ALASKA WORKERS' COMPENSATION

MEDICAL SERVICES REVIEW COMMITTEE MEETING

May 25, 2022

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TAB 1

ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING
May 25, 2022

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
Telephone 977-853-5247 ID 838 4353 6810
Zoom Conference https://us02web.zoom.us/j/83843536810

AGENDA

May 25, 2022

9:00 am Call to order
- Roll call - establishment of quorum
- Approval of Agenda
- Issues from AWCB, DWC staff or MSRC

10:00 am Break

10:15 am Public Comment Period

11:15 am Break

11:30 am Overview/Discussion of 2023 MSRC Fee Schedule Issues
- Approval of meeting dates
- Effects of recent Legislation
- COVID-19 Potential Impacts/WC Claims Update
- Changes in CMS Inpatient PPS PC Pricer
- National Council on Compensation Insurance: Analysis of Alaska Medical Fee Schedule Changes, Effective January 1, 2022

12:00 pm Lunch Break

1:30 pm Roll Call

1:35 pm 2023 Fee Schedule Issues Development
- Existing 2022 Fee Schedule Issues in Meeting Packet
- Review of conversion factors

3:00 pm Break

3:15 pm 2023 Fee Schedule Guidelines Development (cont.)

5:00 pm Adjournment

TAB 2

Alaska Workers' Compensation Medical Services Review Committee, AS 23.30.095(j)

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

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

Committee Membership as of May 25, 2022

Seat	**Last Name**	**First Name**	**Affiliation**
Chairperson	Collins	Charles	Director, Division of Workers' Compensation
Alaska State Medical Association	Moore, MD	Jeffery	Orthopedic Physicians Anchorage, Inc.
Alaska Chiropractic Society	McCloskey, DC	Mason	Kanady Chiropractic Center
Alaska State Hospital & Nursing Home Association	Gilbert	Jeff	St. Elias Specialty Hospital
Medical Care Provider	Foland, MD	Mary Ann	Primary Care Associates
Lay Member – Industry	Steed	Misty	PACBLU
Lay Member – Industry	Scott	Pam	Northern Adjusters, Inc.
Lay Member – Labor	Mittelstead	Valerie	IBEW
Lay Member – Industry	Kosinski	Susan	ARECA Insurance Exchange

TAB 3

Medical Data Report

For the state of

ALASKA

September 2021

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Introduction

Medical costs have been growing over the last 30 years. Today, in many states, close to 60% of workers compensation benefits are attributed to medical costs. Managing the cost and delivery of medical care is one of the major concerns facing workers compensation (WC) stakeholders now and in the foreseeable future. The availability of medical data on WC claims is essential for the pricing of proposed state legislation and assessing impacts of changes to fee schedules.

This publication is a data source for regulators and others who are interested in the driving forces behind changing medical costs in WC claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that underlie the financial soundness of the WC system. When making comparisons to the region and countrywide (CW), it is important to note that some states in this report do not have a fee schedule.

Knowing how payments for different services contribute to WC medical benefit costs provides insight into the growth of medical benefits. This report illustrates the breakdown of services by category, namely:

- Physician
- Hospital Outpatient
- Hospital Inpatient
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Other

The report drills down into these categories to show which procedures represent the greatest share of payments and which are performed the most.

There is one important caveat: Information in this report may not coincide with an analysis of a medical fee schedule change performed in the future. An analysis of a medical fee schedule change requires evaluation of the specific procedures covered by the fee schedule, which may be different from how payments are categorized in this report.

The data contained in this report represents medical transactions for Service Year 2020 (medical services delivered from January 1, 2020, to December 31, 2020), except where otherwise noted. WC insurance carriers must report paid medical transactions if, over the most recent three years, they write at least 1% of the market share in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, it is required to report for all applicable states in which it writes WC insurance. All carriers within an insurance group are required to report.

No data adjustments have been made for the reporting of COVID-19-related claims. For more information on impacts of COVID-19 on medical losses, please see the Medical Indicators & Trends dashboard[1] on **ncci.com**.

For Alaska in Service Year 2020, the reported number of transactions was more than 146,200, with more than $47,211,400 paid, for more than 7,000 claims. This represents data from 93% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

[1] www.ncci.com/Articles/Pages/Insights-Medical-Indicators-Trends-Dashboard.aspx

Unless otherwise noted, the source for all data in this report is:

- NCCI's Medical Data Call, Service Year 2020
- Region includes data from the following states: AZ, CO, HI, ID, MT, NM, NV, OR, and UT.
- Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV

Additional information regarding the data underlying this report is available in the Appendix.

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Medical Cost Statistics

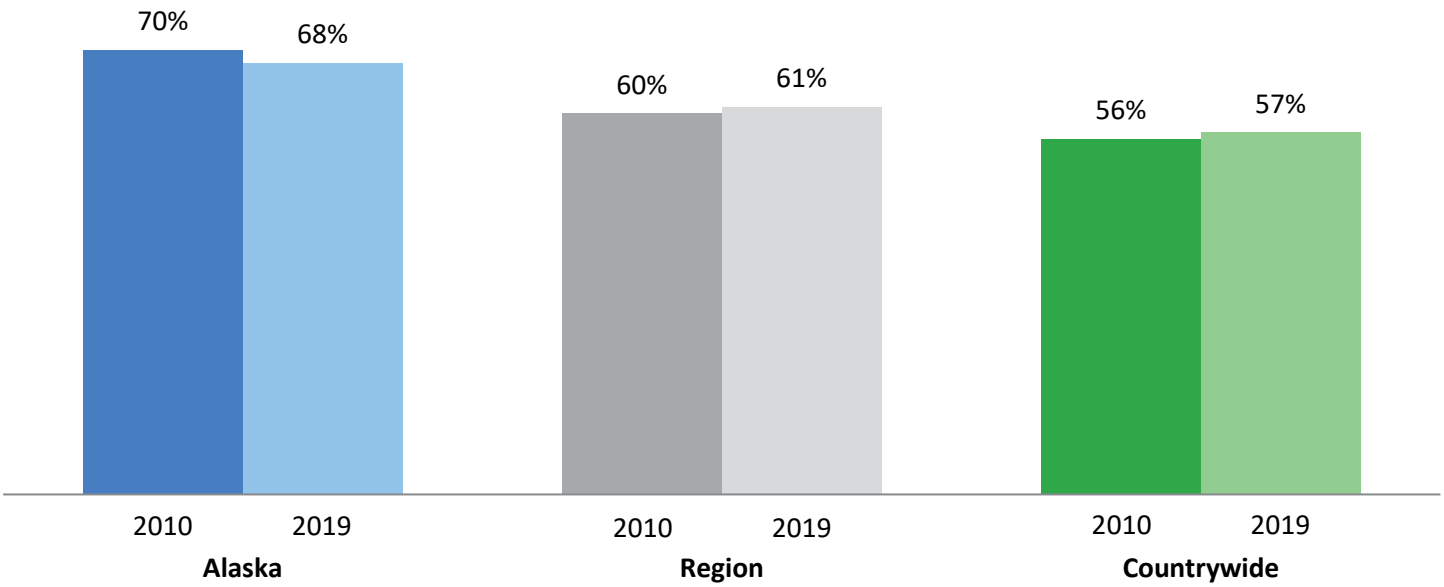
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost drivers for workers compensation claims on a countrywide basis. Because this is a relative measure and benefits for both indemnity and medical may vary from state to state, the share of medical benefit costs may vary across states. In particular, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

Chart 1 displays the medical percentage of total benefit costs for Alaska, the region, and countrywide for Accident Years 2010 and 2019.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

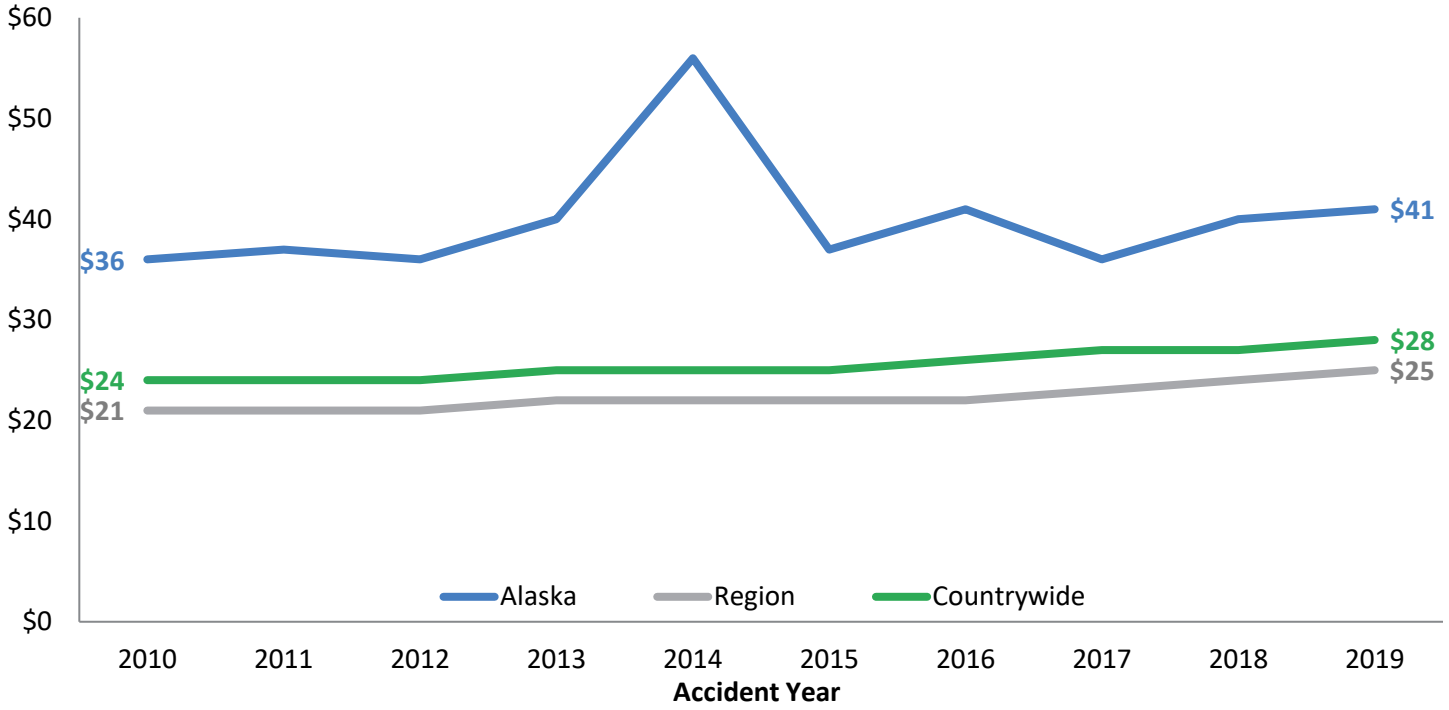
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 2% from Accident Years 2010 to 2019; this has increased at a slightly higher rate than the United States Personal Healthcare Spending per capita.[2] Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for Alaska, the region, and countrywide.

Medical losses are at historical benefit levels and historical dollar values—meaning that no adjustment for inflation or changes in benefits has been made. Since the data is aggregated for all medical losses by accident year, the results shown in this chart provide a high-level perspective of the average medical cost per case.

This chart illustrates how Alaska compares to the regional and countrywide average for each individual accident year and allows for the comparison of the growth in average medical costs.

Chart 2

Overall Medical Average Cost per Lost-Time Claim (in 000s)



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

[2] **State of the Line Report, *Annual Issues Symposium***, May 2021, www.ncci.com/Articles/Documents/AIS2021-SOTL-Presentation.pdf

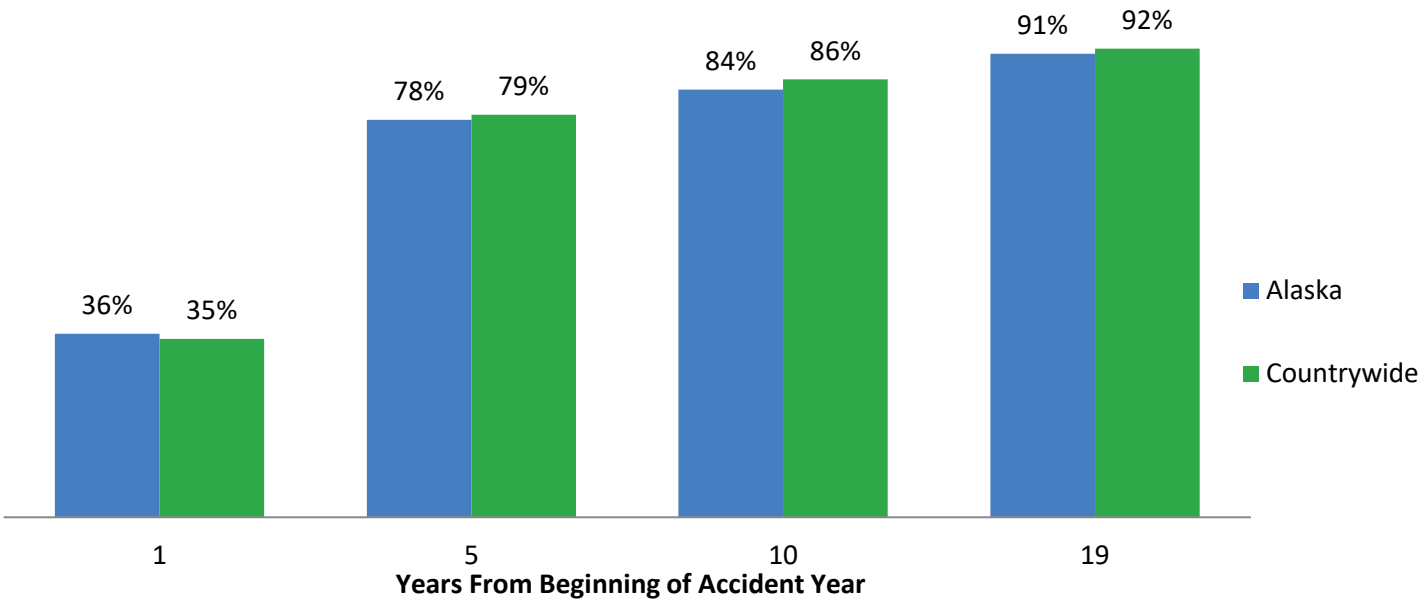
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will be for services provided more than two decades into the future.

A key determinant driving payment patterns for medical services is the effectiveness of dispute resolution processes, settlement practices, and statutory provisions for medical benefits. An aging workforce and continued changes in rules for Medicare set-asides have created a shifting environment for the settlement of claims and, particularly, medical benefits.

Chart 3 shows the percentage of medical benefits paid (including medical settlements) at different claim maturities for Alaska and countrywide.

Chart 3

Percentage of Medical Paid by Claim Maturity



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, OK, OR, RI, SC, SD, TN, UT, VA, and VT.

Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits.

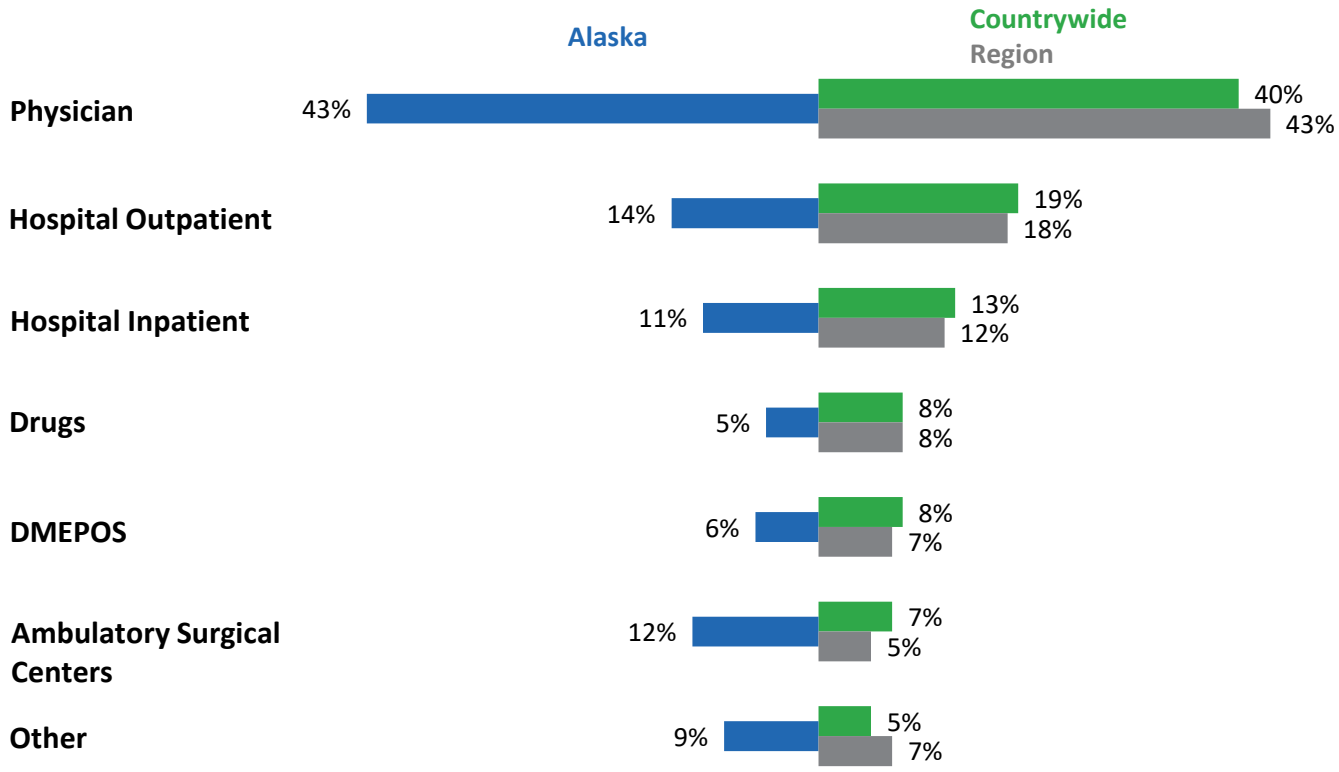
Payments are categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the remaining categories—Physicians, Hospital Outpatient, Hospital Inpatient, and Ambulatory Surgical Centers (ASC)—NCCI relies on a combination of:

- Provider taxonomy code—identifies the type of provider that billed for, and is being paid for, a medical service
- Procedure code—alphanumeric code used to identify procedures performed by medical professionals
- Place of services—alphanumeric code used to identify places where procedures were performed (e.g., physician's office or ambulatory surgical center)

Chart 4 displays the distribution of medical payments by type of service.

Chart 4

Distribution of Medical Payments



Physicians

In the 1970s, fewer than a dozen states had physician fee schedules in place. In the 1990s, several states established such schedules. Today, few states remain without a physician fee schedule. Recent changes in the schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability. NCCI's most recent study, "The Impact of Fee Schedule Updates on Physician Payments" (December 2018), shows that:

- Approximately 80% of any change in the maximum allowable reimbursement (MAR) for a physician service will be realized as a change in prices paid
- Most of the impact of a MAR change on prices paid is realized within one year from the date of a fee schedule change

One measure of workers compensation medical costs is a comparison of current payments to the Medicare rates adjusted for your state.

The chart below shows the average percentage of Medicare schedule reimbursement[3] amounts for physician payments by category for Alaska, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the categories listed in the chart, and the state comparison reflects Medicare's geographic adjustments. In Alaska, 92% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

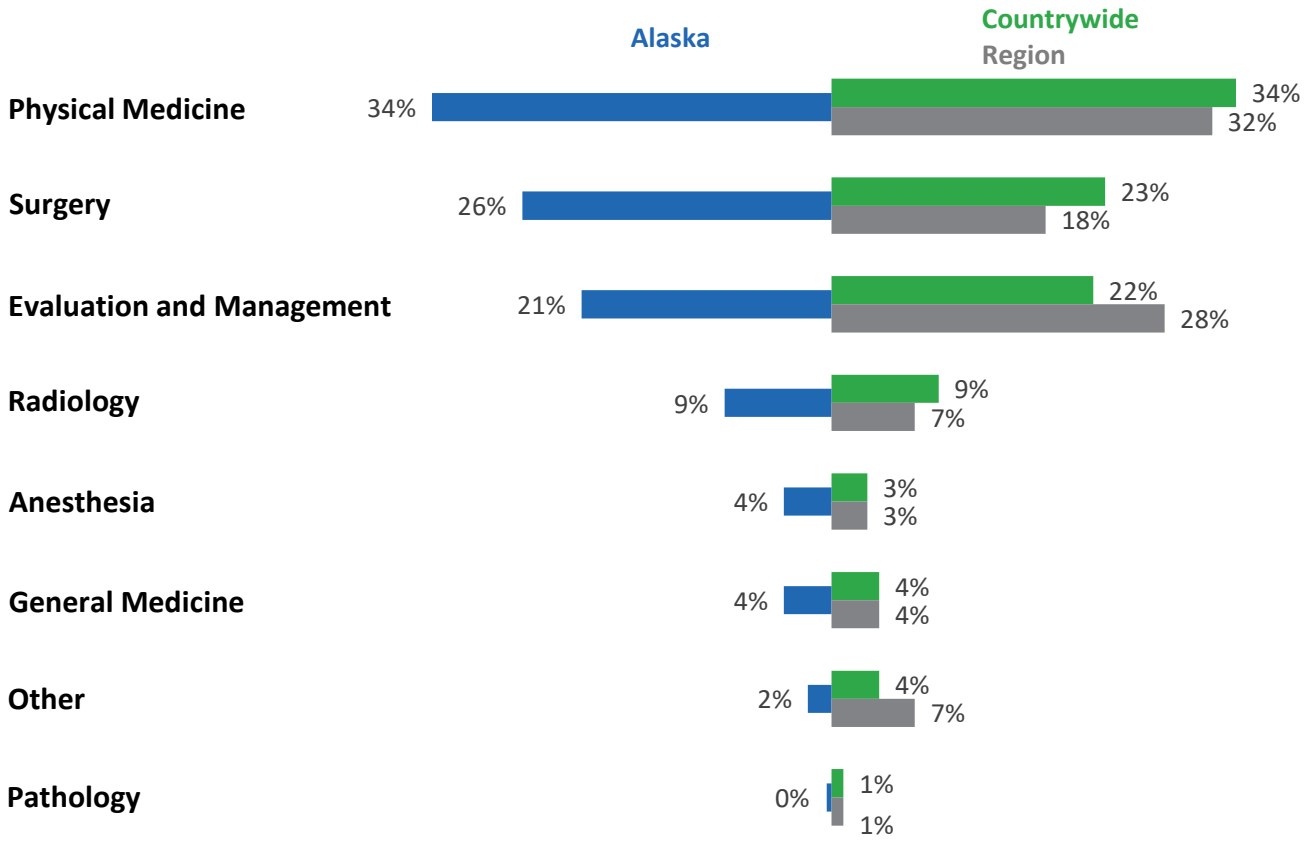
Physician Service Category	Alaska	Region	Countrywide
General and Physical Medicine	158%	136%	132%
Surgery	289%	205%	270%
Evaluation and Management	189%	154%	144%
Radiology	338%	209%	227%
Anesthesia	297%	250%	309%
All Physician Services	**205%**	**158%**	**167%**

[3] The calculation for Surgery takes into account Medicare's endoscopic procedures reimbursement rules.

Chart 6 displays the distribution of physician payments by service category for Alaska, the region, and countrywide.

Chart 6

Distribution of Physician Payments by AMA Service Category



In 2019, NCCI conducted a review of physician costs in workers compensation as compared to group health (GH). Results[4] show that WC physician costs are 77% higher than GH in general, with variation across states ranging from 0% to 200%. The difference in costs for physician services is due to both prices and utilization of services. Most notably, physical medicine services in WC are almost three times the costs of physical medicine services in GH, largely due to the number of services provided.

