that costs are disproportionately shifted to commercial payers.

Establishing an air ambulance fee schedule may lead to legal challenges, as state regulation of the pricing of an air carrier is alleged to be a violation of the Airline Deregulation Act of 1978.

Billing and Payment Rules

The committee finds that AMA modifiers and CMS payment rules are well established and generally accepted, but notes that certain modifiers, status codes, and NCCI edits require state specific rules.

Other Findings

Treatment under workers' compensation differs from treatment in general health, in that there is greater time commitment for providers in workers' compensation, such as depositions and completing reports for insurers, employers, attorneys, and claims administrators.

The committee noted that pricing (fee schedules) is one component of care, but noted that more needs to be done to address utilization, ensure quality of care, and measure treatment outcomes. Some committee members find that treatment guidelines may be an effective tool to address utilization, quality of care, and improve outcomes.

Access to quality data is a challenge. Billing and payment data from healthcare providers was not accessible by the committee. While the data provided by NCCI and FAIR Health was critical to the committee's analysis, having full access to data from all payers would provide for a more complete analysis. The committee finds a state run all payer claims database would improve the quality and quantity of data available for analysis.

In the past, the Division has contracted with vendors to publish fee schedules. The administrative cost to produce the last (2010) fee schedule was $40,000. In addition, payers had to purchase the fee schedule at a cost of $325. To lower administrative costs and allow stakeholder flexibility, the committee finds that the publishing of fee schedules should be left to the private sector.

The medical dispute resolution process follows the same dispute resolution process for disputed claims. The committee finds the medical dispute resolution process very slow and litigious.

Physicians are reporting an increase in marketing in-office drug testing as a profit center for physicians. Each test can screen for up to 30-40 substances, with some labs billing each panel separately. This can result in thousands of dollars for a single drug test. The committee finds the workers' compensation board should consider fee schedule rules on drug testing.

RECOMMENDATIONS OF THE MSRC

Physician Fee Schedule

The MSRC recommends

1. The following conversion factors be multiplied times the CMS relative values established for each CPT code.
    a. Evaluation & Management $80.00
    b. Medicine $80.00
    c. Surgery $205.00
    d. Radiology $257.00
    e. Laboratory $142.00
2. The following multipliers be applied to the CMS fee schedules established for each HCPCS code.
    a. Pathology & Clinical Lab CMS x 6.33
    b. Durable Medical Equipment CMS x 1.84
    c. ASP CMS x 3.375
3. Using separate CMS physician fee schedule relative values for facilities and non-facilities.
4. The maximum allowable reimbursement for medical services that do not have current CMS CPT or HCPCS codes, a currently assigned CMS relative value, or an established conversion factor established shall be the lower of 85% 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.

Hospital Inpatient Fee Schedule

The MSRC recommends

1. Conversion factors be adjusted to account for disproportionate share and case outliers
2. The following conversion factors be multiplied times the CMS Inpatient Prospective Payment System MSDRG weights
    a. Providence Alaska Medical Center $17,085.40
    b. Mat-Su Regional Medical Center $15,326.64
    c. Bartlett Regional Hospital $14,615.18
    d. Fairbanks Memorial Hospital $15,972.59
    e. Alaska Regional Hospital $15,413.63
    f. Yukon Kuskokwim Delta Regional Hospital $28,315.11
    g. Central Peninsula General Hospital $14,385.49
    h. Alaska Native Medical Center $22,681.05
    i. Mt Edgecumbe Hospital $19,621.32
3. On outlier cases, implants be paid separately at invoice plus 10%

Hospital Outpatient Fee Schedule

The MSRC recommends

1. An outpatient conversion factor of $221.79 to be applied to the CMS Outpatient Prospective Payment System relative weights established for each APC or CPT code.
2. Implants be paid at invoice plus 10%.
3. State specific payment rules be adopted for status codes C, E, & P

Ambulatory Surgical Centers

The MSRC recommends that ambulatory surgical centers be paid under the hospital outpatient fee schedule.

