# ALASKA WORKERS' COMPENSATION BOARD

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

JOSHUA KASTELLE,
Employee,

JAMES F. HESTON, D.C.,
Claimant,

v.

NOMAR, LLC/ OHIO CASUALTY INSURANCE COMPANY
Employer/Insurer,
Defendants.

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MOLLY KENNEDY,
Employee,

JAMES F. HESTON, D.C.,
Claimant,

v.

SOUTH PENINSULA BEHAVIORAL HEALTH SERVICES/ALASKA NATIONAL INSURANCE COMPANY,
Employer/Insurer,
Defendants.

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NANCY MARTIN,
Employee,

JAMES F. HESTON, D.C.,
Claimant,

FINAL DECISION AND ORDER

AWCB Case Nos. 201602586, 201602666, and 201519138

AWCB Decision No.16-0127

Filed with AWCB Anchorage, Alaska on December 16, 2016.

| | |
|---|---|
| v. | ) |
| | ) |
| HOMER SENIOR CARE/ALASKA NATIONAL INSURANCE COMPANY, | ) |
| | ) |
| Employer/Insurer, Defendants. | ) |
| | ) |

James F. Heston's claims in these three joined cases were heard on November 22, 2016 in Anchorage, Alaska. This hearing date was selected on August 25, 2016. Dr. Heston (Claimant) appeared, represented himself, and testified. Attorney Martha Tansik appeared and represented Nomar, LLC/Ohio Casualty Insurance Company, South Peninsula Behavioral Health Services/Alaska National Insurance Company, and Homer Senior Care/Alaska National Insurance Company (Employers). Sheila Hanson testified as a witness. The record closed at the hearing's conclusion on November 22, 2016.

## ISSUE

This is the first case addressing payment to medical providers under the fee schedule adopted in response to the 2014 amendments to AS 23.30.097. The facts in all three cases are undisputed. The only issue is whether a chiropractor's charge for extra-spinal manipulation is compensable under the fee schedule. Dr. Heston contends that it is compensable, and the Employers contend that it is not.

***Is extra-spinal manipulation compensable under the fee schedule?***

## FINDINGS OF FACT

The following facts and factual conclusions are undisputed or established by a preponderance of the evidence:

1. 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).

2. The most recent fee schedule, effective December 31, 2010, identified medical services by a Healthcare Common Procedure Coding System (HCPCS) code number. The HCPCS incorporates the Current Procedural Terminology (CPT) code numbers developed by the American Medical Association for services by physicians. For other medical providers, HCPCS uses other code numbers. (Alaska 2010 Medical Fee Schedule, Introduction).
3. The CPT codes and maximum fee for selected procedures under the 2010 Medical Fee Schedule are as follows:

| Code | Description | Fee |
|---|---|---|
| 29881 | Arthroscopic Knee Surgery with Meniscectomy | $5,158.02 |
| 92951 | Hearing Aid Exam, Both Ears | $371.91 |
| 97545 | Work Hardening, First Two Hours | $295.01 |
| 97546 | Work Hardening, Additional Hours | $117.65 |
| 98940 | Chiropractic Manipulation-Spine, One Region | $65.96 |
| 98943 | Chiropractic Manipulation-Extra-spinal | $56.54 |
| 99455 | Impairment Rating by Treating Doctor | BR* |
| 99456 | Impairment Rating –Other than Treating Doctor | BR* |

* BR indicates payment "by report," or no fixed fee. (Alaska 2010 Medical Fee Schedule).

4. In 2014, HB 316 was introduced and referred to the House Labor and Commerce Committee. (House Journal, Page 1634).
5. The first hearing on the bill was held on March 7 2014. Anna Latham, legislative staff, testified that for the past decade, Alaska had the highest workers' compensation rates in the nation. The bill proposed a change in the medical fee schedule. The fee schedule in place at that time was based on a percentage of the usual, customary and reasonable fees, but fees had risen significantly. The bill proposed a fee schedule for physicians based on the relative values for various procedures established by the federal Center for Medicare and Medicaid Services (CMS) multiplied by a conversion factor. (House Labor and Commerce Committee Minutes, March 7, 2014).
6. Ms. Latham later explained that intent of HB 316 was to reduce the extremely inflated workers' compensation medical procedure rates to more reasonable rates. (House Labor and Commerce Committee Minutes, March 24, 2014).
7. On April 19, 2014, Ms. Latham testified before the Senate Finance Committee, explaining that HB316 introduced a new fee schedule. She responded to a committee member's question about additional reforms to the Workers' Compensation Act stating that while some

parties wanted to implement evidence based best practices and utilization review, "[t]he sponsor holds that the process should consist of two parts, lowering fees and implementing utilization and evidence based best practices." (Senate Finance Committee Minutes, April 19, 2009).

