State of Alaska
Department of Labor & Workforce Development
Division of Workers' Compensation

Special Joint Meeting
Medical Services Review Committee &
Workers' Compensation Board

Public Meeting Packet

August 28, 2026

For more information, contact:
Division of Workers' Compensation
labor.alaska.gov/wc/ | (907) 465-2790

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TAB 1

SPECIAL JOINT MEETING
MEDICAL SERVICES REVIEW COMMITTEE
ALASKA WORKERS' COMPENSATION BOARD
August 28, 2026

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
Telephone 977-853-5247 ID 867 2796 5944
Zoom Conference https://us02web.zoom.us/j/86727965944

AGENDA

Friday, August 28, 2026

9:00am	Call to order
	Pledge
	Introductions and welcome remarks
	Roll call and establishment of quorum
	Approval of agenda
9:15am	Approval of August 7, 2026 MSRC meeting minutes
	Approval of August 22, 2025 Joint Board/MSRC Meeting Minutes
9:25am	MSRC presentation of medical fee schedule recommendations to Board
10:05am	Break
10:15am	Public comment period
	• Public comment (in-person and telephonic)
11:15am	MSRC presentation of medical fee schedule recommendations to Board
	• Continued questions and answers
11:15am	New Business
	• Commissioner's letter to the Board regarding MSRC's conversion factor recommendations
	• 8 AAC 45.083 – Fees for Medical Treatment and Services
	• Approval of 2027 meeting dates
1:00pm	Adjournment

Mission: To ensure efficient, fair, and predictable delivery of indemnity, medical, and vocational rehabilitation benefits intended to enable workers to return to work at a reasonable cost to employers

TAB 2

Medical Services Review Committee / Workers' Compensation Board Special Joint Meeting Meeting Minutes

August 22, 2025

I. CALL TO ORDER

Workers' Compensation Director Charles Collins called the MSRC and Board to order at 10:03 am on Friday, August 22, 2025. This meeting was held in person in Anchorage, Alaska, and by Zoom video conference.

II. ROLL CALL

Director Collins conducted a roll call for the board. The following Board members were present, constituting a quorum:

Brad Austin	Randy Beltz	Pamela Cline	John Corbett
Mike Dennis	Sara Faulkner	Bronson Frye	Anthony Ladd
Sarah Lefebvre	Debbie White	Lake Williams	Brian Zematis

Director Collins conducted a roll call for the MSRC. The following Committee members were present, constituting a quorum:

Jeff Gilbert	Susan Kosinski	Valerie Mittelstead
Jeff Moore	Pam Scott	Misty Steed

Members Mary Ann Foland and Mason McCloskey were excused.

III. AGENDA APPROVAL

Member Lefebvre motioned to approve the agenda, which was seconded by member Zematis. The motion passed unanimously.

IV. APPROVAL OF MSRC AUGUST 8, 2025 MEETING MINUTES

Member Kosinski motioned to adopt the minutes from the August 8, 2025 meeting, which was seconded by member Moore. The motion passed unanimously.

V. APPROVAL OF JOINT BOARD/MSRC AUGUST 24, 2024 MEETING MINUTES

A motion to adopt the minutes from the August 24, 2024, special joint meeting of the Board and MSRC was made by member Beltz and seconded by member Lefebvre. The motion passed unanimously.

VI. PUBLIC COMMENT PERIOD 10:15 AM - 11:15 AM

No public comment was made.

VII. MSRC'S PRESENTATION OF RECOMMENDATIONS TO BOARD

Director Collins presented the Director's MSRC Report. Member Lefebvre observed that the MSRC list included Industry and Labor designations for MSRC members, which are not supported by statute. Director Collins will remove these designations from future reports.

The MSRC, through Carla Gee with Optum, presented its recommendation to the Board. Ms. Gee reviewed the track-changes version of the draft 2026 Fee Schedule.

Member Lefebvre noted inconsistencies in how telehealth provisions were worded across different sections (E&M, Medicine, General). Ms. Gee and Ms. Orme will revise for consistency.

Member Lefebvre raised concerns about possible confusion between "medical report" and "physician's report." The committee agreed to align language in the "Properly Submitted Bill" section with the clearer phrasing already used elsewhere in the document.

Member Lefebvre suggested the addition of a cover page to Appendix A to reference applicable regulations and Bulletin 24-03 for clarification on use of the physician's report form.

Member Lefebvre moved that the Fee Schedule be amended in three areas:

1. Telehealth definitions made consistent across sections;
2. The "Properly Submitted Bill" definition in the introduction revised as discussed;
3. Appendix A to include a cover page to the physician's report, stating it may be used as the medical report (as defined in the definitions), with reference to the required regulation for compliance and the applicable bulletin.

Member Beltz seconded. The motion passed unanimously.

Member Kosinski moved to accept the changes proposed by the Board. Member Steed seconded. The motion passed unanimously.

Member Lefebvre moved to adopt the proposed 2026 Alaska Workers' Compensation Medical Fee Schedule, as amended. Member Beltz seconded. The motion passed unanimously.

VIII. ADJOURNMENT

A motion to adjourn was made by member Lefebvre and seconded by member Zematis. The motion passed unanimously.

Meeting Adjourned 11:50 am

TAB 3

Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
August 7, 2026

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:00 a.m. in Juneau, Alaska. Participation was available via Zoom videoconference.

II. ROLL CALL

The following members were present, constituting a quorum:

Dr. Alan Swenson	Dr. Mason McCloskey	Dr. Mary Ann Foland	
Seanne Popp	Kimberley Dean	Jeff Gilbert	Valerie Mittelstead

Member Misty Steed was excused and Member Swenson arrived after roll call.

III. APPROVAL OF AGENDA

Member Foland moved to approve the agenda; Member McCloskey seconded. The motion passed unanimously.

IV. APPROVAL OF July 17, 2026 MEETING MINUTES

Member Foland moved to approve the July 17, 2026 minutes; Member McCloskey seconded. The motion passed unanimously.

V. FEE SCHEDULE DEVELOPMENT DISCUSSION

Pharmacy, Physician Dispensing, and Compounded Medications

Ms. Tedford reviewed revisions to the pharmacy and physician-dispensing provisions, including recommendations received from pharmacy reviewers. The Committee discussed over-the-counter medications that are directed by a physician and dispensed or billed by a pharmacy. Members agreed that medically necessary over-the-counter medications may appropriately be covered, but reimbursement should not include unnecessary additional costs solely because the product is dispensed through a pharmacy.

The Committee agreed to clarify reimbursement using the lowest-cost applicable methodology and that over-the-counter medications would not receive an additional pharmacy dispensing fee. The Committee also supported language requiring identification of the dispensing physician when a third party bills for physician-dispensed medications and additional clarification of reimbursement limits for topical and compounded medications.

The Committee also addressed pharmacy compounding fees. Members agreed that a separate compounding fee is reasonable because preparing an individualized compound requires additional professional expertise and handling beyond ordinary dispensing. The Committee agreed to allow one compounding fee per prescription: $10 for compounds containing three or fewer ingredients and $20 for compounds containing more than three ingredients. The fee would apply only when the medication is compounded for the individual prescription and not to manufacturer-compounded, prepackaged products.

Ms. Tedford will incorporate the revisions into the pharmacy and physician-dispensing provisions for final Committee review.

Hearing Aids and Audiology Services

Ms. Tedford reviewed revised hearing aid provisions clarifying reimbursement when hearing aids are obtained from a source other than the treating audiologist. The proposed language provides that hearing tests, evaluations, fittings, programming, adjustments, and other medically necessary audiology services may be separately reimbursed when the audiologist does not both procure and dispense the hearing aids.

The Committee confirmed its previous direction to reduce the allowance associated with hearing aid procurement from 30 percent to 20 percent. Members noted that the revised schedule separately recognizes additional audiology services that were previously bundled, supporting the lower percentage allowance.

Fee Schedule Organization and Remote Therapeutic Monitoring

Ms. Tedford reviewed organizational changes developed from the Committee's prior discussions. Multiple-procedure payment reduction provisions were moved from their prior location under modifier 51 into the substantive sections where the rules apply, including Radiology and Physical Medicine. Brief references will remain under modifier 51, while the detailed instructions will appear in the applicable sections so the requirements are easier for providers and payers to locate.

Ms. Tedford also reviewed the new Remote Therapeutic Monitoring provisions. The information previously considered by the Committee was reformatted to fit within the existing Medical Fee Schedule and present the billing and reimbursement requirements in a clearer, step-by-step format.

The Committee supported the revised organization and asked members to complete a final review for clarity before the draft is finalized.

Durable Medical Equipment

Ms. Tedford reviewed revisions to the Durable Medical Equipment (DME) provisions intended to clarify reimbursement and address areas that have resulted in inconsistent billing or payment.

The revisions clarify that reimbursement for purchased or rented DME is not calculated at 85 percent of billed charges and identify when an original manufacturer or supplier invoice is required for items without an established fee schedule value.

The draft also provides that cumulative rental payments may not exceed the purchase price of the equipment. Additional language distinguishes reusable rental equipment from batteries, disposable supplies, and other expendable items that are not appropriately treated as rentals.

The Committee generally supported the revisions and agreed to conduct an additional review of the section before finalization.

Pending CMS Changes

The Committee discussed a proposed 2027 outpatient status indicator that had not yet been finalized by CMS. Members considered whether the proposed indicator should be omitted until finalized or included in anticipation of the CMS change.

The Committee agreed to retain the indicator in the draft with a notation that its application is contingent upon final CMS approval. This approach is intended to avoid uncertainty if the proposal is adopted while making clear that the provision will not apply if CMS does not finalize the change.

Director Collins noted that if significant CMS changes occur after Alaska's fee schedule is adopted, the Division may issue a bulletin providing reimbursement guidance when necessary.

Break 10:10 a.m. – 10:15 a.m.

VI. PUBLIC COMMENT PERIOD 10:15 AM - 11:15 AM

Adam Fowler, Director of Regulatory Affairs for MyMatrixx

- Provided clarification regarding compounded medications, recommending that the fee schedule expressly state that only one compounding fee may be reimbursed per compounded prescription. The Committee incorporated the clarification into its direction for the revised pharmacy language.

VII. ADJOURNMENT

Director Collins advised that Ms. Tedford will incorporate the revisions discussed during the meeting and circulate an updated draft. Committee members were assigned specific portions of the fee schedule for focused review to identify any remaining substantive or technical corrections.

The next meeting is scheduled for August 28, 2026, at 9:00 a.m. in Anchorage and by Zoom. The meeting will be held jointly with the Alaska Workers' Compensation Board for consideration of the proposed 2027 Medical Fee Schedule and related regulation changes.

Member Foland moved to adjourn; Member Dean seconded. The motion passed unanimously.

Adjourn 11:19 a.m.

Alaska Workers' Compensation Division
Medical Services Review Committee
Addendum to August 7, 2026 Meeting Minutes

While reviewing minutes from prior MSRC meetings, Member Steed identified a discrepancy concerning the Committee's prior decision regarding reimbursement for hearing aid procurement. The Committee had previously agreed to allow reimbursement at 30 percent above the manufacturer's invoice; however, the draft approved at the August 7, 2026, meeting reflected a 20 percent allowance.

On August 13, 2026, the Chair conducted an email poll of all Committee members to confirm the Committee's prior decision. A majority of the members confirmed that the Committee's prior decision was to allow reimbursement at 30 percent above the manufacturer's invoice.

Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
May 28, 2026

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:04 a.m. in Juneau, Alaska. Participation was available via Zoom videoconference.

II. ROLL CALL

The following members were present, constituting a quorum:

Dr. Alan Swenson	Dr. Mason McCloskey	Jeff Gilbert	Dr. Mary Ann Foland
Misty Steed	Seanne Popp	Kimberley Dean	Valerie Mittelstead

Director Collins introduced Danean Tedford and Judy Engelke from RefMed.

III. FEE SCHEDULE DEVELOPMENT DISCUSSION

Remote Therapeutic Monitoring

The Committee discussed app-based tracking and remote therapeutic monitoring codes billed with physical therapy, including whether these services duplicate in-person treatment or may be separately reimbursable when properly documented and included in the treatment plan. The Committee noted that reimbursement may depend on whether the provider is actively reviewing, modifying, or managing the treatment plan, rather than merely importing app data into the chart. The Committee also discussed the need for clear documentation standards, including whether remote monitoring should be identified in the treatment plan and physician's report. RefMed will research remote patient monitoring and remote therapeutic monitoring rules, including CMS requirements and how other states address overlap with in-person therapy.

Acoustic Medical Devices and FDA Status

The Committee discussed acoustic medical devices, including SAMSport-type devices billed under generic DME code E1399. The Committee discussed concerns regarding cost, accessories, rental versus purchase, and whether the device is FDA-cleared rather than FDA-approved. Dr. McCloskey and Dr. Swenson noted that the device appeared more comparable to low-intensity ultrasound technology than a TENS unit, and the Committee discussed whether E0760 may be a comparable code.

The Committee also discussed the distinction between FDA-approved and FDA-cleared devices and cautioned that excluding FDA-cleared devices could have unintended consequences for other commonly used medical devices. The Committee agreed that any fee schedule language should consider FDA status, documentation, and medical justification without inadvertently excluding appropriate treatment.

RefMed will research comparable codes, surrounding-state treatment of similar devices, FDA-cleared versus FDA-approved language, and rental/purchase considerations.

Break 10:04 a.m. – 10:15 a.m.

IV. PUBLIC COMMENT PERIOD 10:15 AM - 11:15 AM

No public comment.

V. FEE SCHEDULE DEVELOPMENT DISCUSSION CONTINUED

Compound Medications and Physician Dispensing

The Committee discussed concerns regarding compound medications, physician dispensing, repackaged drugs, newly created NDCs, and compounded products containing over-the-counter ingredients or separately priced components. Member Steed noted that minor formulation differences, such as lidocaine 4% versus 5%, can result in significant cost differences, with some compounded medications costing several thousand dollars per month.

The Committee discussed approaches used by other states, including caps on compounded medications, limits on automatic refills, prior authorization requirements, pricing limits, treatment of over-the-counter components, use of original versus repackaged NDCs, and pharmacy or dispensing licensure documentation.

RefMed will provide additional state comparisons regarding compound medications, physician dispensing, repackaged drugs, prior authorization, refill limits, and pricing caps. Director Collins will review Alaska pharmacy and dispensing requirements.

Fee Schedule Versioning and CMS Updates

The Committee discussed whether the fee schedule should more clearly identify which CMS data files and versions apply when CMS updates occur during the year. Director Collins noted that prior legal guidance has favored a bright-line approach tied to the fee schedule's effective date, but CMS files now update dynamically or quarterly in some areas, creating practical challenges for payers and providers.

The Committee discussed whether the fee schedule should adopt static or dynamic CMS references, particularly where software systems automatically update to the most recent Medicare data. The Committee will continue discussing this issue, and Director Collins will follow up with legal as needed.