Anesthesia

The MSRC recommends an anesthesia conversion factor of $121.82, based on the Relative Value Guide, produced by the American Society of Anesthesiologists.

Prescription Drugs

The MSRC recommends

1. The adoption of the manufacturers average wholesale price (AWP) as the pricing benchmark
2. Brand name drugs be reimbursed at manufacturer's AWP plus a $5 dispensing fee
3. Generic drugs be reimbursed at manufacturer's AWP plus a $10 dispensing fee
4. Compound drugs be limited to medical necessity and reimbursed at the manufacturer's AWP for each drug included in the compound (listed separately by NDC) plus a $10 compounding fee.

Air Ambulance Fee Schedule

The MSRC recommends

1. Fixed wing lift off fee not to exceed $11,500
2. Fixed wing air mile rate not to exceed 400% of the CMS fee schedule rate
3. Rotary wing lift off fee not to exceed $13,500
4. Rotary wing air mile rate not to exceed 400% of the CMS fee schedule rate

Billing and Payment Rules

The MSRC recommends the following billing and payment rules for medical services provided by physicians

1. Providers and payers shall follow the billing and coding rules, as amended, in effect at the time of treatment, as established by the Centers Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows:
2. Modifier 50: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU. 50 % of the fee schedule amount or the lesser of the billed charge for the procedure for the second and all subsequent procedures.
3. Modifier 51: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU rendered during the same session as the primary procedure. 50 % of the fee schedule amount or the lesser of the billed charge for the procedure with the second highest RVU and all subsequent procedures during the same session as the primary procedure.
4. Modifiers 80, 81, and 82: Reimbursement shall be twenty percent (20%) of the surgical procedure.
5. Modifier PE: Reimbursement shall be 85% of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants and an advanced practice registered nurse.
6. Modifier AS: Reimbursement shall be fifteen percent (15%) of the value of the procedure. State specific modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.

7. Modifier QZ: Reimbursement shall be 85% of the value of the anesthesia procedure. State specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.
8. Providers and payers shall follow National Correct Coding Initiative edits established by the Centers Medicare and Medicaid Services and the American Medical Association, as amended, in effect at the time of treatment. An exception is when there is a billing rule discrepancy between NCCI edits and AMA CPT Assistant, CPT Assistant guidance governs.
9. The committee recommends establishing relative values of 3.41 for CPT code 97545 and 1.36 for CPT code 97546.

The MSRC recommends the following billing and payment rules for medical services provided by inpatient hospitals, outpatient clinics, and ambulatory surgical centers:

1. The maximum allowable reimbursement for medical services provided by a critical access hospital, rehabilitation hospital, or long term acute care hospital is the lower of one-hundred (100%) 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. Medical services for which there is no APC weight listed shall be the lower of 85% 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. Status codes C, E, and P, shall be the lower of 85% 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.
4. Two (2) or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%).
5. Payers shall subtract implantable hardware from Outpatient clinics and ambulatory surgical centers billed charges and pay separately at manufacturer or supplier invoice cost plus ten percent (10%).
6. When total costs for a hospital inpatient MS-DRG coded service exceeds the CMS outlier threshold in effect at the time of service, then the total payment for that service shall be calculated using the CMS Inpatient PC Pricer tool as follows:
    a. Implantable charges, if applicable, are subtracted from the total amount charged.
    b. The charged amount from (a) is entered into the most recent version of the CMS PC Pricer tool at the time of treatment.
    c. The Medicare price returned by the CMS PC Pricer tool is multiplied by 2.5 (250% Medicare price).
    d. The allowable implant reimbursement, if applicable, is the invoice cost of the implant(s) plus ten percent (110% of invoice cost).
    e. The amounts calculated in (c) and (d) are added together to determine the final reimbursement.

The MSRC recommends the following billing and payment rules for medical services provided by other providers:

The maximum allowable reimbursement for medical services provided by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers, shall be the lower of eighty-five (85%) 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.