8. HB 316, was passed by both chambers of the legislature and approved by the Governor on July 8, 2014. (House Journal, page 2929).

9. HB 316 amended AS 23.30.097 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
> (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
> (i) a physician fee schedule based on the federal Centers for Medicare and Medicaid Services' resource-based relative value scale;
> (ii) an outpatient and ambulatory surgical center fee schedule based on the federal Centers for Medicare and Medicaid Services' ambulatory payment classification; and
> (iii) an inpatient hospital fee schedule based on the federal Centers for Medicare and Medicaid Services' Medicare severity diagnosis related group;
> (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;
>
> . . . .
> (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.
> (k) A fee or other charge for medical treatment or service rendered in another state may not exceed the lowest of
> (1) the fee or charge for a treatment or service set by the workers' compensation statutes of the state where the service is rendered; or
> (2) the fees specified in a fee schedule under (a)(1)(A) of this section.
> (l) A fee or other charge for air ambulance services rendered under this chapter shall be reimbursed at a rate established by the board and adopted in regulation.

> (m) A fee or other charge for durable medical equipment not otherwise included in a covered medical procedure under this section may not exceed the amount of the manufacturer's invoice, plus a markup specified by the board and adopted in regulation.
> (n) Reimbursement for prescription drugs under this chapter may not exceed the amount of the original manufacturer's invoice, plus a dispensing fee and markup specified by the board and adopted in regulation.
> (o) A prescription drug dispensed by a physician under this chapter shall include in a bill or invoice the original manufacturer's code for the drug from the national drug code directory published by the United States Food and Drug Administration.
> (p) A fee or other charge for medical treatment or service provided by a hospital licensed by the Department of Health and Social Services to operate as a critical access hospital is exempt from the fee schedules established under (a)(1)(A) of this section.
> (q) The board may adjust the fee schedules established under (a)(1)(A) of this section to reflect the cost in the geographical area where the services are provided.
> (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.[1]

10. The Medical Services Review Committee (MSRC) met on July 7, 2014 to begin its work on the fee schedule. Michael Monagle, director of the Division of Workers' Compensation at the time, stated that the MSRC's goal was to recommend conversion factors that would be applied to CMS's resource-based relative value units (RBRVUs or RVUs) to arrive at a fee. He explained the intent was not to make draconian cuts to the Workers' Compensation Medical Fee Schedule rates. (MSRC, Minutes, July 7, 2014).
11. CMS periodically revises its relative value schedule. The 2016 Physician Fee Schedule Relative Value File released in January 2016 provides the following for the selected CPT codes used in finding of fact number three[2][3]:

[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.
[2] CMS's Relative Value Table has 31 columns and includes 16,289 HCPCS codes. Only the relevant columns are shown here.
[3] All of the dates of service at issue here were in 2016.

| HCPCS | Mod. | Description | Status Code | Not Used for Medicare Payment | Work RVU | Non-Facility Practice Expense RVU | Facility Practice Expense RVU | Mal-practice RVU |
|---|---|---|---|---|---|---|---|---|
| 29881 | | Knee Arthoscopy/Surgery | A | | 7.03 | 7.17 | 7.17 | 1.39 |
| 92591 | | Hearing Aid Exam-Both Ears | N | | 0.00 | 0.00 | 0.00 | 0.00 |
| 97545 | | Work Hardening | R | | 0.00 | 0.00 | 0.00 | 0.00 |
| 97546 | | Work Hardening Add-On | R | | 0.00 | 0.00 | 0.00 | 0.00 |
| 98940 | | Chiropract. Manip.-1-2 regions | A | | 0.46 | 0.32 | 0.16 | 0.02 |
| 98943 | | Chiropract. Manip. Extra-spinal | N | + | 0.46 | 0.28 | 0.18 | 0.03 |
| 99455 | | Work Related Disability Examination | R | | 0.00 | 0.00 | 0.00 | 0.00 |
| 99456 | | Disability Examination | R | | 0.00 | 0.00 | 0.00 | 0.00 |

(CMS 2016 Physician Fee Schedule Relative Value File; PPRRVU16_V0122.xlsx).