Provider Definitions and Documentation Issues

The Committee discussed whether the fee schedule should better define provider categories, including "other providers" reimbursed at 85% of MAR. The discussion included questions regarding physical therapists, doctors of physical therapy, physician assistants, advanced practice registered nurses, naturopaths, and whether additional clarification would help reduce disputes regarding provider type, scope of practice, and reimbursement level.

The Committee also discussed whether additional documentation should be required for unlisted or miscellaneous codes reimbursed at 85% of billed charges. No decision was made.

Telehealth and Interpreter Services

The Committee discussed telehealth-related issues, including possible documentation, technical, and HIPAA-compliant platform standards. The Committee also discussed interpreter services and noted that interpreter services are commonly needed in Alaska, including for non-English languages, Alaska Native languages, and ASL.

The Committee agreed that telehealth and interpreter services should be considered further as part of the fee schedule review.

Physical Therapy Multiple Procedure Payment Reduction

The Committee discussed the CMS multiple procedure payment reduction rule for physical therapy codes. RefMed explained that the reduction applies only to the practice expense RVU portion of subsequent therapy procedure codes, not to the full reimbursement amount. The Committee noted that additional explanation may help address confusion regarding how the reduction is calculated.

RefMed will prepare a visual or step-by-step example showing how the multiple procedure reduction works for commonly used physical therapy codes.

Facility, Ancillary Services, and DME Rules

The Committee discussed facility, ancillary service, and durable medical equipment issues, including facility reimbursement categories, ambulance rates, DME rental rules, rental-to-purchase rules, repair and maintenance, delivery and setup, replacement standards, automatic resupply, and supplier credentialing.

The Committee also discussed whether current DME rental language in the fee schedule should be clarified, particularly for items without clear Medicare rental values or items rented under workers' compensation even if not traditionally rented under Medicare.

RefMed will review DME rental language and research potential approaches for rental-to-purchase rules and related DME issues.

Hearing Aid and Audiology Codes

The Committee discussed new hearing aid and audiology codes, including concerns that some new timed codes may replace older capped codes and result in significantly higher charges. RefMed noted that the new codes are difficult to crosswalk because the prior codes do not map directly to the new timed codes.

The Committee discussed possible approaches, including reviewing code definitions, other state fee schedules, available commercial data, time-based documentation requirements, provider input, and possible caps to address outlier billing.

RefMed will continue researching new hearing aid and audiology codes. Member Steed will reach out to Aurora for additional provider input.

NCCI and Regional Comparison Data

Member Steed asked about the annual comparison data historically prepared for the Committee showing Alaska's conversion factors compared to regional and national data. RefMed stated that it had obtained the NCCI data and would complete the comparison before the next meeting.

Administrative Burden and Report/Review Time

The Committee discussed administrative burden on medical providers in workers' compensation cases, including paperwork, report review, return-to-work documentation, IME-related requests, and vocational rehabilitation-related requests. The Committee discussed whether providers understand when review or report time may be billable and whether additional outreach or education would be helpful.

Director Collins will consider provider outreach regarding workers' compensation paperwork, report/review billing, and related administrative issues, including possible outreach through the Alaska State Medical Association.

VI. ADJOURNMENT

Member Foland moved to adjourn; Member Steed seconded. The motion passed unanimously.

Adjourn 12:16 p.m.

Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
June 26, 2026

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:04 a.m. in Juneau, Alaska. Participation was available via Zoom videoconference.

II. ROLL CALL

The following members were present, constituting a quorum:

Dr. Alan Swenson	Dr. Mason McCloskey	Dr. Mary Ann Foland	Misty Steed
Seanne Popp	Kimberley Dean	Valerie Mittelstead	

Member Jeff Gilbert was excused. Director Collins introduced Danean Tedford and Judy Engelke from RefMed.

III. APPROVAL OF MAY 28, 2026 MEETING MINUTES

Member Mittlestead moved to approve the May 28, 2026 minutes; Member Steed seconded. The motion passed unanimously.

IV. FEE SCHEDULE DEVELOPMENT DISCUSSION

Fee Schedule Updates and CMS Dynamic Pricing

Director Collins updated the Committee on follow-up with the Department of Law regarding CMS pricing updates that occur during the year. He explained that legal guidance indicated the Division may treat use of updated CMS pricing as a policy decision and does not need to expressly address the issue in the fee schedule. Director Collins noted the practical difficulty for payers and providers when billing software updates dynamically and cannot easily be reset to a prior CMS pricing date.

The Committee discussed whether silence in the fee schedule may continue to result in clarification questions, particularly following the January-to-April transition in the current fee schedule. Director Collins noted that the Division has not identified disputes filed solely because of CMS price changes during the year.

Physician Dispensing, Repackaged Drugs, and Topical Medications

The Committee discussed physician-dispensed medications, repackaged drugs, compounded medications, and high-cost topical medications. RefMed explained that other states have addressed physician dispensing and repackaged drugs in their fee schedules, including language requiring use of the original NDC for repackaged drugs.

The Committee discussed concerns with high-cost topical creams, including instances where over-the-counter products or minor formulation changes resulted in charges of hundreds or thousands of dollars. The Committee also discussed patient safety concerns, including whether patients receive adequate counseling when medications are dispensed in a physician's office rather than by a pharmacy.

The Committee reviewed examples from other states, including Georgia, Colorado, Arizona, South Carolina, Florida, and Idaho. RefMed explained that Georgia adopted specific caps for topical and topical compound medications, including three categories of topical codes and a 30-day maximum supply. Mr. Fowler, Director of Regulatory Affairs with MyMatrix, stated during public comment and discussion that caps have been one of the more effective approaches used by other states to control topical medication costs and that Georgia and South Carolina have seen significant cost reductions without known access-to-care issues.

The Committee generally supported further development of fee schedule language to address topical and topical compound medications, including possible caps. Members also discussed whether Alaska should require original NDC information for repackaged drugs and whether additional limits should apply to physician dispensing, while ensuring that access to care is not unintentionally limited in urgent care or rural settings.

RefMed will research proposed language addressing topical and topical compound medication caps, physician dispensing, repackaged drugs, and original NDC requirements. Director Collins will also review applicable Alaska statutes and regulations regarding physician dispensing and repackaging.

Break 10:10 a.m. – 10:15 a.m.

V. PUBLIC COMMENT PERIOD 10:15 AM - 11:15 AM

Adam Fowler, Director of Regulatory Affairs with MyMatrixx

- Stated that MyMatrixx is willing to provide additional information on pharmaceutical fee schedule language, other states' approaches, and what has or has not worked well in other jurisdictions.

Debbie Ryan, Alaska Chiropractic Society

- Stated that providers have experienced reductions in reimbursement over time while business costs, staffing costs, and other expenses have increased. Commented that some providers and DME suppliers may stop offering certain services or products if reimbursement is not adequate.

VI. FEE SCHEDULE DEVELOPMENT DISCUSSION CONTINUED

NCCI and Regional Comparison Data

The Committee reviewed NCCI data and conversion factor information, including year-over-year changes and comparison data. RefMed discussed changes affecting surgery codes, including CMS changes that reduced certain practice RVUs and affected Alaska reimbursement calculations because Alaska's conversion factor remained static.

The Committee discussed whether reductions in certain surgery codes may affect provider participation in the workers' compensation system. Dr. Swenson stated that he had spoken with providers and that practices are experiencing increased overhead, staffing, and benefit costs. He expressed concern that if workers' compensation reimbursement moves too close to Medicare or Medicaid reimbursement levels, some providers may reconsider whether they can continue accepting workers' compensation patients.

RefMed and Director Collins will provide additional comparison information, including Alaska's reimbursement relative to other states and national benchmarks. Dr. Swenson will continue seeking provider input regarding whether current reimbursement levels are affecting access to care.

Physical Therapy Multiple Procedure Payment Reduction

RefMed reviewed a worksheet explaining the multiple procedure payment reduction for physical therapy codes and explained that the reduction applies to the practice expense portion of subsequent therapy procedure codes, rather than to the entire reimbursement amount.

The Committee discussed questions received regarding the multiple procedure payment reduction and whether additional explanation in the fee schedule would help providers, payers, and bill reviewers understand how the reduction is calculated. Ms. Engelke explained that the multiple procedure reduction is intended to account for overlapping practice expenses when multiple therapy procedures are performed on the same date of service.

The Committee also discussed provider concerns that time-based therapy services may not experience reduced costs in the same way as other multiple procedure services. Dr. Swenson stated that therapy providers have expressed concern that the cost of delivering 45 to 60 minutes of care may not decrease simply because multiple time-based codes are billed. The Committee discussed the need to balance consistency with CMS-based billing logic against provider concerns regarding actual costs. RefMed will prepare possible fee schedule language or an example showing how the multiple procedure payment reduction is calculated for physical therapy codes.

Remote Therapeutic Monitoring

The Committee discussed whether remote therapeutic monitoring and related codes, including app-based or device-based tracking used in connection with physical therapy or rehabilitation, should be reimbursable, whether they may duplicate existing treatment or documentation, and whether they should be subject to specific documentation requirements.

The Committee discussed concerns regarding limited documentation, patient-reported data, general activity tracking that may not relate to the injury, and potential future billing for apps, setup fees, software, or reports.

Dr. Swenson stated that remote monitoring may have value and could reduce some treatment costs when used appropriately, but also noted that the codes could become a significant cost driver if not controlled. Member Dean stated that medical necessity should be documented and approved by the treating physician of record or surgeon, particularly when physical therapy treatment plans or changes in treatment are involved.

The Committee discussed possible approaches, including noncoverage, caps, specific reimbursement values, and documentation guardrails. RefMed will research other state approaches and possible language addressing documentation, medical necessity, device requirements, relationship to the treatment plan, and reimbursement limits.

Acoustic Medical Devices and Miscellaneous DME

The Committee discussed acoustic medical devices, including SAMSport-type devices billed under miscellaneous DME code E1399. RefMed reviewed whether E0760 may be a comparable code and noted that the device is similar in some respects but is not an exact match because the function and intended use differ.

The Committee discussed whether the fee schedule should include language allowing use of a comparable code or requiring reimbursement based on the manufacturer or supplier invoice plus the applicable percentage.

The Committee generally agreed that any approach should avoid allowing unsupported billed charges for miscellaneous devices while still allowing appropriate reimbursement when

documentation and cost information support the device. RefMed will continue researching possible language regarding comparable codes, invoices, and reimbursement of miscellaneous DME.

DME Rental Rules

The Committee discussed DME rental rules, including whether rental payments should be limited so that total rental reimbursement does not exceed the purchase price. Members also discussed how to define purchase price, whether supplies or batteries may be separately rented, and whether rental language should apply to DME items that do not have a specific rental modifier.

The Committee discussed concerns regarding automatic resupply, unnecessary continued rentals, and whether components required for equipment to function should be included in the rental of the equipment. The Committee generally supported clarifying that DME rental should not exceed the applicable purchase price and that the purchase price should be based on the lower of billed charges or the manufacturer/supplier invoice plus the applicable percentage.

RefMed will draft possible clarifying language regarding DME rentals, purchase-price limits, and related supply or component issues.

Hearing Aid and Audiology Codes

The Committee discussed new hearing aid and audiology codes, including possible crosswalks from prior codes, values used by other payers, and whether certain services should remain bundled with hearing aid dispensing, evaluation, fitting, or follow-up services.

The Committee discussed whether new timed codes should be separately reimbursed or bundled when they are part of the initial hearing aid purchase, fitting, or verification process. Members noted that the fee schedule previously bundled related testing, dispensing, evaluation, fitting, accessories, and supplies into the hearing aid reimbursement methodology to address outlier billing.

The Committee discussed several new hearing aid measurement, verification, fitting, and post-fitting follow-up codes. Members generally supported maintaining bundled treatment where the service is part of the initial hearing aid process, while considering whether certain post-fitting or maintenance-related services should be separately reimbursable when appropriate.

RefMed will continue updating the hearing aid and audiology code table using the Committee's discussion, including proposed crosswalks, bundled codes, and possible values for separately reimbursable codes.

Hospital Sections and Future Fee Schedule Work

RefMed noted that additional work remains on the hospital sections, including outpatient status indicators and inpatient wage index information. The Committee discussed questions regarding whether CMS updates that occur after fee schedule preparation should be recognized if they are not specifically listed in the fee schedule.

Director Collins noted that this issue relates to the broader discussion regarding static versus dynamic CMS references and stated that the Division will continue considering whether additional language is needed or whether the fee schedule should remain silent and address issues as they arise.

VII. ADJOURNMENT

Member Steed moved to adjourn; Member Dean seconded. The motion passed unanimously.

Adjourn 1:51 p.m.

Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
July 17, 2026

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:04 a.m. in Juneau, Alaska. Participation was available via Zoom videoconference.

II. ROLL CALL

The following members were present, constituting a quorum:

Dr. Alan Swenson	Dr. Mason McCloskey	Dr. Mary Ann Foland	Misty Steed
Seanne Popp	Kimberley Dean	Jeff Gilbert	Valerie Mittelstead

Member Mittelstead arrived after roll call.

III. APPROVAL OF AGENDA

Member Foland moved to approve the agenda; Member Steed seconded. The motion passed unanimously.

IV. APPROVAL OF JUNE 26, 2026 MEETING MINUTES

Member Foland moved to approve the June 26, 2026 minutes; Member Steed seconded. The motion passed unanimously.

V. FEE SCHEDULE DEVELOPMENT DISCUSSION

Medical Cost and Utilization Data

The Committee reviewed general information concerning retail drug pricing, physician dispensing, and the most frequently reported medical procedure codes. Director Collins noted that Alaska does not regulate pharmacy retail prices. The utilization data showed that physical and occupational therapy services remain among the most frequently reported services, while certain durable medical equipment services occurred relatively infrequently.

Repackaged Drugs

Ms. Tedford presented proposed language addressing reimbursement for repackaged drugs. She explained that the current fee schedule does not clearly require submission of the drug's original National Drug Code.

The Committee agreed that the fee schedule should require the original NDC and calculate reimbursement using the original manufacturer's NDC and average wholesale price. No separate repackaging, relabeling, or handling fee would be payable.

Physician-Dispensed Drugs

The Committee reviewed proposed language addressing medications dispensed from a physician's office. Ms. Tedford noted that AS 23.30.097 refers specifically to physician dispensing, although other practitioners may dispense medications while working under a physician's supervision.

The Committee distinguished ordinary physician-dispensed medications from topical and compounded medications. Ordinary medications dispensed by a physician would be reimbursed using the original NDC calculation in the same manner as a pharmacy-dispensed medication, but without a separate dispensing, compounding, or handling fee.

The Committee agreed that the physician-dispensing provision should cross-reference the separate requirements and caps applicable when the physician-dispensed medication is a topical or topical compounded drug. Members stated that the cross-reference is necessary to prevent an argument that a physician-dispensed topical medication is exempt from the applicable topical drug caps.