Other Recommendations

The MSRC makes the following additional recommendations

- Adopt CMS ICD-10
- Address over utilization
- Establish an all payer claims database
- Publish conversion factors and rules, but leave publishing fee schedules to private sector vendors
- Improve the medical dispute resolution process to expedite resolution and lower legal costs
- Adopt fee schedule rules for drug testing

GLOSSARY

APC	Ambulatory Payment Classification. CMS' method of paying outpatient facilities under the outpatient prospective payment system for outpatient medical services. APC payments apply to outpatient procedures, outpatient clinics, and emergency department services.
AWCB	Alaska Workers' Compensation Board.
AWP	Average Wholesale Price. The average price at which drugs are purchased from at the wholesale level.
CF	Conversion Factor. A dollar amount by which the unit value of a medical service is multiplied to derive the fee for the medical service.
CMS	Centers for Medicare and Medicaid Services. The US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.
CPT	Current Procedure Terminology. A classification system developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures.
DME	Durable Medical Equipment.
DSH	Disproportionate Share Hospital.
GPCI	Geographic Practice Cost Index. The area in which medical services are provided. The GPCI is one of the factors used to calculate a reimbursement amount in Alaska.
HCPCS	Healthcare Common Procedure Coding System. A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology.
MAR	Maximum Allowable Reimbursement. The maximum amount payable to a health care provider for medical treatment or services provided under the Alaska Workers' Compensation Act.
MSDRG	Medicare Severity Diagnosis Related Group. CMS' method of paying inpatient facilities under the inpatient prospective payment system for inpatient medical services.
MSRC	Medical Services Review Committee.
NCCI	(1) National Council on Compensation Insurance. An industry provider of workers' compensation loss costs calculated by actuaries and shared with their insurance company and other industry members. (2) National Correct Coding Initiative. A set of medical coding policies established by CMS to promote correct coding methodologies, based upon coding conventions defined by the American Medical Association and national medical societies.
NDC	National Drug Code. A unique product code assigned by the US Food and Drug Administration to identify all prescription and nonprescription medications.
RBRVS	Resource Based Relative Value System. Created by Harvard University in 1988, and submitted to the Health Care Financing Administration (today CMS) to replace the existing Medicare payment system. It was signed into law under the Omnibus Budget Reconciliation Act of 1989, and became effective January 1, 1992.
RVU	A measure of value used by CMS to calculate the reimbursement formula for physician services. Each RVU is comprised of three components: • Physician work (51% RVU value) – This component addresses the relative level of time, skill, training and intensity to provide a given service. • Practice Expense (45% RVU value) - This component addresses the costs of maintaining a practice including rent, equipment, supplies and non-physician staff costs. • Professional Liability Insurance (4% RVU value) – This component addresses the cost of professional liability expenses.

APPENDIX OF PROPOSED SAMPLE FEE SCHEDULES

SURGERY

CPT Code	Description	Medicare NF Price	2010 FS MAR	Proposed FS MAR	MAR Diff
20610	Arthrocentesis aspiration and/or injection	77.23	383	443	15.61%
12001	Simple repair of superficial wounds	110.39	489	633	29.43%
64483	Injection anesthetic agent/steroid epidural	270.63	2,365	1,552	-34.39%
64415	Injection anesthetic agent; brachial plexus	151.30	1,182	867	-26.61%
62311	Injection of diagnostic/therapeutic substance	268.62	1,295	1,540	18.93%
29881	Knee arthroscopy with meniscectomy, including debridement	696.35	5,158	3,993	-22.60%
23350	Injection for shoulder x-ray	160.27	515	919	78.43%
29826	Arthroscopy shoulder surgical w/decompression	235.68	5,437	1,351	-75.15%
12002	Rpr s/n/ax/gen/trnk2.6-7.5cm	136.06	591	780	32.00%
29822	Arthroscopy shoulder surgical; debridement	733.37	4,740	4,205	-11.29%
23430	Tenodesis of tendon	965.24	5,837	5,534	-5.19%
23412	Repair of ruptured musculotendinous cuff; chronic	1,105.07	7,726	6,336	-17.99%
23120	Partial removal collar bone	747.89	2,704	4,288	58.58%
20680	Removal of support implant	768.33	2,134	4,405	106.43%
64416	N block cont infuse b plex	113.16	1,478	649	-56.10%
64493	Injection diagnostic or therapeutic substance, lumbar or sacral, single level	213.33	1,774	1,223	-31.05%
29824	Arthroscopy, shoulder, distal claviculectomy	863.53	4,531	4,951	9.27%
29888	Arthroscopic ligament repair	1,285.45	8,783	7,370	-16.09%
29827	Arthroscopy shoulder surgical w/cuff repair	1,384.23	7,319	7,937	8.44%
64721	Neuroplasty and/or transposition	543.32	5,188	3,115	-39.96%
64484	Inj foramen epidural add-on	111.22	1,256	638	-49.23%
29823	Shoulder arthroscopy/surgery	800.56	5,437	4,590	-15.58%
63030	Laminotomy w/ decompression	1,246.18	10,391	7,145	-31.24%
64494	Inj paravert f jnt l/s 2 lev	110.54	1,035	634	-38.76%