12. In general, the Non-Facility Practice Expense RVU is used when the service is performed in the provider's office. The Facility Practice Expense RVU is used when the service is provided in a hospital or ambulatory surgery center. (CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2679, MM7631.pdf).
13. CMS also publishes a Geographic Practice Cost Index which is periodically updated. GPCIs are provided for a number of geographic areas, and consist of a Work GCPI, a Practice Expense GCPI, and a Malpractice GCPI, which correspond to the RVU components in the relative value table. For 2016, Alaska 2016 has a Work GPCI of 1.5, a Practice Expense GPCI of 1.107, and a Malpractice GPCI of 0.611. (CMS 2016 Physician Fee Schedule Relative Value File; CY2016_GPCIs.xlsx).
14. Both the 2010 Medical Fee Schedule and the CMS Relative Value Table provide for the use of modifiers in certain situations, none of which are relevant in this case. However, the Relative Value Table includes Status Codes, which were not used in the 2010 Medical Fee Schedule. (2010 Medical Fee Schedule; 2016 Physician Fee Schedule Relative Value File).
15. There are a number of CMS status codes. Those relevant here include:

| Status Code | Description |
|---|---|
| A | Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; [Medicare Administrative Contractors] remain responsible for coverage decisions in the absence of a national Medicare policy |
| C | [Medicare Administrative Contractors] price the code. [Medicare Administrative Contractors] will establish RVUs and payment amounts for these services, generally |

| | |
|---|---|
| | on an individual case basis following review of documentation such as an operative report. |
| E | Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures. |
| N | Non-covered service. These codes are carried on the HCPCS tape as noncovered services. |
| P | Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.<br><br>If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).<br><br>If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act. |
| R | Restricted coverage. Special coverage instructions apply. |
| T | There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. |

(Medicare Claims Processing Manual, Chapter 23, §30.2.2 http://www.cms.gov/manuals/downloads/clm104c23.pdf).

16. In CMS's 2016 Physician Fee Schedule Relative Value table, every status code A item has a relative value; although in some instances one of the components may be zero, the combined RVU for every status code A item is a positive value. In contrast every status code C, E, P, and Q item has a relative value of 0.00. There are only eight status code T items, and all of them have positive relative values. In contrast, while 71 of the 705 status code N items have positive relative values, the remainder all have a relative value of zero. (CMS 2016 Physician Fee Schedule Relative Value File; PPRRVU16_V0122.xlsx; Observation).
17. At the July 7, 2014 meeting, the MSRC was provided a significant amount of material, including Idaho's regulations and Utah's Medical Fee Standard, both of which incorporate CMS's relative values, as well as a CMS Payment Formula sheet providing examples of how Medicare payments are calculated for various types of providers. (MSRC, Meeting Materials, July 7, 2014).

18. The CMS Payment Formula example for Physicians is:

> **Medicare – Physician's Fee Schedule**
> [(Work RVU x Work GPCI) +
> (Practice Expense RVU x Practice Expense GPCI*****)
> + (Malpractice RVU x Malpractice GPCI)] x
> Conversion Factor (CF)
> *Geographic Price Cost Index
>
> Example CPT 29881 – Arthroscopy of Knee
> Using CMS conversion factor of $34.0230 (CY2013) $25.7109 (projected CY2014)
> [(7.03 x 1.5)+(7.81 x 1.067)+(1.37 x .661)] x 34.0230=
> (10.545+8.333+.905) x 34.0230=
> 19.783 x 34.0230=
> $673.098
> (MSRC, Meeting Materials, CMS Payment Formula, July 7, 2014).

19. The Idaho regulations provided to the MSRC provide for payments to physicians by multiplying the RVUs for a procedure for a particular location by a conversion factor. Services for which there is no current CPT code or RVU, are paid at the usual, customary, and reasonable charge. (IDAPA 17.02.09.031). The Idaho regulation dealing with payment to hospitals and ambulatory surgery centers establishes a method of calculating the payment, but provides "[s]tatus code N items other than implantable hardware) or items with no CPT code or Healthcare Common Procedure Coding System ((HCPCS) code shall receive no payment." (IDAPA 17.02.09.032).
20. Utah has also adopted a Relative Value System for payments to providers under its workers' compensation system. However, rather than directly incorporating CMS's relative value table it has adopted a relative value table published by an independent contractor. Because the contractor has provided relative values for many codes for which CMS does not provide a value, Utah's fee standards only refer to status codes for a very limited number of procedures, none of which are relevant in this case. (Utah, 2013 Medical Fee Standards; Observation).
21. At the September 5, 2014 MSRC meeting, director Monagle informed the committee that Optum had been retained to provide professional services to the committee. (MSRC, Minutes, September 5, 2014).