Physicians typically use current procedure terminology (CPT) codes to identify the services that they provide to claimants. These codes are specific and provide detailed information on what service was performed. The charts below display the top 10 procedure codes reported by physicians for the following service categories: anesthesia, surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code is displayed in the corresponding table below each chart.

Except for anesthesia codes and physical & general medicine codes, the charts also include the average amount paid per transaction (PPT) for these codes in Alaska, in the region, and countrywide. The average PPT is calculated by taking the total payments for the procedure code and dividing by the number of transactions for the procedure code. Other fields, such as the secondary paid procedure code, modifier, diagnosis code, place of service, and quantity/units, may need to be considered when evaluating average payments per service. The charts for the top 10 anesthesia codes and physical & general medicine codes include the average amount paid per unit (PPU) for the codes in Alaska, in the region, and countrywide. The PPU is calculated by taking the total payments for the procedure code and dividing by the number of units for the procedure code. For these codes, a unit is typically a measurement of time (15-minute increment, 30-minute increment, 1-hour increment, etc.) but can also be one transaction. The procedure code description will indicate the unit measurement.

The Top 10 charts rank the procedure codes for each service category using two different methods. The first method ranks procedure codes by total payments. Procedure codes are sorted from highest total payments to lowest total payments. The procedure code with the highest amount paid is ranked first, the procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows those procedures that represent the highest percentage share of payments.

The second method ranks procedure codes by total count of transactions. The procedure code with the highest total transaction count is ranked first, the procedure code with the second highest total transaction count is ranked second, and so on. This method reveals the most frequently used procedures.

Additional charts show time until first treatment and results for telemedicine services. Time to initial treatment (TTT) is a measure of the availability of medical services and is measured by the number of days between the date of injury and the date on which the worker first received medical services. Telemedicine services charts are based on transactions reported with a telemedicine-specific procedure code, modifier, or place of service and show the distribution, as well as the top 10 procedure codes, for telemedicine service.

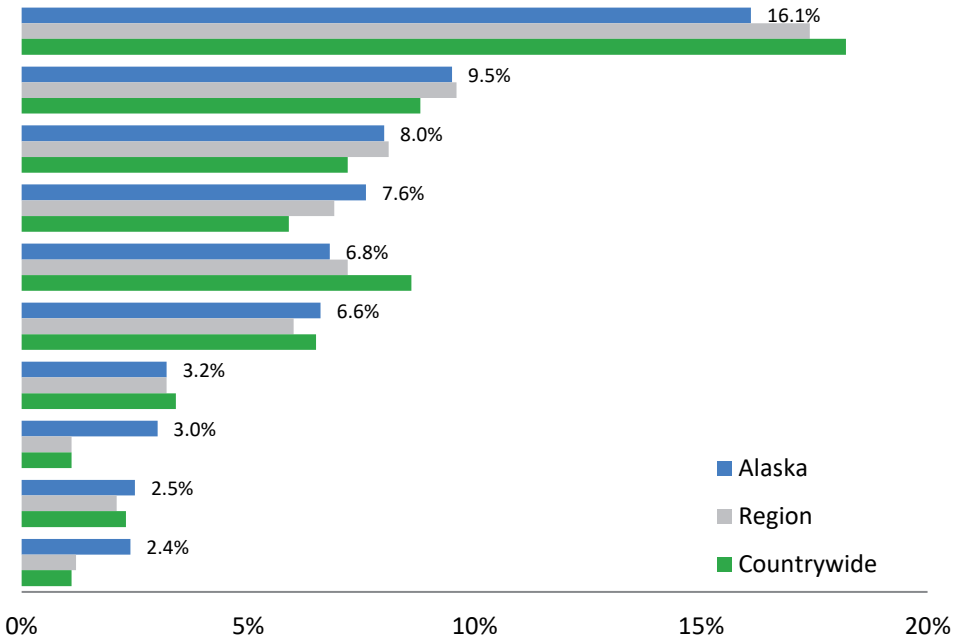
[4] Lipton, Barry, *Work Comp vs. Group Health—The Price We Pay* (Channel NCCI, video file), May 23, 2019, www.youtube/fb3tnbQoMSY

In Alaska, physician payments for anesthesia services provided in 2020 are, on average, 297% of Medicare-scheduled reimbursement amounts, compared to 250% in the region and 309% countrywide. Payments for these services comprise 4% of physician payments, compared to 3% in the region and 3% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid

	Average PPU[5]			
Code	**AK**	**Region**	**CW**	**Paid Share**
01630	$144	$88	$95	16.1%
01400	$166	$97	$101	9.5%
01830	$139	$79	$81	8.0%
01480	$108	$74	$76	7.6%
00670	$172	$106	$110	6.8%
01810	$149	$89	$94	6.6%
00630	$159	$106	$107	3.2%
01610	$162	$90	$102	3.0%
01710	$136	$80	$86	2.5%
00830	$153	$95	$100	2.4%



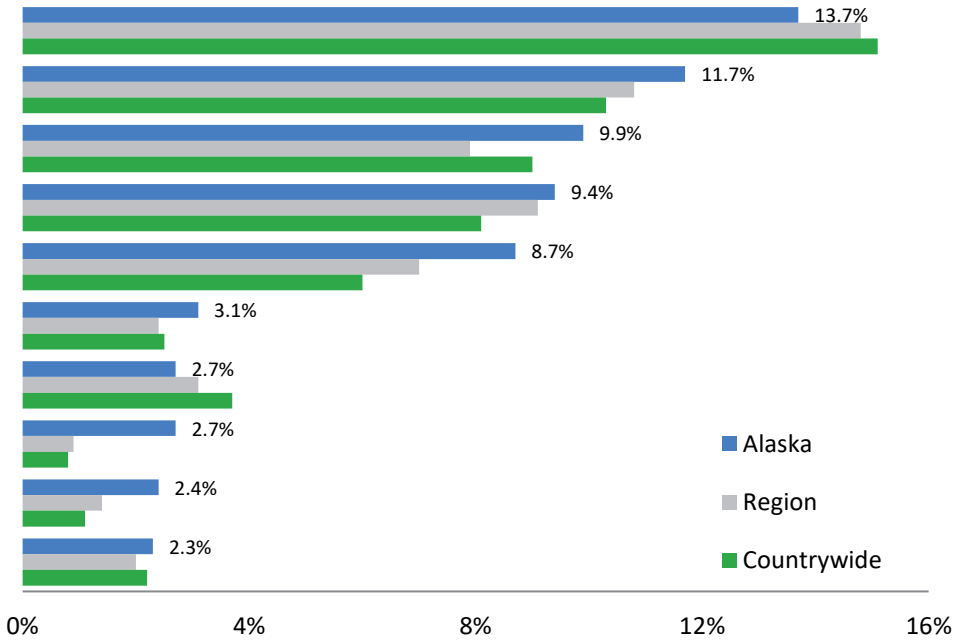
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00630	Anesthesia for procedures in lumbar region; not otherwise specified
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified

[5] A unit is an increment of 15 minutes unless otherwise defined in the description.

Chart 8

Top 10 Anesthesia Procedure Codes by Transaction Counts

Code	Average PPU AK	Region	CW
01630	$144	$88	$95
01400	$166	$97	$101
01810	$149	$89	$94
01830	$139	$79	$81
01480	$108	$74	$76
01710	$136	$80	$86
00400	$132	$80	$83
01610	$162	$90	$102
00830	$153	$95	$100
00630	$159	$106	$107



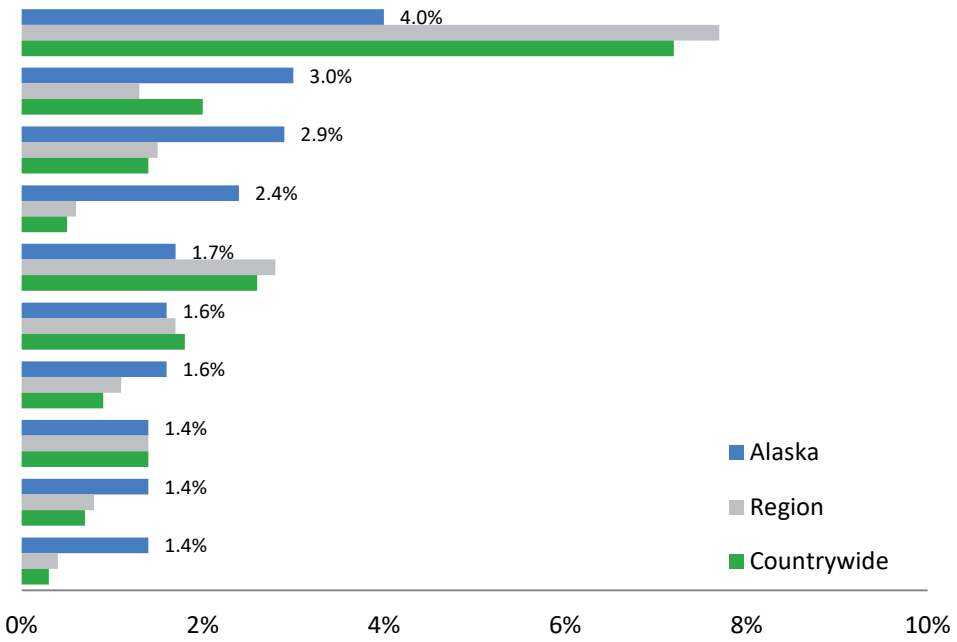
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified
00630	Anesthesia for procedures in lumbar region; not otherwise specified

In Alaska, physician payments for surgery services provided in 2020 are, on average, 289% of Medicare-scheduled reimbursement amounts, compared to 205% in the region and 270% countrywide. Payments for these services comprise 26% of physician payments, compared to 18% in the region and 23% countrywide.

Chart 9

Top 10 Surgery Procedure Codes by Amount Paid

Code	Average PPT AK	Region	CW
29827	$2,447	$1,839	$2,155
22551	$4,979	$3,350	$4,075
23430	$1,337	$937	$1,213
23412	$2,596	$1,297	$1,667
29881	$1,866	$1,158	$1,500
64483	$890	$415	$576
29806	$3,894	$2,203	$2,851
20610	$245	$123	$131
25609	$2,911	$1,961	$1,991
23410	$2,496	$1,635	$1,697

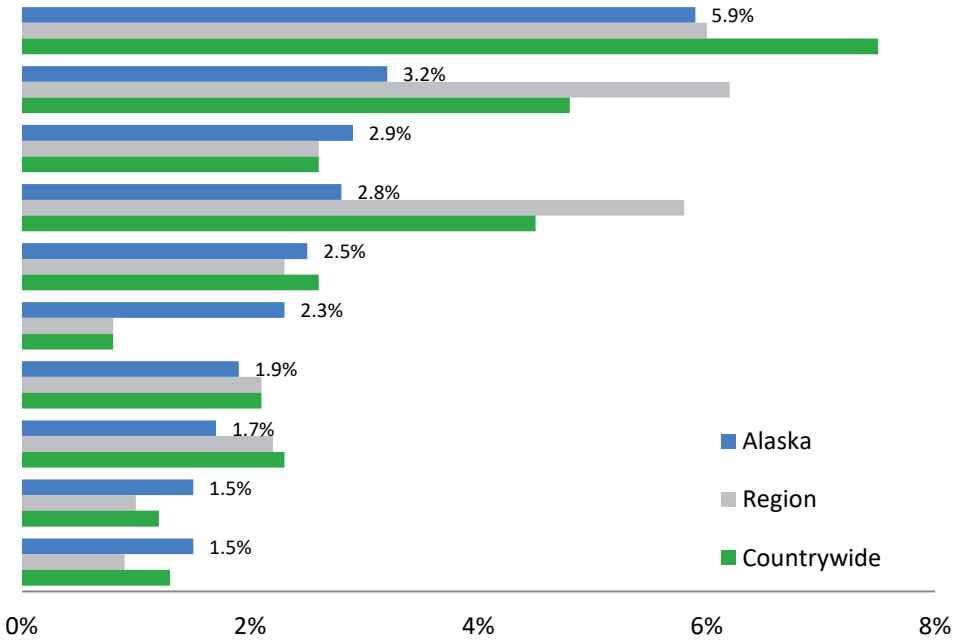


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below C2
23430	Tenodesis of long tendon of biceps
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute

Chart 10

Top 10 Surgery Procedure Codes by Transaction Counts

Code	Average PPT AK	Region	CW
20610	$245	$123	$131
36415	$11	$11	$11
64415	$355	$163	$286
12001	$336	$157	$182
29826	$492	$529	$987
23430	$1,337	$937	$1,213
64483	$890	$415	$576
29827	$2,447	$1,839	$2,155
29125	$245	$116	$119
29824	$961	$685	$822

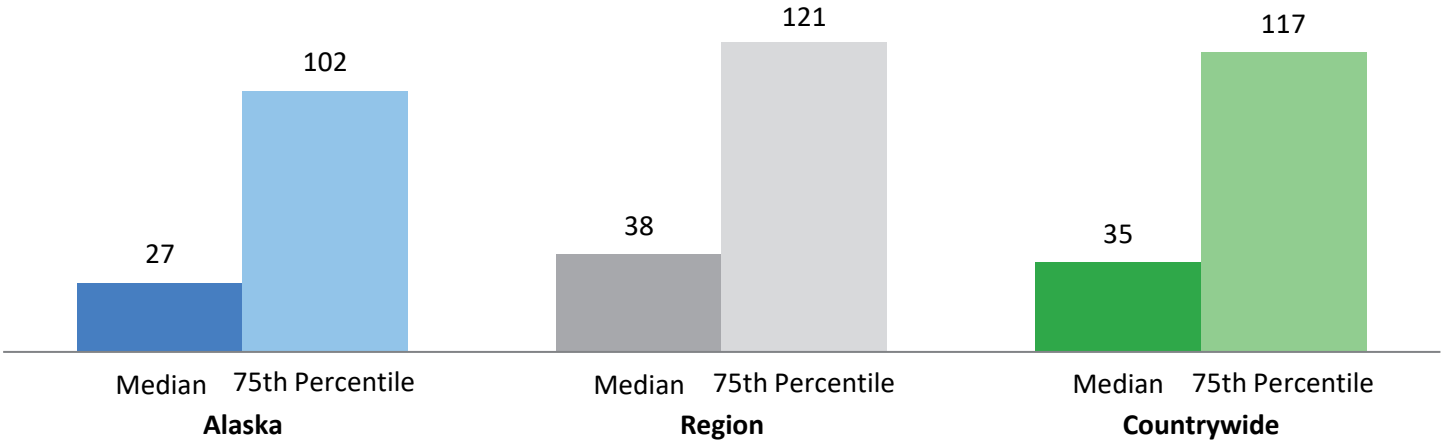


Code	Description
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
36415	Collection of venous blood by venipuncture
64415	Injection, anesthetic agent; brachial plexus, single
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
23430	Tenodesis of long tendon of biceps
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29125	Application of short arm splint (forearm to hand); static
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)

Chart 11 shows the median and 75th percentile[6] time until first treatment for major surgery for Alaska, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 11

Time Until First Treatment for Major Surgery[7] (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

[6] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 11 indicates that out of 100 claimants, 75 will receive a major surgery within 102 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

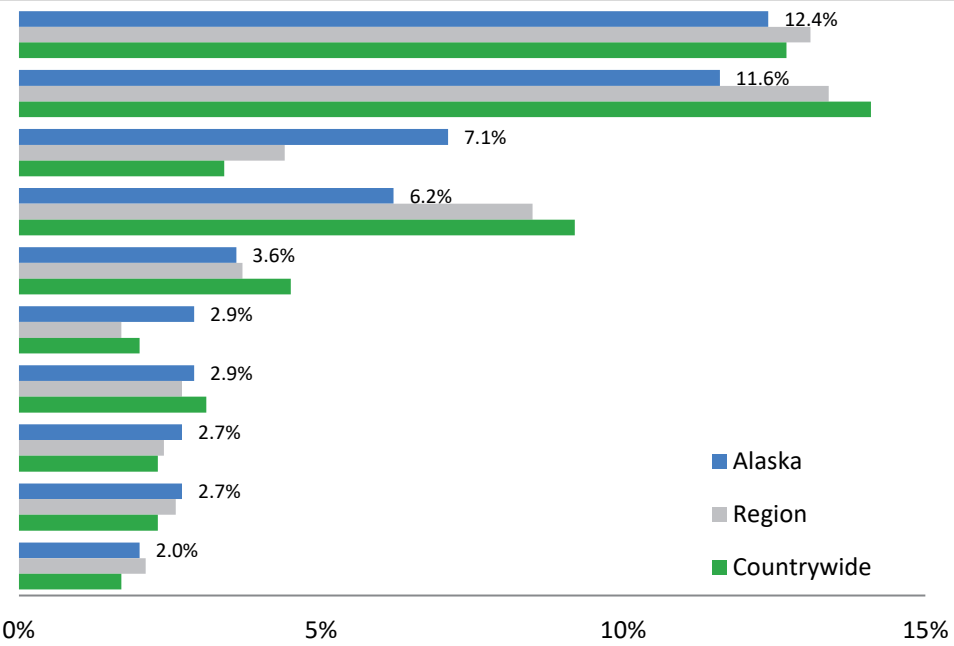
[7] A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow-up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection.

In Alaska, physician payments for radiology services provided in 2020 are, on average, 338% of Medicare-scheduled reimbursement amounts, compared to 209% in the region and 227% countrywide. Payments for these services comprise 9% of physician payments, compared to 7% in the region and 9% countrywide.

Chart 12

Top 10 Radiology Procedure Codes by Amount Paid

Code	Average PPT AK	Region	CW
73721	$797	$420	$484
73221	$805	$424	$492
73222	$1,243	$517	$633
72148	$636	$407	$470
72141	$652	$397	$464
76942	$178	$76	$112
73030	$118	$52	$59
73110	$128	$58	$62
73610	$114	$53	$56
73562	$126	$61	$64

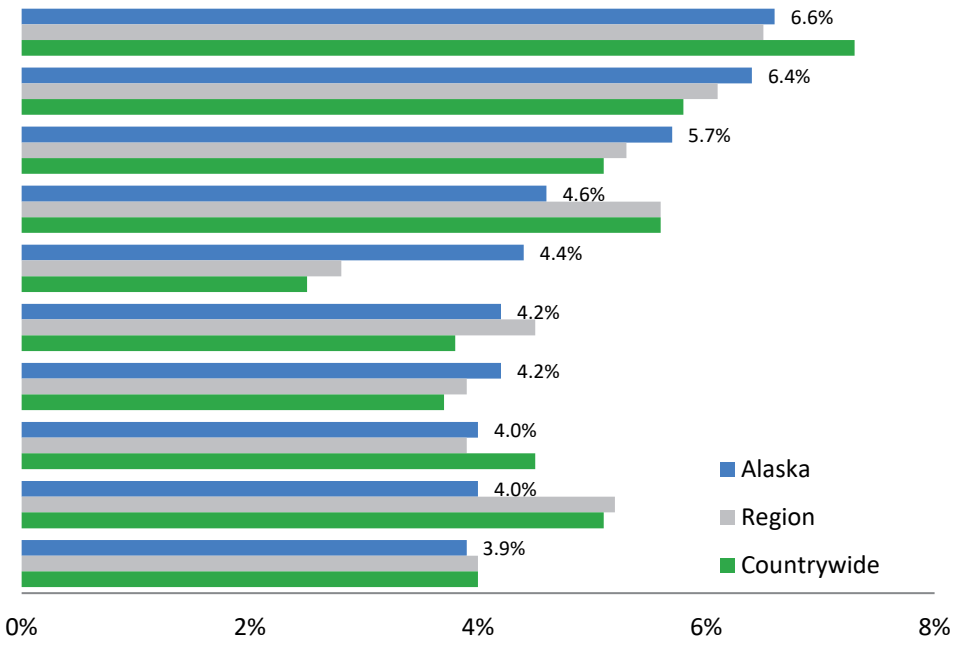


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
73030	Radiologic examination, shoulder; complete minimum of 2 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73562	Radiologic examination, knee; 3 views

Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts

Code	Average PPT AK	Region	CW
73030	$118	$52	$59
73610	$114	$53	$56
73110	$128	$58	$62
73630	$111	$51	$54
76942	$178	$76	$112
73562	$126	$61	$64
73721	$797	$420	$484
72100	$130	$66	$65
73140	$115	$51	$54
73221	$805	$424	$492

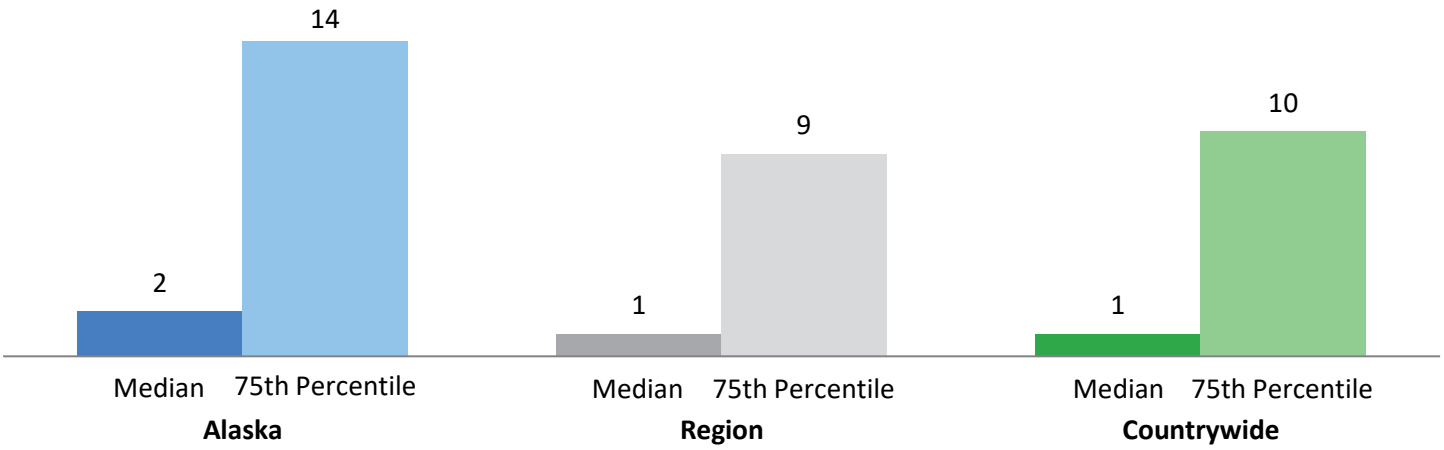


Code	Description
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73630	Radiologic examination, foot; complete minimum of 3 views
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
73562	Radiologic examination, knee; 3 views
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
73140	Radiologic examination, finger(s); minimum of 2 views
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material

Chart 14 shows the median and 75th percentile time until first treatment for radiology procedures for Alaska, the region, and countrywide.

Chart 14

Time Until First Treatment for Radiology (in Days)



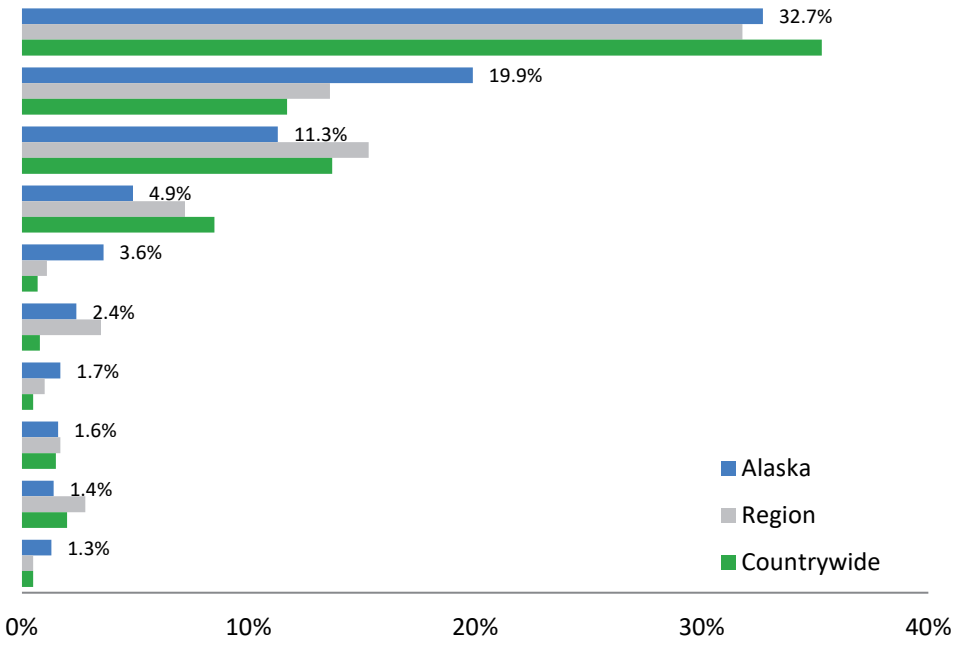
Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

In Alaska, physician payments for physical and general medicine services provided in 2020 are, on average, 158% of Medicare-scheduled reimbursement amounts, compared to 136% in the region and 132% countrywide. Payments for these services comprise 38% of physician payments, compared to 36% in the region and 38% countrywide.

