ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

ARN G. SALAO, Employee, PROVIDENCE ALASKA MEDICAL CENTER, Claimant, v. MUNICIPALITY OF ANCHORAGE, Self-Insured Employer, Defendant.	FINAL DECISION AND ORDER AWCB Case No. 201616530 AWCB Decision No. 17-0106 Filed with AWCB Anchorage, Alaska on September 1, 2017

Providence Alaska Medical Center's February 21, 2017 claim was heard on August 1, 2017 in Anchorage, Alaska. This hearing date was selected on June 15, 2017. Arn G. Salao (Employee) was notified of the hearing, but declined to participate. Karen Norton and Linda Walker appeared, represented Providence Alaska Medical Center (Providence), and testified. Attorney Shelby Nuenke-Davison appeared and represented the Municipality Of Anchorage (Employer). Darcy Tavares, Bill Review Manager with PacBlu testified as a witness. The record closed at the hearing's conclusion on August 1, 2017.

ISSUE

This case addresses payment to medical providers under the fee schedule adopted in response to the 2014 amendments to AS 23.30.097. The facts are undisputed. The only issue is how outlier cases under the inpatient hospital fee schedule are determined. Claimant contends this case is not an outlier, and it should be paid under 8 AAC 45.083(e). Employer contends the case is an outlier, and the fee should be determined under 8 AAC 45.083(k)(5).

Is Providence entitled to payment under 8 AAC 45.083(e)?

FINDINGS OF FACT

1. Employee is a police officer for Employer. On November 12, 2016 in the course of his work, he suffered multiple gunshot wounds injuring his hip and internal organs and was hospitalized at Providence. Employee underwent surgery and was discharged on November 22, 2016. (First Report of Injury, November 14, 2016; Operative Note, November 12, 2016; Hearing Stipulation).
2. Providence's billed charges were $211,454.65, which included $11,074.01 for implants. For Medicare purposes, inpatient services provided by hospitals are grouped by Medicare Severity-Diagnosis Related Group (MS-DRG). The MS-DRG for Employee's care was 956. The Centers for Medicare and Medicaid Services (CMS) provides a relative weight for each MS-DRG; the weight for the 956 MS-DRG is 3.8187. CMS also assigns every hospital a Medicare identification number; Providence's Medicare ID number is 020001. Providence is also classified as an acute care hospital by CMS. (Hearing Stipulations; Observation; PBC Re-evaluation).
3. Under CMS rules, acute care hospitals are typically paid for inpatient stays based on the MS-DRG weight multiplied by a base rate that is established for each hospital. Cases that are unusually costly, outlier cases, are paid differently. (Tavares; Observation and Experience).
4. Prior to December 1, 2015, medical fees in workers' compensation cases were established by a medical fee schedule that was updated periodically. Under the version of AS 23.30.097(a) then in effect, the fee schedule provided for payment at 90 percent of the usual, customary, and reasonable (UCR) fee in the geographical area where the services were provided. (Observation; Experience).
5. In 2014, AS 23.30.097 was amended to state:

> **AS 23.30.097. Fees for medical treatment and services.**
> (a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section. A fee or other charge for medical treatment or service
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> (1) rendered in the state may not exceed the lowest of
>
> (A) the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, for treatment or service provided on or after December 31, 2010, not to exceed the fees or other charges as specified in the fee schedules established by the medical services review

> committee and adopted by the board in regulation; the fee schedules must include
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> . . . .
>
> (iii) an inpatient hospital fee schedule based on the federal Centers for Medicare and Medicaid Services' Medicare severity diagnosis related group;
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> (B) the fee or charge for the treatment or service when provided to the general public; or
>
> (C) the fee or charge for the treatment or service negotiated by the provider and the employer under (c) of this section;
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> . . . .
>
> (j) The board shall annually renew and adjust fees on the fee schedules established by the medical services review committee under (a)(1)(A) of this section by a conversion factor established by the medical services review committee and adopted by the board in regulation.[1]