Topical and Compounded Medications

The Committee reviewed the existing term "compounded and/or mixed drugs." The Committee discussed whether the term might refer to medications added to intravenous solutions or other combination products, but no clear or consistently recognized definition was identified. The Committee directed RefMed to revise the terminology throughout the applicable sections so that the fee schedule consistently distinguishes:

1. Topical drugs;
2. Topical compounded drugs; and
3. Non-topical compounded drugs.

References to "mixed drugs" will be revised or removed as necessary to maintain consistent terminology. Non-topical compounded medications will be addressed separately from the caps developed for topical and topical compounded drugs.

The Committee supported the proposed tiered reimbursement caps for topical and topical compounded medications and agreed to retain an overall maximum reimbursement of $240 for any single prescription. The capped amount will include any applicable dispensing fee, and no separate dispensing fee may be added to the capped reimbursement.

The proposed language also stated that compounded topical medications would require prior authorization. Member Dean explained that workers' compensation adjusters do not generally provide prior authorization and cannot direct an injured worker's medical care. Members agreed to remove the prior-authorization requirement while retaining language allowing review for medical necessity.

The Committee discussed compounded products that contain over-the-counter ingredients or closely resemble an available over-the-counter product. Participants noted that a minor change in concentration may technically make a product a customized prescription, but the provider should still be able to establish why the compounded product is medically necessary instead of an available lower-cost alternative.

The Committee agreed to retain language providing that reimbursement will be based on the lesser of the applicable cap, the equivalent average wholesale price, or an available lower-cost therapeutic or over-the-counter equivalent. Medical necessity may be reviewed when a compounded product differs only slightly from an available lower-cost product.

Remote Therapy Monitoring

Ms. Tedford reviewed the remote therapy monitoring codes, existing Alaska fee schedule values, and documentation requirements. She explained that the applicable device-supply codes are based on the number of monitoring days during a calendar month and that only one of the applicable codes should be billed within a 30-day period. The Committee supported

adding language to clarify this limitation and reduce the potential for overlapping or improper billing.

Ms. Tedford advised that CMS has proposed replacing certain remote therapy monitoring codes with new G-codes in 2027. Because the proposed codes may not have an established Alaska conversion factor, the Committee deferred a final decision on how replacement codes should be valued. RefMed will consolidate the remote therapy monitoring provisions under a separate heading in the Medicine section, include appropriate cross-references, and present revised language for further review.

Break 10:10 a.m. – 10:15 a.m.

VI. PUBLIC COMMENT PERIOD 10:15 AM - 11:15 AM

No public comment.

VII. FEE SCHEDULE DEVELOPMENT DISCUSSION CONTINUED

Remote Therapy Monitoring Continued

The Committee discussed whether remote monitoring should be billed in addition to regular in-person physical therapy. Members recognized that remote monitoring could improve access to care, particularly for injured workers in rural communities, but expressed concern about duplicative reimbursement when it is added to frequent in-person treatment without a clearly documented need. Members agreed that the medical record should support the service, including the monitoring performed and how the information was used in the treatment plan.

The Committee also discussed whether exercise or tracking applications qualify under the remote therapy monitoring codes. RefMed explained that the existing codes appear to require a qualifying medical device that is supplied to the patient and transmits information to the provider. The Committee agreed that application-only programs would not be reimbursable under these codes and should be monitored for possible consideration in a future fee schedule cycle.

Durable Medical Equipment and Unlisted Devices

RefMed presented proposed language addressing durable medical equipment, supplies, and devices billed under unlisted or miscellaneous codes such as E1399 and CPT 99070. The Committee discussed concerns that these codes may be used as catch-all codes when a more specific code is available or to obtain reimbursement based on billed charges rather than the actual cost of the item.

The Committee agreed that providers should use a specific code when one exists. When no specific code is available, the provider must submit the original manufacturer or supplier invoice. Reimbursement will be based on the invoice amount plus 20 percent, and the general provision allowing reimbursement at 85 percent of billed charges will not apply. Members agreed that no reimbursement should be made when the required invoice is not provided.

The Committee supported using criteria-based language that applies to all unlisted or miscellaneous durable medical equipment, supplies, devices, and accessories rather than identifying only E1399. Members noted that this would prevent providers from avoiding the invoice requirement by selecting another unlisted code.

Durable Medical Equipment Rentals

RefMed presented proposed language providing that total rental reimbursement for an item may not exceed its purchase price. Once cumulative rental payments equal the purchase price, the item will be considered purchased and no additional rental reimbursement will be payable.

The Committee supported the proposed limitation. Members noted that the provision would prevent circumstances in which rental payments ultimately exceed the cost of purchasing the equipment.

The Committee also discussed products that are available only as rentals and may not have an identifiable purchase price. RefMed will clarify how the provision applies to rental-only products and to equipment that has an established purchase value but no separately listed rental rate.

Hearing Aids and Audiology Services

RefMed reviewed the hearing-aid provisions in light of changes to audiology procedure codes. The current fee schedule reimburses hearing aids at the manufacturer or supplier invoice amount plus a 30 percent markup. Director Collins explained that the higher markup was intended to compensate providers for related evaluations, testing, fitting, adjustments, repairs, and reprogramming that were included in the hearing-aid reimbursement rather than separately payable.

Ms. Engelke noted that changes to the audiology codes may now allow separate reimbursement for some services that were previously included in the markup. The Committee discussed whether retaining the 30 percent markup while also paying separately for those services could result in duplicative reimbursement.

Members also expressed concern that making evaluation and testing services nonpayable could leave an audiologist uncompensated when the provider performs the evaluation but the patient ultimately obtains hearing aids elsewhere. The Committee agreed that medically necessary evaluation and testing should remain reimbursable when hearing aids are not dispensed by the evaluating provider.

The Committee discussed limiting separately reimbursable hearing evaluations and testing to no more than once per year to prevent repeated testing or frequent follow-up billing. RefMed will revise the section to clarify which services are included in the hearing-aid markup, which services may be separately reimbursed, and how the provisions apply during the initial dispensing process.

The Committee also reviewed the existing provisions allowing replacement hearing aids generally once every four years when supported by appropriate medical evaluation and documentation. No final change to the 30 percent markup or replacement provisions was made pending review of the revised language.

Conversion Factors and Provider Reimbursement

Director Collins asked Dr. Swenson to report on provider concerns regarding the surgical conversion factor and recent federal reimbursement changes. Dr. Swenson stated that the primary concern was the cumulative effect of reimbursement reductions, increasing practice costs, administrative requirements, and the additional time required to manage workers' compensation cases.

Dr. Swenson reported that providers do not believe Alaska reimbursement has yet reached the point where accepting workers' compensation patients is financially impractical. However, providers are increasingly evaluating whether the administrative burden and reimbursement justify continued participation, particularly because many providers in other states have already limited or discontinued workers' compensation services.

Director Collins noted that the surgical conversion factor was reduced approximately three years earlier when Alaska reimbursement was substantially above countrywide levels. Current data showed that Alaska surgical reimbursement remained somewhat above the countrywide comparison but was much closer to the Committee's intended range. Members agreed that an additional reduction could negatively affect provider participation and injured-worker access to care.

The Committee agreed not to change the conversion factors for the 2027 fee schedule. The Committee will continue monitoring medical inflation, administrative costs, reimbursement comparisons, and provider participation during future fee schedule reviews.

Fee Schedule Organization and Cross-References

The Committee agreed to improve cross-references throughout the fee schedule so providers and payers can more easily locate applicable requirements. Multiple-procedure payment-reduction rules will remain in the Medicine section, with references added to the Physical Medicine and other applicable sections. Remote therapy monitoring will also be placed under a separate heading in the Medicine section, with appropriate cross-references.

Technical and Annual Fee Schedule Updates

Ms. Tedford summarized the remaining technical and annual revisions for the 2027 fee schedule, and provided a high-level overview of proposed CMS changes. The Committee noted that the federal proposals were not yet final and that changes to the federal conversion factor would not automatically change Alaska's established conversion factors.

Member Gilbert asked whether the hospital reimbursement multipliers should continue. Director Collins explained that the multipliers are based on Medicare classifications that account for differences among facilities, including the volume of uninsured or uncompensated care. The Committee agreed that the explanation supported retaining the current methodology, and no change was recommended.

VIII. ADJOURNMENT

Member Foland moved to adjourn; Member Stead seconded. The motion passed unanimously.

Adjourn 1:32 p.m.

TAB 4

Alaska Workers' Compensation Division
Medical Services Review Committee
Committee Roster

AS 23.30.095(j)

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

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

Committee Membership as of May 28, 2026

Seat	**Name**	**Affiliation**
Chairperson	Charles Collins	Director, Division of Workers' Compensation
Alaska State Medical Association	Alan Swenson, MD	Orthopedic Physicians Anchorage, Inc.
Alaska Chiropractic Society	Mason McCloskey, DC	Kanady Chiropractic Center
Alaska State Hospital & Nursing Home Association	Jeff Gilbert	St. Elias Specialty Hospital
Medical Care Provider	Mary Ann Foland, MD	Primary Care Associates
Lay Member	Misty Steed	PACBLU
Lay Member	Seanne Popp	Northern Adjusters, Inc.
Lay Member	Valerie Mittelstead	IBEW
Lay Member	Kimberley Dean	ARECA Insurance Exchange

TAB 5

ALASKA WORKERS' COMPENSATION BOARD

Chair, Commissioner Catherine Muñoz
Alaska Department of Labor and Workforce Development

Name	Seat	District	Affiliation
Charles Collins	Commissioner's Designee		
Brad Austin	Labor	1st Judicial District	Plumbers and Pipe Fitters Local 262
Debbie White	Industry	1st Judicial District	
Randy Beltz	Industry	3rd Judicial District	
Pamela Cline	Labor	3rd Judicial District	Intl. Brotherhood of Electrical Workers LU 1547
Mike Dennis	Industry	3rd Judicial District	
Sara Faulkner	Industry	3rd Judicial District	
Bronson Frye	Labor	3rd Judicial District	Painters and Allied Trades Local 1959
Anthony Ladd	Labor	3rd Judicial District	
Randall McLellan	Labor	3rd Judicial District	
Rebecca Tamaki	Industry	3rd Judicial District	
Shayne Wescott	Labor	3rd Judicial District	
Vacant	Industry	3rd Judicial District	
John Corbett	Labor	2nd/4th Judicial District	Laborers Local 942
Sarah Lefebvre	Industry	2nd/4th Judicial District	Colaska
Lake Williams	Labor	2nd/4th Judicial District	Operating Engineers Local 302
Vacant	Industry	2nd/4th Judicial District	
Amy Bender	Industry	At Large	
Brian Zematis	Labor	At Large	

TAB 6

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Labor and Workforce Development

Office of the Commissioner

PO Box 111149
Juneau, Alaska 99811
Main: 907.465.2700

August 20, 2026

Alaska Workers' Compensation Board
P.O. Box 115512
Juneau, AK 99811-5512

Dear Alaska Workers' Compensation Board,

Thank you for your continued service to the great State of Alaska. The commitment of board member volunteers is an inspiration and provides a critical function to the citizens of Alaska.

The report recommendations will maintain employee access to medical care provided through workers' compensation insurance, while improving medical cost stability and predictability to employers operating in Alaska. Thank you for taking up this important matter at your August 28, 2026, joint meeting with the Medical Services Review Committee (MSRC).

As required by AS 23.30.097(r), I formally approve the conversion factor adjustment recommendations contained in the MSRC report dated August 19, 2026.

Sincerely,

Catherine Muñoz
Commissioner Department of Labor and Workforce Development

cc: Charles Collins, Director Workers' Compensation

ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

Workers' Compensation Medical Services Review Committee

Medical Services Review Committee Members

Charles Collins, Chair
Alan Swenson, MD
Mason McCloskey, DC
Mary Ann Foland, MD
Jeff Gilbert
Misty Steed
Seanne Popp
Valerie Mittelstead
Kimberley Dean

Proposed Schedule for 2027

The Medical Services Review Committee (MSRC) meeting dates for 2027 are as follows:

The committee will begin the year with an in-person meeting on **June 4 at 9:00 a.m.** at the Eagle Street building. Additional meetings will be held virtually via Zoom on **June 25**, **July 16, and August 6 at 9:00 a.m.**

All meetings, including the June 4 meeting, will also be accessible via Zoom. A quorum is required for each meeting. Public comment will be accepted at each meeting and will be summarized in the official minutes.

A joint **AWCB/MSRC** meeting will be held **in person on August 20, 2027,** at the Eagle Street location. The Committee's recommendations will be presented during this meeting.

Meeting Location:
Department of Labor and Workforce Development
3301 Eagle Street, Suite 208
Anchorage, AK 99503

Medical Services Committee Authority and Composition

Alaska Statute 23.30.095(j)

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

(1) one member who is a member of the Alaska State Medical Association;

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(3) one member who is a member of the Alaska State Hospital and Nursing Home Association;

(4) one member who is a health care provider, as defined in AS 09.55.560;

(5) four public members who are not within the definition of "health care provider" in AS 09.55.560; and

(6) one member who is the designee of the commissioner and who shall serve as chair.

Charles Collins, Director of the Division of Workers' Compensation, serves as the commissioner's designee and chair.

Dr. Alan Swenson, an orthopedic surgeon with Orthopedic Physicians Alaska, represents the Alaska State Medical Association.

Dr. Mason McCloskey represents the Alaska Chiropractic Society. Dr. McCloskey has been a member of the MSRC since 2021.

Jeff Gilbert is the CFO of St. Elias Specialty Hospital, affiliated with the Providence Hospital System, and represents the Alaska State Hospital and Nursing Home Association.

Dr. Mary Ann Foland, a general practitioner with Primary Care Associates, holds the health care seat. Dr. Foland has served on the MSRC since inception in 2014.

Misty Steed serves as a public member. She joined the MSRC in 2017 and is affiliated with PACBLU as a bill reviewer.

Kimberley Dean, a claims manager with Alaska Public Risk Alliance and joined the MSRC as a public member in 2026. This risk pool entity is new but made up of very established programs that have recently merged, Alaska Public Entity Insurance and Alaska Municipal League Joint Insurance Association.

Seanne Popp, a Senior Claims Adjuster for Northern Adjusters, Inc., serves as a public member.

Valerie Mittelstead joined the MSRC in 2022 and serves as a public member. She is a retired medical billing professional and union member.

Fee Schedule Issues Considered

During its 2026 review of the Alaska Workers' Compensation Medical Fee Schedule, the Committee considered the following questions and concerns raised by Fee Schedule users:

- Which DMEPOS items should qualify for rental when CMS has not assigned an RR designation?
- Should Alaska regulate reimbursement discounts between providers and payors when negotiated contract prices fall within the Fee Schedule limits?
- Does physician dispensing of drugs require further regulation?
- Which CMS file or application should be used to establish annual reimbursement rates, and should those rates change when CMS files are updated quarterly?
- The Fee Schedule directs Maximum Allowable Reimbursement, MAR, to be limited to 85 percent for services provided by "other providers". A question about who other providers consist of.
- The Fee Schedule limits reimbursement to 85 percent of the maximum allowable reimbursement (MAR) for services provided by 'other providers.' Which providers fall within that category?