22. At its October 24, 2014 meeting during a presentation by Optum, the MSRC discussed whether to adopt rules to incorporate status payment codes and how to address gaps for status codes not covered by CMS. (MSRC, Minutes, October 24, 2014).
23. At the January 15 and 16, 2015 MSRC meeting, a representative of Optum pointed out that the committee needed to make a decision on how to address status codes, particularly when CMS denies payment for a procedure performed on an outpatient basis. Another Optum representative pointed out that the committee would have to decide how they wanted to handle for unlisted codes or "gaps." (MSRC, Minutes, January 15 and 16, 2015).
24. At its February 23, 2015 meeting, the MSRC discussed status codes, in the context of medical facilities, particularly status codes C, E. N, P, Q, and T. An Optum representative recommended the committee be very specific when adopting rules because many CMS rules may not apply in the workers' compensation environment. In discussions regarding facility fees, Director Monagle noted that Idaho had determined that Status Code N items, other than implantable hardware, and items with no CPT code or RVU were not payable. Director Monagle stated that the goal was to make the conversion from UCR to RVU "fee schedule neutral." (MSRC, Minutes, February 23, 2015).
25. At the March 16, 2015 meeting, the MSRC considered a draft of its recommendations through the February 23, 2015 meeting. They discussed fees related to status code J and B items, such as implants, prescription drugs, and laboratory fees, for which CMS does not provide a relative value. There was no discussion related to the physician fees schedule, but the committee amended and adopted its draft conversion factors, including those related to physicians' fees. The committee requested information from Optum on how other states have handled status code C, E, and P items as well as items with no CPT codes or relative values. One member of the committee provided information illustrating a conflict between the CPT coding rules and the NCCI edits involving chiropractic CPT codes. Under the NCCI Edit Manual, certain CPT codes for therapeutic exercise should not be reported separately when chiropractic manipulation is done in the same area. The CPT Assistant states that it is appropriate to report both the therapeutic exercise and the chiropractic manipulation. The CPT Assistant example includes CPT code 98943, with no indication that it has a status code of N and is not payable by Medicare. (MSRC, Minutes, March 16, 2015).

26. At its April 20, 2015 meeting, the MSRC approved the following rules related to the physician fee schedule:

> **Physician Fee Schedule Payment Rules**
> 1. Separate CMS relative values shall be used for physician services provided in facilities and physician services provided in non-facilities.
>
> 2. The maximum allowable reimbursement for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor shall be the lower of 85% of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.
>
> 3. Providers and payers shall follow the billing and coding rules, as amended, in effect at the time of treatment, as established by the Centers Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows:
>
> 4. Modifier 50: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU. 50% of the fee schedule amount or the lesser of the billed charge for the procedure for the second and all subsequent procedures.
>
> 5. Modifier 51: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU rendered during the same session as the primary procedure. 50% of the fee schedule amount or the lesser of the billed charge for the procedure with the second highest RVU and all subsequent procedures during the same session as the primary procedure.
>
> 6. Modifiers 80, 81, and 82: Reimbursement shall be twenty percent (20%) of the surgical procedure.
>
> 8. (sic 7.) Modifier PE: Reimbursement shall be 85% of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants and an advanced practice registered nurse.
>
> Member Foland stated that PA's and APRN's are reimbursed in her clinic at 100%. The chair stated that the long standing practice in workers' compensation is reimbursement at 85%. Member Scott asked Sheila Hansen from Coventry what bill review is paying, and Ms. Hansen responded that they are paid at 85%.
>
> 9. (sic 8) Modifier AS: Reimbursement shall be fifteen percent (15%) of the value of the procedure. State specific modifier AS shall be used when a

> physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.
>
> 10. (sic 9) Modifier QZ: Reimbursement shall be 85% of the value of the anesthesia procedure. State specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.
>
> 11. (sic 10) Providers and payers shall follow National Correct Coding Initiative edits established by the Centers Medicare and Medicaid Services and the American Medical Association, as amended, in effect at the time of treatment.
> (MSRC, Minutes, April 20, 2015).