RADIOLOGY

CPT Code	Description	Medicare NF Price	2010 FS MAR	Proposed FS MAR	MAR Diff
73030	Radiologic examination shoulder; 2 views	$ 34.17	$ 257	$ 246	-4.44%
73610	Radiologic examination ankle; 3 views	$ 36.80	$ 215	$ 264	23.02%
72100	Radiologic examination spine lumbosacral; 2 or 3 views	$ 41.46	$ 242	$ 298	23.13%
73721	MRI lower extremity; without contrast	$ 278.67	$3,012	$ 2,003	-33.50%
73110	Radiologic examination wrist; complete minimum of 3 views	$ 41.15	$ 216	$ 296	36.93%
72148	MRI spinal; lumbar; without contrast	$ 265.86	$3,268	$ 1,911	-41.53%
73221	MRI upper extremity; without contrast	$ 279.07	$3,042	$ 2,006	-34.06%
76942	Ultrasonic guidance for needle placement	$ 76.00	$1,256	$ 546	-56.51%
77002	Fluoroscopic guidance for needle placement	$ 109.54	$1,085	$ 787	-27.43%
77003	Fluoroscopic guidance or therapeutic injection	$ 102.86	$1,055	$ 739	-29.92%
72141	MRI spinal; cervical; without contrast	$ 267.04	$3,248	$ 1,919	-40.90%
73222	MRI upper extremity; with contrast	$ 441.30	$3,517	$ 3,172	-9.81%
72158	MRI spinal without contrast followed by contrast	$ 449.87	$4,674	$ 3,234	-30.82%
72146	MRI spinal; thoracic; without contrast	$ 267.04	$3,446	$ 1,919	-44.30%

MEDICINE

CPT Code	Description	Medicare NF Price	2010 FS MAR	Proposed FS MAR	MAR Diff
97110	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises	$ 42.06	$ 96	$ 94	-1.97%
97140	Manual therapy techniques 1 or more regions each 15 minutes	$ 39.15	$ 74	$ 88	18.37%
98941	Chiropractic manipulative treatment (CMT); spinal 3-4 regions	$ 55.21	$ 85	$ 124	45.33%
97035	Application of a modality to 1 or more areas; ultrasound each 15 minutes	$ 17.06	$ 62	$ 38	-38.44%
98940	Chiropractic manipulative treatment (CMT); spinal 1-2 regions	$ 37.59	$ 66	$ 84	27.44%
97124	Therapeutic procedure 1 or more areas each 15 minutes; massage	$ 34.32	$ 63	$ 77	21.89%
97112	Therapeutic procedure 1 or more areas each 15 minutes; neuromuscular reeducation	$ 43.39	$ 94	$ 97	3.27%
97530	Therapeutic activities direct patient contact each 15 minutes	$ 44.83	$ 77	$ 100	30.27%