- Should the Fee Schedule be reorganized to make its requirements easier to locate, including the multiple procedure payment reduction (MPPR) provisions in the Medicine section?
- Should repackaged drugs be billed using the original NDC or the NDC assigned to the repackaged drug?
- How should topical and compounded drugs be reimbursed? Should reimbursement be capped?
- Remote Therapeutic Monitoring technology is becoming more prevalent. Should these services be assigned reimbursement rates?
- Audiology codes changed substantially this year. How should those changes be incorporated into the 2027 Fee Schedule?

Synopsis of MSRC Work

The committee devoted substantial time to addressing known concerns raised by Medical Fee Schedule users and aligning updates with CMS changes planned for 2026 and 2027.

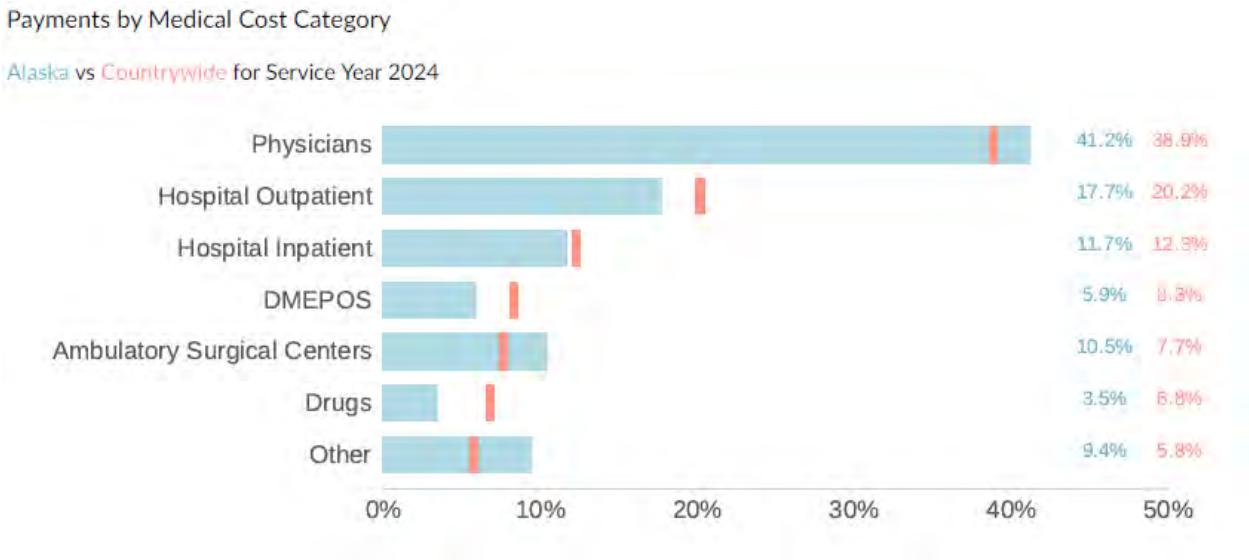
RefMed, the Division's contractor based in Lakeland, Florida, completed a comprehensive section-by-section assessment identifying concerns and proposed revisions. The resulting Fee Schedule provides improved guidance intended to support accurate and timely reimbursement. Several ambiguous references and payment procedures were clarified to reduce billing errors.

The review concentrated on previously identified issues involving repackaged drugs, physician dispensing, topical drugs, and audiology code revisions. The Medicine section was systematically edited and reorganized to improve usability. Standardized language was applied across sections, most notably for the multiple procedure payment reduction (MPPR), to promote consistency. In addition, all GPCI and RVU values were updated and validated, typographical errors were corrected, and applicable dates were updated.

The detailed change log and the Committee's careful review, particularly its focus on usability, were essential to the process. The draft presented to the AWCB incorporates revisions and reflects the Committee's active discussion throughout the review. I want to thank the MSRC members for their sustained hard work, as well as our partners at RefMed for accommodating late-stage revisions. This was one of the most energized and productive review cycles we have had in many years, and I commend them for their efforts.

NCCI Cost Comparisons

This information is provided annually from National Council on Compensation Insurance, NCCI, as a resource to monitor aggregated medical data reported by market insurance companies in the states NCCI represents. This data does not include self-insured entities, such as the State of Alaska, in those markets.



The payment distribution by cost category in Alaska is generally consistent with national trends. Physician costs in Alaska are modestly higher than the countrywide average, which is expected given the state's rural geography and the unique challenges associated with delivering healthcare across dispersed populations. Ambulatory Surgery Centers (ASCs) in Alaska have continued to demonstrate strong performance and provide cost-effective, high-quality services for the workers' compensation system.

Physician Payments as a Percentage of Medicare

Service Year 2024

Physician Service Category	Alaska	Countrywide
Anesthesia	298%	316%
Evaluation and Management	189%	148%
Physical and General Medicine	167%	142%
Surgery	275%	258%
Radiology	322%	236%
All Physician Services	**205%**	**169%**

Top Procedure Codes by Taxonomy from NCCI Data 2024

Here are the **top-used procedure codes for each provider taxonomy**, based on the highest number of **transactions** in the NCCI dataset. (Analysis performed programmatically.)

Acupuncturist	**97140**	**47**
Anesthesiology	**97140**	**5**
Chiropractor	**97140**	**1718**
Clinic/Center	**97110**	**1544**
Clinical Exercise Physiologist	**97140**	**21**
Durable Medical Equipment & Medical Supplies	**97760**	**11**
Family Medicine	**97140**	**65**
General Practice	**97530**	**558**
Health Maintenance Organization	**97140**	**9**
Internal Medicine	**97110**	**35**
Massage Therapist	**97140**	**359**
Military Health Care Provider	**97112**	**7**
Neuromusculoskeletal Medicine & OMM	**97597**	**23**
Nurse Practitioner	**97140**	**6**
Occupational Therapist	**97530**	**995**
Occupational Therapy Assistant	**97530**	**210**
Orthopedic Surgery	**97110**	**3197**
Physical Medicine & Rehabilitation	**97110**	**45**
Physical Therapist	**97110**	**11383**
Physical Therapy Assistant	**97112**	**6**
Physician Assistant	**97140**	**18**
Prosthetic/Orthotic Supplier	**97799**	**1**
Psychiatry & Neurology	**97130**	**6**
Registered Nurse	**97067**	**2**
Single Specialty	**97140**	**31**
Social Worker	**97110**	**21**
Specialist	**97530**	**31**
Student in an Organized Health Care Education/Training Program	**97530**	**4**
(blank)	**97140**	**446**

Top Medicine Codes by usage 2026 SY 2024				Alaska Conversion Factor
Codes 90281-99199				$80.00
CPT Code	Total Payments	Total Transactions	Cost Each	Description
97110	$ 2,021,963.98	18,246	$ 110.82	Therapeutic treatment to develop strength and range of motion.
97140	$ 1,367,853.36	13,519	$ 101.18	Manual therapy techniques
97530	$ 1,687,472.13	12,643	$ 133.47	Therapeutic activities functional improvement
97112	$ 1,003,819.70	9,452	$ 106.20	Therapeutic procedure reeducation of movement
99199	$ 755,979.37	5,975	$ 126.52	Unlisted / Miscellaneous
98941	$ 255,396.25	2,847	$ 89.71	Chiropractic manipulative treatment Spinal 3-4 regions
97014	$ 35,689.45	1,063	$ 33.57	Electrical Stimulation
98943	$ 68,227.70	1,060	$ 64.37	Chiropractic manipulative treatment extraspinal region
97035	$ 33,152.55	986	$ 33.62	Ultrasound Therapy
97545	$ 211,548.71	976	$ 216.75	2-hour session work hardening program

Durable Medical Equipment

As the medical industry evolves with new technology and methodology it has been a challenge to keep pace with proper reimbursement. The main issue faced by regulators is the frequent use of catch all or miscellaneous codes which have no relative value and can become quite controversial on the pricing. Language in the Alaskan Fee Schedule has been strengthened to control the costs by requiring a manufacturer's invoice for the product in question when an unvalued code is applied for reimbursement. Below is an excerpt from Workers' Compensation Research Institute on the issue and following that is a table with the most common HCPCS codes, (used for DME and other non-physician services), in Alaska.

The most common DME code without fee schedule rates, E1399, contributed to the growth in frequency and payments for DME outside fee schedule coverage. In nearly 80 percent of jurisdictions with fee schedules, E1399 represented a bigger share of DME services without assigned fee schedule rates in 2025 compared with 2019 (Table 9). In two-thirds of jurisdictions with fee schedules, E1399 accounted for a larger share of DME payments in 2025 than in 2019 (Table 8). In the median state, the frequency and payment shares for E1399 increased 9 percentage points and 8 percentage points, respectively, from 2019 to 2025 (Figure 2).

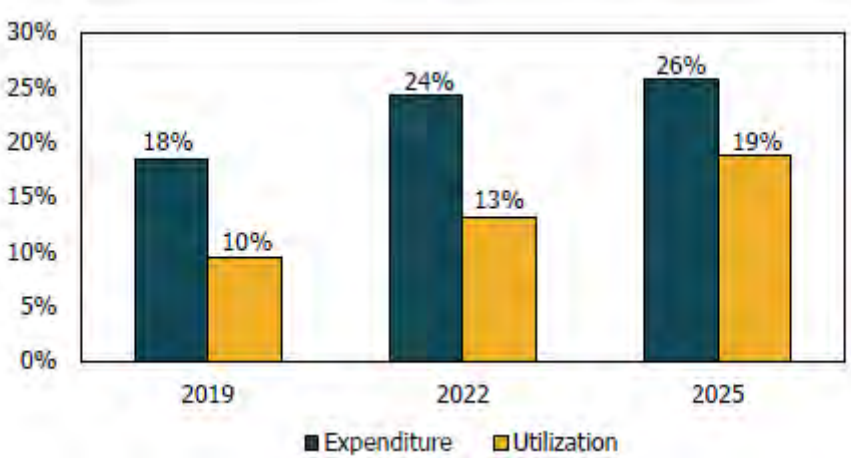


Figure 2 Expenditure and Utilization Shares for Most Common DME Code (E1399) without Established Fee Schedule Rates for Median State over Time

Notes: Services in calendar year 2019, 2022, and 2025 (January through June).
Code E1399 is for durable medical equipment, miscellaneous.

Top HCPCS Codes by Usage 2026 SY 2024				
HCPCS Codes Level II A0000 - V9999				
HCPCS Multiplier 32.3465, Drug ASP 3.375, DME 1.66				
HCPCS Code	**Total Payments**	**Total Transactions**	**Cost Each**	**Description**
G0283	$ 45,702.64	1067	$ 42.83	Electric Stimulation other than wound care
S9122	$ 405,386.68	732	$ 553.81	in home Health Aide hourly
A0425	$ 48,199.36	365	$ 132.05	Ambulance Ground Mileage
E1399	$ 223,019.50	287	$ 777.07	DME Misc.
S9124	$ 259,219.93	263	$ 985.63	in home Nursing care hourly
T1013	$ 28,001.28	222	$ 126.13	sign language or oral interpretive services
T2021	$ 52,211.89	207	$ 252.23	community-based day habilitation services
S9123	$ 208,260.20	196	$ 1,062.55	in home Nursing care (RN) hourly
E0114	$ 13,254.20	189	$ 70.13	Crutch underarm non-wood

Work Document
Joint AWCB / MSRC meeting
August 28, 2026

TAB 7

Official

ALASKA

WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2027

STATE OF ALASKA DISCLAIMER

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

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

NOTICE

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

QUESTIONS ABOUT THE OFFICIAL WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

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

GENERAL QUESTIONS ABOUT WORKERS' COMPENSATION

General questions regarding the statutes, regulations, or claims process should be addressed to the State of Alaska Workers' Compensation Division at 907-465-2790.

AMERICAN MEDICAL ASSOCIATION NOTICE

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

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AMERICAN SOCIETY OF ANESTHESIOLOGISTS NOTICE

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Contents

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.

In all cases of accepted compensable injury or illness, the injured worker **SHALL NOT** be liable for payment for any services for the injury or illness. For more information, refer to AS 23.30.097(f).

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

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

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

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

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

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

See the DMEPOS section for specific fee schedule instructions regarding DME items that do not have a valid HCPCS and/or an established fee schedule value.

SCOPE OF PRACTICE LIMITS

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

ORGANIZATION OF THE FEE SCHEDULE

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

- Introduction
- General Information and Guidelines
- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine
  - Physical Medicine

- Category II
- Category III
- HCPCS Level II
- Outpatient Facility
- Inpatient Hospital
- Critical Access Hospital, Rehabilitation Hospital, Long-term Acute Care Hospital

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

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

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

PROVIDER SCHEDULE

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

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

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

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total relative value units (RVUs) are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total RVUs 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 RVU is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

SERVICES BY OUT-OF-STATE PROVIDERS

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

DRUGS AND PHARMACEUTICALS

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

The maximum allowable reimbursement for prescription drugs dispensed and billed by a pharmacy 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;

Over-the-counter (OTC) medications are drugs available for purchase by the general public without a prescription. Reimbursement for OTC medications shall be the lowest average wholesale price (AWP) among therapeutically equivalent products, based on the original manufacturer's national drug code (NDC). OTC medications shall not be eligible for a dispensing fee.

Additionally, repackaged or relabeled drugs shall be reimbursed at the original NDC (the manufacturer's average wholesale price). No separate repackaging or relabeling fee is payable.

PHYSICIAN-DISPENSED DRUGS

All drugs dispensed and billed by a physician in the physician's office including repackaged drugs are reimbursed at the manufacturer's average wholesale price using the original manufacturer NDC. No separate dispensing, compounding, or handling fee is payable to the physician. The bill must include the original NDC, as required by AS 23.30.097(o). Drugs and pharmaceuticals dispensed shall only be billed by the dispensing physician.

Physician-dispensed topicals, topical compounds, and non-topical compounded drugs are also subject to the applicable requirements and caps in the sections below.

TOPICALS AND TOPICAL COMPOUNDS

This section applies whether the drug is physician-dispensed or pharmacy-dispensed. Both topicals and topical compounds require documented medical necessity. No automatic refills are permitted; each fill requires a new prescription.

Topicals (non-compounded). A topical drug, such as (but not limited to) a cream, gel, ointment, lotion, or patch, is reimbursed at a lower-cost therapeutic or over-the-counter (OTC) equivalent when available. Reimbursement is based on that equivalent and shall not exceed the lesser of the applicable cap or the equivalent's average wholesale price.

Topical compounds. Topical compounds must be an FDA-approved combination and are billed at the ingredient level using each ingredient's original manufacturer NDC. An ingredient without a valid NDC is not reimbursable. Each ingredient is reimbursed at the lowest generic NDC available for that specific prescription or OTC drug. Reimbursement is based on that equivalent and shall not exceed the lesser of the applicable cap (for the entire topical compound) or the sum of each ingredient's average wholesale price. Only one compounding fee may be reimbursed per compounded prescription. The compounding fee shall be $10.00 for a compound containing three (3) or fewer ingredients and $20.00 for a compound containing more than three (3) ingredients.