27. 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.
> . . . .
>
> ***General***
> . . .
>
> CMS does not produce relative values for all medical services, including pathology and clinical labs, durable medical equipment, parenteral and enteral nutrition items and services, some drug and pharmaceutical supplies. In addition, the committee acknowledged there will be some gaps for procedure codes not valued by CMS. The committee finds it needed to recommend payment rules for unvalued services and gaps where no CMS produces no relative values.
> . . . .
>
> ***Billing and Payment Rules***
> The committee finds that AMA modifiers and CMS payment rules are well established and generally accepted, but notes that certain modifiers, status codes, and NCCI edits require state specific rules.
>
> **RECOMMENDATIONS OF THE MSRC**
> ***Physician Fee Schedule***
> The MSRC recommends
> 1. The following conversion factors be multiplied times the CMS relative values established for each CPT code.
>    a. Evaluation & Management $80.00

b. Medicine $80.00
c. Surgery $205.00
d. Radiology $257.00
e. Laboratory $142.00

2. The following multipliers be applied to the CMS fee schedules established for each HCPCS code.
   a. Pathology & Clinical Lab CMS x 6.33
   b. Durable Medical Equipment CMS x 1.84
   c. ASP CMS x 3.375
3. Using separate CMS physician fee schedule relative values for facilities and non-facilities.
4. The maximum allowable reimbursement for medical services that do not have current CMS CPT or HCPCS codes, a currently assigned CMS relative value, or an established conversion factor established shall be the lower of 85% of billed charges, the charge for the treatment or to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

. . . .

***Hospital Outpatient Fee Schedule***

The MSRC recommends

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

. . . .

***Billing and Payment Rules***

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

1. Providers and payers shall follow the billing and coding rules, as amended, in effect at the time of treatment, as established by the Centers Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows:
2. Modifier 50: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU. 50 % of the fee schedule amount or the lesser of the billed charge for the procedure for the second and all subsequent procedures.
3. Modifier 51: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU rendered during the same session as the primary procedure. 50 % of the fee schedule amount or the lesser of the billed charge for the procedure with the second highest RVU

and all subsequent procedures during the same session as the primary procedure.

4. Modifiers 80, 81, and 82: Reimbursement shall be twenty percent (20%) of the surgical procedure.
5. Modifier PE: Reimbursement shall be 85% of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants and an advanced practice registered nurse.
6. Modifier AS: Reimbursement shall be fifteen percent (15%) of the value of the procedure. shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.
7. Modifier QZ: Reimbursement shall be 85% of the value of the anesthesia procedure. State specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.
8. Providers and payers shall follow National Correct Coding Initiative edits established by the Centers Medicare and Medicaid Services and the American Medical Association, as amended, in effect at the time of treatment. An exception is when there is a billing rule discrepancy between NCCI edits and AMA CPT Assistant, CPT Assistant guidance governs.
9. The committee recommends establishing relative values of 3.41 for CPT code 97545 and 1.36 for CPT code 97546.

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

. . . .

3. Status codes C, E, and P, shall be the lower of 85% of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.
4. Two (2) or more medical procedures with a status code T on the same claim shall be de paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%).

28. After approval by the Commissioner, on October 29, 2015, the board adopted an emergency regulation codifying the MRSC's recommendations as 8 AAC 45.083. (Workers' Compensation Board Meeting Minutes, October 25, 2015).

29. At its January 15, 2016 meeting, after approving minor amendments in form and language required by the Department of Law, the board voted to make the emergency regulation permanent. (Workers' Compensation Board Meeting Minutes, January 15, 2016).

30. 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 a physician, the Bulletin states:

> For medical services provided by a physician, other than anesthesiology, the Alaska maximum allowable reimbursement (MAR) payment is calculated using the *Resource-Based Relative Value Scale*, produced by the Centers for Medicare and Medicaid Services (CMS). RVU is Relative Value Unit; GPCI is Geographic Practice Cost Index.
>
> (Work RVUs x Work GPCI) + (Practice Expense RVUs x Practice Expense GPCI) + (Malpractice RVUs x Malpractice GPCI) = Total RVU
>
> Then multiply the Total RVU by the applicable conversion factor set out in 8 AAC 45.083(b) to obtain the Alaska MAR payment. The Alaska MAR for anesthesiology is calculated as explained in 8 AAC 45.083(c).
>
> The conversion factors found in 8 AAC 45.083(b) are listed here with their applicable *Current Procedural Terminology* (CPT®) code ranges for your convenience. (CPT is registered trademark of the American Medical Association.)
> . . . .
>
> 8 AAC 45.083(b) applies to medical services provided by a physician. Under AS 23.30.395(32) and *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1258 (Alaska 2007), "physician" includes doctors of medicine, surgeons, chiropractors, osteopaths, dentists, optometrists, and psychologists.
> . . . .
>
> Under 8 AAC 45.083(j), for medical treatment or services provided by a physician, providers and payers shall follow CMS and AMA billing and coding rules, including the use of modifiers. If there is a billing rule discrepancy between National Correct Coding Initiative edits and the AMA Current Procedural Terminology Assistant, AMA Current Procedural Terminology Assistant guidance governs.
>
> Under CMS billing and coding rules and CPT coding rules, chiropractic manipulation treatment codes include a pre-manipulation patient assessment; additional E&M services may be reported separately using modifier -25, but only if the patient's condition requires a significant separately identifiable E&M service.
>
> 8 AAC 45.083(g) applies where a CPT code has a relative value of zero. For example, CPT code 99456 returns a relative value of zero, so the Alaska MAR