Chart 15

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

	Average PPU			
Code	**AK**	**Region**	**CW**	**Paid Share**
97110	$66	$42	$42	32.7%
97140	$59	$39	$38	19.9%
97530	$75	$54	$46	11.3%
97112	$69	$46	$43	4.9%
98941	$85	$67	$56	3.6%
97124	$52	$35	$35	2.4%
98940	$67	$52	$44	1.7%
97161	$183	$117	$120	1.6%
99199	$550	$395	$228	1.4%
97113	$74	$48	$47	1.3%

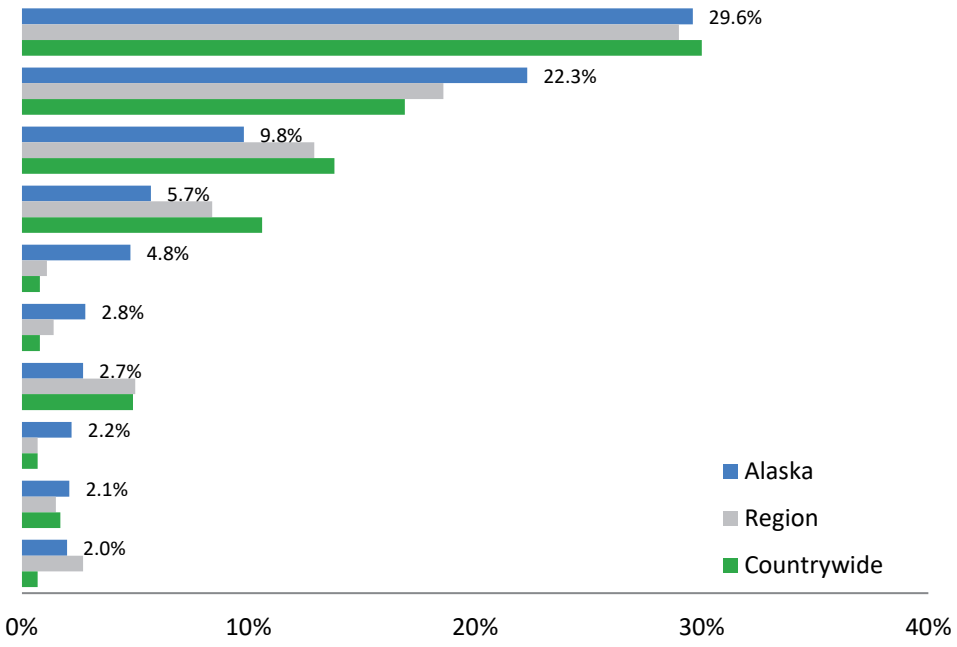


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
99199	Unlisted special service procedure or report
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPU AK	Region	CW
97110	$66	$42	$42
97140	$59	$39	$38
97530	$75	$54	$46
97112	$69	$46	$43
98941	$85	$67	$56
98940	$67	$52	$44
97014	$37	$20	$22
97012	$38	$21	$22
97035	$34	$19	$22
97124	$52	$35	$35

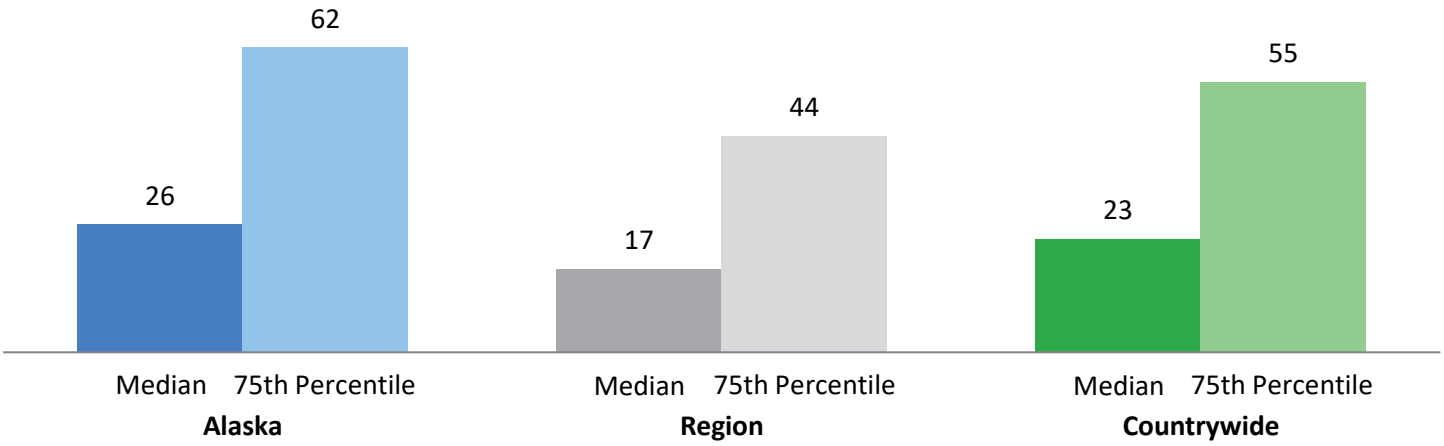


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97012	Application of a modality to 1 or more areas; traction, mechanical
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

Chart 17 shows the median and 75th percentile time until first treatment for physical and general medicine procedures for Alaska, the region, and countrywide.

Chart 17

Time Until First Treatment for Physical and General Medicine (in Days)



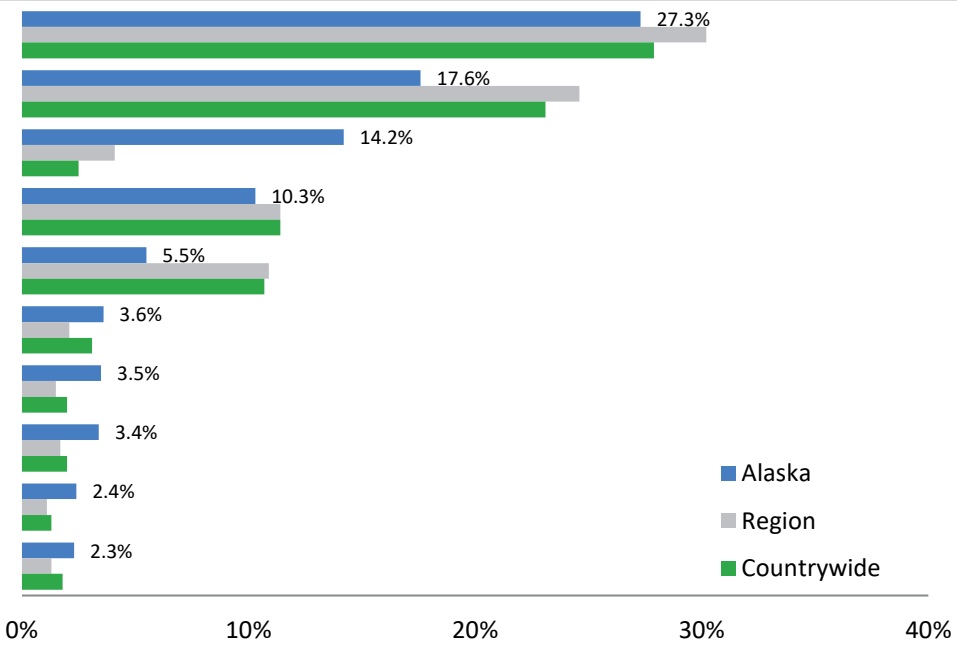
Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

In Alaska, physician payments for evaluation and management services provided in 2020 are, on average, 189% of Medicare-scheduled reimbursement amounts, compared to 154% in the region and 144% countrywide. Payments for these services comprise 21% of physician payments, compared to 28% in the region and 22% countrywide.

Chart 18

Top 10 Evaluation and Management Procedure Codes by Amount Paid

Code	Average PPT AK	Region	CW
99213	$179	$115	$104
99214	$250	$162	$148
99456	$1,671	$1,510	$1,083
99203	$261	$167	$152
99204	$383	$247	$227
99284	$398	$231	$279
99283	$238	$139	$179
99212	$111	$69	$67
99202	$182	$118	$109
99285	$516	$380	$412

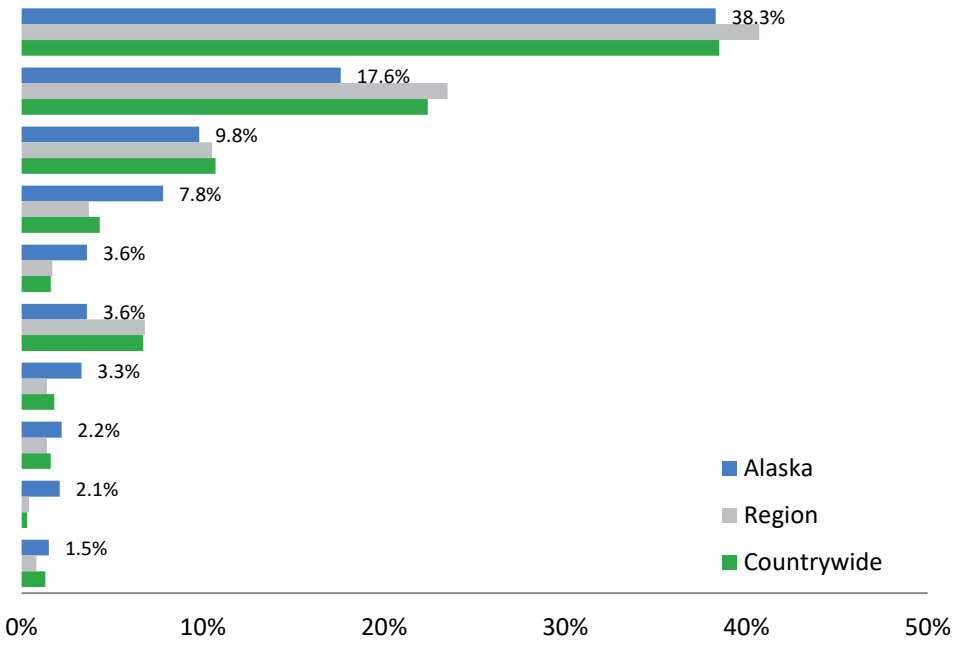


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99456	Work related or medical disability examination by other than the treating physician.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts

Code	Average PPT AK	Region	CW
99213	$179	$115	$104
99214	$250	$162	$148
99203	$261	$167	$152
99212	$111	$69	$67
99283	$238	$139	$179
99204	$383	$247	$227
99202	$182	$118	$109
99284	$398	$231	$279
99456	$1,671	$1,510	$1,083
99232	$179	$119	$104

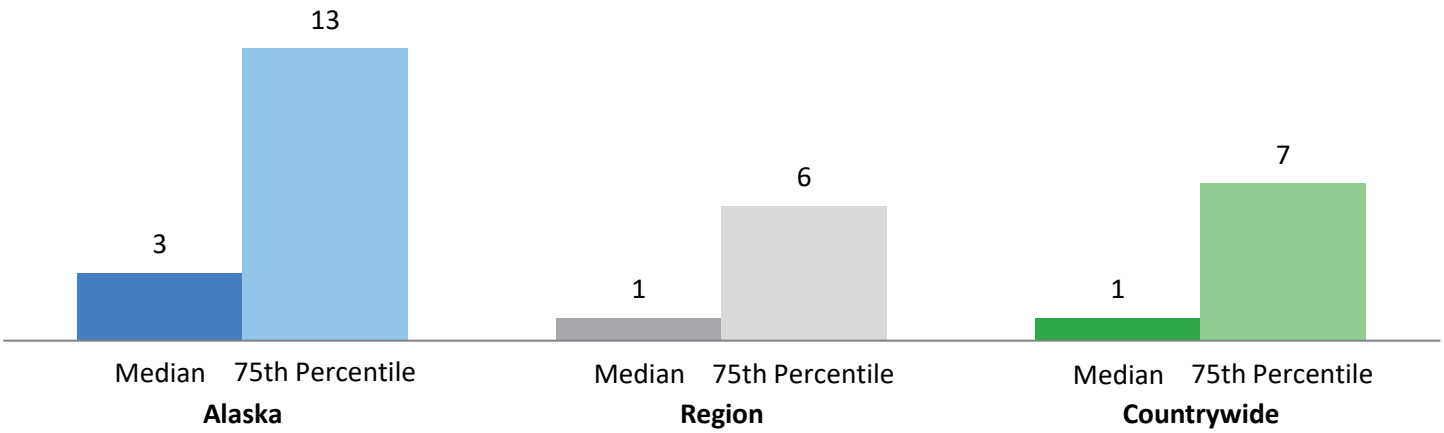


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99456	Work related or medical disability examination by other than the treating physician.
99232	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Chart 20 shows the median and 75th percentile time until first treatment for evaluation and management procedures for Alaska, the region, and countrywide.

Chart 20

Time Until First Treatment for Evaluation and Management (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

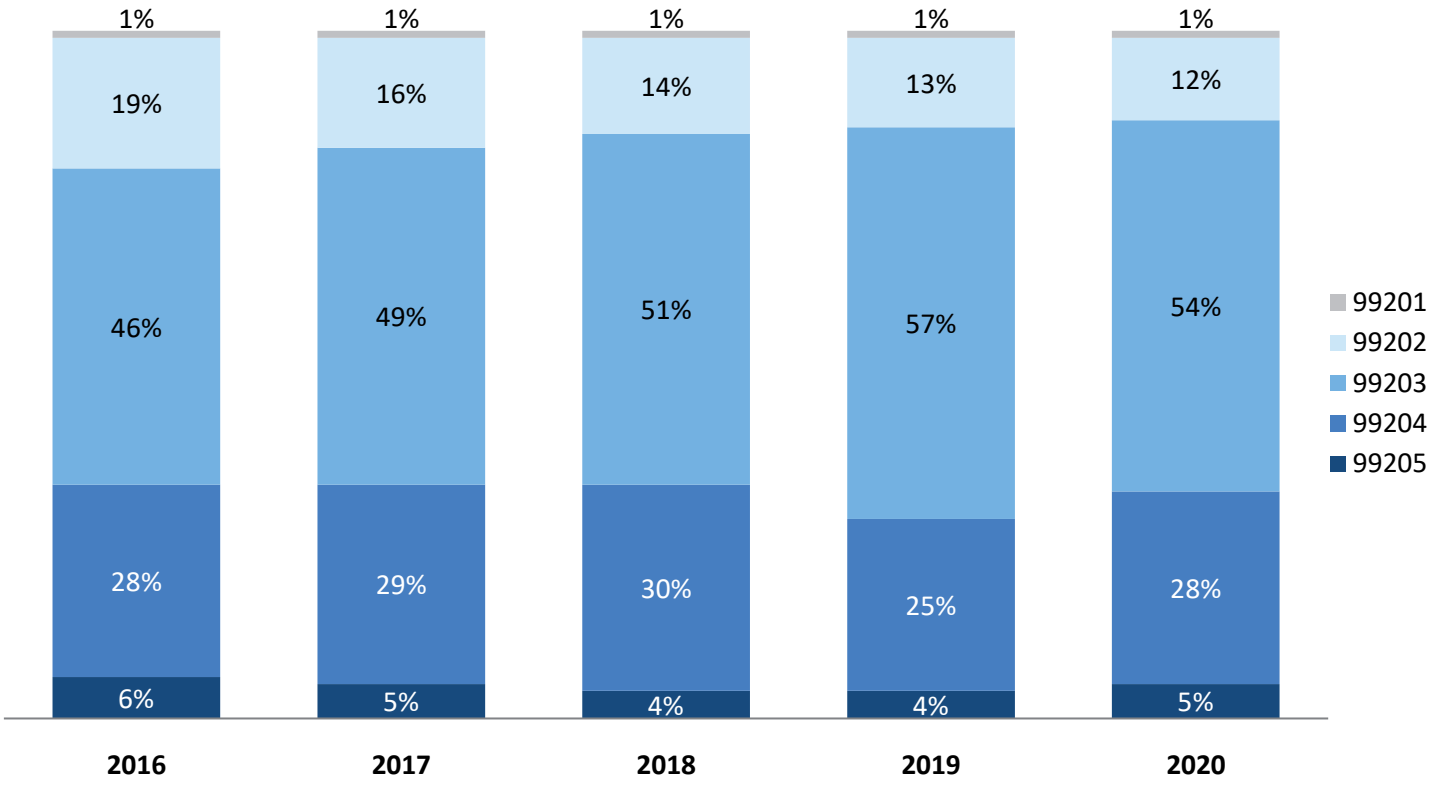
Evaluation and Management services consist largely of office or outpatient visits for a new patient or an established patient.

There are five periods of time spent with a *new* patient, ranging from 10 minutes for Procedure Code 99201 to 60 minutes for Procedure Code 99205. Chart 21 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for new patients.

Chart 21

Office or Other Outpatient Visit for the Evaluation and Management of a New Patient

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2016 to 2020.

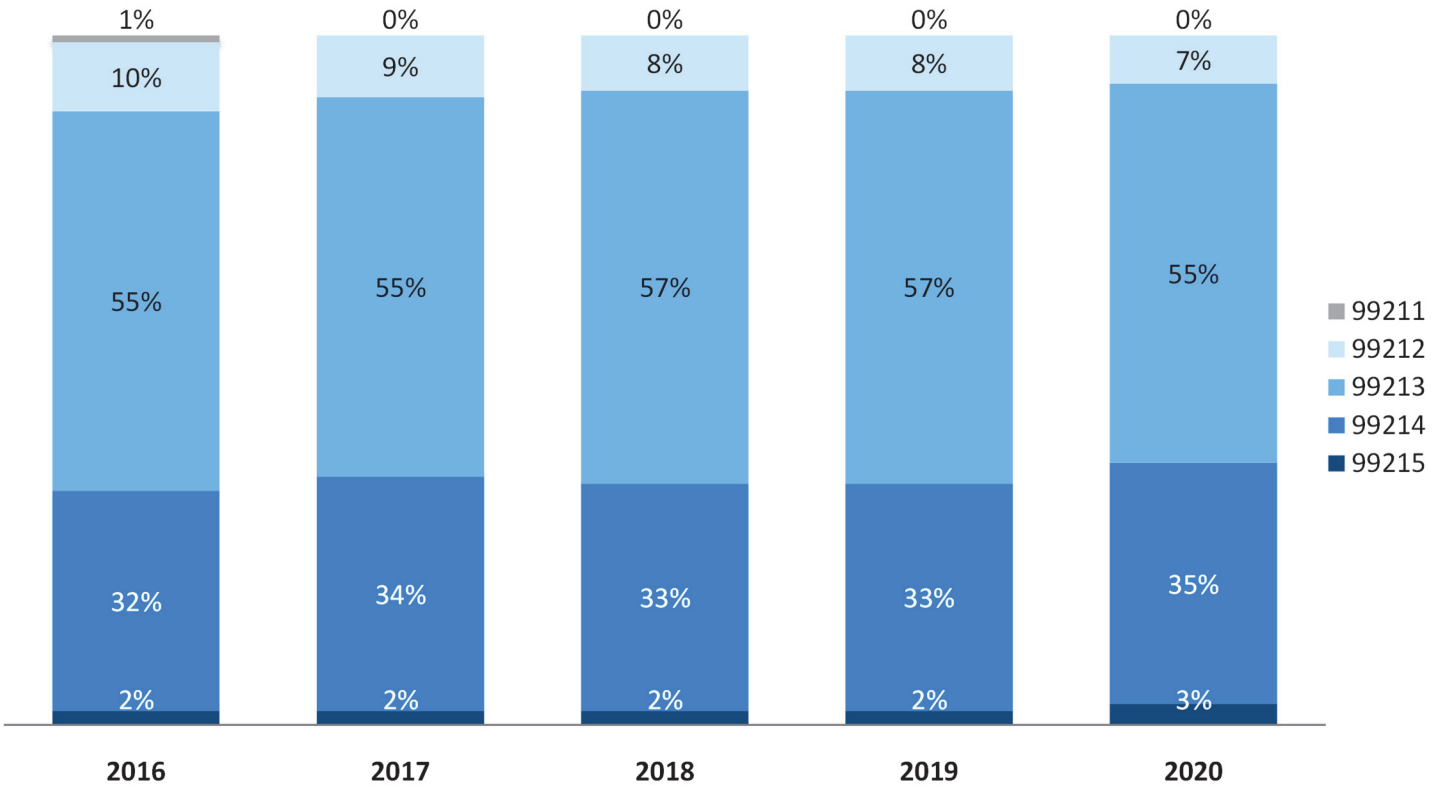
		Average PPT				
Code	**Severity/Time**	**2016**	**2017**	**2018**	**2019**	**2020**
99201	Low to Moderate; 10 minutes with patient	$110	$111	$113	$108	$114
99202	Low to Moderate; 20 minutes with patient	$183	$181	$176	$179	$182
99203	Moderate; 30 minutes with patient	$248	$256	$253	$261	$261
99204	Moderate to High; 45 minutes with patient	$364	$377	$376	$382	$383
99205	Moderate to High; 60 minutes with patient	$421	$424	$406	$455	$491

Similarly, for established patients, there are five periods of time spent with the patient, ranging from 5 minutes for Procedure Code 99211 to 40 minutes for Procedure Code 99215. Chart 22 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for an established patient.

Chart 22

Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2016 to 2020.