Caps. Reimbursement for topicals or topical compounds shall not exceed the applicable cap below for the drug and quantity dispensed. Each 30-day cap is prorated to the exact days' supply or quantity dispensed and includes any pharmacy dispensing or compounding fee:

1. OTC or prescription topical cream, gel, ointment, lotion, or other topical formulation other than a patch: $30 per 30-day supply
2. OTC or prescription topical patch: $70 per 30-day supply
3. Topical compounded preparation: $240 per 30-day supply

NON-TOPICAL COMPOUNDED DRUGS

A non-topical compounded drug shall be limited to medical necessity and must be an FDA-approved combination. The compounding pharmacy's original invoice must be submitted and include an itemized original manufacturer NDC for each ingredient. Each ingredient is reimbursed at the average wholesale price of the lowest generic NDC available for that specific drug. Only one compounding fee may be reimbursed per compounded prescription. The compounding fee shall be $10.00 for a compound containing three (3) or fewer ingredients and $20.00 for a compound containing more than three (3) ingredients.

HCPCS LEVEL II

DURABLE MEDICAL EQUIPMENT

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

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

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

AMBULANCE SERVICES

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

OUTPATIENT FACILITY

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB-04 (CMS 1450) claim form. This includes, but is not limited to, ambulatory surgical centers (ASC), hospitals, and freestanding clinics within hospital property. Only the types of facilities described above will be reimbursed using outpatient facility fees. Only those charges that apply to the facility services—not the professional—are included in the Outpatient Facility section.

INPATIENT HOSPITAL

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

DEFINITIONS

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

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

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

Board — the Alaska Workers' Compensation Board.

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

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

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

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

Day — a continuous 24-hour period.

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

Drugs — a controlled substance as defined by law.

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

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

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

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

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

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

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

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

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

Medical report — an electronic or paper record in which the medical service provider records the information required under AS 23.30.095 and 8 AAC 45.086, using the Physician's Report form 07-6102 or a similar format, including the subjective and objective findings, diagnosis, treatment rendered, treatment plan, opinions regarding medical stability and return to work status and/or goals, and impairment rating, as applicable.

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

Modifier — a two-character alphanumeric code 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.

Physician's report — Physician's report refers to the Physician's Report form 07-6102 available at https://www.labor.alaska.gov/wc/forms/wc6102.pdf. The physician's report must include the information outlined in 8 AAC 45.086, https://www.akleg.gov/basis/aac.asp#8.45.086, and be submitted within 14 days of service.

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 — is a request by a provider for payment of health care services submitted to an insurer. The provider must submit its bill and completed medical report in a form prescribed by 8 AAC 45.086. Alternately, a Physician's Report form can be found in the Fee Schedule Appendix A or at https://www.labor.alaska.

gov/wc/forms/wc6102.pdf. The report must be submitted within 14 days after each service, see 8 AAC 45.086. Medical providers' bills must be paid within 30 days after the date the bill and a completed report are received by the insurer, whichever is later, see AS 23.30.097. Physician reports must include the information outlined in 8 AAC 45.086.

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

Prosthesis — an artificial substitute for a missing body part.

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

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

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

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

Special report — a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan. Medical providers may bill using CPT code 99080 only for special reports responding to specific inquiries from an employer or insurance company, except a medical provider **MAY NOT** bill an employer or insurance company for inquiries seeking the information required under 8 AAC 45.086 but omitted from a prior report.

Telehealth — is defined in AS 47.05.270(e). Only services identified by CPT or the Centers for Medicare and Medicaid Services (CMS) as appropriately rendered telehealth services may be reported.

Treatment plan — is defined in Alaska Regulation 8 AAC 45.086, and includes expected length and nature of treatment, objectives, modalities, frequency of treatment and justification of frequency.

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 reimbursement 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
Non-facility Practice Expense RVU x Practice Expense GPCI	1.84	1.065	1.9596
Malpractice RVU x Malpractice GPCI	0.15	0.551	0.08265
Total RVU			3.58725

Data for the purpose of example only

Calculation using example data:

1.03 x 1.500 = 1.545

+ 1.84 x 1.065 = 1.9596

+ 0.15 x 0.551 = 0.08265

= 3.58725

3.58725 x $119.00 (CF) = 426.88275

Payment is rounded to $426.88

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

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

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total RVUs are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total RVUs 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 RVU is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

The conversion factors are listed here with their applicable CPT code ranges.

MEDICAL SERVICE	CPT CODE RANGE	CONVERSION FACTOR
Surgery	10004–69990	$119.00
Radiology	70010–79999	$121.00
Pathology and Lab	80047–89398	$122.00
Medicine (excluding anesthesia)	90281– 97814 and 98925 - 99082 and 99151–99199 and 99500–99607	$80.00
Evaluation and Management	98000-98016, 99091, 99202–99499	$80.00
Anesthesia	00100–01999 and 99100–99140	$100.00

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 the lesser of billed charge or MAR for codes 97014 and 97810–97814.

In all cases of accepted compensable injury or illness, the injured worker **SHALL NOT** be liable for payment for any services for the injury or illness. 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.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
M	Measurement Codes. Used for reporting purposes only.	These codes are supplemental to other covered services and for informational purposes only.
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.
R	Restricted Coverage. Special coverage instructions apply. If covered, the service is contractor 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	T = Injections. There are RVUs and payment amounts for these services, but they are paid only if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***.
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.

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

EXEMPT FROM MODIFIER 51 CODES

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

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

PROFESSIONAL AND TECHNICAL COMPONENTS

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

GLOBAL DAYS

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

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

MMM Designates services furnished in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care.

XXX Designates services where the global concept does not apply.

YYY Designates services where the payer must assign a follow-up period based on documentation submitted with the claim. Procedures designated as YYY include unlisted procedure codes.

ZZZ Designates services that are add-on procedures and as such have a global period that is determined by the primary procedure.

TELEHEALTH SERVICES

Telehealth services are covered and reimbursed at the lower of the billed amount or non-facility MAR. Telehealth services are identified in CPT with a star ★ icon for audiovisual services and with the 🔈 icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services may be reported with CPT codes 99202-99215 with modifier 93 or 95 as appropriate, or may be reported with codes 98000-98015. Telehealth services should be reported with modifier 93 or 95 appended.

CPT code 98016 Brief communication technology-based service may be reported for a virtual check-in that is:

- Provided by a physician or qualified health care provider (QHP) who can report E/M services
- Provided to an established patient
- Initiated by the patient
- Not related to a service provided in the previous 7 days
- Does not result in an E/M or procedure within 24 hours or soonest available
- Medical discussion of 5-10 minutes duration

This may be an audio only service and video is not required.

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 or treatment plan required by the Workers' Compensation Division. A medical provider's report must include the information required under 8 AAC 45.086(a)(1) - (25). Alternatively, a provider can complete a Physician's Report Form (Form 07-6102) found in the Fee Schedule Appendix A or at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

A medical provider may not charge a separate fee for medical reports or treatment plans that are required to substantiate the medical necessity of a service. Provider medical reports are furnished to the payer/employer within 14 days after the encounter or 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 **SHALL NOT** be liable for payment for any services for the injury or illness. For more information, refer to AS 23.30.097(f).

TREATMENT PLANS

Treatment plans are furnished to the payer/employer within 14 days after the treatment begins and must include expected length and nature of treatments, objectives, modalities, frequency of treatments, and justification for the frequency of treatments exceeding:

A) three treatments per week during the first month;

B) two treatments per week during the second and third months;

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

D) one treatment per month during the sixth through twelfth months.

See Alaska Regulation 8 AAC 45.086. A Physician's Report form can be found in the Fee Schedule Appendix A or at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

MEDICAL EVALUATIONS

Medical Evaluations include Independent Medical Evaluations (IMEs), Employer Medical Evaluations (EMEs), and Second Independent Medical Evaluations (SIMEs). Evaluations performed for the purpose of claim evaluation or medical dispute resolution—including EMEs pursuant to AS 23.30.095(e) and Board-ordered SIMEs pursuant to AS 23.30.095(k)—are not subject to the Alaska Workers' Compensation Medical Fee Schedule. These evaluations are considered medical services but are not provided for diagnosis or treatment. Therefore, reimbursement by the payer for such evaluations, including associated record reviews, reports, and testimony preparation, shall be determined by agreement between the payer and the evaluating provider. Providers performing EMEs or SIMEs may not bill using standard treatment-related CPT codes governed by the Fee Schedule. Separate billing and reimbursement arrangements should reflect the complexity, time, and nature of the evaluation.

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 both the medical provider's bill, and the completed medical report, that complies with regulation 8 AAC 45.086, as prescribed by the Board under Alaska Statute 23.30.097. If the medical provider's bill and medical report are not submitted at the same

time, the requirement that the bill is due and payable does not begin to run until the insurance carrier has received both. Unless the treatment, prescription charges, and/or transportation expenses are disputed, the employer shall reimburse the employee for such expenses within 30 days after receipt of the bill, chart notes, and medical report, itemization of prescription numbers, and/or the dates of travel and transportation expenses for each date of travel. A provider of medical treatment or services may receive payment for medical treatment and services under this chapter only if the bill for services is received by the employer or appropriate payer within 180 days after the later of: (1) the date of service; or (2) the date that the provider knew of the claim and knew that the claim was related to employment, see AS 23.30.097(h).

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. See AS 23.30.097(i).

See Alaska Regulation 8 AAC 45.086. A Physician's Report form can be found in the Fee Schedule Appendix A or at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

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.

HOME HEALTH AND IN-HOME CARE SERVICES

The Alaska Workers' Compensation Medical Fee Schedule is based on the use of CPT and HCPCS Level II codes as defined by the Centers for Medicare & Medicaid Services (CMS) for reimbursable medical services. In-home care services that do not meet the CMS definition of skilled care or are not billed using standard CPT/HCPCS codes are not subject to the Alaska Workers' Compensation Medical Fee Schedule.

REIMBURSEMENT BY AGREEMENT

Specifically, services such as personal care assistance, companion care, and attendant care that are custodial in nature, or do not require the involvement of a licensed medical provider, are excluded from the fee schedule. These services are not considered treatment governed by CMS coding methodology and therefore must be reimbursed based on a separate agreement between the payer and the provider.

REIMBURSEMENT BY FEE SCHEDULE

In contrast, qualified providers, including skilled nursing services or therapies (e.g., physical therapy, occupational therapy, or speech-language pathology), rendering care services in the home shall be subject to the Fee Schedule if they:

- Are medically necessary;
- Are billed using CPT or HCPCS codes recognized under the Alaska Fee Schedule;
- And meet applicable CMS guidelines for coverage and reimbursement.

Providers and payers are encouraged to consult the Alaska Workers' Compensation Medical Fee Schedule and CMS coding requirements to determine applicability before billing for in-home care services.

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 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 in addition to modifier 80, 81, or 82.

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

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

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

Procedure 1 (Modifier 80, AS)	$1,350.00
Procedure 2 (Modifier 80, 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 TC—TECHNICAL COMPONENT

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

MODIFIER QZ—CRNA WITHOUT MEDICAL DIRECTION BY A PHYSICIAN

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

STATE-SPECIFIC MODIFIERS

MODIFIER PE—PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

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

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

Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

This brief overview of the current guidelines should not be the provider's or payer's only experience with this section of the CPT book. Carefully read the complete guidelines in the CPT book; much information is presented regarding the elements of medical decision making. The maximum allowable reimbursement (MAR) for Evaluation and Management services is calculated using the RBRVS and GPCI for Alaska and a conversion factor of $80.00. See the General Information and Guidelines section for more information.

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.

When exact text of the AMA 2026 CPT guidelines is used, the text is either in quotations or is preceded by a reference to the CPT book, CPT instructional notes, or CPT guidelines.

BILLING AND PAYMENT GUIDELINES

TELEHEALTH SERVICES

Telehealth services are covered and reimbursed at the lower of the billed amount or non-facility MAR. Telehealth services are identified in CPT with a star ★ icon for audiovisual services and with the 🔈 icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services may be reported with CPT codes 99202-99215 with modifier 93 or 95 as appropriate, or may be reported with codes 98000-98015. Telehealth services should be reported with modifier 93 or 95 appended.

CPT code 98016 Brief communication technology-based service may be reported for a virtual check-in that is:

- Provided by a physician or qualified health care provider (QHP) who can report E/M services
- Provided to an established patient
- Initiated by the patient
- Not related to a service provided in the previous 7 days
- Does not result in an E/M or procedure within 24 hours or soonest available
- Medical discussion of 5-10 minutes duration

This may be an audio only service and video is not required.

MEDICAL EVALUATIONS

Medical Evaluations include Independent Medical Evaluations (IMEs), Employer Medical Evaluations (EMEs), and Second Independent Medical Evaluations (SIMEs). Evaluations performed for the purpose of claim evaluation or medical dispute resolution—including EMEs pursuant to AS 23.30.095(e) and Board-ordered SIMEs pursuant to AS 23.30.095(k)—are not subject to the Alaska Workers' Compensation Medical Fee Schedule. These evaluations are considered medical services but are not provided for diagnosis or treatment. Therefore, reimbursement by the payer for such evaluations, including associated record reviews, reports, and testimony preparation, shall be determined by agreement between the payer and the evaluating provider. Providers performing EMEs or SIMEs may not bill using standard treatment-related CPT codes governed by the Fee Schedule. Separate billing and reimbursement arrangements should reflect the complexity, time, and nature of the evaluation.

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 or other qualified health care professional or another physician or other 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 or other qualified health care professional, or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."

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

E/M SERVICE COMPONENTS

E/M COMPONENT GUIDELINES FOR CPT CODES

Changes to the E/M codes placed emphasis on code selection based on time or a revised medical decision making (MDM) table.

History and exam should still be documented but will be commensurate with the level required by the practitioner to evaluate and treat the patient. Prolonged E/M visit will be a covered service with CPT codes 99358-99359, 99415-99418, or HCPCS codes G0316-G0318 and G2212.

The MDM for E/M codes is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2026 MDM table are:

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

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

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

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

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

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

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

Note: Time is not a factor when reporting emergency room visits (99281–99285) like it is with other E/M services.

PROBLEM

According to the CPT book, "a problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter." The CPT book defines various types of problems. These definitions should be reviewed frequently, but remember, this information merely contributes to code selection. For a complete explanation of evaluation and management services refer to the CPT book.

SUBCATEGORIES OF EVALUATION AND MANAGEMENT

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

TELEHEALTH SERVICES (98000-98016)

Codes 98000-98015 may be used to report telehealth services. Codes describe audiovisual versus audio only services, new or established patient, and level of care.

CPT code 98016 Brief communication technology-based service may be reported for a virtual check-in that is:

- Provided by a physician or qualified health care provider (QHP) who can report E/M services
- Provided to an established patient
- Initiated by the patient
- Not related to a service provided in the previous 7 days
- Does not result in an E/M or procedure within 24 hours or soonest available
- Medical discussion of 5-10 minutes duration

This may be an audio only service and video is not required.