6. The Medical Services Review Committee (MSRC) met numerous times to develop its recommendation for the fee schedules mandated by AS 23.30.097. (Observation). Outlier exceptions to the inpatient fee schedule were discussed at several meetings. Most relevant was the discussion at the April 20,2015 meeting:

> Member Griffith stated that the outlier threshold should be determined by "total costs" not "total charges". After further discussion, the committee acknowledged that the inpatient fee schedule methodology is intended to be calculated by multiplying the hospital's conversion factor by the MSDRG weight. The PC Pricer would be used when a case is an outlier case. The challenge is coming up with language to adequately define what an outlier case is. (MSRC Minutes, April 20, 2015).

7. On June 1, 2015, the MSRC sent its recommendations to the Commissioner of the Department of Labor and Workforce Development. The following recommendations are relevant here:

> **FINDINGS OF THE MSRC**
> The MSRC's findings follow in this section. Recommendations are listed separately under the "Recommendations of the MSRC" section.
> . . . .

[1] Sections (l) through (r) were initially to become effective on July 1, 2015. That date was later changed to December 1, 2015. Sec. 1, ch. 31, SLA 2015.

General

. . . .

Hospital Inpatient Fee Schedule

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

Optum's analysis of NCCI and CMS data resulted in an inpatient base rate of $21,449.74, which is 239.8% of the average CMS FY15 base rate of $8,944.40 for the 9 Alaskan acute care hospitals. CMS base rates in Alaska vary from $7,498.69 for the Central Peninsula General Hospital to $12,991.50 for the Yukon Kuskokwim Delta Regional Hospital. The differences reflect the variances in each hospital's operating base rate, capital base rate, and wage index.

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

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RECOMMENDATIONS OF THE MSRC

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Hospital Inpatient Fee Schedule

The MSRC recommends

1. Conversion factors be adjusted to account for disproportionate share and case outliers

2. The following conversion factors be multiplied times the CMS Inpatient Prospective Payment System MSDRG weights
   a. Providence Alaska Medical Center $17,085.40

      . . . .

3. On outlier cases, implants be paid separately at invoice plus 10%

. . . .

Billing and Payment Rules

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

. . . .

4. When total costs for a hospital inpatient MS-DRG coded service exceeds the CMS outlier threshold in effect at the time of service, then the total payment for that service shall be calculated using the CMS Inpatient PC Pricer tool as follows:
   a. Implantable charges, if applicable, are subtracted from the total amount charged.
   b. The charged amount from (a) is entered into the most recent version of the CMS PC Pricer tool at the time of treatment.
   c. The Medicare price returned by the CMS PC Pricer tool is multiplied by 2.5 (250% Medicare price).
   d. The allowable implant reimbursement, if applicable, is the invoice cost of the implant(s) plus ten percent (110% of invoice cost).
   e. The amounts calculated in (c) and (d) are added together to determine the final reimbursement. (Workers' Compensation Medical Fee Schedule Recommendations, June 1, 2015).

8. The CMS outlier threshold in November 2016, when Employee was treated, was $23,573.00. (Hearing Stipulation).
9. At its September 3, 2015 meeting, the MSRC revised its recommendation regarding hospital inpatient fees, increasing the base rate to 328.2 percent of the average CMS FY15 base rate. (MRSC Meeting Minutes, September 3, 2015).
10. After approval by the Commissioner, on October 29, 2015, the board adopted an emergency regulation codifying the MRSC's revised recommendations as 8 AAC 45.083. (Workers' Compensation Board Meeting Minutes, October 25, 2015).
11. At its January 15, 2016 meeting, after approving minor amendments in form and language, the board voted to make the emergency regulation permanent. (Workers' Compensation Board Meeting Minutes, January 15, 2016).
12. On May 11, 2016, the Division issued Bulletin 16-01 (Revised), which was the Director's interpretation of issues related to the fee schedule. The bulletin was intended to provide guidance, but is not binding. For medical services provided by an inpatient hospital, the Bulletin states:

> For medical services provided by an inpatient hospital not described in 8 AAC 45.083(e)(1) or 8 AAC 45.083(k)(5), the Alaska MAR payment is calculated as follows:
>
> *Medicare Severity Diagnosis Related Groups (DRG)* Relative Weight x Facility Base Rate = MAR

> The facility base rate for most Alaska inpatient hospitals are listed in 8 AAC 45.083(e)(2)-(10). To calculate the facility base rate for all other inpatient hospitals, multiply the CMS base rate by 328.2%.
>
> 8 AAC 45.083(k)(5) governs when and how an inpatient hospital outlier is triggered and calculated. The CMS outlier threshold is used to determine when an outlier is triggered. Under subsection (k)(5), implant charges, if any, are subtracted from the total amount charged and reimbursed at 110% of invoice cost. The non-implant charges are entered into the CMS PC Pricer tool and the Medicare price returned by CMS is then multiplied by 250%. The final reimbursement for outlier cases is therefore the sum of the implant reimbursement and the non-implant charges (run through the PC Pricer and multiplied by 250%).

13. On October 6, 2016 meeting, the Board approved amendments to 8 AAC 45.083 with the intent "to clarify the existing fee schedule and incorporate the most recent MSRC recommendations. (Board Minutes, October 6, 2016). The primary effect of proposed amendment was the adoption of an official medical fee schedule effective April 1, 2017. (8 AAC 45.083 (a)). A draft copy of the medical fee schedule was included in the Board's information packet for the meeting. (Board Meeting Packet, October 6-7, 2016).
14. At its January 12-13, 2017 meeting, the Board adopted the amendment to 8 AAC 45.083. Again, the Board's information packet included the medical fee schedule. (Board Minutes, January 12-13, 2017). The portion of the fee schedule addressing inpatient hospitals is unchanged from the October 6, 2016 draft. (Board Meeting Packet, January 12-13, 2017).
15. For inpatient hospitals, the Medical Fee Schedule states:

> **GENERAL INFORMATION AND GUIDELINES**
> For medical services provided by inpatient hospitals under AS 23.30 (Alaska Workers' Compensation Act), the multiplier of 328.2 percent of the hospital specific total base rate shall be applied to the *Medicare Severity Diagnosis Related Groups* (MS-DRG) weight adopted by reference in 8 AAC 45.083(m).
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> Except:
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> . . . .
> (2) the base rate for Providence Alaska Medical Center is $23,383.10;
> . . . .
>
> (11) on outlier cases, implants shall be paid at invoice plus 10 percent.
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> Any additional payments for high-cost acute care inpatient admissions are to be made following the methodology described in the Centers for Medicare and Medicaid Services (CMS) final rule CMS-1243-F published in the Federal

> Register Vol. 68, No. 110 and updated with federal fiscal year values current at the time of the patient discharge.
>
> In no event should a hospital be reimbursed more than actual charges for services rendered. (Alaska Workers' Compensation Medical Fee Schedule, April 1, 2017).

16. The MSRC did not make any recommendations regarding the inpatient fee schedule between September 3, 2015 and January 12, 2017. (MSRC Minutes, July 15, 2016, July 29, 2016, August 12, 2016, and August 19, 2016).
17. The Federal Register explains how outliers are determined:

> To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers).
>
> Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold. (68 Fed. Reg. 110, 34495 (2003)).