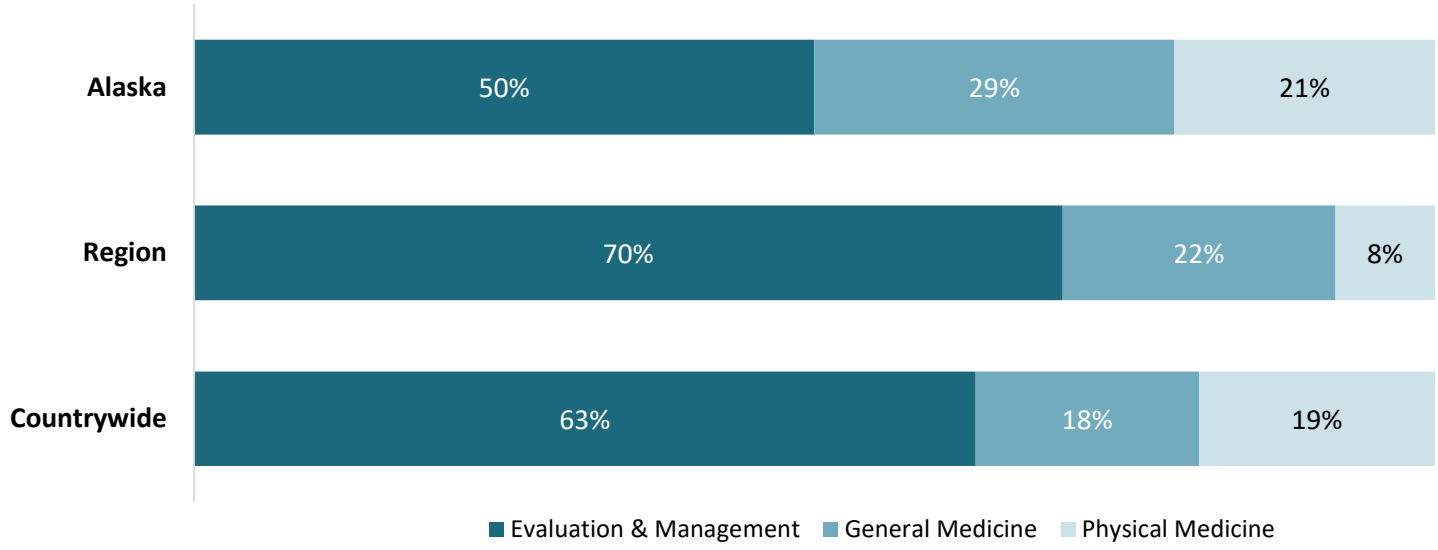
		Average PPT				
Code	**Severity/Time**	**2016**	**2017**	**2018**	**2019**	**2020**
99211	Low to Moderate; 5 minutes with patient	$54	$52	$51	$61	$57
99212	Low to Moderate; 10 minutes with patient	$106	$108	$107	$109	$111
99213	Moderate; 15 minutes with patient	$165	$171	$173	$176	$179
99214	Moderate to High; 25 minutes with patient	$230	$235	$238	$244	$250
99215	Moderate to High; 40 minutes with patient	$282	$270	$278	$291	$312

In Service Year 2020, telemedicine services were utilized more than in prior years[8] and were generally observed in the evaluation and management, physical medicine, and general medicine physician service categories. Telemedicine services represent about 2% of the physician costs in these categories countrywide. The share of payments varies across jurisdictions, ranging from about 1% to about 5%.

In Alaska, the share of claimants receiving physician services (evaluation and management, physical medicine, and general medicine) who had telemedicine encounters increased from 0.4% in 2019 to 11.6% in 2020. Chart 23 shows the distribution of telemedicine payments for these physician service categories in Alaska, the region, and countrywide.

Chart 23

Distribution of Telemedicine Payments by Physician Service Category



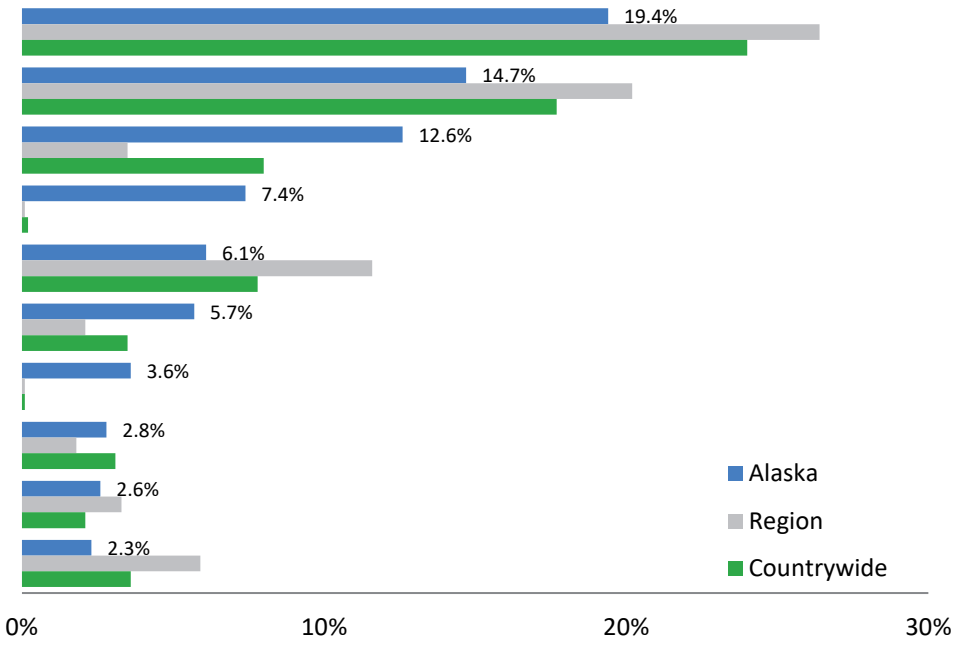
[8] www.ncci.com/Articles/Documents/Insights-COVID-19-Impact-Medical-Treatment-Workers-Comp-3QTR-2020-Perspective.pdf

Chart 24 shows the top 10 procedure codes reported as a telemedicine service by paid amount for Alaska with comparative values for the region and countrywide.

Chart 24

Top 10 Procedure Codes by Amount Paid for Telemedicine Services

Code	Average PPU[9] AK	Region	CW
99213	$168	$113	$102
99214	$233	$154	$142
97110	$68	$44	$42
96158	$187	$135	$135
90837	$208	$218	$179
97530	$80	$55	$46
96159	$65	$72	$62
90834	$151	$140	$129
99443	$204	$114	$97
99442	$103	$76	$63



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
90837	Psychotherapy, 60 minutes with patient
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
90834	Psychotherapy, 45 minutes with patient
99443	Telephone evaluation and management service by a physician or other qualified health care professional; 21-30 minutes of medical discussion.
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.

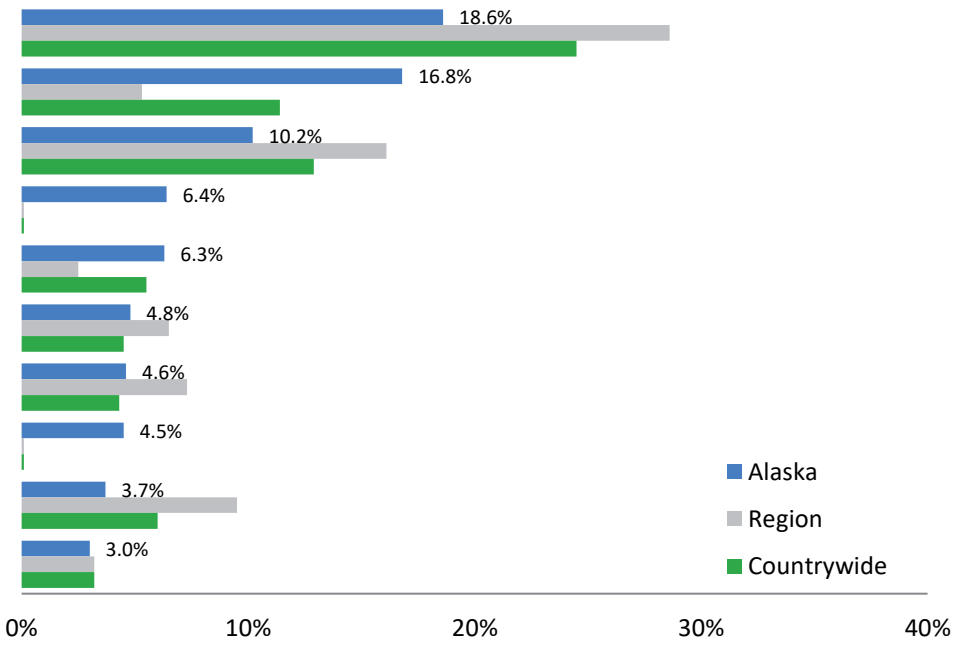
[9] Based on the number of units for the procedure code (typically in increments of time) but can also be one transaction.

Chart 25 shows the top 10 procedure codes reported as a telemedicine service by transaction count for Alaska with comparative values for the region and countrywide.

Chart 25

Top 10 Procedure Codes by Transaction Counts for Telemedicine Services

Code	Average PPU AK	Region	CW
99213	$168	$113	$102
97110	$68	$44	$42
99214	$233	$154	$142
96158	$187	$135	$135
97530	$80	$55	$46
90837	$208	$218	$179
99441	$52	$45	$38
96159	$65	$72	$62
99442	$103	$76	$63
99212	$103	$66	$66



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
90837	Psychotherapy, 60 minutes with patient
99441	Telephone evaluation and management service by a physician or other qualified health care professional; 5-10 minutes of medical discussion.
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Hospital Inpatient

Payments attributed to facilities represent hospital inpatient services, hospital outpatient services, and ambulatory surgical center services. General healthcare trends may be the primary driver of the cost distribution; however, the fee schedule may also play a role. In many states, the fee schedule varies by type of facility, which may help explain differences observed between states.

Hospital inpatient fee schedules in workers compensation vary across jurisdictions. Some states have fee schedules based on a group of facility services related to the hospital admission, such as a diagnosis-related group (DRG); others are on a per-diem basis, with some variation on the per-diem amount by type of admission. Other states have provisions for the reimbursement to be a certain percentage of hospital charges. Several states remain without any regulation today.

A hospital inpatient stay is typically reported with one of two types of codes: DRG code or revenue code. Data reporters are instructed to report the code that is consistent with how the reimbursement was determined.

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Alaska, 78% of hospital inpatient payments are reported with a DRG code.

Due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide, comparisons by procedure code for inpatient costs should be interpreted with caution. Some measures for hospital inpatient services include the average cost of an inpatient stay, the average length of stay, or the average cost per day.

Unless otherwise stated, the inpatient results are based on inpatient stays with a discharge date in 2020.

A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital inpatient payments for Alaska, the region, and countrywide, based on hospital episodes that are reported with a DRG code.

Chart 26

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Alaska	Region	Countrywide
Hospital Inpatient	149%	173%	194%

Source: NCCI's Medical Data Call for inpatient stays discharged in Calendar Year 2020. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

The distribution of medical payments for hospital inpatient is 11% for Alaska, 12% for the region, and 13% for countrywide. One comparative measure of inpatient service costs is the average payment per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 27 displays the average amount paid per stay for hospital inpatient services, while Chart 28 displays the average amount paid per day for hospital inpatient services for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 27

Average Amount Paid per Stay for Hospital Inpatient Services

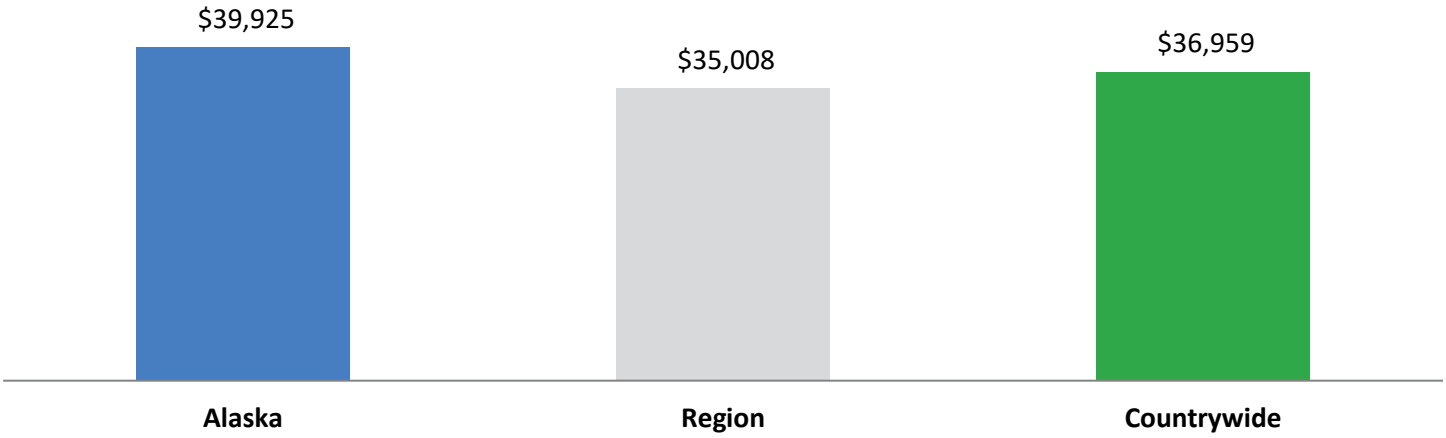


Chart 28

Average Amount Paid per Day for Hospital Inpatient Services

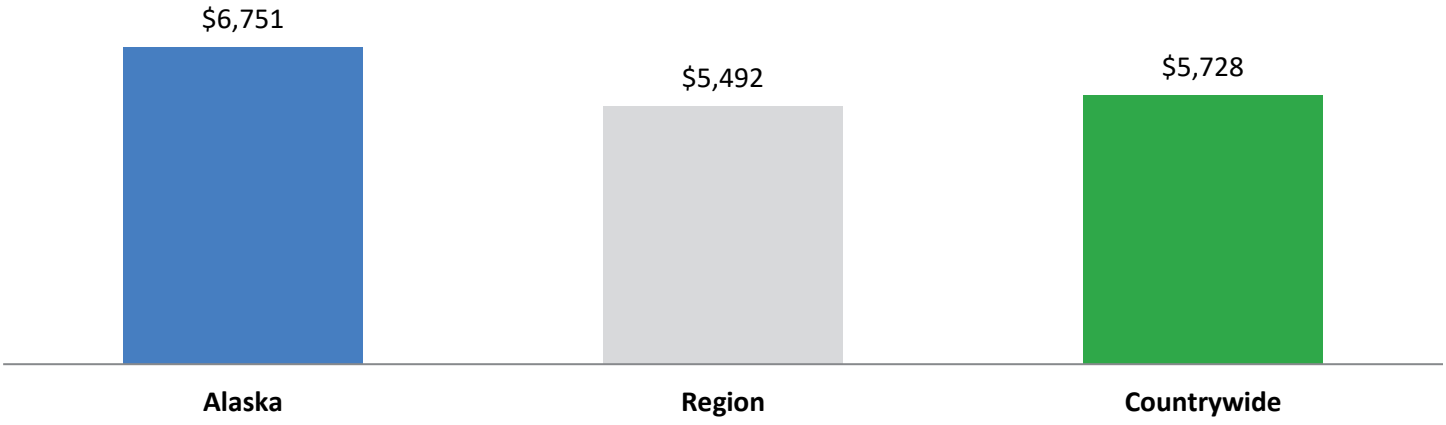


Chart 29 displays the average number of hospital inpatient stays per 1,000 active claims in 2020 for Alaska, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 30 displays the average and median length of stay for hospital inpatient services for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 29

Average Number of Inpatient Stays per 1,000 Active Claims

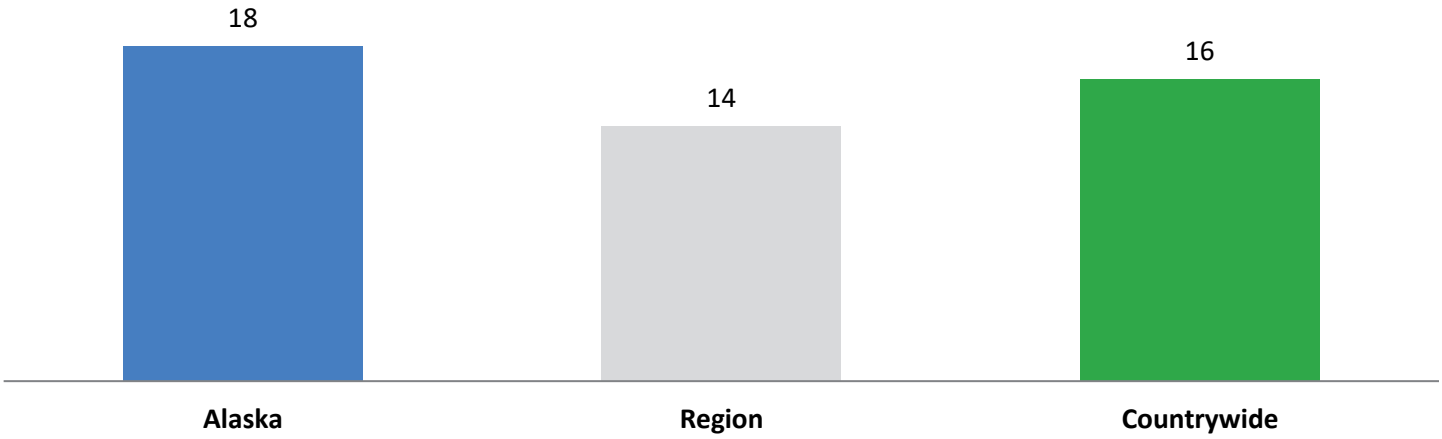


Chart 30

Length of Stay for Hospital Inpatient Services (in Days)

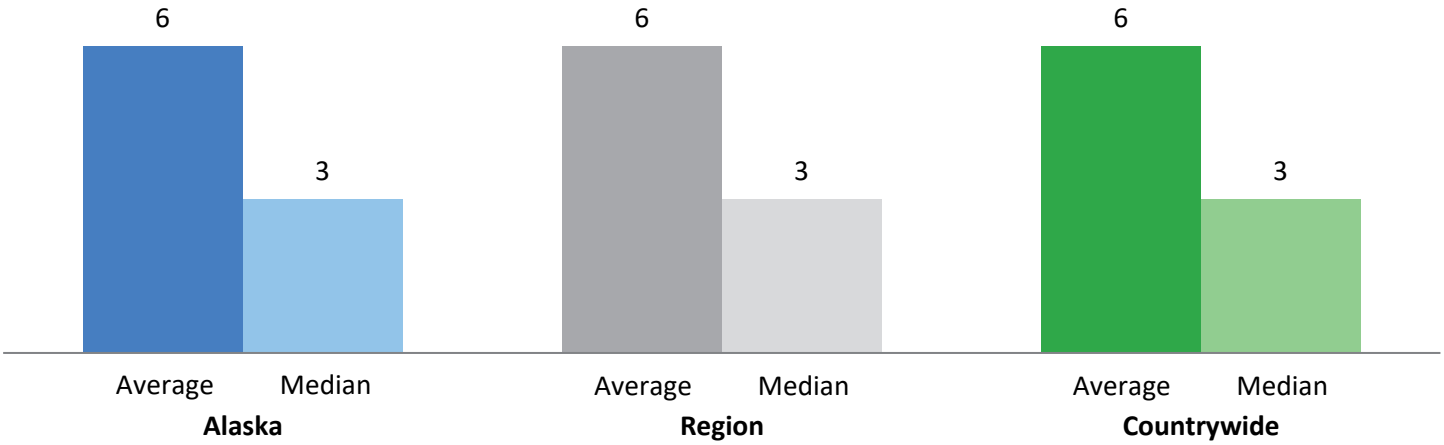
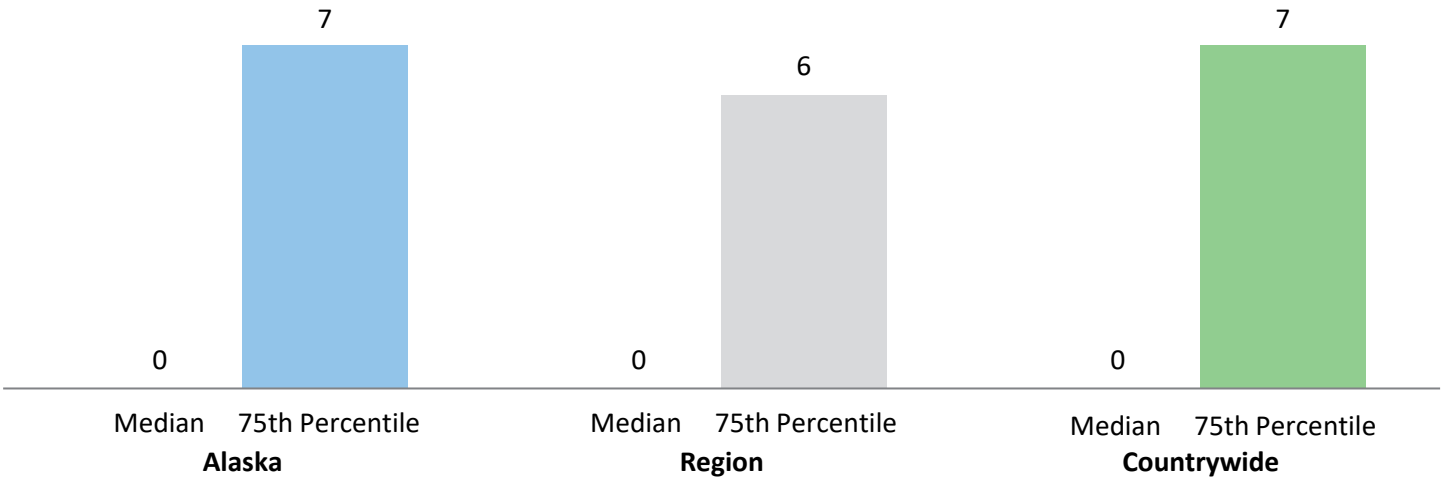


Chart 31 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Alaska, the region, and countrywide.

Chart 31

Time Until First Treatment for Hospital Inpatient Stays (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Charts 32 and 33 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient stays. A diagnosis group is identified for each stay based on an ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments for hospital inpatient services in Alaska. A brief description of each DRG code is displayed in the table below chart 33. The information is based on inpatient stays with a discharge date in 2019 or 2020.

Chart 32

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

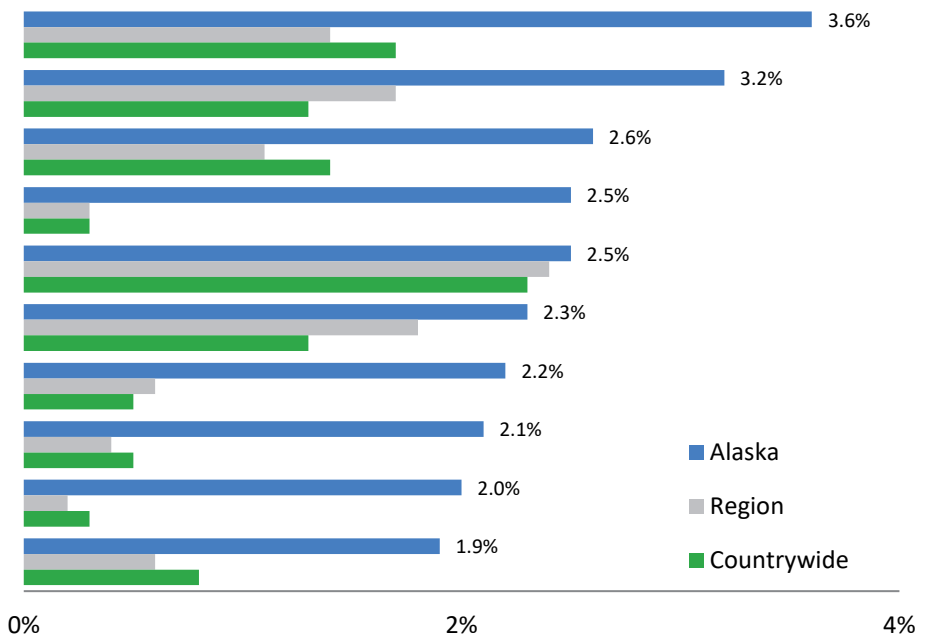
		Median Amount Paid per Stay		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Lumbar spine degeneration	9.2%	$66,452	$39,460	$37,580
Tibia/fibula fracture	8.7%	$47,980	$21,460	$23,339
Sepsis	7.1%	$36,745	$20,786	$21,322
Complication from surgical device	5.6%	$41,057	$25,174	$24,149
Chest trauma major	5.3%	$30,666	$23,056	$21,188
Hip/pelvis fracture/major trauma	5.1%	$37,929	$20,660	$21,518
Traumatic brain injury	3.7%	$30,356	$24,212	$24,706
Femur fracture	2.5%	$37,472	$22,310	$25,767
Burn and corrosion, third degree, other than head, face, and neck	2.3%	$65,860	$51,152	$44,946
Cervical spine degeneration	2.1%	$40,695	$24,481	$25,888

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in Calendar Year 2019 or 2020.