OFFICE OR OTHER OUTPATIENT SERVICES (99202–99215)

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

HOSPITAL INPATIENT OR OBSERVATION CARE SERVICES (99221–99223, 99231–99239)

The codes for hospital inpatient and observation care services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge-day management. Per CPT guidelines for inpatient and observation care, the time component includes both face-to-face time and non-face-to-face time spent on the date of service on or off the unit. 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 another encounter (office, emergency department, nursing facility, etc.), report the service in the initial site separately with a modifier 25 to indicate that a significant, separately identifiable service was performed by the same physician or other qualified health care professional.

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

Only one hospital visit per day shall be payable. Hospital visit codes shall be combined into the single code that best describes the service rendered when more than one visit by a particular provider occurs on the same calendar date in the same setting.

CONSULTATIONS (99242-99245, 99252–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient or Observation Consultations. Follow-up visits by the consultant in an office or other outpatient facility are reported with established patient office codes 99212-99215 or home or residence codes 99347-99350. For follow-up consultation services during the same admission as the initial consultation, see Subsequent Hospital Inpatient or Observation 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 E/M code for the site of service (office, home or residence, hospital inpatient or observation). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99242–99245 or Initial Inpatient Consultations 99252–99255). The general rules and requirements of a consultation are defined by the CPT book as follows:

- A consultation is "a type of evaluation and management service provided at the request of another physician, or other qualified healthcare professional, or appropriate source to recommend care for 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.

- 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, consultation codes are no longer appropriate. Report the appropriate code for the site of service (office, home or residence, hospital inpatient or observation).
- Follow-up visits with the consultant should be reported with the appropriate subsequent or established patient codes, depending on the location.

EMERGENCY DEPARTMENT SERVICES (99281–99288)

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

CRITICAL CARE SERVICES (99291–99292)

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

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

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

NURSING FACILITY SERVICES (99304–99316)

Nursing facility E/M services have been grouped into the subcategories: Initial Nursing Facility Care, Subsequent Nursing Facility Care, and Nursing Facility Discharge. Included in these codes are E/M services provided to patients in psychiatric residential treatment centers and intermediate care facilities for individuals with intellectual disabilities. Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

HOME OR RESIDENCE SERVICES (99341–99350)

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

PROLONGED SERVICES (99358–99360, 99415-99418)

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

Prolonged Service With or Without Direct Patient Contact on Date of an Evaluation and Management Service

These codes report services involving total prolonged time on the same date as another evaluation and management service. The codes include the combined time with and without direct (face-to-face) contact with the patient.

CPT codes 99417 and 99418 are add-on codes that should be reported in addition to the code for the E/M service that was performed on the same date. They can be reported only when time was used to select the E/M level and the highest-level service has been exceeded by 15 minutes. These codes cannot be reported for any time increment of less than 15 minutes.

Prolonged Service Without Direct Patient Contact on Date Other Than the Face-to-Face Evaluation and Management Service

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. This prolonged service is provided on a different date than the face-to-face E/M encounter with the patient and/or family/caregiver. Use 99358 to report the first hour and 99359 for each additional 30 minutes. 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.

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

These codes report face-to-face time spent by the clinical staff with the patient and/or family/caregiver on the same date as another evaluation and management service. The physician provides direct supervision to the staff.

CPT codes 99415 and 99416 are add-on codes that should be reported in addition to the code for an E/M service performed on the same date. Services lasting less than 30 minutes are not reportable in this category, and the service must extend 15 minutes or more into the next time period to be reportable.

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 15 minutes or more are spent during the 30 days. Do not use this code for supervision of patients in nursing facilities or under the care of home health agencies unless the patient requires recurrent supervision of therapy. Also, low intensity and infrequent supervision services are not reported separately.

TELEPHONE SERVICES

(See Telehealth Services 98000-98016)

SPECIAL EVALUATION AND MANAGEMENT SERVICES (99450, 99455–99456)

This series of codes reports physician evaluations in order to establish baseline information for insurance certification and/or work related or medical disability.

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

99455	10.63
99456	21.25

OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

This is an unlisted code to report services not specifically defined in the CPT book.

MODIFIERS

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

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

STATE-SPECIFIC MODIFIER

MODIFIER PE: PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

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 $100.00. Relative values for anesthesia procedures (00100–01999, 99100–99140) are as specified in the current *Relative Value Guide* published by the American Society of Anesthesiologists.

TIME FOR ANESTHESIA PROCEDURES

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

CALCULATING ANESTHESIA CHARGES

The following scenario is for the purpose of example only:

01382 Anesthesia for diagnostic arthroscopic procedure of knee joint

Dollar Conversion Unit = $100.00

Base Unit Value = 3

Time Unit Value = 8 (4 units per hr x 2 hrs)

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

Anesthesia Fee = $100.00 x (3 Base Unit Value + 8 Time Unit Value + 0 Physical Status Modifier Value + 0 Qualifying Circumstances Value) = $1,100.00

Physical status modifiers and qualifying circumstances are discussed below. Assigned unit values are added to the base unit for calculation of the total maximum allowable reimbursement (MAR).

ANESTHESIA SUPERVISION

Reimbursement for the combined charges of the nurse anesthetist and the supervising physician shall not exceed the scheduled value for the anesthesia services if rendered solely by a physician.

ANESTHESIA MONITORING

When an anesthesiologist is required to participate in and be responsible for monitoring the general care of the patient during a surgical procedure but does not administer anesthesia, charges for these services are based on the extent of the services rendered.

OTHER ANESTHESIA

Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the unit value for the surgical procedure.

If the attending surgeon administers the regional anesthesia, the value shall be the lower of the "basic" anesthesia value only, with no added value for time, or billed charge (see Anesthesia by Surgeon in the Surgery guidelines). Surgeons are to use surgical codes billed with modifier 47 for anesthesia services that are performed. No additional time units are allowed.

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

ANESTHESIA MODIFIERS

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

PHYSICAL STATUS MODIFIERS

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

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 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

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

MODIFIERS

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

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

APPLICABLE HCPCS MODIFIERS

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

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

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

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

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

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

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

CONVERSION FACTOR

The maximum allowable reimbursement (MAR) for Surgical services is calculated using the RBRVS and GPCI for Alaska and a conversion factor of $119.00. See the General Information and Guidelines section of this fee schedule for more information.

GLOBAL REIMBURSEMENT

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

In addition to the surgical procedure, global reimbursement includes:

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

FOLLOW-UP CARE FOR DIAGNOSTIC PROCEDURES

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

FOLLOW-UP CARE FOR THERAPEUTIC SURGICAL PROCEDURES

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

ADDITIONAL SURGICAL PROCEDURE(S)

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

INCIDENTAL PROCEDURE(S)

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

SUTURE REMOVAL

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

ASPIRATIONS AND INJECTIONS

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

SURGICAL ASSISTANTS

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

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

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

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

Procedure 1 (Modifier 80, AS)	$1,350.00
Procedure 2 (Modifier 80, 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.

PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended. Modifier PE is applied before modifiers 50, 51, or other modifiers that reduce reimbursement for multiple procedures.

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

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

Data for the purpose of example only

ANESTHESIA BY SURGEON

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

MULTIPLE OR BILATERAL PROCEDURES

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

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

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

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

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

Example of two procedures during same surgical session:

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

Data for the purpose of example only

ENDOSCOPIC PROCEDURES

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

Example:

Code	MAR	Adjusted amount
29827	$4,777.92	$4,777.92 (100%)
29824	$3016.59	$920.61 (the value of 29824 minus the value of 29805)
29805	$2,095.98	
	Total	$5,698.53

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.

APPLICABLE HCPCS MODIFIERS

Modifier AS—Physician Assistant or Nurse Practitioner Assistant at Surgery Services. When assistant at surgery services are performed by a physician assistant or nurse practitioner, the service is reported by appending modifier AS in addition to modifier 80, 81, or 82.

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

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 80, AS)	$1,350.00
Procedure 2 (Modifier 80, AS, 51)	$1,100.00
Reimbursement	$285.00 [($1,350.00 x .15) + ((1,100.00 x .15) x .50)]

Data for the purpose of example only

STATE-SPECIFIC MODIFIERS

MODIFIER PE—PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

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

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

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

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

CONVERSION FACTOR

The maximum allowable reimbursement (MAR) for Radiology services is calculated using the RBRVS and GPCI for Alaska and a conversion factor of $121.00. See the General Information and Guidelines section of this fee schedule for more information.

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.

Alaska MAR:

72142	$1,178.66
72142-TC	$762.10
72142-26	$416.56
72147	$1,168.08
72147-TC	$754.25
72147-26	$413.82

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	$762.10	100% of the TC
72147-TC	$377.13	(50% of the TC for the second procedure)
Total	$1,139.23	

Professional Component:

72142-26	$416.56	100% of the 26
72147-26	$393.13	(95% of the 26 for the second procedure)
Total	$809.69	

Global Reimbursement:

72142	$1,178.66	100% of the global
72147-51	$770.26	($377.13 + $393.13 TC and 26 above)
Total	$1,948.92	

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific CPT modifiers shall be reimbursed as follows:

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

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

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

APPLICABLE HCPCS MODIFIERS

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

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

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	0.43	1.500	0.645
Practice Expense RVU x Practice Expense GPCI	0.36	1.065	0.3834
Malpractice RVU x Malpractice GPCI	0.02	0.551	0.01102
Total RVU			1.03942

Data for the purpose of example only

Calculation using example data:

0.43 x 1.500 = .645

+ 0.36 X 1.065 = 0.3834

+ 0.02 x 0.551 = 0.01102

= 1.03942

1.03942 x $122.00 (CF) = 126.80924

Payment is rounded to $126.81

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

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

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

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

BILLING AND PAYMENT GUIDELINES

PROFESSIONAL COMPONENT

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

TECHNICAL COMPONENT

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

ORGAN OR DISEASE ORIENTED PANELS

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (CPT codes 80047–80081), use the code number corresponding to the appropriate panel test. The individual tests performed should not be reimbursed separately. Refer to the CPT book for information about which tests are included in each panel test.

DRUG SCREENING

Drug screening is reported with CPT codes 80305–80307. These services are reported once per patient encounter. These codes are used to report urine, blood, serum, or other appropriate specimen. Drug confirmation is reported with codes G0480–G0483 dependent upon the number of drug classes tested. 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.

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 at the lesser of billed charges or the maximum allowable reimbursement (MAR) for codes 97014 and 97810-97814.

CONVERSION FACTOR

The MAR for Medicine services is calculated using the RBRVS and GPCI for Alaska and a conversion factor of $80.00. See the General Information and Guidelines section of this fee schedule for more information.

MEDICAL REPORTS

A medical provider may not charge any fee for completing a medical report form or treatment plan required by the Workers' Compensation Division. A medical provider's report must include the information required under 8 AAC 45.086(a)(1) - (25). Alternatively, a provider can complete a Physician's Report Form (Form 07-6102) found in the Fee Schedule Appendix A or at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

A medical provider may not charge a separate fee for medical reports or treatment plans that are required to substantiate the medical necessity of a service. Provider medical reports are furnished to the payer/employer within 14 days after the encounter or 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 **SHALL NOT** be liable for payment for any services for the injury or illness. For more information, refer to AS 23.30.097(f).

TREATMENT PLANS

Treatment plans are furnished to the payer/employer within 14 days after the treatment begins and must include expected length and nature of treatments, objectives, modalities, frequency of treatments, and justification for the frequency of treatments exceeding:

A) three treatments per week during the first month;

B) two treatments per week during the second and third months;

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

D) one treatment per month during the sixth through twelfth months.

See Alaska Regulation 8 AAC 45.086. A Physician's Report form can be found in the Fee Schedule Appendix A or at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

MEDICAL EVALUATIONS

Medical Evaluations include Independent Medical Evaluations (IMEs), Employer Medical Evaluations (EMEs), and Second Independent Medical Evaluations (SIMEs). Evaluations performed for the purpose of claim evaluation or medical dispute resolution—including EMEs pursuant to AS 23.30.095(e) and Board-ordered SIMEs pursuant to AS 23.30.095(k)—are not subject to the Alaska Workers' Compensation Medical Fee Schedule. These evaluations are considered medical services but are not provided for diagnosis or treatment. Therefore, reimbursement by the payer for such evaluations, including associated record reviews, reports, and testimony preparation, shall be determined by agreement between the payer and the evaluating provider. Providers performing EMEs or SIMEs may not bill using standard treatment-related CPT codes governed by the Fee Schedule. Separate billing and reimbursement arrangements should reflect the complexity, time, and nature of the evaluation.

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	$187.52
92060-TC	$70.52
92060-26	$117.00
92132	$85.91
92132-TC	$36.80
92132-26	$49.11

Data for the purpose of example only

Technical Component:

92060-TC	$70.52	100% of the TC
92132-TC	$29.44	(80% of the TC for the second procedure)
Total	$99.96	

Global Reimbursement:

92060	$187.52	100% of the global
92132	$78.55	(80% of the TC for the second procedure + 100% of the 26) ($29.44 + $49.11 = $78.55)
Total	$266.07	

MULTIPLE PROCEDURES

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

See below for examples of the reduction calculations.

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	$598.63
93303-TC	$400.96
93303-26	$197.68
93351	$650.12
93351-TC	$384.14
93351-26	$265.99

Data for the purpose of example only

Technical Component:

93303-TC	$400.96	100% of the TC
93351-TC	$288.11	(75% of the TC for the second procedure)
Total	$689.07	

Global Reimbursement:

93303	$598.63	100%
93351	$554.10	(75% of the TC for the second procedure + 100% of the 26) ($288.11 + $265.99 = $554.10)
Total	$1,152.73	

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 1.66.

TELEHEALTH SERVICES

Telehealth services are covered and reimbursed at the lower of the billed amount or non facility MAR. Telehealth services are identified in CPT with a star ★ icon for audiovisual services and with the ◖ icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services may be reported with CPT codes 99202-99215 with modifier 93 or 95 as appropriate, or may be reported with codes 98000-98015. Telehealth services should be reported with modifier 93 or 95 appended.

CPT code 98016 Brief communication technology-based service may be reported for a virtual check-in that is:

- Provided by a physician or qualified health care provider (QHP) who can report E/M services
- Provided to an established patient
- Initiated by the patient
- Not related to a service provided in the previous 7 days
- Does not result in an E/M or procedure within 24 hours or soonest available
- Medical discussion of 5-10 minutes duration

This may be an audio only service and video is not required.

PHYSICAL MEDICINE

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

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

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

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

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

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

MULTIPLE PROCEDURES

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	$36.52
[(.18 x 1.5) + (0.17 x 1.065) + (0.01 x .551)] x 80	
97024	$20.42
[(.06 x 1.5) + (0.15 x 1.065) + (0.01 x .551)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	$29.28
[(.18 x 1.5) + ((0.17 x 1.065) x .5) + (0.01 x .551)] x 80	
97024	$14.03
[(.06 x 1.5) + ((.15 x 1.065) x .5) + (0.01 x .551)] x 80	

Example:

97016	$36.52
97016 (2nd unit same date)	$29.28
97024 (additional therapy same date)	$14.03

TENS UNITS

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician's prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.66. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

PUBLICATIONS, BOOKS, AND VIDEOS

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

FUNCTIONAL CAPACITY EVALUATION

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

WORK HARDENING

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

97545 3.41
97546 1.36

OSTEOPATHIC MANIPULATIVE TREATMENT

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

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

CHIROPRACTIC MANIPULATIVE TREATMENT

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

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

- Chiropractors may report, but are not limited to, codes 97014, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943. See AS 08.20.100. Practice of Chiropractic.