> is the lowest of 85% percent of billed charges, the charge for treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer. However, when a CPT code is modified with 26 or TC (technical component) and the relative value is zero and reflects 0% of the global, the MAR is zero. (Bulletin 16-01, may 11, 2016).

31. Claimant explained that extra-spinal manipulation refers to any chiropractic manipulation other than to the spine. (Heston).
32. Here, Claimant provided chiropractic treatment to each of the injured workers, including extra-spinal manipulation on two or more occasions. Claimant submitted bills using CPT code 98943. (Claims). Employer denied payment for the extra-spinal manipulations on the grounds 98943 was a non-covered service based on Medicare guidelines or non-covered based on state regulations. (Claims; Explanations of Review).
33. Under Medicare's definitions, a chiropractor is only considered a physician if the treatment is limited to manual manipulation of the spine to correct a subluxation. No other services furnished by chiropractors are covered. (Medicare Manual Pub 100-1 Medicare General Information, Eligibility, and Entitlement Chapter 5 –Definitions, §70.6 – Chiropractors).
34. On July 15, 2016, the MSRC met for the first time since the fee regulation became effective. It was noted that several issues had arisen regarding the application of the fee schedule. One member stated that there had been no blanket opinion at prior MSRC meetings adopting all CMS rules. The committee also discussed a problem that had arisen has arisen because certain codes had an RVU of zero. The example cited was code 99456, related to permanent partial impairment ratings. The Committee stated it was clearly not their intent to value PPI ratings at zero. A member of the public commented that clarification was needed on two of the codes related to chiropractic manipulation, including 98943. However, the Committee needed additional information before commenting on other specific codes, and directed Optum to compile a list of codes with zero value to present the Committee for review. (MSRC, Minutes, July 15, 2016). While the committed discussed modifiers, it did not address status codes. (Observation).
35. At the MSRC's July 29, 2016 meeting, a representative of Optum explained the various status codes, and recommended the Committee address those codes that had a relative value of zero. A member asked for clarification about whether all Medicare rules had been adopted

when the Committee agreed to adopt CMS billing and coding rules. Marie Marx, Director of the Division of Workers' Compensation, clarified that it was not the intent of the Division to use CMS billing and coding rules. The member stated his belief was that the committee was not adopting all Medicare rules, but only those related to billing and coding. The committee agreed to address chiropractic codes as well as status codes N and I at its next meeting. (MSRC, Minutes, July 29, 2016).

36. The MSRC again met on August 12, 2016[4]. The committee agreed to address specific carve-out provisions, and discussed a carve-out for 99455 and 99456, which relate to permanent partial impairment ratings. The committee concludes CPT code 99455 should be assigned an RVU of 10.63 and code 99456 and RVU or 21.25. A committee member requested carve-outs for status code N items as well some CPT codes related to chiropractic care, including code number 98943. The committee directed Optum to draft language to include these codes as carve outs. (MSRC, Minutes, August 12, 2016) (citations omitted).

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;
>
> . . . .
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

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).

[4] The MSRC also met on August 19, 2016, but the minutes of that meeting have not been finalized or approved.

> **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 cases where the employment causes a hearing loss, the board has found the employee entitled to hearing aids under the Act, including the cost of the exam. *See, e.g., Rizzo v. Municipality of Anchorage*, AWCB Decision No. 11-0017(February 18, 2011).