18. The PC Pricer is a program provided by CMS. A hospital's Medicare ID number, the MS-DRG number, the date of discharge, and the total charges are entered. The program provides the hospital-specific cost-to-charge ratios and other adjustments, determines whether the case is an outlier under the CMS rules, and provides the total MS-DRG payment. (PC Pricer Printout, April 27, 2017, Walker, Tavares). The PC Pricer results can be manually calculated by using information and formulas published by CMS, but doing so would be significantly more time consuming. (Walker).
19. CMS publishes two cost-to-charge ratios for each hospital, an operating cost-to-charge ratio and a capital cost-to charge ratio. The PC Pricer also provides these ratios. (Norton). Here, the PC Pricer states Providence's operating cost-to-cost ratio is 0.2470 and its capital cost-to-charge ratio is 0.0200. The PC Pricer printout indicates whether a case is paid under the normal DSG rule or as an outlier, but it does not provide the result of multiplying the total charges by the cost-to charge ratios. (PC Pricer Printout, April 27, 2017).
20. Employer determined the case was an outlier and paid Providence $88,688.75 under 8 AAC 45.083(k)(5). (Claim, February 21, 2017).

21. On February 21, 2017, Providence filed a claim for an additional $604.29, contending it should have been paid under 8 AAC 45.083(e) rather than 8 AAC 45.083(k)(5). (Claim, February 21, 2017).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
> . . . .

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987). An adjudicative body must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson*, 221 P.3d 998 (Alaska 2009).

> **AS 23.30.095. Medical treatments, services, and examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement . . . .

In *Bockness v. Brown Jug, Inc.*, 980 P.2d 462, 466 (Alaska 1999), the Court explained that the Act does not require an employer to pay for all medical treatment, but only that which is reasonable and necessary.

> **AS 23.30.097. Fees for medical treatment and services. (2014)**
> (a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section. A fee or other charge for medical treatment or service
> (1) rendered in the state may not exceed the lowest of

> (A) the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, for treatment or service provided on or after December 31, 2010, not to exceed the fees or other charges as specified in the fee schedules established by the medical services review committee and adopted by the board in regulation; the fee schedules must include
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> . . . .
>
> (iii) an inpatient hospital fee schedule based on the federal Centers for Medicare and Medicaid Services' Medicare severity diagnosis related group;
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> (B) the fee or charge for the treatment or service when provided to the general public; or
>
> (C) the fee or charge for the treatment or service negotiated by the provider and the employer under (c) of this section;

. . . .

(f) An employee may not be required to pay a fee or charge for medical treatment or service provided under this chapter.

. . . .

(r) The medical services review committee shall formulate a conversion factor and submit the conversion factor to the commissioner of labor and workforce development. If the commissioner does not approve the conversion factor, the medical services review committee shall revise the conversion factor and submit the revised conversion factor to the commissioner for approval.

AS 23.30.395. Definitions. In this chapter,

. . . .

(32) "physician" included doctors of medicine, surgeons, chiropractors, osteopaths, dentists, and optometrists;

AS 44.62.030. Consistency between regulation and statute.

If, by express or implied terms of a statute, a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, a regulation adopted is not valid or effective unless consistent with the statute and reasonably necessary to carry out the purpose of the statute.

> **AS 44.62.300. Judicial review of validity.**
> An interested person may get a judicial declaration on the validity of a regulation by bringing an action for declaratory relief in the superior court. In addition to any other ground the court may declare the regulation invalid . . . .

When reviewing a regulation, the Supreme Court looks at three factors:

> We review an agency's regulation for whether it is "consistent with and reasonably necessary to implement the statutes authorizing [its] adoption." Toward this end we consider: (1) whether [the agency] exceeded its statutory authority in promulgating the regulation; (2) whether the regulation is reasonable and not arbitrary; and (3) whether the regulation conflicts with other statutes or constitutional provisions. *Manning v. State*, 355 P.3d 530, 534-35 (Alaska 2015).

Alaska courts apply a sliding-scale approach to statutory interpretation. Under this approach, the plain language of a statute is significant but does not always control; rather, "legislative history can sometimes alter a statute's literal terms." As a general rule, "the plainer the language of the statute, the more convincing contrary legislative history must be." *Hillman v. Alaska*, 382 P.2d 1198, 1199 (Alaska 2016).