Chart 33

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay AK	Region	CW
494	$45,541	$19,995	$20,349
483	$52,451	$24,982	$24,904
493	$46,488	$27,254	$28,557
853	$111,791	$57,702	$66,849
455	$79,599	$50,288	$48,060
454	$66,452	$59,871	$58,357
472	$57,499	$30,057	$30,057
492	$116,371	$37,943	$40,162
463	$216,965	$56,488	$81,769
906	$51,227	$20,438	$21,180



Code	Description
494	Lower extremity and humerus procedures except hip, foot, and femur without complications or comorbidities/major complications or comorbidities
483	Major joint/limb reattachment procedure of upper extremities
493	Lower extremity and humerus procedures except hip, foot, and femur with complications or comorbidities
853	Infectious and parasitic diseases with operating room procedure with major complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
472	Cervical spinal fusion with complications or comorbidities
492	Lower extremity and humerus procedures except hip, foot, and femur with major complications or comorbidities
463	Wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders with major complications or comorbidities
906	Hand procedures for injuries

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in 2019 or 2020. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.
Note: In Alaska, 78% of hospital inpatient payments are reported with a DRG code.

Hospital Outpatient

Hospital outpatient services are reported with several types of procedure codes. Data reporters are instructed to report the code that is consistent with the way the reimbursement was determined.

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by current procedure terminology (CPT) or other healthcare common procedure coding system (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by a specific ambulatory payment classification (APC) code. An APC code represents a group of services provided by the facility on an outpatient basis.

If the hospital outpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type. Revenue codes are very generic and do not provide much information about the specific services that were performed.

Due to these differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide, comparisons by procedure code for outpatient benefits should be interpreted with caution. One comparative measure of outpatient service costs is the average cost per outpatient visit. A visit is defined as any service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claim may have more than one visit.

Hospital outpatient visits can vary in nature. A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow-up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection. In this section, we provide measures of hospital outpatient payments that account for the type of visit because the level of reimbursement varies considerably by type of visit. A hospital outpatient visit could be the result of an emergency visit. Outpatient visits arising from emergency room services are shown separately. Next, nonemergency outpatient visits are shown for visits with major surgery services and for visits without major surgery services.

The distribution of medical payments for hospital outpatient is 14% for Alaska, 18% for the region, and 19% for countrywide.

One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital outpatient payments for Alaska, the region, and countrywide. In Alaska, 81% of hospital outpatient payments are included in the chart below.

Chart 34

Hospital Outpatient Payments as a Percentage of Medicare

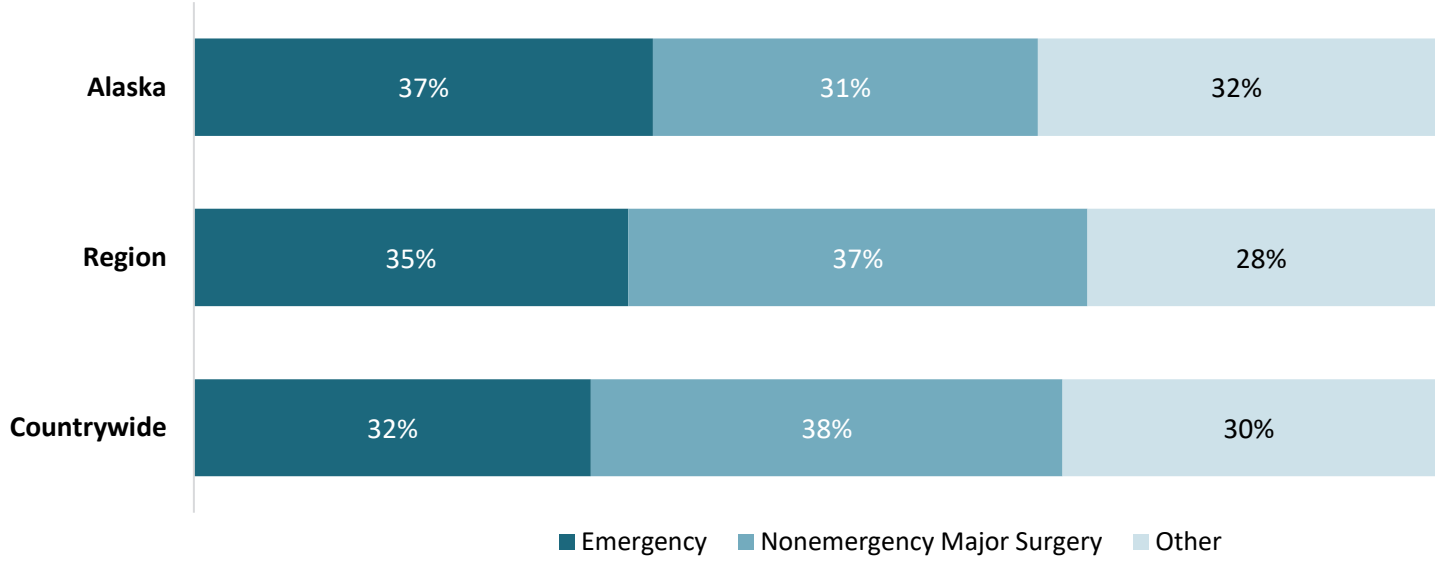
Medical Cost Category	Alaska	Region	Countrywide
Hospital Outpatient	225%	198%	242%

Source: NCCI's Medical Data Call for Service Year 2020. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 35 displays the distribution of hospital outpatient payments by visit type for Alaska, the region, and countrywide.

Chart 35

Distribution of Payments for Outpatient Services by Hospital Outpatient Visit Type



Emergency hospital outpatient visits represent 37% of hospital outpatient payments in Alaska. Chart 36 displays the average amount paid per emergency visit for outpatient services, while Chart 37 displays the average number of emergency hospital outpatient visits per 1,000 active claims for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 36

Average Amount Paid for Hospital Outpatient Services per Emergency Visit

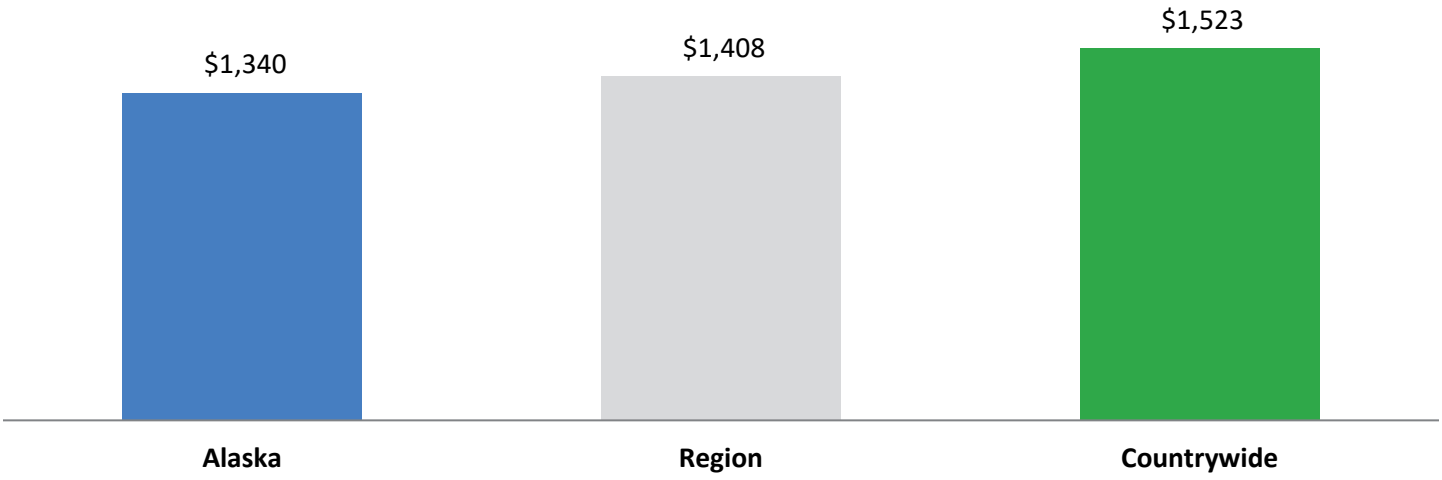


Chart 37

Average Number of Emergency Hospital Outpatient Visits per 1,000 Active Claims

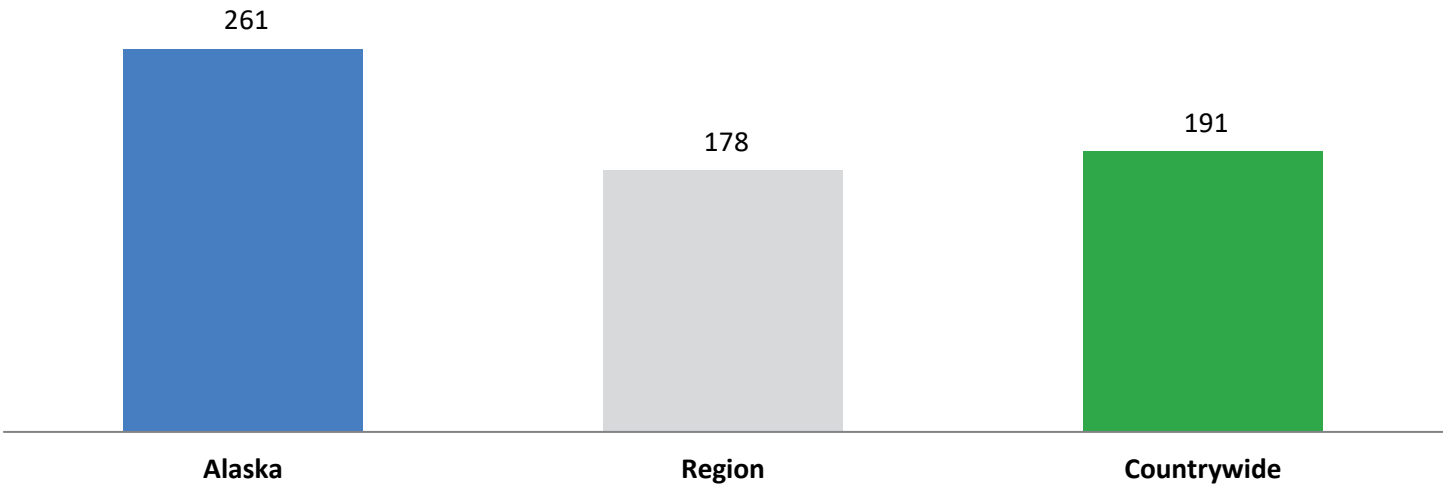


Chart 38 displays the top 10 diagnosis groups for emergency outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Alaska.

Chart 38

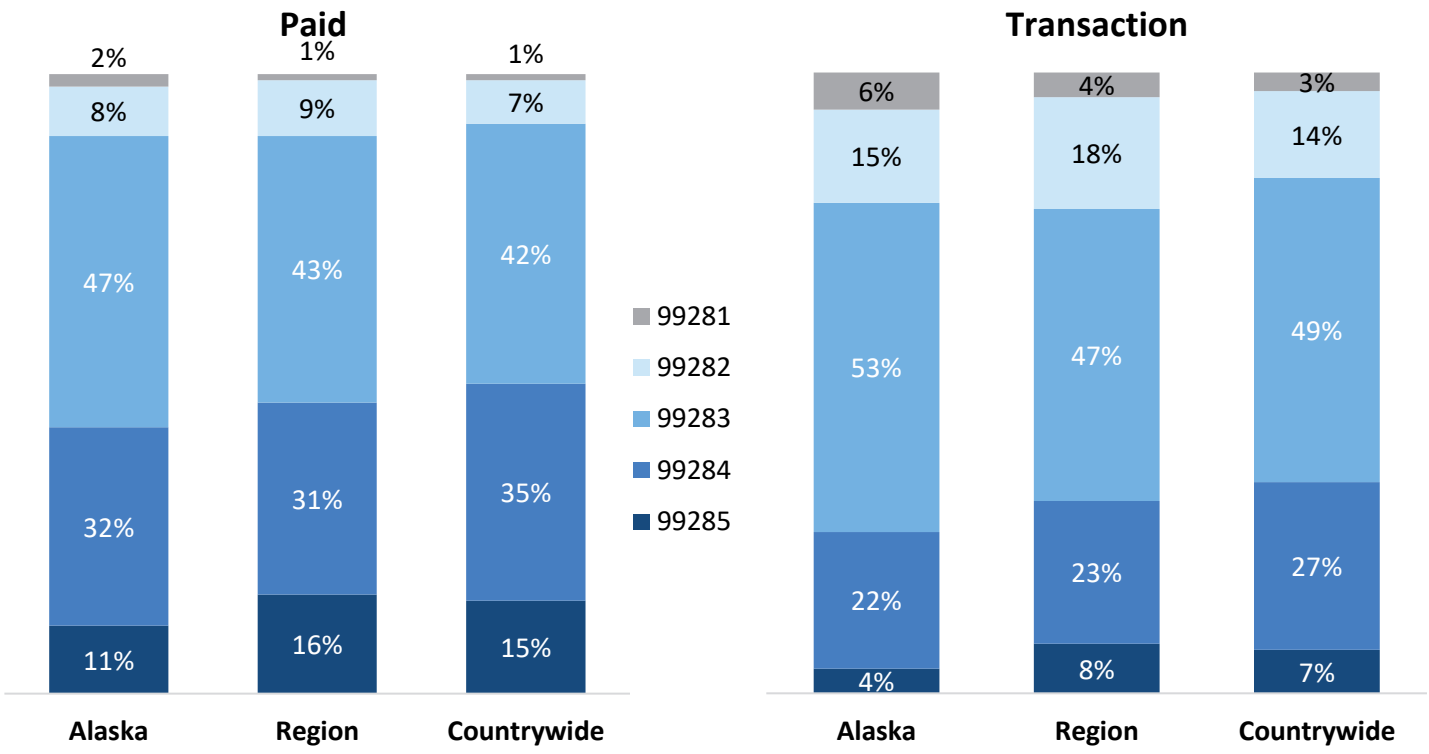
Top 10 Diagnosis Groups by Amount Paid for Emergency Hospital Outpatient Visits

		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Minor hand/wrist injuries	13.6%	$653	$645	$710
Low back pain	4.7%	$902	$723	$794
Concussion/minor traumatic brain injury	3.7%	$1,273	$1,018	$1,206
Minor ankle/foot injuries	3.7%	$793	$642	$706
Hand/wrist fracture	3.2%	$1,193	$1,106	$1,139
Minor knee injury	2.4%	$804	$657	$756
Neck pain	2.3%	$826	$1,096	$1,218
Tibia/fibula fracture	2.3%	$987	$1,054	$1,179
Upper back pain	2.2%	$858	$816	$895
Dislocation, hand/wrist	2.2%	$2,019	$1,179	$1,223

For emergency room visits, there are five levels of severity, ranging from limited or minor problems reported with Procedure Code 99281 to life-threatening situations reported with Procedure Code 99285. About 84% of all emergency visits had outpatient services. Chart 39 shows the distribution of emergency room outpatient services by procedure code for both paid amount and transactions for Service Year 2020 as well as the average payment per transaction.

Chart 39

Distribution of Emergency Room Outpatient Services by Procedure Code



Emergency Room Outpatient Paid per Transaction by Procedure Code

		Average PPT		
Code	**Severity**	**Alaska**	**Region**	**Countrywide**
99281	Minor	$240	$170	$190
99282	Low to Moderate	$361	$284	$288
99283	Moderate	$602	$495	$491
99284	High	$974	$760	$739
99285	High and immediately life-threatening	$1,785	$1,239	$1,153

Nonemergency outpatient visits with major surgery services represent 31% of hospital outpatient payments in Alaska. Chart 40 displays the average amount paid per major surgery visit for outpatient services, while Chart 41 displays the average number of major surgery hospital outpatient visits per 1,000 active claims for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 40

Average Amount Paid for Hospital Outpatient Services per Nonemergency Major Surgery Visit

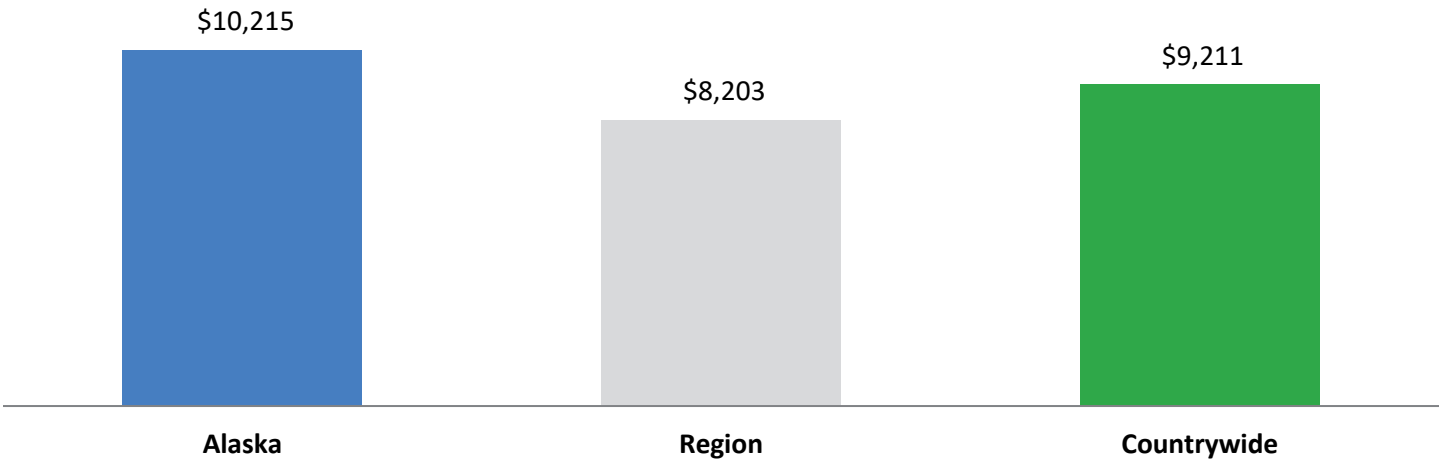


Chart 41

Average Number of Nonemergency Major Surgery Hospital Outpatient Visits per 1,000 Active Claims

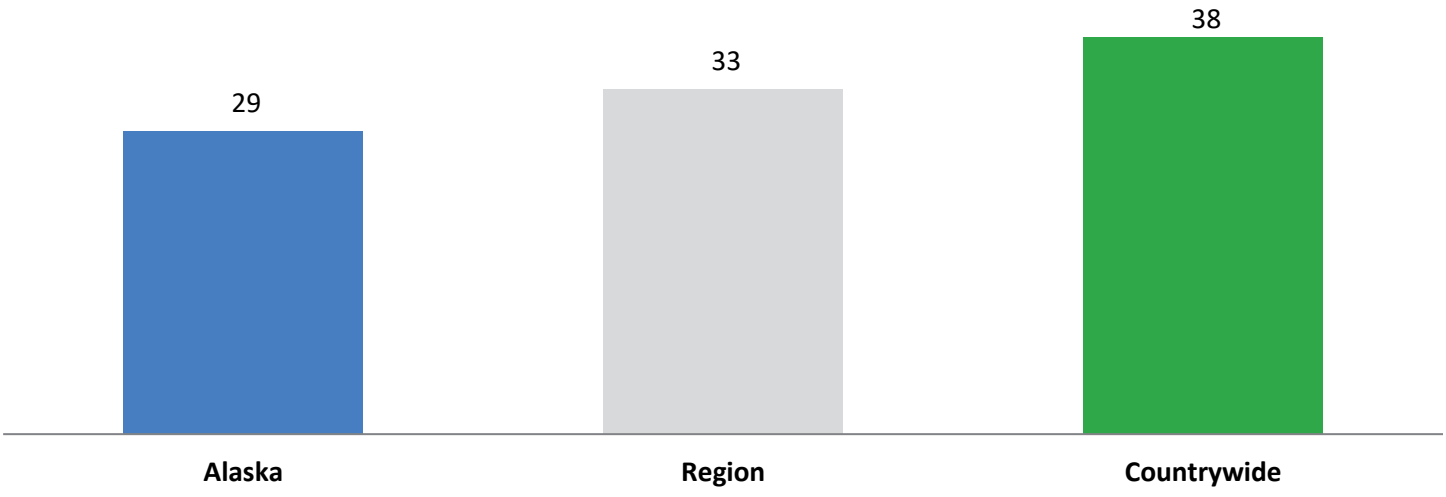
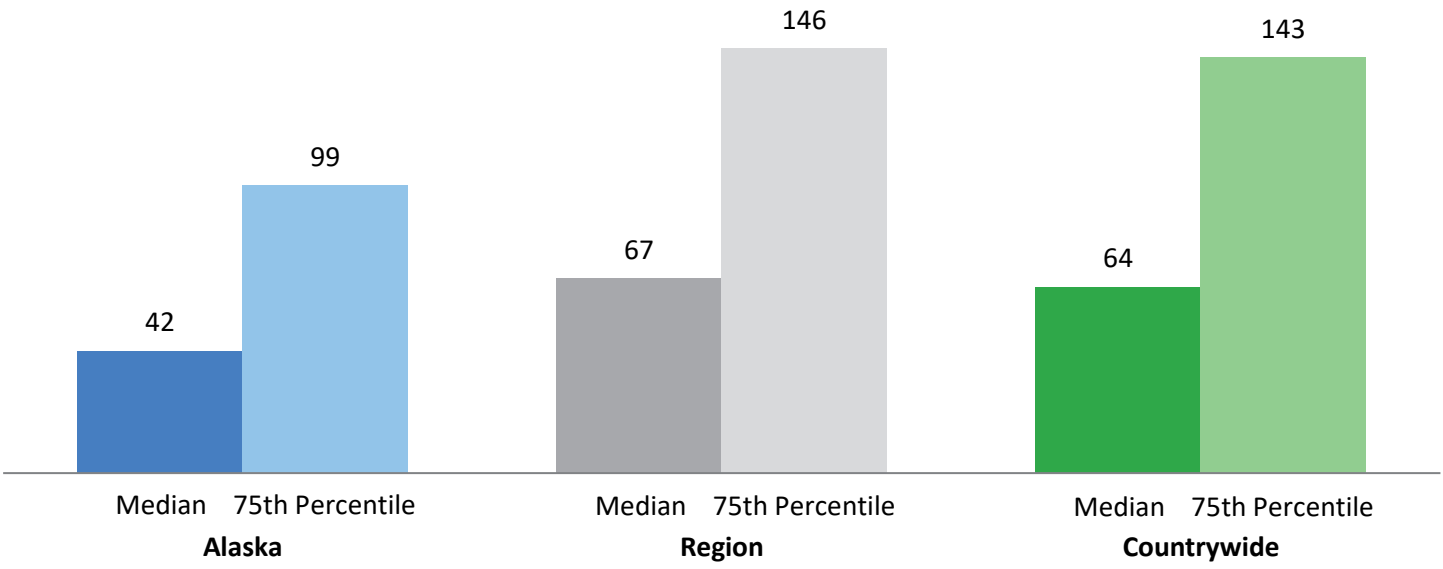


Chart 42 shows the median and 75th percentile time until first treatment for nonemergency major surgery outpatient visits for Alaska, the region, and countrywide.

Chart 42

Time Until First Treatment for Nonemergency Major Surgery Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Chart 43 displays the top 10 diagnosis groups for nonemergency major surgery outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Alaska.