EVALUATION AND MANAGEMENT

CPT Code	Description	Medicare NF Price	2010 FS MAR	Proposed WC MAR	MAR Diff
99213	Office visit for E&M established patient; low to moderate severity; 15 minutes	$ 93.53	$ 170	$ 209	23.10%
99214	Office visit for E&M established patient; moderate to high severity; 25 minutes	$ 139.59	$ 246	$ 312	26.97%
99212	Office visit for E&M established patient; minor issue; 10 minutes	$ 54.86	$ 133	$ 123	-7.70%
99203	Office visit for E&M new patient; moderate severity; 30 minutes	$ 138.56	$ 266	$ 310	16.55%
99283	Emergency department visit; moderate severity.	$ 86.40	$ 399	$ 193	-51.55%
99202	Office visit for E&M new patient; moderate severity; 20 minutes	$ 95.20	$ 204	$ 213	4.41%
99204	Office visit for E&M new patient; moderate to high severity; 45 minutes	$ 214.69	$ 380	$ 480	26.41%
99284	Emergency department visit; high severity; not an immediate threat to life	$ 164.39	$ 596	$ 368	-38.29%
99285	Emergency department visit; high severity; immediate threat to life	$ 243.16	$ 889	$ 544	-38.80%

PATHOLOGY AND LAB

CPT Code	Description	Medicare NF Price	2010 FS MAR	Proposed FS MAR	MAR Diff
83925	Opiate(s), drug and metabolites, each procedure	$ 27	$ 132	$ 171	29.48%
82570	Creatinine, other source	$ 7	$ 63	$ 44	-29.67%
80053	Comprehensive metabolic panel	$ 14.37	$ 112	$ 91	-18.78%
83789	Mass spectrometry & tandem mass spectrometry, quantitative, each specimen	$ 24.58	$ 201	$ 156	-22.59%
82542	Column chromatography, quantitative, single stationary & mobile phase	$ 24.58	$ 177	$ 156	-12.10%
83992	Phencyclidine	$ 20.00	$ 146	$ 127	-13.52%
86703	Antibody, HIV-1 & HIV-2, single result	$ 18.66	$ 122	$ 118	-3.18%
82492	Multiple analytes, single stationary and mobile phase	$ 24.58	$ 170	$ 156	-8.46%
86803	Hepatitis C antibody	$ 19.42	$ 149	$ 123	-17.50%
80061	Lipid Panel	$ 18.22	$ 128	$ 115	-10.16%
85025	Complete CBC w/Auto Diff WBC	$ 10.58	$ 67	$ 67	0.00%
83036	Clycosylated Hemoglobin Test	$ 13.21	$ 82	$ 84	2.44%
81001	Urinalysis Auto w/Scope	$ 4.31	$ 41	$ 27	-34.15%
84443	Assay Thyroid Stim Hormone	$ 22.87	$ 138	$ 145	5.07%
85610	Prothrombin Time	$ 5.35	$ 48	$ 34	-29.17%
81003	Urinalysis Auto w/o Scope	$ 3.06	$ 34	$ 19	-44.12%
84153	Microalbumin Quantitative	$ 25.03	$ 141	$ 158	12.06%
84550	Assay of Blood/Uric Acid	$ 6.15	$ 37	$ 39	5.41%