> **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
>
> (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
>
> (i) a physician fee schedule based on the federal Centers for Medicare and Medicaid Services' resource-based relative value scale;
>
> (ii) an outpatient and ambulatory surgical center fee schedule based on the federal Centers for Medicare and Medicaid Services' ambulatory payment classification; and
>
> (iii) an inpatient hospital fee schedule based on the federal Centers for Medicare and Medicaid Services' Medicare severity diagnosis related group;
>
> (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.

. . . .

(q) The board may adjust the fee schedules established under (a)(1)(A) of this section to reflect the cost in the geographical area where the services are provided.

(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 23.30.098. Regulations.** Under AS 44.62.245(a)(2), in adopting or amending regulations under this chapter, the department may incorporate future amended versions of a document or reference material incorporated by reference if the document or reference material is one of the following:

(1) Current Procedural Terminology Codes, produced by the American Medical Association;

(2) Healthcare Common Procedure Coding System, produced by the American Medical Association;

(3) International Classification of Diseases, published by the American Medical Association;

(4) Relative Value Guide, produced by the American Society of Anesthesiologists;

(5) Diagnostic and Statistical Manual of Mental Disorders, produced by the American Psychiatric Association;

(6) Current Dental Terminology, published by the American Dental Association;

(7) Resource-Based Relative Value Scale, produced by the federal Centers for Medicare and Medicaid Services;

(8) Ambulatory Payment Classifications, produced by the federal Centers for Medicare and Medicaid Services; or

(9) Medicare Severity Diagnosis Related Groups, produced by the federal Centers for Medicare and Medicaid Services.

> **AS 23.30.395. Definitions. In this chapter,**
> . . . .
>
> (24) "injury" means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection that arises naturally out of the employment or that naturally or unavoidably results from an accidental injury; "injury" includes breakage or damage to eyeglasses, hearing aids, dentures, or any prosthetic devices that function as part of the body . . . .
>
> . . . .
>
> (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).

**8 AAC 45.083. Fees for medical treatment and services**

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

(b) For medical services provided by physicians under AS 23.30 (Alaska Workers' Compensation Act), the following conversion factors shall be applied to the total facility or non-facility relative value unit in the Resource-Based Relative Value Scale, adopted by reference in (m) of this section. Medical service or treatment shall be identified by a code assigned to that treatment or service in the Current Procedural Terminology, adopted by reference in (m) of this section:

(1) the conversion factor for evaluation and management is $80;

(2) the conversion factor for medicine, excluding anesthesiology, is $80;

(3) the conversion factor for surgery is $205;

(4) the conversion factor for radiology is $257;

(5) the conversion factor for pathology and laboratory is $142;

(6) the relative value for Current Procedural Terminology code 97545 is 3.41, and the relative value for Current Procedural Terminology code 97546 is 1.36.

(c) The conversion factor for anesthesiology is $121.82, which is to be multiplied by the base and time units for each Current Procedural Terminology code established in the Relative Value Guide, adopted by reference in (m) of this section.

(d) For supplies, materials, injections, and other services and procedures coded under the Healthcare Common Procedure Coding System, adopted by reference in (m) of this section, the following multipliers shall be applied to the following fee schedules established by the Centers for Medicare and Medicaid Services, and in effect at the time of treatment or service:

(1) Clinical Diagnostic Laboratory services, multiplied by 6.33;

(2) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), multiplied by 1.84;

(3) Payment Allowance Limits for Medicare Part B Drugs, Average Sale Price, multiplied by 3.375.

(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

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

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

(3) the base rate for Mat-Su Regional Medical Center is 20,976.66;
(4) the base rate for Bartlett Regional Hospital is $20,002.93;
(5) the base rate for Fairbanks Memorial Hospital is $21,860.73;
(6) the base rate for Alaska Regional Hospital is $21,095.72;
(7) the base rate for Yukon Kuskokwim Delta Regional Hospital is $38,753.21;
(8) the base rate for Central Peninsula General Hospital is $19,688.56;
(9) the base rate for Alaska Native Medical Center is $31,042.20;
(10) the base rate for Mt. Edgecumbe Hospital is $26,854.53; (
11) on outlier cases, implants shall be paid at invoice plus 10 percent.

(f) For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers' Compensation Act), an outpatient conversion factor of $221.79 shall be applied to the relative weights established for each Current Procedural Terminology or Ambulatory Payment Classifications code adopted by reference in (m) of this section. For procedures performed in an outpatient setting, implants shall be paid at invoice plus 10 percent.