Chart 43

Top 10 Diagnosis Groups by Amount Paid for Nonemergency Major Surgery Hospital Outpatient Visits

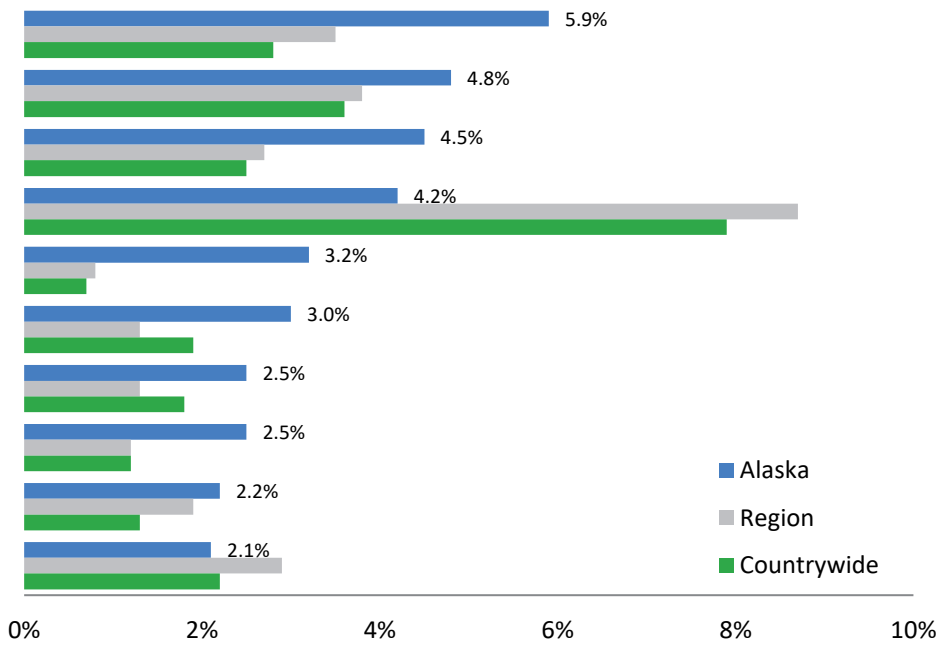
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Alaska	Region	Countrywide
Rotator cuff tear	10.0%	$11,625	$9,699	$9,808
Inguinal hernia	10.0%	$11,877	$7,197	$7,809
Knee internal derangement - meniscus injury	9.1%	$7,557	$4,675	$5,219
Minor shoulder injury	5.2%	$10,259	$7,972	$8,814
Ventrical incisional hernia	5.1%	$12,848	$5,477	$6,748
Hand/wrist fracture	5.0%	$7,515	$5,611	$5,946
Lumbosacral intervertebral disc disorders	4.7%	$16,421	$9,664	$10,417
Superior labral tear from anterior to posterior (SLAP) lesion	4.0%	$8,036	$9,107	$8,660
Ankle fracture	3.8%	$13,929	$9,083	$9,015
Heel/midfoot fracture	3.4%	$12,764	$8,920	$8,591

Charts 44 displays the average amount paid per nonemergency major surgery visit for outpatient services in Alaska, the region, and countrywide for the top 10 CPT codes in Alaska. The codes are ranked based on total outpatient payments in Alaska, where the code shown below is the code with the highest total paid on a nonemergency major surgery visit. In 2020, 95% of Hospital Outpatient costs were reported with a CPT code being the highest paid code. A brief description of each code is displayed in the table below.

Chart 44

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Nonemergency Major Surgery Visits

Code	Average Paid per Visit AK	Region	CW
49650	$12,614	$8,615	$10,322
29881	$8,555	$5,478	$6,726
63030	$15,813	$10,992	$12,455
29827	$12,603	$10,513	$12,107
27792	$16,967	$9,346	$10,865
22551	$32,029	$16,480	$18,513
29823	$8,784	$7,771	$10,215
29880	$7,604	$5,746	$7,091
27447	$23,529	$16,078	$17,121
20680	$5,483	$5,766	$6,816



Code	Description
49650	Laparoscopy, surgical; repair initial inguinal hernia
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below C2
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)

Nonemergency outpatient visits without a major surgery service, referred to as "Other" outpatient visits, represent 32% of hospital outpatient payments in Alaska. Chart 45 displays the average amount paid per other visit for hospital outpatient services, while Chart 46 displays the average number of other visits per 1,000 active claims for hospital outpatient services for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 45

Average Amount Paid for Hospital Outpatient Services per Other Outpatient Visit

Chart 46

Average Number of Other Hospital Outpatient Visits per 1,000 Active Claims

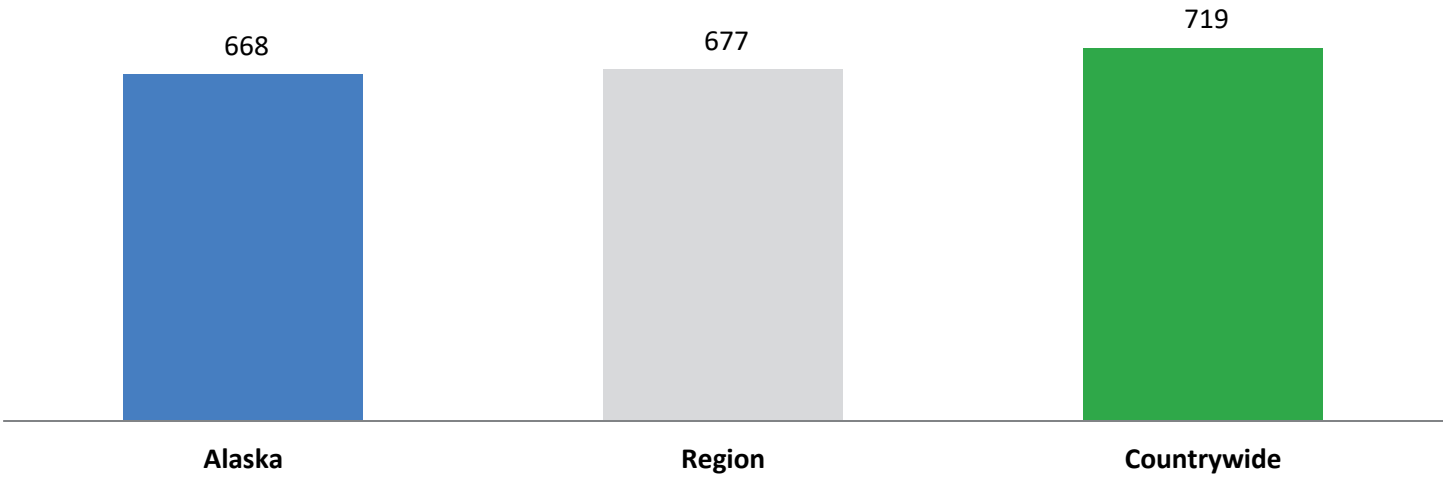
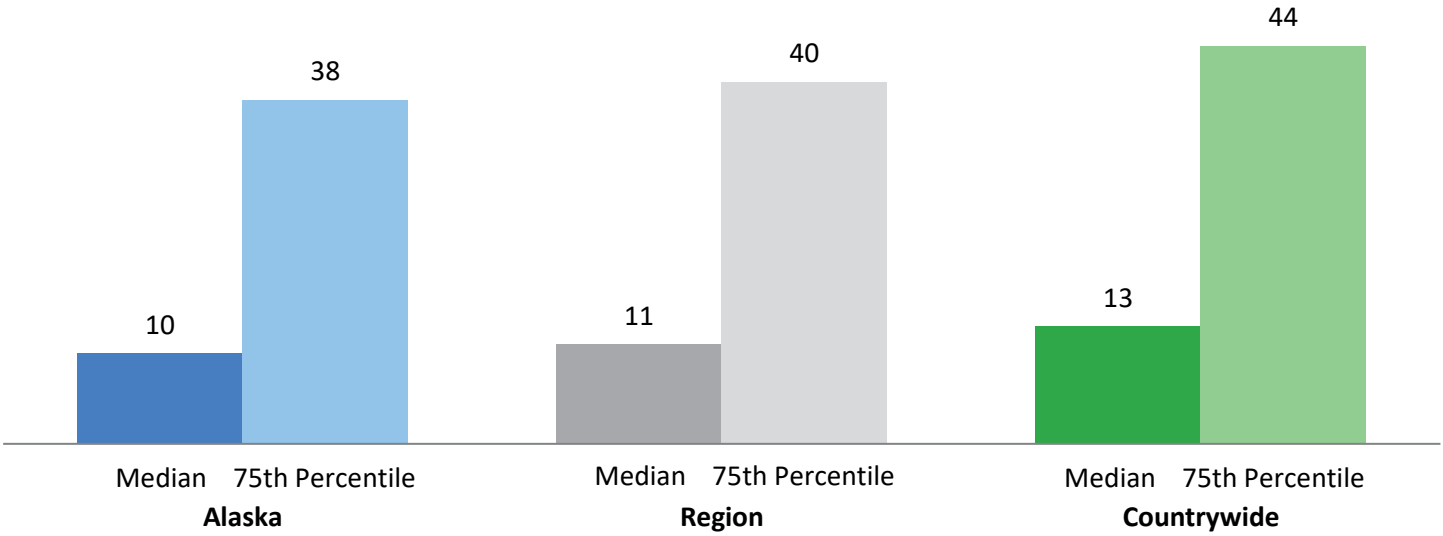


Chart 47 shows the median and 75th percentile time until first treatment for other outpatient visits for Alaska, the region, and countrywide.

Chart 47

Time Until First Treatment for Other Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Chart 48 displays the top 10 diagnosis groups for other outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Alaska.

Chart 48

Top 10 Diagnosis Groups by Amount Paid for Other Hospital Outpatient Visits

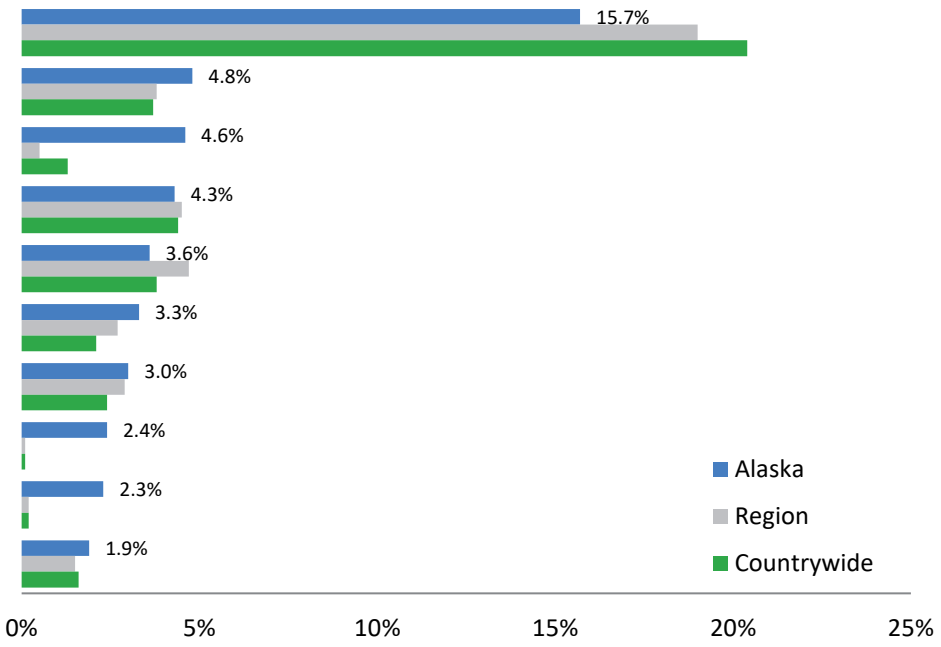
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Minor shoulder injury	7.6%	$233	$151	$175
Minor hand/wrist injuries	4.2%	$266	$138	$163
Rotator cuff tear	3.8%	$261	$151	$173
Complications of procedures, not elsewhere classified	3.8%	$1,566	$266	$284
Lumbar spine degeneration	3.7%	$316	$310	$349
Orthopedic aftercare	3.4%	$289	$160	$176
Low back pain	3.1%	$291	$151	$166
Lumbosacral intervertebral disc disorders	3.1%	$575	$238	$279
Neck pain	3.0%	$416	$150	$171
Chronic pain	2.9%	$161	$169	$194

Charts 49 displays the average amount paid per other visit for outpatient services in Alaska, the region, and countrywide for the top 10 CPT codes in Alaska. The codes are ranked based on total outpatient payments in Alaska, where the code shown below is the code with the highest total paid on an "Other" outpatient visit. A brief description of each code is displayed in the table below.

Chart 49

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Other Visits

Code	Average Paid per Visit AK	Region	CW
97110	$286	$156	$206
97140	$295	$154	$216
G0463	$299	$192	$195
73221	$1,290	$910	$1,349
73721	$1,358	$889	$1,282
73222	$2,738	$1,622	$2,461
72148	$1,532	$942	$1,361
G0277	$1,715	$931	$1,252
97597	$449	$305	$357
97530	$234	$183	$234



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
G0463	Hospital outpatient clinic visit for assessment and management of a patient
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
97597	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Ambulatory Surgical Centers

An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries. The distribution of medical payments for ASCs is 12% for Alaska, 5% for the region, and 7% for countrywide.

Typically, surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes.

One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for ASC payments for Alaska, the region, and countrywide. In Alaska, 91% of ASC payments are included in the chart below.

Chart 50

ASC Payments as a Percentage of Medicare

Medical Cost Category	Alaska	Region	Countrywide
Ambulatory Surgical Center	358%	205%	265%

Source: NCCI's Medical Data Call for Service Year 2020. Region includes AZ, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

ASC visits with major surgery services represent 94% of ASC payments in Alaska. Other ASC visits typically include minor procedures, with injections for therapeutic or diagnostic purposes being the most common. Chart 51 displays the average amount paid per major surgery visit for ASC services, while Chart 52 displays the average number of major surgery ASC visits per 1,000 active claims for Alaska, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 51

Average Amount Paid per Major Surgery Visit for ASC Services

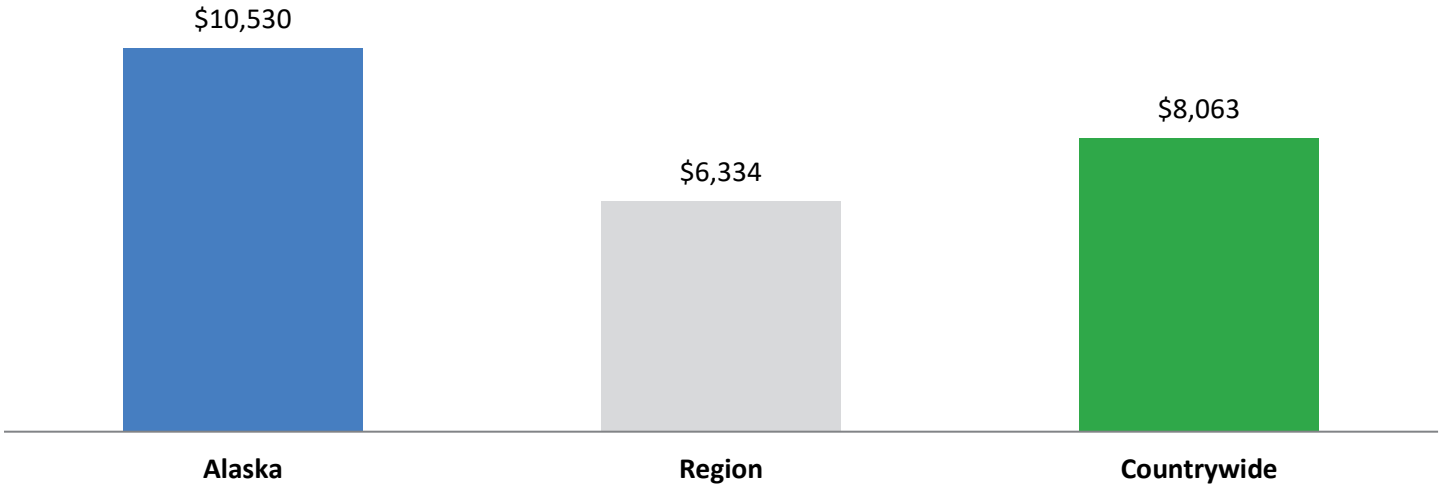


Chart 52

Average Number of ASC Major Surgery Visits per 1,000 Active Claims

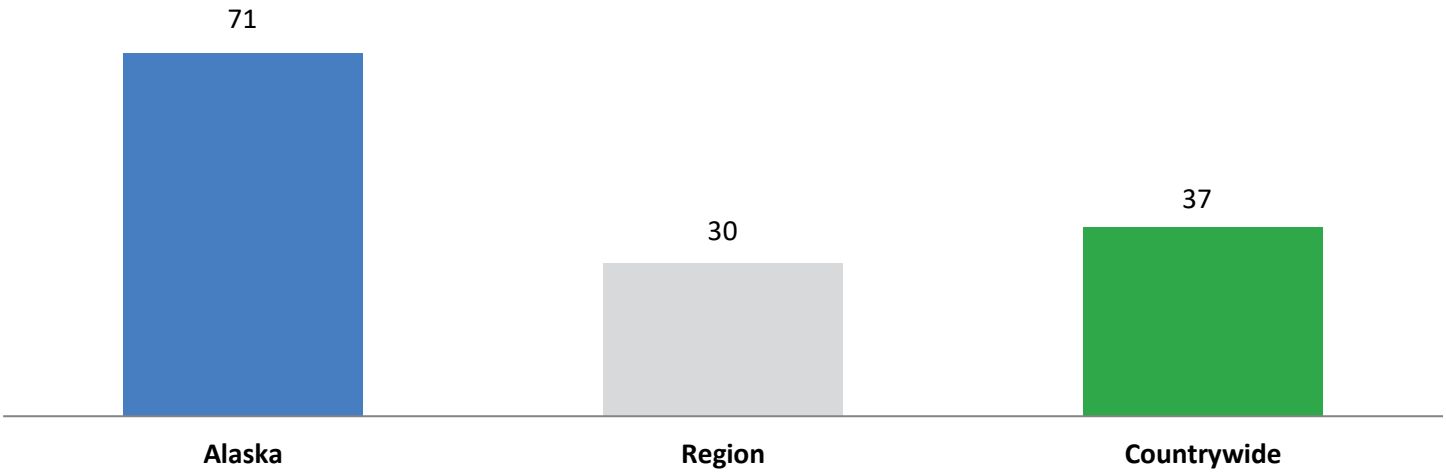
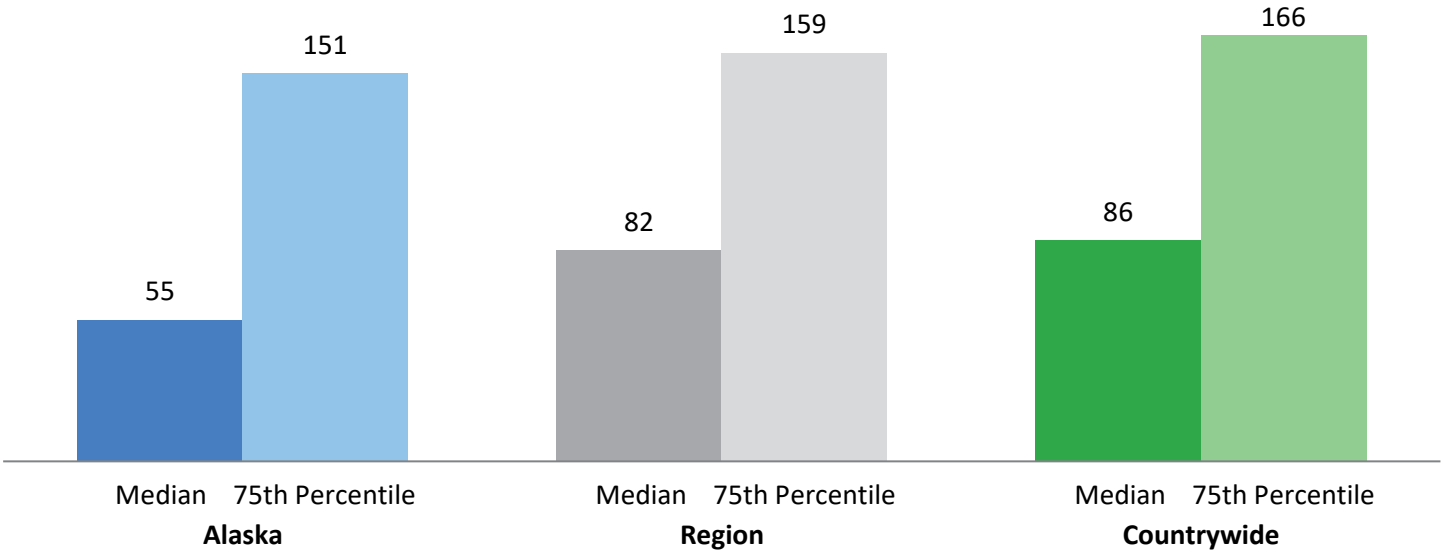


Chart 53 shows the median and 75th percentile time until first treatment for ASC major surgery visits for Alaska, the region, and countrywide.

Chart 53

Time Until First Treatment for ASC Major Surgery Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Chart 54 displays the top 10 diagnosis groups for ASC major surgery visits. The diagnosis groups are ranked based on total payments for ASC services in Alaska.

Chart 54

Top 10 Diagnosis Groups by Amount Paid for ASC Major Surgery Visits

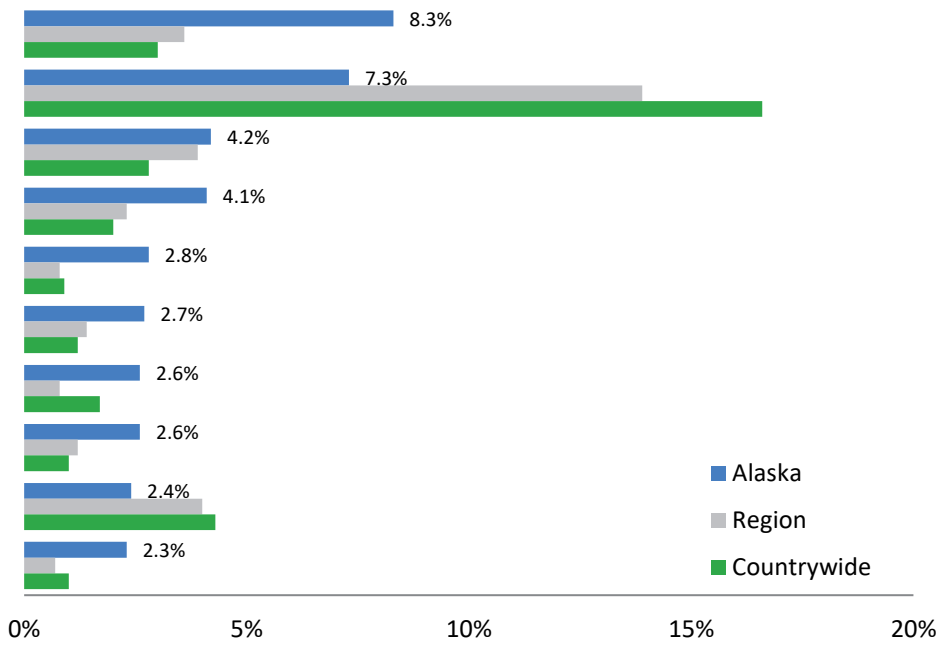
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Rotator cuff tear	16.0%	$13,105	$7,316	$10,347
Hand/wrist fracture	6.1%	$5,997	$4,321	$5,351
Knee internal derangement - meniscus injury	5.3%	$5,997	$3,352	$4,196
Minor shoulder injury	5.2%	$13,105	$6,365	$7,932
Knee internal derangement - cruciate ligament tear	3.7%	$14,980	$8,339	$9,355
Knee degenerative/overuse injuries	3.4%	$9,551	$3,855	$5,651
Lumbosacral intervertebral disc disorders	2.7%	$13,105	$6,381	$8,793
Superior labral tear from anterior to posterior (SLAP) lesion	2.7%	$14,042	$6,199	$8,833
Ankle fracture	2.7%	$13,105	$6,859	$8,546
Bicipital tendinitis	2.5%	$13,105	$7,270	$10,542

Chart 55 displays the average amount paid per major surgery visit for ASC services in Alaska, the region, and countrywide for the top 10 CPT codes in Alaska. The codes are ranked based on total ASC payments in Alaska, where the code shown below is the code with the highest total paid on a major surgery visit. A brief description of each procedure code is displayed in the table beneath the chart. Chart 56 displays similar results for visits in an outpatient setting for the list of codes in Chart 55, if applicable.