DURABLE MEDICAL EQUIPMENT

CPT Code	Description	Medicare Price	2010 WC FS MAR	New WC MAR	MAR Diff
A4556	Electrodes, per pair	$ 11.46	$ 26	$ 21	-18.90%
L3908	Wrist hand orthosis, wrist extension control cock-up, prefabricated	$ 91.62	$ 132	$ 169	27.71%
E0114	Crutches, underarm other than wood	$ 52.90	$ 84	$ 97	15.88%
E0730	Tens device four or more leads	$ 394.43	$ 845	$ 726	-14.11%
L4360	Walking boot, pneumatic and/or vacuum	$ 291.99	$ 621	$ 537	-13.48%
L4386	Walking boot, non-pneumatic, with or without joints	$ 148.12	$ 340	$ 273	-19.84%
L3906	Wrist hand orthosis, without joints, custom fabricated	$ 473.72	$ 868	$ 872	0.42%
L1832	Knee orthosis, adjustable joints, rigid & prefabricated	$ 634.81	1365	$ 1,168	-14.43%
E0935	Continuous passive motion exercise device for knee	$ 22.36	$ 69	$ 41	-40.37%
L3808	Upper limb rigid without joint(s)	$ 459.94	$ 727	$ 846	16.41%
E0650	Pneumatic compressor, non-segmental home model	$ 885.15	$ 2,191	$ 1,629	-25.67%
L3020	Foot insert, longitudinal/metatarsal support	$ 185.35	$ 425	$ 341	-19.75%
A4222	Infusion supplies for infusion pump	$ 49.51	$ 99	$ 91	-7.98%
L1846	Knee orthosis, double upright, thigh & calf, adjustable	$ 1,427.73	$ 2,507	$ 2,627	4.79%
A4353	Intermittent urinary catheter with incision supplies	$ 7.84	$ 15	$ 14	-3.83%
L1845	KO Double Upright Pre Cst	$ 747.82	$ 1,834	$ 1,376	-24.97%
L3960	Sewho Airplan Desig Abdu Pos	$ 932.59	$ 1,614	$ 1,716	6.32%
E2402	Neg Press Wound Therapy Pump	$ 1,642.09	$ 4,500	$ 3,021	-32.87%
E0747	Elec Osteogen Stim Not Spine	$ 4,361.64	$ 8,850	$ 8,025	-9.32%
L5679	Socket Insert w/o Lock Mech	$ 665.29	$ 1,331	$ 1,224	-8.04%

INPATIENT (PROVIDENCE)

DRG Code	Description	Medicare Price	2010 FS MAR	Proposed FS MAR	MAR Diff
103	HEADACHES W/O MCC	$ 4,192	$ 45,216	$ 11,815	-73.87%
121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	$ 6,448	$ 78,636	$ 18,170	-76.89%
163	MAJOR CHEST PROCEDURES W MCC	$ 30,509	$212,317	$ 85,977	-59.51%
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	$ 22,196	$171,033	$ 62,550	-63.43%
175	PULMONARY EMBOLISM W MCC	$ 9,258	$102,227	$ 26,091	-74.48%
176	PULMONARY EMBOLISM W/O MCC	$ 5,863	$ 68,807	$ 16,522	-75.99%
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	$ 5,681	$ 66,841	$ 16,009	-76.05%
200	PNEUMOTHORAX W CC	$ 6,114	$ 66,841	$ 17,229	-74.22%
206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	$ 4,815	$ 49,148	$ 13,569	-72.39%
208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	$ 13,926	$ 98,295	$ 39,243	-60.08%
250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	$ 18,119	$100,261	$ 51,060	-49.07%
291	HEART FAILURE & SHOCK W MCC	$ 9,153	$ 92,397	$ 25,794	-72.08%
301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	$ 4,108	$ 53,079	$ 11,577	-78.19%
310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	$ 3,330	$ 37,352	$ 9,385	-74.87%
350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	$ 14,954	$112,056	$ 42,141	-62.39%
351	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	$ 8,502	$ 68,807	$ 23,961	-65.18%
352	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	$ 5,631	$ 41,284	$ 15,869	-61.56%
378	G.I. HEMORRHAGE W CC	$ 6,076	$ 64,875	$ 17,121	-73.61%
453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	$ 67,683	$186,761	$190,736	2.13%
454	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	$ 48,614	$ 96,329	$136,998	42.22%
458	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	$ 31,913	$ 66,841	$ 89,932	34.55%
460	SPINAL FUSION EXCEPT CERVICAL W/O MCC	$ 24,250	$ 58,977	$ 68,338	15.87%
464	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	$ 18,240	$123,852	$ 51,401	-58.50%
467	REVISION OF HIP OR KNEE REPLACEMENT W CC	$ 20,754	$ 74,704	$ 58,485	-21.71%
468	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	$ 16,765	$ 57,011	$ 47,245	-17.13%