In *Mechanical Contractors of Alaska, Inc. v. State*, 91 P.3d 240, 248 (Alaska 2004), the Alaska Supreme Court gave the following guidance on statutory construction:

> When we engage in statutory construction we will presume 'that the legislature intended every word, sentence, or provision of a statute to have some purpose, force, and effect, and that no words or provisions are superfluous.' At the same time, strict construction does not require that statutes be given the narrowest meaning allowed by their language; rather, the language should be given a 'reasonable or common sense construction, consonant with the objectives of the legislature.' (Citations omitted).

Lawless v. George Miller Construction, Inc., AWCB Decision No.10-0155 (September 13, 2010), addressed the question of whether there was a distinction between "charges" and "fees" under a prior statute and regulation. Neither "charge" nor "fee" were defined in the Act. The decision noted that one dictionary definition of "charge" was "cost." In its analysis, *Lawless* relied on *Mechanical Contractors* to conclude "charges" and "fees" were not synonymous.

8 AAC 45.083. Fees for medical treatment and services

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

. . . .

(e) For medical services provided by inpatient hospitals under AS 23.30 (Alaska Workers' Compensation Act), the conversion factor of 328.2 percent of the hospital specific total base rate shall be applied to the Medicare Severity Diagnosis Related Groups weight adopted by reference in (m) of this section, except that

. . . .

(2) the base rate for Providence Alaska Medical Center is $23,383.10;

. . . .

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

. . . .

(k) The following billing and payment rules apply for medical treatment or services provided by inpatient hospitals, hospital outpatient clinics, and ambulatory surgical centers:

. . . .

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

(A) implantable charges, if applicable, are subtracted from the total amount charged;

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

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

(D) the allowable implant reimbursement, if applicable, is the invoice cost of the implant plus 10 percent, or 110 percent of invoice cost;

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

(m) The following material is adopted by reference:

. . . . .

> (9) Medicare Severity Diagnosis Related Groups, effective January 1, 2015, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.
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> (n) In this section, "maximum allowable reimbursement" means the charge for medical treatment or services calculated in accordance with the fee schedule.

ANALYSIS

Is Providence entitled to payment under 8 AAC 45.083(e)?

This dispute hinges entirely on the interpretation of 8 AAC 45.083(k)(5), a question of law. Under Employer's interpretation, this is an outlier case, which results in a lower payment to Providence. Under Providence's interpretation the case is not an outlier, and, as a result, it should be paid under 8 AAC 45.083(e).

Under 8 AAC 45.083(k)(5), the first step is to determine whether "total costs" exceeds the "CMS outlier threshold" plus the "MS-DRG payment." If so, the case is an outlier, and the balance of 8 AAC 45.083(k)(5) applies. Employer contends "total costs" is the total amount billed by Providence, $211,454.65, and the MS-DRG payment is Providence's base rate from 8 AAC 45.083(e)(2), $23,383.10, multiplied by the MS-DRG weight of 3.8187, or $89,293.04. The parties agree the CMS outlier threshold is $23,573.00. Consequently, Employer contends the case is an outlier because $211,454.65 exceeds $112,866.04 ($23,573.00 + $89,293.04).

Providence contends "total costs" should be calculated by applying CMS's hospital-specific cost-to-charge ratios to the billed charges, and this amount compared to the CMS outlier threshold plus the CMS DRG payment. Because it relied on the PC Pricer determination the case was not an outlier, Providence did not make the calculation required by the first step of 8 AAC 45.083. However, given Providence's argument, those figures are easily derived. Providence contends "total costs" are the billed charges multiplied by its cost-to-charge ratios, which would be $211,454.65 times the operating cost-to-charge ratio of 0.2470 plus $211,454.65 times the capital cost ratio of 0.0200, or $56,458.39 (($211,454.65 x 0.2470) + ($211,454.65 x 0.0200) = $56,458.39). The parties agree the CMS outlier threshold is $23,573.00, and Providence contends the MS-DRG payment is the normal DRG payment as calculated by CMS, or $34,785.83. As a result, Providence maintains the case is not an outlier as determined in the

first step of 8 AAC 45.083(k)(5) because the total costs of $56,458.39 does not exceed $58,358.83, which is the outlier threshold of $23,573.00 plus the normal DRG payment of $34,785.83.