Chart 55

Top 10 Procedure Codes by Amount Paid for ASC Services in Major Surgery Visits

Code	Average Paid per Visit AK	Region	CW
23430	$14,091	$9,327	$12,811
29827	$13,256	$8,693	$12,497
29888	$14,736	$9,542	$10,931
29806	$16,443	$8,328	$10,417
27447	$29,086	$16,301	$21,271
25609	$14,362	$8,072	$9,268
22551	$27,596	$15,337	$24,616
23410	$13,693	$8,997	$11,313
29881	$6,102	$3,609	$4,651
23472	$40,998	$18,240	$26,410



Code	Description
23430	Tenodesis of long tendon of biceps
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below C2
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

Chart 56

Major Surgery Outpatient Visit Comparisons for Procedure Codes in Chart 55

Code	Average Paid per Visit in AK ASC	Outpatient	Distribution of Major Surgery Visits in AK in an ASC or Outpatient Setting
23430	$14,091	$11,311	89% / 11%
29827	$13,256	$12,603	81% / 19%
29888	$14,736	$8,615	94% / 6%
29806	$16,443	$15,600	93% / 7%
27447	$29,086	$23,529	71% / 29%
25609	$14,362	N/A	100%
22551	$27,596	$32,029	71% / 29%
23410	$13,693	$15,169	77% / 23%
29881	$6,102	$8,555	64% / 36%
23472	$40,998	N/A	100%

Prescription Drugs

The distribution of medical payments for drugs is 5% for Alaska, 8% for the region, and 8% for countrywide. Prescription drugs are uniquely identified by a national drug code (NDC). Charts 57 through 62 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

The Controlled Substances Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups of drugs, determined by varying qualifications, such as the drug's medical uses, if any, and its potential for abuse. For example, Schedule V drugs are defined as having the lowest potential for abuse, while Schedule I drugs are illegal at the federal level, mainly because they are defined as having no currently accepted medical uses and a high potential for abuse.

In Alaska, the share of claims observed in Service Year 2020 with at least one controlled substance was 10%. This compares to the region and countrywide shares of 9% and 10%, respectively. In 2020, Alaska spent $0.3M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 57 shows the distribution of prescription drug payments by CSA schedule in Alaska, the region, and countrywide.

Chart 57

Distribution of Prescription Drug Payments by CSA Schedule

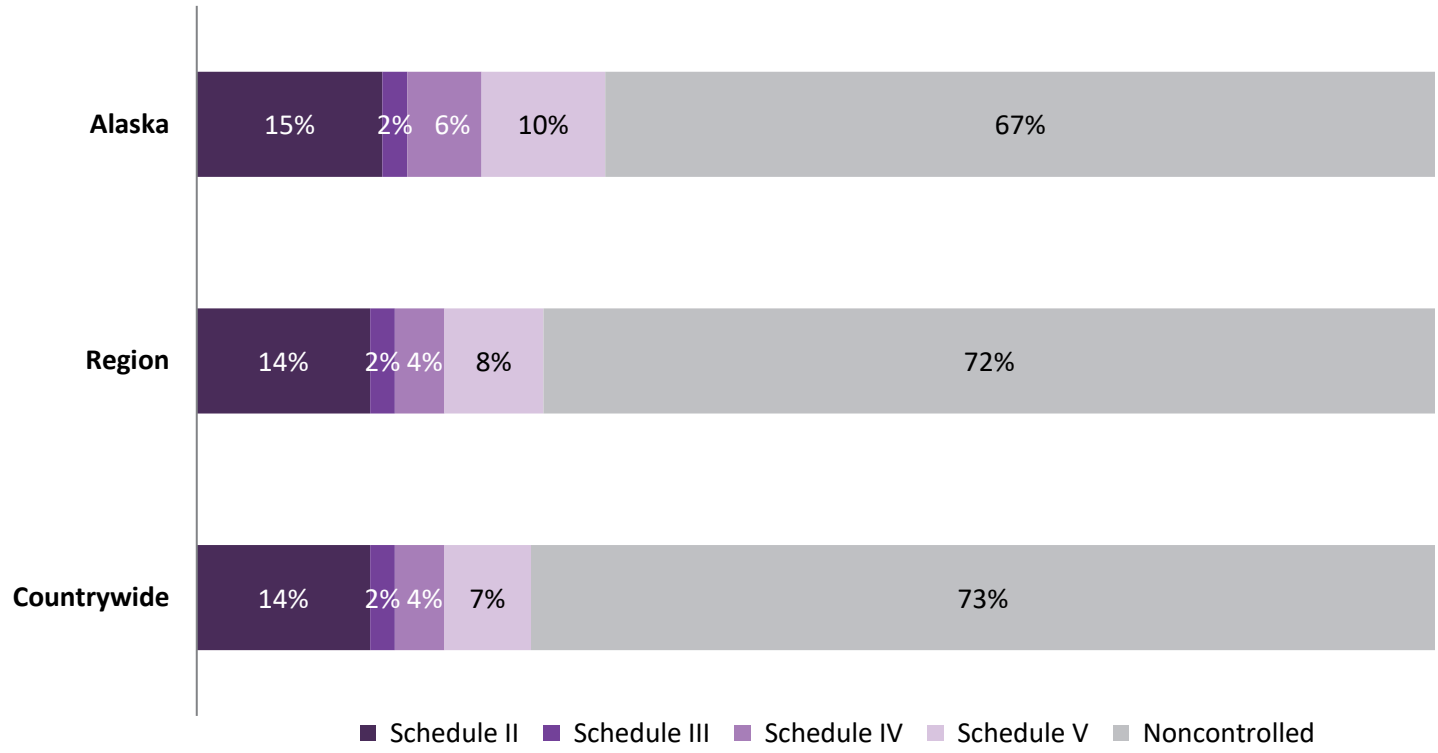


Chart 58 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Alaska. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See the Glossary for the definition of *unit*.)

Chart 58

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU AK	Average PPU Region	Average PPU CW	Alaska Paid Share
Pregabalin	$4.35	$4.59	$4.61	8.4%
Oxycontin®	$9.84	$8.88	$9.67	4.1%
Gabapentin	$0.84	$0.86	$0.91	3.9%
Pennsaid®	$22.28	$22.94	$22.99	3.1%
Lidocaine	$5.31	$5.74	$6.49	3.0%
Oxycodone HCl-Acetaminophen	$1.27	$1.14	$0.97	3.0%
Celecoxib	$3.94	$4.42	$5.11	2.7%
Duloxetine HCl	$3.86	$4.41	$4.44	2.5%
MACI®	$22,324.83	$36,322.55	$39,850.41	2.4%
Oxycodone HCl	$0.83	$0.70	$0.80	1.9%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	1
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	5
Gabapentin	G	Neurontin®	Anticonvulsants	None	4
Pennsaid®	B	N/A	Analgesics/Antipyretics	None	39
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	3
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	10
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	6
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	8
MACI®	B	N/A	Skin/Mucous Membrane	None	64
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	19

Chart 59 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in Alaska. This chart reveals the most frequently prescribed drugs and the average PPU.

Chart 59

Top 10 Workers Compensation Drugs by Prescription Counts

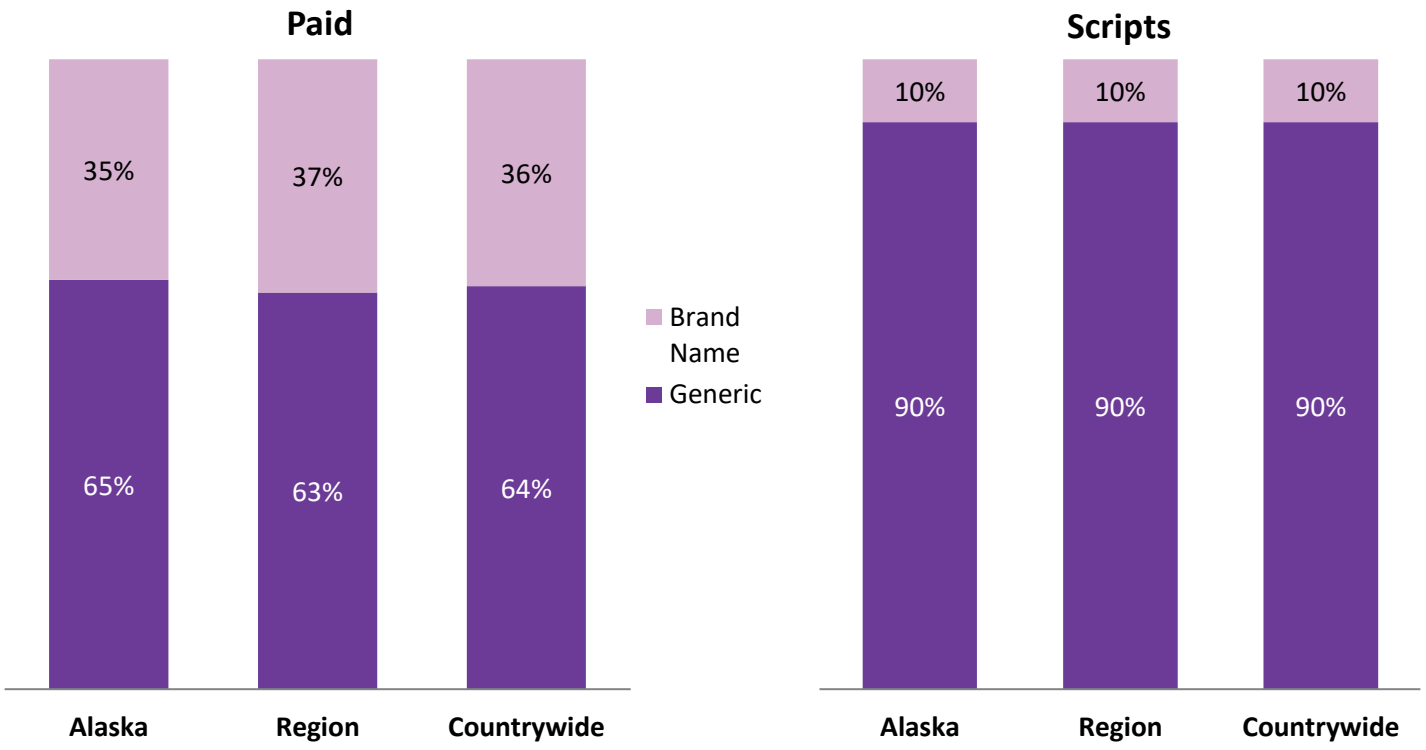
Drug Name	Average PPU AK	Average PPU Region	Average PPU CW	Alaska Prescription Share
Hydrocodone Bitartrate-Acetaminophen	$0.52	$0.56	$0.53	7.5%
Gabapentin	$0.84	$0.86	$0.91	6.2%
Oxycodone HCl-Acetaminophen	$1.27	$1.14	$0.97	4.8%
Oxycodone HCl	$0.83	$0.70	$0.80	4.3%
Tramadol HCl	$0.64	$0.75	$0.90	3.7%
Cyclobenzaprine HCl	$0.85	$1.05	$1.74	3.3%
Pregabalin	$4.35	$4.59	$4.61	3.2%
Tizanidine HCl	$1.06	$1.10	$1.06	2.9%
Meloxicam	$2.69	$2.72	$3.03	2.4%
Diclofenac Sodium (NSAID)	$0.62	$1.22	$1.83	2.4%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	7
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	9
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	6
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	12
Tizanidine HCl	G	Zanaflex®	Muscle Relaxants, Skeletal	None	10
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	5
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	8

Chart 60 shows the distribution of prescription drugs by brand name and generic for Alaska, the region, and countrywide. The share between brand name and generic is displayed based on the prescription counts and the payments. Typically, a higher percentage of drugs is given in the generic form; however, higher costs occur when brand name drugs are prescribed. In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs.

Chart 60

Distribution of Drugs by Brand Name and Generic



The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into the drivers of drug costs.

Chart 61 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for Alaska, the region, and countrywide.

Chart 61

Distribution of Drugs by Pharmacy and Nonpharmacy

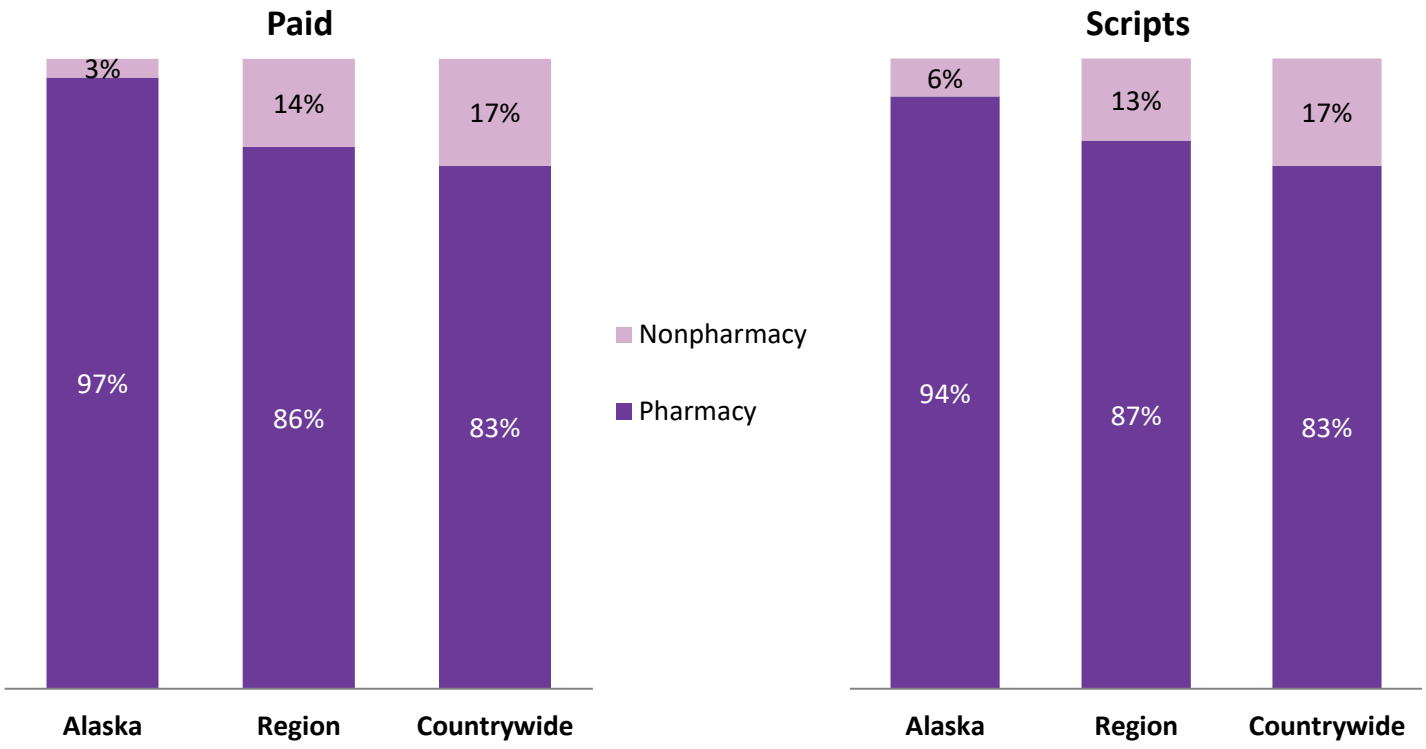


Chart 62 displays the shares of the payments for the top 5 nonpharmacy-dispensed prescription drugs used in workers compensation treatment, by amount paid in Alaska. A pharmacy-dispensed comparison, along with values for the region and countrywide, are also included. All values shown below are specific either to nonpharmacy-dispensed prescription drugs or to pharmacy-dispensed prescription drugs.

Chart 62

Top 5 Nonpharmacy-Dispensed Drugs by Amount Paid with Pharmacy-Dispensed Comparison

	Nonpharmacy-dispensed				Pharmacy-dispensed			
Drug Name	Paid Share	AK PPU	Region PPU	CW PPU	Paid Share	AK PPU	Region PPU	CW PPU
Remicade®	17.1%	$215.00	$650.00	$352.57	N/A	N/A	$1,170.55	$1,100.64
Botox®	13.7%	$286.76	$306.91	$252.95	N/A	N/A	$503.29	$650.14
Diclofenac Sodium (NSAID)	12.2%	$6.98	$3.88	$5.43	0.8%	$0.42	$0.96	$1.28
EnovaRX-Lidocaine HCl	8.2%	$4.76	$5.59	$5.51	0.1%	$5.05	$5.81	$5.66
Kenalog-40®	3.5%	$8.78	$5.36	$6.25	N/A	N/A	$6.27	$6.26

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	Nonpharmacy CW Rank
Remicade®	B	N/A	Immunosuppressants	None	195
Botox®	B	N/A	Toxins	None	9
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	1
EnovaRX-Lidocaine HCl	G	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	30
Kenalog-40®	B	N/A	Adrenals	None	37

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The distribution of medical payments for DMEPOS is 6% for Alaska, 7% for the region, and 8% for countrywide.

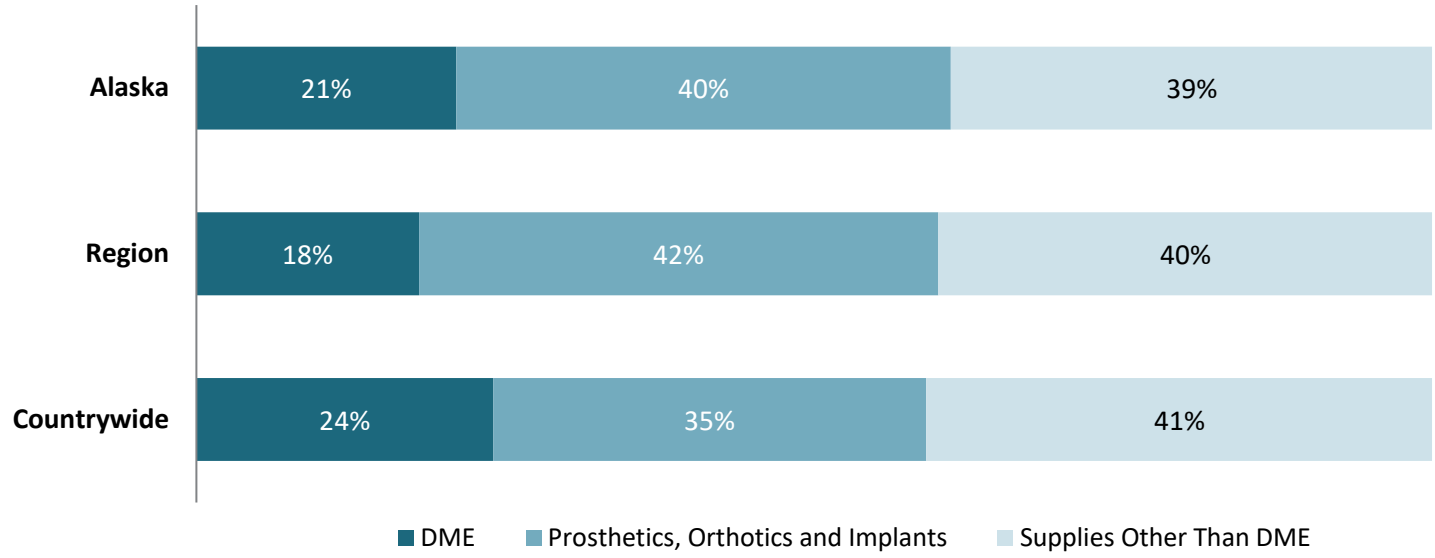
Chart 63 displays the distribution of payments among three separate DMEPOS categories:

- Durable Medical Equipment (DME)
- Prosthetics, Orthotics and Implants
- Supplies Other Than DME

Payments are mapped to each of these categories based on the procedure code reported, regardless of who provides the service or where the service is performed.

Chart 63

Distribution of Payments by DMEPOS



Injuries that include an implant or prosthetic device tend to be more expensive than other injuries. Chart 64 shows the top 10 diagnosis groups for claims that include an implant or a prosthetic device by total paid amount. Chart 65 shows the same diagnosis groups with the average amount paid per claim for claims that do not include an implant or prosthetic.

Chart 64

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2019 for Claims *With* an Implant or Prosthetic

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Tibia/fibula fracture	12.0%	$117,910	$73,391	$78,888
Rotator cuff tear	7.6%	$54,351	$32,820	$39,641
Minor shoulder injury	7.4%	$44,953	$26,850	$31,575
Hand/wrist fracture	5.1%	$26,871	$23,772	$28,519
Chest trauma major	4.3%	$336,088	$199,288	$219,144
Knee internal derangement - cruciate ligament tear	4.0%	$39,729	$28,010	$34,829
Inguinal hernia	4.0%	$23,947	$12,524	$13,120
Elbow/forearm fracture	3.6%	$70,835	$39,128	$45,397
Other joint disorder, not elsewhere classified	3.1%	$40,408	$33,285	$34,919
Knee internal derangement - meniscus injury	3.0%	$33,422	$20,735	$27,802

Chart 65

Average Amount Paid per Claim *Without* an Implant or Prosthetic for Diagnosis Groups in Chart 64

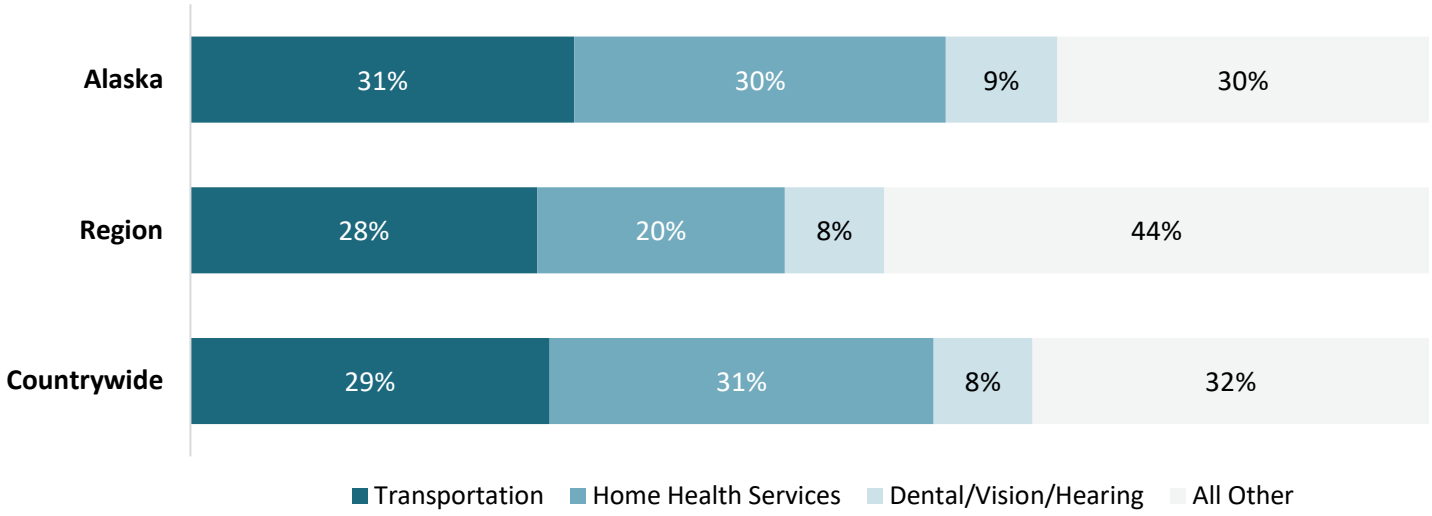
	Average Amount Paid Per Claim		
Diagnosis Group	**Alaska**	**Region**	**Countrywide**
Tibia/fibula fracture	$34,817	$18,186	$18,063
Rotator cuff tear	$21,831	$15,863	$19,965
Minor shoulder injury	$6,906	$3,771	$4,051
Hand/wrist fracture	$12,733	$5,921	$5,981
Chest trauma major	$50,701	$37,465	$39,876
Knee internal derangement - cruciate ligament tear	$33,937	$19,903	$21,620
Inguinal hernia	$9,400	$8,743	$10,281
Elbow/forearm fracture	$26,527	$9,649	$9,892
Other joint disorder, not elsewhere classified	$12,318	$12,908	$13,088
Knee internal derangement - meniscus injury	$15,097	$10,843	$12,849

Other Medical Services

For Service Year 2020, other medical services represent 5% of total medical costs countrywide. Chart 66 shows the distribution of these services by four categories: transportation, home health services, dental/vision/hearing, and all other. The "All Other" category typically includes services that may have a missing, invalid, or unlisted procedure, in addition to some other valid services (e.g., payments for interpreters, vehicle modifications, etc.).