OUTPATIENT

CPT Code	APC	Description	Medicare Price	2010 FS MAR	Proposed FS MAR	MAR Diff
99283	0614	Emergency department visit, moderate complexity	$ 235	$ 399	$ 593	48.68%
99282	0613	Emergency department visit; low to moderate severity.	$ 133	$ 265	$ 337	27.27%
99284	0615	Emergency department visit; high severity; not an immediate threat to life	$ 395	$ 596	$ 998	67.47%
93005	0099	Electrocardiogram tracing	$ 93	$ 369	$ 235	-36.41%
96372	0437	Ther/proph/diag inj sc/im	$ 63	$ 87	$ 160	84.01%
73030	0260	X-ray exam of shoulder	$ 112	$ 513	$ 284	-44.62%
73610	0260	Radiologic examination ankle; 3 views	$ 112	$ 507	$ 284	-43.96%
71020	0260	Chest x-ray 2vw frontal&latl	$ 70	$ 537	$ 178	-66.94%
73130	0260	X-ray exam of hand	$ 70	$ 421	$ 178	-57.83%
72100	0260	X-ray exam l-s spine 2/3 vws	$ 112	$ 506	$ 284	-43.85%
73110	0260	X-ray exam of wrist	$ 70	$ 425	$ 178	-58.23%
73140	0260	X-ray exam of finger(s)	$ 70	$ 316	$ 178	-43.82%
73630	0260	X-ray exam of foot	$ 70	$ 498	$ 178	-64.35%
73562	0260	X-ray exam of knee 3	$ 112	$ 551	$ 284	-48.44%
96374	0438	Ther/proph/diag inj iv push	$ 128	$ 87	$ 324	272.02%
99281	0609	Emergency dept visit	$ 72	$ 197	$ 181	-8.19%
70450	0332	Computed tomography, head or brain, W/O contrast	$ 142	$ 1,854	$ 359	-80.64%
12001	0013	Rpr s/n/ax/gen/trnk 2.5cm/<	$ 117	$ 3,885	$ 295	-92.42%
96375	0437	Tx/pro/dx inj new drug addon	$ 39	$ 152	$ 97	-35.90%
72148	0336	Magnetic resonance imaging, spinal canal & contents, lumbar, W/O contrast	$ 339	$ 4,362	$ 856	-80.37%
73221	0336	Magnetic resonance imaging, upper extremity joint, W/O contrast	$ 339	$ 2,956	$ 856	-71.03%
73721	0336	Magnetic resonance imaging, lower extremity joint, W/O contrast	$ 339	$ 3,372	$ 856	-74.60%
96365	0439	Ther/proph/diag iv inf init	$ 205	$ 323	$ 519	60.71%
72040	0260	X-ray exam neck spine 2-3 vw	$ 112	$ 479	$ 284	-40.69%
96521	0439	Refill/maint portable pump	$ 205	$ 519	$ 519	0.01%
97597	0015	Rmvl devital tis 20 cm/<	$ 173	$ 204	$ 437	114.20%