At its April 20, 2015 meeting, the MSRC noted the challenge was to come up with language to adequately define what an outlier case is. As is apparent from this case, that was an exceptionally difficult challenge.

The first question is what "total costs" means in 8 AAC 45.083(k)(5). Citing *Lawless*, Employer contends "total costs" equates to "total billed charges." Although one of the definitions in *Lawless* defined "charge" as "cost, Employer's contention is rejected. First, while there is very little in the history of the regulation, the comment at the April 20, 2015 MSRC meeting distinguishing between "total costs" and "total charges" strongly suggests the MSRC did not intend the terms to be synonymous. Second, in *Mechanical Contractors*, the Supreme Court explained that in construing a statute, or in this case a regulation, every word is deemed to have a purpose. 8 AAC 45.083(k)(5) uses both "total costs" and "charges," and it must be presumed they have different meanings.

However, merely rejecting Employer's definition of "total costs" does not necessarily mean Providence's interpretation is correct. The question of what "total costs" means must still be determined. The MSRC's June 1, 2015 recommendations only state the "total costs for a hospital inpatient MS-DRG coded service" should be used. The Division's May 11, 2016 Bulletin 16-01 only states the "CMS outlier threshold is used to determine when an outlier is triggered." Neither are particularly helpful. Although the April 1, 2017 Fee Schedule was not adopted until well after 8 AAC 45.083 was adopted, it provides the best understanding of the Board's and the MSRC's original intent. At its October 6, 2016 meeting, the Board stated the intent of the new fee schedule was "to clarify the existing fee schedule and incorporate the most recent MSRC recommendations." As the MSRC had not recommended any changes to the inpatient fee schedule since 8 AAC 45.083 was first adopted, any changes must have been intended to clarify the existing fee schedule. The April 1, 2017 Fee Schedule clearly explains that the CMS methodology is used to determine outliers to the impatient fee schedule. This is

the approach that Providence used. The case is not an outlier, and Providence is entitled to payment under 8 AAC 45.083(e).

Employer also contends Providence erred by using the PC Pricer in first step of 8 AAC 45.083(k)(5) analysis. While the regulation does require the use of the PC Pricer after a case has been determined to be an outlier, it does not preclude the use of the PC Pricer at the first step to determine whether the case is an outlier. As Ms. Walker explained, the PC Pricer merely automates what would otherwise be a manual process. If a case is found to be an outlier using either the PC Pricer or manual calculations, 8 AAC 456.083(k)(5) requires that the charges for implants be deducted from the total charges and the balance re-entered into the PC Pricer.

CONCLUSION OF LAW

Providence is entitled to payment under 8 AAC 45.083(e).

ORDER

1. Providence's February 21, 2017 claim is granted.

Dated in Anchorage, Alaska on September 1, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Donna Phillips, Member

/s/
Robert Weel, Member

If compensation is payable under terms of this decision, it is due on the date of issue. A penalty of 25 percent will accrue if not paid within 14 days of the due date, unless an interlocutory order staying payment is obtained in the Alaska Workers' Compensation Appeals Commission.
If compensation awarded is not paid within 30 days of this decision, the person to whom the awarded compensation is payable may, within one year after the default of payment, request from the board a supplementary order declaring the amount of the default.

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of ARN G. SALAO, employee; PROVIDENCE ALASKA MEDICAL CENTER, claimant; v. MUNICIPALITY OF ANCHORAGE, self-insured employer / defendant; Case No. 201616530; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on September 1, 2017.

/s/
Elizabeth Pleitez, Office Assistant