REMOTE THERAPEUTIC MONITORING (RTM)

Remote Therapeutic Monitoring (RTM) reimburses a provider for supplying a monitoring device and managing non-physiologic therapy data collected outside the clinic, such as musculoskeletal, cognitive behavioral, or respiratory status and a patient's adherence and response to therapy. The data may be objective (device-generated) or subjective (reported by the patient). RTM is distinct from remote physiologic monitoring (RPM), which measures vital data, and the two cannot be billed together in the same month.

The codes in scope span three functions: setup, device supply, and treatment management. Code 98975 covers device setup and patient education. The device-supply codes cover the respiratory system, musculoskeletal system, and cognitive behavioral therapy, and are chosen by the number of days of data collected: 98984, 98985, and 98986 for 2 to 15 days, and codes 98976, 98977, and 98978 for 16 to 30 days. Treatment-management time is reported with 98979, 98980, and 98981.

REMOTE MONITORING THERAPY SETUP AND DEVICE SUPPLY

To support billing these codes, the documentation should include:

Patient consent should be obtained before or at the time services are furnished and documented in the record.

A documented order and plan of care by the physician or other qualified healthcare professional furnishing the service.

Medical necessity related to the compensable injury.

Identification of the FDA-defined device, and how it collects and transmits data. (This is not applicable to solely using an application for tracking).

Initial device setup and patient education once per episode of care (98975).

Electronic collection and secure transmission of the data for the billing practitioner's review.

Subjective (patient-reported) input where used, such as pain scores, function or mobility, symptom reports, and home-exercise or medication adherence.

Secure, auditable records retained for the applicable period, including the device data, logs, time entries, and interaction notes.

A date-stamped transmission log showing the number of days data was collected, which supports the tier billed (2 to 15 days for 98984-98986; 16 to 30 days for 98976-98978).

One RTM device code is billable per 30-day period: The RTM device codes are not additive and are not a base-and-add-on pair; billed on the last date of treatment within the 30-day period

Segregated time when RTM is concurrent with active physical therapy. RTM management minutes are separate and distinct from timed therapy minutes and no time is counted twice.

REMOTE MONITORING TREATMENT MANAGEMENT

To support billing these codes, the documentation should include:

For treatment management (98979-98981): A physician or other qualified healthcare professional (QHP) documents a monthly time log and at least one real-time, synchronous, interactive communication with the patient or caregiver each calendar month; report only one base per month (98979 for the first 10 minutes or 98980 for the first 20 minutes, not both, with 98981 for each additional 20 minutes), counting time by calendar month rather than the device 30-day period. Do not count time toward these codes on a day when reporting an E&M service by the physician or other QHP.

HOME HEALTH AND IN-HOME CARE SERVICES

The Alaska Workers' Compensation Medical Fee Schedule is based on the use of CPT and HCPCS Level II codes as defined by the Centers for Medicare & Medicaid Services (CMS) for reimbursable medical services. In-home care services that do not meet the CMS definition of skilled care or are not billed using standard CPT/HCPCS codes are not subject to the Alaska Workers' Compensation Medical Fee Schedule.

REIMBURSEMENT BY AGREEMENT

Specifically, services such as personal care assistance, companion care, and attendant care that are custodial in nature, or do not require the involvement of a licensed medical provider, are excluded from the fee schedule. These services are not considered treatment governed by CMS coding methodology and therefore must be

reimbursed based on a separate agreement between the payer and the provider.

REIMBURSEMENT BY FEE SCHEDULE

In contrast, qualified providers, including skilled nursing services or therapies (e.g., physical therapy, occupational therapy, or speech-language pathology), rendering care services in the home shall be subject to the Fee Schedule if they:

- Are medically necessary;
- Are billed using CPT or HCPCS codes recognized under the Alaska Fee Schedule;
- And meet applicable CMS guidelines for coverage and reimbursement.

Providers and payers are encouraged to consult the Alaska Workers' Compensation Medical Fee Schedule and CMS coding requirements to determine applicability before billing for in-home care services.

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 (services identified with a "6" in the multiple procedure column of the RBRVS), ophthalmology (services identified with a "7" in the multiple procedure column of the RBRVS), and therapy (services identified with a "5" in the multiple procedure column of the RBRVS) procedures apply when multiple services are furnished to the same patient on the same day. The MPPRs apply independently to cardiovascular, ophthalmology, and physical therapy services per examples above.

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT

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

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

Category II

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

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

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

Category III

Category III codes are temporary codes identifying emerging technology and should be reported when available. These codes are alphanumeric with an ending value of "T" for temporary.

The use of these codes supersedes reporting the service with an unlisted code. It should be noted that the codes in this section may be retired if not converted to a Category I, or standard CPT code. Category III codes are updated semiannually by the American Medical Association (AMA).

Category III codes are listed numerically as adopted by the AMA and are not divided into service type or specialty.

CATEGORY III MODIFIERS

As the codes in category III span all of the types of CPT codes all of the modifiers are applicable. Please see a list of CPT modifiers in the General Information and Guidelines section.

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 HCPCS the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges.

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

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value for Alaska in effect at the time of treatment or service multiplied by 1.66 or billed charges. If no code identifies the supply, bill using the appropriate unlisted, miscellaneous, or not otherwise specified HCPCS code. An original invoice is required and reimbursement shall be the lower of the submitted original manufacturer/supplier's invoice plus 20 percent or billed charges. The MAR for purchased or rented DME items are never calculated at 85% of billed charges.

DME items that are unvalued (i.e., $0.00) in the DMEPOS fee schedule are still reported with the correct HCPCS code. An original invoice is required for items without a stated value and reimbursement shall be the lower of the submitted original manufacturer/supplier's invoice plus 20 percent or billed charges. Rental items are reported with modifier RR. The monthly reimbursement is the value as calculated using the invoice multiplied by 0.10. Only those DME rental items calculated using the invoice may be reimbursed at a daily rate based on the monthly reimbursement divided by 30 (multiplied by 0.0333). In no event shall the total accumulated rental reimbursement for an item exceed its purchase price; when cumulative rental payments equal the purchase price, the item is considered purchased and no further rental is payable.

Example:
Invoice amount E0218

Cold/Ice and compression machine	$3,395.00
Shoulder Wrap	$529.00
Carry Bag	$240.00
Shipping	$55.00
Total Invoice Cost	$4,219.00

Data for the purpose of example only

Alaska MAR
$4,219.00 x 1.20 = $5,062.80
(Total Invoice x 1.20 = Alaska MAR)

Alaska MAR Rental Amount (Modifier RR)
$5,062.80 x 0.10 = $506.28
(Alaska Invoice MAR x 0.10 = Alaska Invoice MAR Monthly Rental)

Alaska MAR Daily Rental Amount
$506.28 x 0.0333 = $16.86
(Alaska Invoice MAR Monthly Rental x 0.0333 = $16.86)

Some DME codes are listed in the DMEPOS fee schedule with a value but without a separate rental (RR) rate. Examples include, but are not limited to: E0720 and E0730 (TENS units) and codes in the oxygen and oxygen equipment (OX) category. When such an item is rented, the monthly reimbursement is the lesser of the billed charges or the code's DMEPOS purchase value multiplied by 0.10, for each month of rental. For this purpose, the purchase value is the amount listed for the code without a modifier or, where applicable, the amount listed under the NU modifier. This rental calculation applies only to reusable equipment; it does not apply to consumable,

disposable, or single-use items, such as batteries and other expendable supplies, which are reimbursed as purchased items rather than rented. In no event shall the total accumulated rental reimbursement for an item exceed its purchase price; when cumulative rental payments equal the purchase price, the item is considered purchased and no further rental is payable.

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician's prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.66. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

HEARING AIDS

The injured worker must be referred by the treating medical physician with proof of medical necessity for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes all related evaluations, tests, adjustments, repairs, or reprogramming for the life of the hearing aids. Testing conducted by the physician or clinic dispensing the hearing aids (or ordered at the request of the physician or clinic dispensing the hearing aids) to determine necessity for hearing aids is not separately reimbursable. New hearing aids may be dispensed 1) once every four years or 2) when the new medical evaluation by a treating physician and testing documents changes necessitate a new device prescription as related to the work-related injury or 3) replacement of a nonworking device that is no longer covered by warranty. Extended warranties are not reimbursable. Repairs will not be paid when a device is still under the manufacturer's warranty. An evaluation and management service shall not be billed at the time of any hearing aid evaluations or testing. The dispensing of hearing aids is reported with appropriate HCPCS Level II codes and a copy of the manufacturer/supplier's invoice. Reimbursement for hearing aids is the lower of the manufacturer/supplier's invoice cost plus 30 percent or billed charges including related testing, dispensing, evaluations, and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V5110, V5160, V5240, and V5241 are not separately reimbursed services. All accessories and supplies are reimbursed at 20 percent above manufacturer's/supplier's submitted invoice.

HEARING AID SERVICES

When hearing aids are not both procured and dispensed by the treating audiologist, hearing tests, evaluations, fittings, programming, adjustments, and other medically necessary audiology services are separately reimbursable to the audiologist. The procedure codes listed below shall be reimbursed at the lesser of the Maximum Allowable Reimbursement (MAR) or the provider's billed charge.

CODE	MAR
92628	$195 Max one visit per year
92629	$50 Max one visit per year
92636	$150 Max one visit per year
92637	$50 Max one visit per year
92639	$70 Max one visit per year
92641	$70 Max one visit per year
V5014	$249.31 Max one visit per year
V5020	$116.17 Max one visit per year

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

NU New equipment

RR Rental (use the RR modifier when DME is to be rented)

UE Used durable medical equipment

AMBULANCE SERVICES

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

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

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

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

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

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

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

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

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

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

The Outpatient Facility section represents services performed in an outpatient facility and billed utilizing the 837i format or UB04 (CMS 1450) claim form. For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers' Compensation Act), a conversion factor shall be applied to the hospital outpatient relative weights established for each CPT or *Ambulatory Payment Classifications* (APC) code adopted by reference in 8 AAC 45.083(m). The outpatient facility conversion factor will be $221.79 and the ambulatory surgical center (ASC) conversion factor will be $168.00. Payment determination, packaging, and discounting methodology shall follow the CMS OPPS methodology for hospital outpatient and ambulatory surgical centers (ASCs). For procedures performed in an outpatient setting, implants shall be paid at manufacturer/supplier's invoice plus 10 percent.

The maximum allowable reimbursement (MAR) for medical services that do not have valid CPT or HCPCS codes, currently assigned Centers for Medicare and Medicaid Services (CMS) relative value, or an established conversion factor is the lowest of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

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

(1) medical services or procedures without an APC weight

  (a) where a payment rate is available the allowable is calculated using the multiplier of 2.08 for ASCs and 2.75 for outpatient facilities;

  (b) when no weight or payment rate is listed reimburse at the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;

(2) status indicator codes C, E1, E2, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;

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

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

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.

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 • Physical, occupational, and speech therapy • Diagnostic mammography • Screening mammography • Unclassified drugs and biologicals reportable under HCPCS code C9399	Not paid under OPPS. See the appropriate section under the provider fee schedule. Unclassified drugs and biologicals priced at 95 percent of drug or biological's average wholesale price (AWP) using Red Book or an equivalent recognized compendium and paid under OPPS. *Alaska Specific Guideline: Drugs and biologicals are paid at 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.*
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. May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but 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. Admit patient. Bill as inpatient. *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 or any other Medicare payment system.
E1	Items, codes, and services not covered by any Medicare outpatient benefit category; statutorily excluded; 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.* *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.*
E2	Items and services for which pricing information and claims data are not available	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.*
F	Corneal tissue acquisition; certain CRNA services	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.*
H1	Non-opioid medical devices for post-surgical pain relief	Separate payment based on hospital's charges adjusted to cost. Subject to criteria and payment limitation under Section 4135 of the CAA, 2023 *Alaska Specific Guideline: A payer shall subtract non-opioid medical devices from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 20 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, H1, K1 [SEE ADDENDUM J], L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products).

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
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, H1, K1 [SEE ADDENDUM J], L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services, services assigned to a new technology APC, self-administered drugs, all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products). (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.
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radio pharmaceuticals	Paid under OPPS; separate APC payment.
K1	Non-opioid drugs and biologicals for post-surgical pain relief	Paid under OPPS; Separate APC payment. Subject to criteria and payment limitation under Section 4135 of the CAA, 2023. *Alaska Specific Guideline: 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.*
L	Influenza vaccine; pneumococcal pneumonia vaccine; Hepatitis B vaccine; Covid-19 Vaccine, Monoclonal Antibody Therapy Product	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. 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.*
O1	Software as a Medical Service	Paid under OPPS; separate APC payment. (Pending adoption of CMS Proposed Rule 1850-P for 2027).
P	Partial hospitalization or Intensive Outpatient Program	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 claim as a HCPCS code assigned OPSI of S, T, or V. (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
Q2	T packaged codes	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
Q3	Codes that may be paid through a composite APC	Paid under OPPS; addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments. (1) Composite APC payment on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS). (1) Packaged APC payment if billed on the same 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 OPSI = 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.
S1	Skin substitute product paid separately	Paid under OPPS; separate APC payment. Subject to payment based on FDA regulatory pathway.
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. *Alaska Specific Guideline: Not separately paid in ASC/OPPS. Equipment sent home with the patient may be separately reported by the DME supplier and paid under the DME guidelines of this fee schedule.*

SURGICAL SERVICES

Outpatient facility services directly related to the procedure on the day of an outpatient surgery comprise the comprehensive, or all-inclusive, surgical outpatient facility charge. The comprehensive outpatient surgical facility charge usually includes the following services:

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

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

DRUGS AND BIOLOGICALS

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

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

For drugs and injections coded under the HCPCS, including non-opioid drugs and biologicals for post-surgical pain relief, 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.

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

See the HCPCS section for DME reporting guidelines.

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.

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

Example of Implant Outlier:

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

Implant invoice	$28,000
Less threshold	($25,000)
Outlier amount	= $ 3,000
	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 and updated with federal fiscal year values current at the time of the patient discharge.