ASC

CPT Code	APC	Description	Medicare Price	2010 FS MAR	Proposed WC MAR	MAR Diff
64483	0207	Injection anesthetic agent/steroid epidural	$ 795	$ 2,918	$ 2,227	-23.69%
62311	0207	Injection of diagnostic/therapeutic substance	$ 795	$ 2,254	$ 2,227	-1.20%
64415	0206	Injection anesthetic agent; brachial plexus	$ 441	$ 2,254	$ 1,235	-45.20%
29881	0041	Knee arthroscopy with meniscectomy, including debridement	$ 2,546	$11,264	$ 7,129	-36.71%
29822	0041	Arthroscopy shoulder surgical; debridement	$ 2,546	$12,288	$ 7,129	-41.98%
64493	0207	Injection diagnostic or therapeutic substance, lumbar or sacral, single level	$ 795	$ 3,978	$ 2,227	-44.02%
23412	0051	Repair of ruptured musculotendinous cuff; chronic	$ 4,453	$14,370	$ 12,469	-13.23%
23430	0051	Tenodesis of tendon	$ 4,453	$12,933	$ 12,469	-3.59%
64416	0207	Injection, anesthetic agent, brachial plexus, single	$ 795	$ 2,254	$ 2,227	-1.20%
23120	0050	Claviculectomy, partial	$ 3,079	$15,806	$ 8,622	-45.45%
20680	0022	Removal of implant, deep	$ 2,159	$12,194	$ 6,045	-50.43%
62310	0207	Injection diagnostic or therapeutic substance, cervical or thoracic	$ 795	$ 2,254	$ 2,227	-1.20%
29880	0041	Arthroscopy knee surgical; with meniscectomy	$ 2,546	$11,264	$ 7,129	-36.71%
29888	0052	Arthroscopic ligament repair	$ 7,482	$12,288	$ 20,950	70.49%
23130	0051	Acromioplasty or acromionectomy, partial, with or W/O coracoacromial ligament release	$ 4,453	$17,243	$ 12,469	-27.69%
64479	0207	Injection anesthetic agent or steroid, transforaminal epidural, cervical or thoracic	$ 795	$ 2,254	$ 2,227	-1.20%
64721	0220	Neuroplasty and/or transposition	$ 1,638	$ 9,548	$ 4,586	-51.97%
29827	0042	Arthroscopy shoulder surgical w/cuff repair	$ 5,142	$12,288	$ 14,399	17.18%
29824	0042	Arthroscopy, shoulder, distal claviculectomy	$ 5,142	$12,288	$ 14,399	17.18%

PRESCRIPTION DRUG

Prescription Drug	MFG AWP	2010 WC FS MAR	New WC MAR
Hydrocodone-Acetaminophen 10-325mg	$ 0.70250	$ 0.84	$ 0.70
Oxycodone-Acetaminophen 5-325mg	$ 1.36870	$ 1.64	$ 1.37
Cyclobenzaprine 10mg	$ 1.11424	$ 1.34	$ 1.11
Oxycodone HCL 10 mg	$ 0.62500	$ 0.75	$ 0.63
Tramadol 50 mg	$ 0.83290	$ 1.00	$ 0.83
Gabapentin 300mg	$ 1.34180	$ 1.61	$ 1.34
Ibuprofen 800mg	$ 0.68500	$ 0.82	$ 0.69
Tizanidine 4mg	$ 2.54913	$ 3.06	$ 2.55
Cymbalta 30mg	$ 8.72400	$ 10.47	$ 8.72
Lyrica 75mg	$ 6.04922	$ 7.26	$ 6.05
Diazepam 10mg	$ 0.29690	$ 0.36	$ 0.30
Naproxen 500 mg	$ 1.25770	$ 1.51	$ 1.26
Oxycontin 20mg	$ 6.10095	$ 7.32	$ 6.10
Morphine Sulfate ER 30mg	$ 5.48004	$ 6.58	$ 5.48
Zolpidem Tartrate 10mg	$ 4.62540	$ 5.55	$ 4.63
Celebrex 200 mg	$ 9.21553	$ 11.06	$ 9.22
Meloxicam 15mg	$ 4.84400	$ 5.81	$ 4.84
Endocet 10-325mg	$ 3.55080	$ 4.26	$ 3.55
Lidoderm 5%	$11.43000	$ 13.72	$ 11.43
Carisoprodol 350 mg	$ 0.59630	$ 0.72	$ 0.60
Fentanyl Patch 50mcg	$26.36000	$ 31.63	$ 26.36
Hydromorphone 8mg	$11.34200	$ 13.61	$ 11.34
Omeprazole 20mg	$ 4.15150	$ 4.98	$ 4.15
Lunesta 2mg	$14.90400	$ 17.88	$ 14.90
Baclofen 20mg	$ 1.06990	$ 1.28	$ 1.07