Chart 66

Distribution of Other Medical Services Payments



Diagnosis Group and Body System

Charts 67 and 68 display the top 10 body systems and diagnosis groups, respectively. A body system and diagnosis group are identified for each claim based on an ICD-10 code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for Alaska. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2019, and December 31, 2019, and they include all reported services provided for those claims through December 31, 2020.

Chart 67

Top Body Systems by Amount Paid for Dates of Injury in 2019

		Average Amount Paid Per Claim		
Body System	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Shoulder	17.9%	$13,792	$8,432	$9,995
Hand/wrist	13.2%	$3,338	$2,051	$2,427
Knee	11.2%	$9,232	$5,574	$6,096
Lumbar spine	9.7%	$5,670	$3,882	$4,584
Leg	7.0%	$12,451	$5,516	$6,606
Arm	5.8%	$11,937	$5,363	$5,895
Ankle/foot	5.7%	$4,278	$3,408	$3,666
Neck	5.4%	$9,910	$5,084	$6,178
Head	3.3%	$4,110	$3,690	$3,934
Nervous system	2.8%	$31,552	$15,521	$22,776

Chart 68

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2019

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Alaska**	**Region**	**Countrywide**
Minor shoulder injury	7.1%	$8,340	$4,244	$4,660
Hand/wrist fracture	5.7%	$14,011	$7,119	$7,480
Rotator cuff tear	5.5%	$25,990	$18,619	$23,192
Minor hand/wrist injuries	4.7%	$1,593	$1,206	$1,330
Low back pain	4.5%	$3,680	$2,461	$2,427
Tibia/fibula fracture	4.5%	$54,961	$30,192	$30,785
Knee internal derangement - meniscus injury	3.0%	$16,903	$11,155	$13,347
Minor knee injury	2.8%	$3,633	$2,553	$2,647
Neck pain	2.3%	$5,869	$3,497	$3,368
Lumbosacral intervertebral disc disorders	2.2%	$18,492	$17,157	$20,240

Comparison of Selected Results by Year

The charts in this section provide a comparison of results for Alaska. These comparisons are over the latest five service years unless otherwise noted. Analysis in the growth of shares may provide additional insight into medical cost drivers above and beyond an analysis at a specific point in time.

Results in the charts below may vary compared to medical reports from previous years. This is due to a lag in reporting, as well as improved derivations affecting categories for certain charts.

Distribution of Medical Payments (Chart 4)

Medical Category	2016	2017	2018	2019	2020
Physician	47%	48%	49%	47%	43%
Hospital Outpatient	13%	14%	13%	14%	14%
Hospital Inpatient	11%	12%	11%	10%	11%
Drugs	6%	5%	5%	5%	5%
DMEPOS	5%	4%	5%	5%	6%
ASC	12%	11%	11%	11%	12%
Other	6%	6%	6%	8%	9%

Distribution of Physician Payments by AMA Service Category (Chart 6)

AMA Service Category	2016	2017	2018	2019	2020
Physical Medicine	31%	31%	32%	33%	34%
Surgery	28%	28%	26%	26%	26%
Evaluation and Management	18%	18%	20%	20%	21%
Radiology	13%	14%	12%	11%	9%
Anesthesia	4%	4%	4%	4%	4%
General Medicine	3%	3%	4%	3%	4%
Other	2%	1%	1%	2%	2%
Pathology	1%	1%	1%	1%	0%

Median Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)[10]

Medical Category	AY 2015	AY 2016	AY 2017	AY 2018	AY 2019
Physicians – Major Surgery	34	33	32	41	27
Physicians – Radiology	2	2	2	2	2
Physicians – Physical and General Medicine	27	22	25	22	26
Physicians – Evaluation and Management	4	4	4	4	3
Hospital Inpatient	2	1	1	1	0
Hospital Outpatient – Major Surgery	46	41	39	54	42
Hospital Outpatient – All Other	13	12	10	10	10
ASC – Major Surgery	58	56	51	50	55

75th Percentile of Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)[10]

Medical Category	AY 2015	AY 2016	AY 2017	AY 2018	AY 2019
Physicians – Major Surgery	104	104	101	114	102
Physicians – Radiology	14	13	14	14	14
Physicians – Physical and General Medicine	59	61	57	57	62
Physicians – Evaluation and Management	15	17	16	14	13
Hospital Inpatient	59	8	10	6	7
Hospital Outpatient – Major Surgery	139	117	105	133	99
Hospital Outpatient – All Other	45	44	37	36	38
ASC – Major Surgery	128	142	142	128	151

Hospital Inpatient Statistics (Charts 27 and 29)

	2016	2017	2018	2019	2020
Average Amount Paid Per Stay	$40,478	$45,486	$46,386	$44,014	$39,925
Number of Stays per 1,000 Active Claims	19	18	15	15	18

[10] In the charts displaying the distribution of time until first treatment, the data is organized by the year in which the injury occurred, rather than by service year, and includes services performed within 365 days of the date of injury.

Distribution of Hospital Outpatient Payments by Outpatient Visit Type (Chart 35)

Visit Type	2016	2017	2018	2019	2020
Emergency	34%	33%	37%	39%	37%
Nonemergency Major Surgery	31%	33%	28%	30%	31%
Other	34%	34%	35%	31%	32%

Emergency Hospital Outpatient Statistics (Charts 36 and 37)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$1,083	$1,120	$1,148	$1,230	$1,340
Number of Visits per 1,000 Active Claims	281	282	276	287	261

Emergency Room Outpatient Services Paid per Transaction (Chart 39)

Code	Severity	2016	2017	2018	2019	2020
99281	Minor	$177	$210	$250	$221	$240
99282	Low to moderate	$292	$312	$334	$352	$361
99283	Moderate	$558	$597	$602	$595	$602
99284	High	$948	$995	$995	$998	$974
99285	High and immediately life-threatening	$1,424	$1,559	$1,643	$2,002	$1,785

Nonemergency Major Surgery Hospital Outpatient Statistics (Charts 40 and 41)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$9,154	$9,969	$9,331	$10,158	$10,215
Number of Visits per 1,000 Active Claims	29	32	25	27	29

Other Hospital Outpatient Statistics (Charts 45 and 46)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$437	$442	$451	$474	$462
Number of Visits per 1,000 Active Claims	692	739	652	611	668

ASC Major Surgery Statistics (Charts 51 and 52)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$11,579	$11,878	$11,458	$11,097	$10,530
Number of Visits per 1,000 Active Claims	58	55	53	58	71

Distribution of Prescription Drug Payments by CSA Schedule (Chart 57)

CSA Schedule	2016	2017	2018	2019	2020
Schedule II	27%	23%	20%	17%	15%
Schedule III	2%	3%	2%	3%	2%
Schedule IV	6%	5%	5%	6%	6%
Schedule V	10%	11%	11%	13%	10%
Noncontrolled	55%	58%	62%	61%	67%

Distribution of Drug Payments by Brand Name and Generic (Chart 60)

Type of Drug	2016	2017	2018	2019	2020
Brand Name	40%	40%	43%	39%	35%
Generic	60%	60%	57%	61%	65%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 61)

Type of Provider	2016	2017	2018	2019	2020
Pharmacy	93%	94%	93%	93%	97%
Nonpharmacy	7%	6%	7%	7%	3%

Distribution of Payments by DMEPOS (Chart 63)

Category	2016	2017	2018	2019	2020
DME	16%	19%	13%	15%	21%
Prosthetics, Orthotics and Implants	50%	43%	52%	46%	40%
Supplies Other Than DME	34%	38%	35%	39%	39%

Distribution of Payments by Other Medical Services (Chart 66)

Category	2016	2017	2018	2019	2020
Transportation	51%	50%	51%	43%	31%
Home Health Services	11%	11%	9%	27%	30%
Dental/Vision/Hearing	11%	10%	14%	9%	9%
All Other	27%	29%	26%	21%	30%

Glossary

75th Percentile: The point on a distribution that is higher than 75% of observations and lower than 25% of observations.

Accident Year: A loss accounting definition in which experience is summarized by the calendar year in which an accident occurred.

Ambulatory Payment Classification (APC): Unit of payment under Medicare's Outpatient Prospective Payment System (OPPS) for hospital outpatient services where individual services are grouped based on similar characteristics and similar costs.

Ambulatory Surgical Center (ASC): A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of physicians, has continuous physician and nursing care, and does not provide for overnight stays. An ASC can bill for facility fees much like a hospital, but it generally has a separate fee schedule.

Controlled Substances: Drugs that are regulated by the Controlled Substances Act (CSA) of 1970. Each controlled substance is contained in one of five schedules based on its medical use(s) and its potential for abuse and addiction.

CPT Code Modifiers: Modifiers are codes added to a CPT code that further describe the procedure performed without changing the meaning of the original code.

Current Procedure Terminology (CPT): A numeric coding system maintained by the American Medical Association (AMA). The CPT coding system consists of five-digit codes that are primarily used to identify medical services and procedures performed by physicians and other healthcare professionals.

Diagnosis Groups: Based on ICD-10 codes; groups based on similar injuries and parts of body.

Diagnosis-Related Groups (DRG): A system of hospital payment classifications that groups patients with similar clinical problems who are expected to require similar amounts of hospital resources.

Drugs: Includes any data reported by a National Drug Code (NDC), which is referred to as a prescription drug. Also included are data for revenue codes, the Healthcare Common Procedure Code System (HCPCS), and other state-specific codes that represent drugs.

Durable Medical Equipment (DME): Equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and is not generally useful to a person in the absence of an illness or injury.

Emergency Services: Services performed for patients requiring immediate attention.

Emergency Visit: A visit where emergency services are performed.

Healthcare Common Procedure Coding System (HCPCS): Alphanumeric codes that include mostly nonphysician items or services such as medical supplies, ambulatory services, prostheses, etc. These are items and services not covered by Current Procedure Terminology (CPT) procedures.

ICD-10 Codes: The *International Classification of Diseases, Tenth Revision,* is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States.

Hospital Inpatient Service: Services for a patient who is admitted to a hospital for treatment that requires at least one overnight stay (more than 24 hours in a hospital).

Hospital Inpatient Stay: A hospital admission of a patient requiring hospitalization of at least one 24-hour period.

Hospital Outpatient Service: Any type of medical or surgical care, performed at a hospital, that is not expected to result in an overnight hospital stay (less than 24 hours in a hospital).

International Statistical Classification of Diseases and Related Health Problems (ICD-10): A classification of diseases and other health problems based on a diagnosis maintained by the World Health Organization (WHO).

Length of Stay: The amount of time, in days, between admission to a hospital and discharge.

Major Surgery Visit: A visit in which at least one surgery procedure is performed based on the reported procedure code, and where the surgery procedure has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, and is not an injection.

Medical Data Call: Captures transaction-level detail for medical billings that were processed on or after July 1, 2010. All medical transactions with the jurisdiction state in any applicable Medical Data Call state are reportable. This includes all workers compensation claims, including medical-only claims.

Other Outpatient Visit: A nonemergency outpatient visit where no major surgery services are performed.

(Paid) Procedure Code: A code from the jurisdiction-approved code table that identifies the procedure associated with the reimbursement. Examples include CPT code or revenue code.

Revenue Code: A numeric coding system used in hospital billings that provides broad classifications of the types of services provided. Some examples are emergency room, operating room, recovery room, room and board, and supplies.

Service Year: A loss accounting definition where experience is summarized by the calendar year in which a medical service was provided.

Taxonomy Code: A code that identifies the type of provider that billed for, and is being paid for, a medical service. Data reporters are instructed to use the provider taxonomy list of standard codes maintained by the National Uniform Claim Committee.

Telemedicine Service: Services reported with a telemedicine-specific procedure code, modifier, or place of service.

Time to Treatment (TTT): The amount of time, measured in days, between the date on which an accident occurs and the date on which the first medical service in a given category is provided.

Transaction: A line item of a medical bill.

Units: The number of units of service performed or the quantity of drugs dispensed. For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug:

- For tablets, capsules, suppositories, nonfilled syringes, etc., *units* represent the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the procedure code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement, such as milliliters, grams, or ounces. For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as four units.

Visit: Any hospital outpatient or ASC service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claimant may have more than one visit.

Appendix

The data contained in this report is reported under the jurisdiction state—the state under whose workers compensation act the claimant's benefits are being paid. Medical transactions must continue to be reported until the transactions no longer occur (i.e., the claim is closed) or 30 years from the accident date. There are nearly 30 data elements reported.

Wherever possible, standard industry codes are used because they provide a clear definition of the data, improve its accuracy and quality, and increase efficiency of computer systems.

Carriers differ in their handling of medical data reporting. Some carriers retain all medical claims handling internally and submit the data themselves. Others use business partners for various aspects of medical claim handling, such as third party administrators or medical bill review vendors. It is possible for a carrier to authorize its vendor to report the data on its behalf. Some carriers may use a combination of direct reporting and vendors. Although data may have been provided by an authorized vendor on behalf of a carrier, the quality, timeliness, and completeness of the data is the responsibility of the carrier.

Before a medical data provider can send files, each submitter's electronic data file must pass certification testing. This ensures that all connections, data files, and systems are functioning and processing correctly. Each medical data provider within a reporting group is required to pass certification testing. If a medical data provider reports data for more than one reporting group, that data must be certified for each group.

For more information about the Medical Data Call, please refer to the ***Medical Data Call Reporting Guidebook*** on **ncci.com**.

TAB 4

ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE FEBRUARY 24, 2022

NCCI estimates that the changes to the medical fee schedule in Alaska, effective February 24, 2022[1], will result in an impact of -0.3% on overall workers compensation system costs.

SUMMARY OF CHANGES

The Alaska medical fee schedule (MFS), effective February 24, 2022, is based on 2022 Medicare values with state-specific conversion factors (CFs) established by the Department of Labor and Workforce Development (DLWD).

The changes to the Alaska MFS, effective February 24, 2022, include the following:

Provider Schedule

- Update the maximum allowable reimbursements (MARs) to be based on 2022 Medicare Resource-Based Relative Value Units (RBRVUs) established for each CPT[2] code and published by the Centers for Medicare and Medicaid Services (CMS). The prior MARs were based on 2021 Medicare RBRVUs.

- Update the following CFs established by the DLWD:

Physician Practice Category	Prior CF	Updated CF
Anesthesia	$105	$100
Surgery	$125	$119
Radiology	$134	$121

All other physician services' CFs remain unchanged.

Hospital Outpatient and Ambulatory Surgical Center (ASC)

- Update the MARs to be based on 2022 Medicare Outpatient Prospective Payment System (OPPS) relative weights. The prior MARs were based on 2021 OPPS relative weights.

- The CFs for Hospital Outpatient and ASC remain unchanged.

[1] Per Alaska DLWD Bulletin 22-02: "Due to unanticipated delays, the Alaska Workers' Compensation Medical Fee Schedule published January 1, 2022, will not take effect until February 24, 2022."
[2] Current Procedural Terminology maintained by the American Medical Association.

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Hospital Inpatient

- Update the MARs to be based on 2022 Medicare Severity Diagnosis Related Group (MS-DRG) weights. The prior MARs were based on 2021 MS-DRG weights. The DLWD establishes multipliers for each hospital to be applied to the Medicare MAR. There is no change to the multipliers.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

- Update the MARS to be based on 2022 Medicare DMEPOS Fee Schedule. The prior MARs were based on 2021 DMEPOS Fee Schedule.

- There is no change to the multiplier established by the DLWD.

ACTUARIAL ANALYSIS

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    - Compare the prior and revised maximum reimbursements by procedure code to determine the percentage change by procedure code. For hospital inpatient services, the prior and revised maximum reimbursements are compared by episode.
    - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights. For hospital inpatient services, the observed payments by episode are used as weights. For hospital outpatient and ASC services, observed payments are aggregated according to packaging rules, where applicable.

2. Determine the share of costs that are subject to the fee schedule
    - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.
    - Any potential impact from the share of costs not subject to the fee schedule will be realized in future claim experience and reflected in subsequent NCCI loss cost filings.

3. Estimate the price level change as a result of the revised fee schedule
    - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change.
    - For facility and DMEPOS fee schedule changes, a price realization factor of 80% is assumed.

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In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Alaska for Service Year 2020. Reported medical experience for COVID-19 claims as reported in NCCI Call 31 for Large Loss and Catastrophe have been excluded from the data on which this analysis is based.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from Policy Years 2016, 2017, 2018, and 2019 projected to the effective date of the benefit changes.

SUMMARY OF IMPACTS

The impacts from the fee schedule changes in Alaska, effective February 24, 2022, are summarized below.

Type of Service	(A) Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Impact on Medical Costs
Physician	-1.8%	44.3%	-0.8%
Hospital Inpatient	+0.5%	10.3%	+0.1%
Hospital Outpatient	+0.4%	14.2%	+0.1%
ASC	+0.4%	11.9%	Negligible[3] Increase
DMEPOS	+1.1%	5.8%	+0.1%
Combined Impact on Medical Costs (D) = Total of (C)			**-0.5%**
Medical Costs as a Share of Overall Costs (E)			69%
Combined Impact on Overall Costs (F) = (D) x (E)			**-0.3%**

Refer to the appendix for the weighted-average changes in MARs by physician practice category, the share of costs subject to the fee schedule by type of service, and the weighted-average change in MAR by type of service.

ADDITIONAL CONSIDERATIONS

Maximum reimbursement for dental and ambulance services are also governed by the fee schedule in Alaska. The share of these payments with a MAR makes up a small portion of medical costs. Therefore, the impact on overall costs due to updating the fee schedule for these services is not anticipated to be material. As such, any potential impact from this change will be realized in future claim/loss experience and reflected in subsequent NCCI loss cost filings in Alaska, as appropriate.

[3] Negligible is defined in this document to be an impact smaller in magnitude than +/-0.1%.

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APPENDIX

Weighted-Average Percentage Change in MARs Prior to Price Realization by Physician Practice Category

Physician Practice Category	Share of Physician Costs	Percentage Change in MARs
Anesthesia	3.7%	-4.8%
Surgery	25.8%	-4.3%
Radiology	9.0%	-10.5%
Pathology & Laboratory	0.5%	0.0%
Evaluation & Management	20.6%	+0.3%
Medicine	36.3%	-0.2%
Other HCPCS*	0.0%	0.0%
Payments with no MAR	4.1%	–
Total	**100.0%**	**-2.2%**

*Healthcare Common Procedure Coding System

Share of Costs Subject to the Fee Schedule and Weighted-Average Percentage Change in MARs by Type of Service

Type of Service	Share of Costs Subject to the Fee Schedule	Percentage Change in MARs	Impact after 80% Price Realization
Physician	95.9%	-2.2%	-1.8%
Hospital Inpatient	77.6%	+0.6%	+0.5%
Hospital Outpatient	92.9%	+0.5%	+0.4%
ASC	94.1%	+0.5%	+0.4%
DMEPOS	28.7%	+1.4%	+1.1%

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TAB 5

ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

Workers' Compensation Medical Fee

Utilization Research

Medical Services Review Committee

Charles Collins, Chair
Robert Hall, MD
Mason McCloskey, DC
Mary Ann Foland, MD
Jennifer House
Misty Steed
Pam Scott
Vince Beltrami
Susan Kosinski

Based on 2019 numbers.

Source: NCCI Medical Data Call for Alaska, Service Year 2019.

Physician Services

CPT Code	Sum Non-Facility	Description	Sum Facility	Sum Other	Total	Transactions
97110	$ 3,019,154.87	Therapeutic treatment to develop strength and range of motion.	$ 25,513.20	$ 485.53	$ 3,045,153.60	25,057
97140	$ 1,944,652.71	Manual therapy techniques	$ 9,137.81	$ 6,633.79	$ 1,960,424.31	19,406
99213	$ 1,356,979.78	Office or outpatient visit existing patient	$ 53,613.42	$ 711.85	$ 1,411,305.05	8,020
97530	$ 1,020,431.77	Therapeutic activities functional improvement	$ 563.68	$ 1,266.35	$ 1,022,261.80	13,805
99214	$ 781,798.42	Therapeutic procedure / massage	$ 15,964.79	$ 482.91	$ 798,246.12	3,273
99456	$ 661,316.35	Work related or medical disability exam by non-treating physician	$ 1,595.00	$ 27,118.38	$ 690,029.73	432
99203	$ 606,679.59	Office or outpatient visit new patient	$ 7,795.41	$ 489.51	$ 614,964.51	2,359
97112	$ 476,097.65	Therapeutic procedure reeducation of movement	$ 1,349.29	$ 36.72	$ 477,483.66	5,198
73721	$ 334,791.19	MRI on lower extremity	$ 37,973.31	$ 203.15	$ 372,967.65	356
73221	$ 310,395.45	MRI on upper extremity	$ 26,734.25	$ 1,531.71	$ 338,661.41	312

CPT codes for direct services.

Alaska Procedure/Modifier Codes for Hospital Outpatient Services by Service Year			
CPT Code	Description	Amount of Payment in 2019	Transactions
99283	Emergency department visit moderate complexity medical decision.	$ 844,182.44	1,415
99284	Emergency department visit moderate complexity medical decision and detailed exam.	$ 441,980.61	441
97110	Therapeutic treatment to develop strength and range of motion.	$ 382,800.37	2,208
99183	Physician attended hyperbaric oxygen treatment	$ 215,698.94	71
97140	Manual therapy techniques	$ 196,044.15	1,319
99285	Emergency department visit high complexity medical decision and comprehensive exam.	$ 169,272.07	85
99282	Emergency department visit low complexity medical decision.	$ 151,791.74	429
23430	Tenodesis of long tendon of biceps.	$ 149,291.07	14
G0463	Facility evaluation and management visit.	$ 140,034.21	1
90376	Rabies immune globulin vaccine.	$ 133,906.20	13

Same for the ASC

Ambulatory Surgical Centers				
CPT Code	Description	Payments		Transactions
23430	Tenodesis of long tendon of biceps.	$	497,596.25	44
29827	Arthroscopic rotator cuff repair	$	393,378.78	33
29888	ACL repair	$	329,557.40	20
23412	Repair of shoulder / chronic	$	244,185.44	17
29881	Arthroscopic menisectomy with debridement o cartilage	$	214,833.71	31
24342	Reinsertion of ruptured biceps/triceps tendon	$	179,650.05	12
63685	Insertion of spinal neurstimulator	$	174,051.88	3
29806	Artroscopy shoulder	$	167,170.19	13
63030	Endoscopic on lumbar region	$	165,183.66	11
23410	Repair of rotator cuff	$	154,202.84	10

Inpatient uses different codes.

Hospital Inpatient Services			
DRG Code	Description	Sum of Payments	Transactions
957	Operating room procedures for multiple significant trauma.	$ 333,039.34	17
492	Operating room procedures for significant trauma lower extremity with major complication.	$ 304,460.21	32
473	Cervical spinal fusion w/o complication.	$ 209,071.38	4
483	Operating room procedures for significant trauma upper extremity.	$ 207,520.46	5
467	Hip or knee replacment.	$ 196,583.71	9
454	Anterior/posterior spinal fusion.	$ 192,695.89	7
494	Operating room procedures for significant trauma lower extremity w/o complication.	$ 189,314.48	24
907	Operating room procedures for injuries with major complication.	$ 178,078.64	2
453	Anterior/posterior spinal fusion with major complication.	$ 175,083.56	8
482	Hip or femur procedure w/o complication.	$ 172,546.12	9