EXEMPT FROM THE MS-DRG

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

SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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

PREPARING TO DETERMINE A PAYMENT

The CMS IPPS Web Pricer is normally available on the CMS web site one to two months after the Inpatient Prospective Payment System rule goes into effect each October 1. The version that is available on January 1, 2027, remains in effect, unless the Alaska Workers' Compensation Division publishes a notice that a new version is in effect. Besides the IPPS Web Pricer, two additional elements are required to determine a payment:

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

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

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

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

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

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

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

The current version of the IPPS Web Pricer application may be accessed here:

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

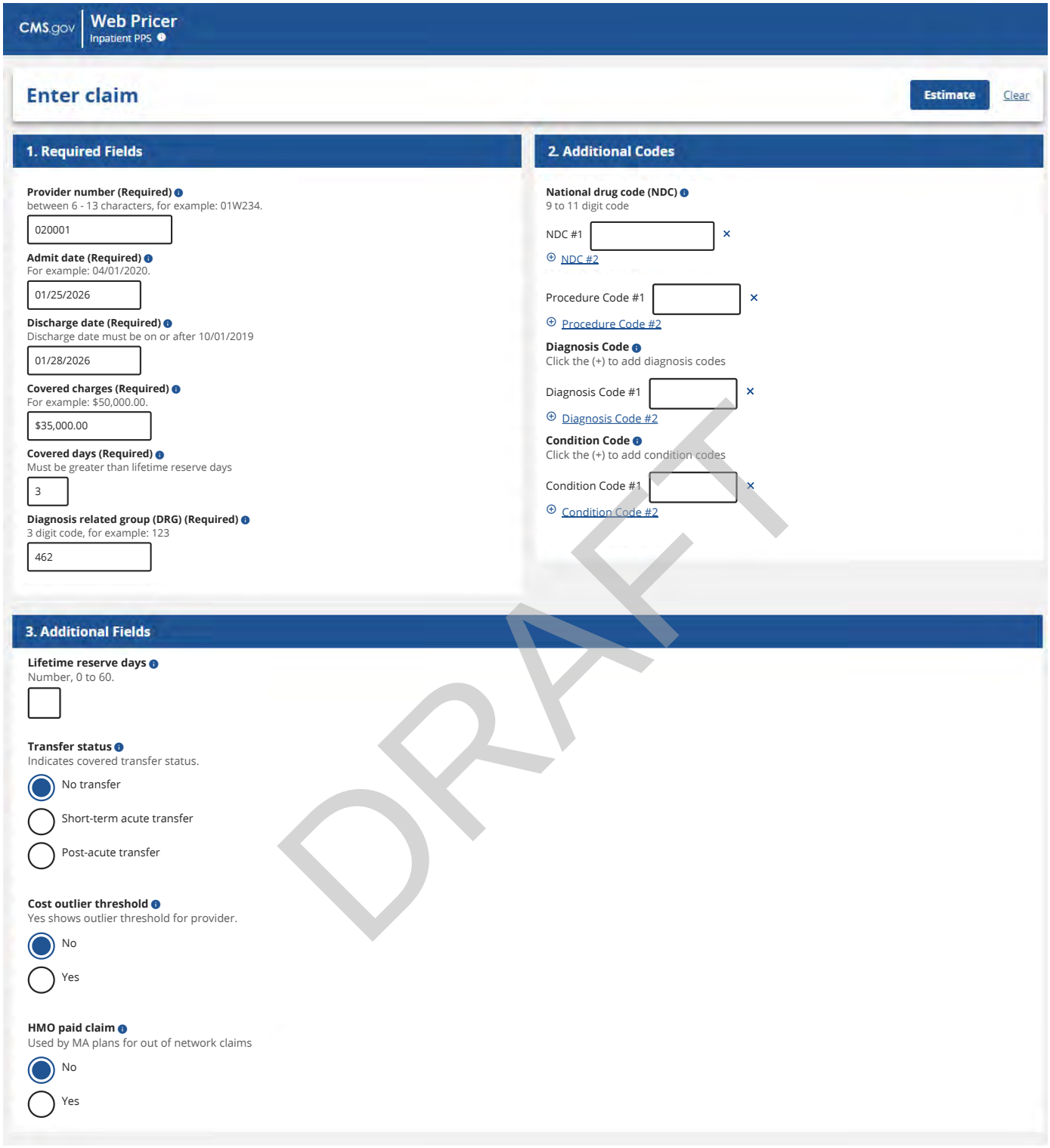
DATE OF SERVICE RECOMMENDATION

The Alaska Workers' Compensation Division recommends that calculations should be made using a date of service that will result in the reimbursement amount effective January 1 of the calendar year.

EXAMPLE

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

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



The IPPS Web Pricer instructions are included below:

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

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

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

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

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

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

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

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

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

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

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

CONDITION CODE – Enter the condition code when required

LIFETIME RESERVE DAYS – not required to be entered.

TRANSFER STATUS – Select the correct option from

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

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

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

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

Click the "Estimate" button at the top of the screen. The results will display on the right-hand side of the screen

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

Review results

Edit Claim Clear

Summary

Calculation version	**2026.1**
Return code	**14**
Description: PAID DRG WITH PERDIEM	
Key claim information	
Provider number	020001
Effective date	10/15/2025
Diagnosis related group (DRG)	462
Claim estimate	
Claim estimate with provider adjustments	$25,449.88
Outlier calculation	$0.00
Grand total amount	**$25,449.88**

The estimate is based on submitted claim info

↓Download CSV

Provider details

Provider type	00
Geographic CBSA	11260
Reclassification CBSA	--

Capital amounts

Capital federal specific portion	$1,634.13
Capital outlier	--
Capital disproportionate share hospital	$158.51
Capital indirect medical education	$34.86

Claim information

Admit date	01/25/2026
Discharge date	01/28/2026
Length of stay	3
Covered days	3
Lifetime reserve days	0
Regular days	3
Covered charges	$35,000.00
Review code	00
National drug code (NDC)	--
Procedure Code	--
Diagnosis Code	--
Condition Code	--
Cost outlier threshold	No
HMO paid claim	No

Operating amounts

Operating federal specific portion	$21,010.23
Operating hospital-specific payment	$0.00
Operating outlier	$0.00
Operating disproportionate share hospital	$1,413.99
Operating indirect medical education	$618.42
Uncompensated care amount	$801.43
Readmission adjustment	--
Value-based purchasing adjustment	$-51.95
New technology	--

Review results

Edit Claim Clear

PPS factors & adjustments

Operating cost to charge ratio	0.198
Capital cost to charge ratio	0.011
Operating disproportionate share hospital percent	0.2692
Capital disproportionate share hospital percent	0.097
National labor	$4,456.72
National non labor	$2,295.89
Inpatient Wage Index	1.1438
Inpatient DRG Weight	2.66
Inpatient DRG geometric mean average length of stay	2.2
Readmission adjustment factor	1
Value-based purchasing adjustment factor	0.9975273577
Bundle percent	0
Electronic health record reduction indicator	--
Hospital-acquired condition reduction indicator	Y
Cost outlier threshold amount	$0.00

Pass-through amounts

Capital	--
Direct medical education	$28.82
Organ acquisition	$0.00
Allogeneic Stem Cell Acquisition	$0.00
Supply Chain Costs	--
Total pass-through & miscellaneous	$28.82
Estimated total pass-through amount	**$86.46**

Other PPS amounts

Hospital acquired condition adjustment	$-256.20
Low-volume payment adjustment factor	--
Islet add-on	--
Electronic health record adjustment	--
Bundle adjustment	--

A NOTE ON PASS-THROUGH PAYMENTS IN THE IPPS WEB PRICER

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

PASS-THROUGH ESTIMATES SHOULD BE INCLUDED WHEN DETERMINING THE ALASKA WORKERS' COMPENSATION PAYMENT.

DETERMINING THE FINAL MAXIMUM ALLOWABLE REIMBURSEMENT (MAR)

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

CMS IPPS Web Pricer Grand Total Amount	$25,449.88
Multiplied by Providence Alaska Medical Center multiplier	x 2.38
Alaska Workers' Compensation Payment	$60,570.71

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, Division of Health Care Services.

Appendix A

The provider must submit their bill and completed medical report in a form prescribed by 8 AAC 45.086 or using the Physician's Report in this appendix. The form must be submitted within 14 days after each service. Additional information regarding the the Physician's Report may be found in Bulletin No. 24-03. See: https://www.labor.alaska.gov/wc/bulletins.htm

PHYSICIAN'S REPORT

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

◯ INITIAL Employee: Sections 1 & 2/Physician: Sections 3 & 4
◯ PROGRESS Physician: Sections 1 & 4
◯ TREATMENT PLAN Employee: Sections 1 & 2/ Physician: Sections 3 & 4

AWCB Case Number:

SECTION 1

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number	3. Date of Injury
4. Address				5. Sex ◯ Male ◯ Female	6. Social Security Number
City	State	Zip Code	Telephone		7. Date of Birth
8. Employer				9. Insurer	
10. Address				11. Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

SECTION 2

12. Date Last Worked
13. Was Body Part Injured Before? ◯ No ◯ Yes If yes, when and describe:
14. Describe Injury and Tell How It Happened:
15. Have You Seen Any Other Doctor for This Injury? ◯ No ◯ Yes If yes, list name and address:
16. Hospitalized As Inpatient? ◯ No ◯ Yes Name of Hospital:

SECTION 3

17. Your First Treatment Date
18. Describe Complaints:
19. Fully Describe Findings on First Examination (Specify Right or Left):
20. Diagnosis:
21. X-Rays? ◯ No ◯ Yes X-Ray Diagnosis:
22. Is Condition Work Related? ◯ No ◯ Yes Explain:
◯ Undetermined (Explain):

SECTION 4

23. Treatment Date(s) Since Last Report
24. Next Treatment Date
25. Estimate Length of Further Treatment Days Weeks Months
26. Medically Stable? ◯ No ◯ Yes
27. Date of Medical Stability
28. Injury May Permanently Preclude Return to Job at Time of Injury ◯ No ◯ Yes ◯ Undetermined
29. Will Injury Result in Permanent Impairment? ◯ No ◯ Yes ◯ Undetermined
30. Impairment Rating
31. Factors on Which Rating is Based
32. Released for Work ◯ No Estimate Length of Disability ◯ 1-3 Days ◯ 4-7 Days ◯ 8-14 Days ◯ 15-21 Days ◯ 22-28 Days ◯ More ____ Weeks ____ Months
◯ Yes ◯ Regular Work (Date): ◯ Modified Work (Date): Give Limitations:
33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.
34. Describe Treatment (and/or Attach Notes)
35. If Case Referred to Another Physician, State Name and Address:
36. IRS I.D. Number
37. Physician's Name and Degree (Print or Type)
38. Physician's Signature
39. Report Date
40. Address City State Zip Code
41. Telephone

SEE INSTRUCTIONS ON BACK

Form 07-6102 (Rev 01/2013)

INSTRUCTIONS TO PHYSICIANS:

1. Clearly mark on reverse whether you are making an Initial, Treatment Plan, or Progress Report.
2. When making an Initial Report or Treatment Plan Report, ask employee to complete Sections 1 and 2. You should complete Sections 3 and 4.
3. When making a Progress Report, complete Items 1, 3, 6, 7, 8 and 9 of Section 1 (you may complete additional items for your own convenience) and Section 4.
4. A Treatment Plan IS REQUIRED ONLY if you treat the injured worker MORE OFTEN than provided in the following chart:

1st MONTH	2nd & 3rd MONTHS	4th & 5th MONTHS	6th THRU 12th MONTH
3 treatments per week	2 treatments per week	1 treatment per week	1 treatment per month

5. Within 14 days after each treatment, send the ORIGINAL report to the Employer. If you treat the employee more frequently than once every 14 days, you may report all treatments during a 14-day period on one form.
6. Send your billing only to the employer/insurer; the Board does not pay medical expenses.
7. If you need more space than that provided on the front of the form, use the space below.
8. You may make copies of this form.
9. Late or incomplete reporting may delay the employee's compensation payments. The employer/insurer may not be required to pay your treatment if reports are not submitted timely.

INSTRUCTIONS TO EMPLOYEE:

1. Complete Sections 1 and 2 of the Initial Report.
2. The report is NOT a substitute for your written notice of injury to your employer and the Alaska Workers' Compensation Board. If you have not already done so, immediately contact your employer and complete Items 1 through 17 of the Report of Occupational Injury or Illness (Form 07-6101).

42. Employee's Name (Last, First, Middle Initial)	43. Report Date
44. REMARKS (or Treatment Plan continued)	

Medical records in an employee's file maintained by the board are not public records subject to public inspection and copying under AS 09.25.

Form 07-6102 (Rev 01/2013)

Appendix B

Workers' Compensation Medical Fee Schedule Acronyms

ADA	Americans with Disabilities Act (Federal)
AMA	American Medical Association
APC	Ambulatory Payment Classification
APRN	Advanced Practice Registered Nurse
ASC	Ambulatory Surgery Center
AWCB	Alaska Workers Compensation Board
CCU	Critical Care Unit
CLAB	Clinical Diagnostic Laboratory Fee Schedule
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CT	Computed Tomography Scan
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DRG	Diagnosis-related group
EBM	Evidence-based Medicine
EME	Employer Medical Evaluation
E/M	Evaluation and Management
FDA	Food and Drug Administration
GPCI	Geographic Practice Cost Index
HCPCS	Healthcare Common Procedure Coding System
ICU	Intensive Care Unit
IME	Independent Medical Evaluation
IPPS	Inpatient Prospective Payment System
MAR	Maximum Allowable Reimbursement
MDM	Medical Decision Making
MPPR	Multiple Procedure Payment Reduction
MRA	Magnetic Resonance Angiogram
MRI	Magnetic Resonance Image
MS-DRG	Medicare Severity Diagnosis Related Group
MSRC	Medical Services Review Committee
NDC	National Drug Code
PC	Professional Component
PICU	Pediatric Intensive Care Unit
RBRVS	Resource-Based Relative Value Scale
RCU	Respiratory Care Unit
RPM	Remote Physiologic Monitoring
RTM	Remote Therapeutic Monitoring
RVU	Relative Value Units
SIME	Second Independent Medical Evaluation
SNF	Skilled Nursing Facility
TC	Technical Component
TENS	Transcutaneous Electrical Nerve Stimulation
U&C	Usual and Customary

TAB 8

Chapter 45. Compensation, Medical Benefits, and Proceedings Before the Alaska Workers' Compensation Board.

8 AAC 45.083. Fees for medical treatment and services.

8 AAC 45.083(a)(11) is amended to read:

(11) provided on or after April 1, 2026, **but before January 1, 2027,** may not exceed the maximum allowable reimbursement established in the Official Alaska Workers' Compensation Medical Fee Schedule, April 1, 2026 edition, and adopted by reference.

8 AAC 45.083(a) is amended by adding a new paragraph to read:

(12) provided on or after January 1, 2027, may not exceed the maximum allowable reimbursement established in the Official Alaska Workers' Compensation Medical Fee Schedule, January 1, 2027 edition, and adopted by reference.

(Eff. 12/1/2015, Register 216; am 3/11/2016, Register 217; am 4/1/2017, Register 221; am 1/1/2018, Register 224; am 1/1/2019, Register 228; am 5/12/2019, Register 230; am 12/21/2019, Register 232; am 1/1/2021, Register 236; am 2/24/2022, Register 241; am 1/29/2023, Register 245; am 1/1/2024, Register 248; am 1/1/2025, Register 252; am 4/1/2026, Register 257; am ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098