(g) The maximum allowable reimbursement for medical services that do not have current Centers for Medicare and Medicaid Services, Current Procedural Terminology, or Healthcare Common Procedure Coding System codes, a currently assigned Centers for Medicare and Medicaid Services relative value, or an established conversion factor is the lowest of 85 percent of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

(h) The maximum allowable reimbursement for prescription drugs is as follows:
(1) brand name drugs shall be reimbursed at the manufacturer's average wholesale price plus a $5 dispensing fee;
(2) generic drugs shall be reimbursed at manufacturer's average wholesale price plus a $10 dispensing fee;
(3) reimbursement for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's average wholesale price for each drug included in the compound, listed separately by National Drug Code, plus a $10 compounding fee.

(i) The maximum allowable reimbursement for lift off fees and air mile rates for air ambulance services rendered under AS 23.30 (Alaska Workers' Compensation Act) is as follows:
(1) for air ambulance services provided entirely in this state that are not provided under a certificate issued under 49 U.S.C. 41102 or that are provided under a certificate issued under 49 U.S.C. 41102 for charter air transportation by a charter air carrier, the maximum allowable reimbursements are as follows:
(A) a fixed wing lift off fee may not exceed $11,500;

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

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

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

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

(j) The following billing and payment rules apply for medical treatment or services provided by physicians. Providers and payers shall follow the billing and coding rules adopted by reference in (m) of this section as established by the Centers for Medicare and Medicaid Services and the American Medical Association, including the use of modifiers. The procedure with the largest relative value unit is the primary procedure and shall be listed first on the claim form. Specific modifiers shall be reimbursed as follows:

(1) Modifier 50: reimbursement is the lowest of 100 percent of the fee schedule amount or the billed charge for the procedure with the highest relative value unit; reimbursement is the lowest of 50 percent of the fee schedule amount or the billed charge for the procedure for the second and all subsequent procedures;

(2) Modifier 51: reimbursement is the lowest of 100 percent of the fee schedule amount or the billed charge for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lowest of 50 percent of the fee schedule amount or the billed charge for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure;

(3) Modifiers 80, 81, and 82: reimbursement is 20 percent of the surgical procedure;

(4) Modifier PE: reimbursement is 85 percent of the value of the procedure; state specific modifier PE shall be used when services and procedures are provided by a physician assistant or an advanced practice registered nurse;

(5) Modifier AS: reimbursement is 15 percent of the value of the procedure; state specific modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon;

(6) Modifier QZ: reimbursement is 85 percent of the value of the anesthesia procedure; state specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist;

(7) providers and payers shall follow National Correct Coding Initiative edits established by the Centers for Medicare and Medicaid Services and

the American Medical Association in effect at the time of treatment; if there is a billing rule discrepancy between National Correct Coding Initiative edits and the American Medical Association Current Procedural Terminology Assistant, American Medical Association Current Procedural Terminology Assistant guidance governs.

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

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

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

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

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

(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.

(l) For medical treatment or services provided by other providers, the maximum allowable reimbursement for medical services provided by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers is the

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

(m) The following material is adopted by reference:

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

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

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

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

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

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

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

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

(9) Medicare Severity Diagnosis Related Groups, effective January 1, 2015, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(n) In this section, "maximum allowable reimbursement" means the charge for medical treatment or services calculated in accordance with the fee schedule.

## ANALYSIS

***Is extra-spinal manipulation compensable under the fee schedule?***

There are no factual disputes; the parties' sole disagreement is whether the extra-spinal manipulation Claimant provided to the Employees is compensable under the fee schedule. Extra-spinal manipulation, CPT code 98943, has a Status Code of "N" in CMS's Physician Fee Schedule Relative Value File, meaning it is not a service covered by Medicare. Employer contends that when the MSRC and the board adopted CMS's "billing and coding rules," that included any restrictions on payment due to a status code. Claimant contends the intent of HB316 and 8 AAC 45.083 was to create a new fee schedule, not to limit treatment or benefits to injured workers.

The MSRC's intent as to status code N for physicians is not clear. Prior to its recommendations to the Commissioner, the MSRC heard a variety of relevant testimony. At its first meeting on July 7, 2014, Director Monagle stated MSRC's goal was to recommend conversion factors to be applied to CMS's relative values, not to make draconian cuts to the existing fee schedule. The materials provided at that meeting are also of little help. The payment formula provided to the MSRC as an example did not refer to status codes, and, while the Idaho regulations specifically state that status code N items were not compensable, the limitation is only for hospitals and ambulatory surgery centers. At the October 24, 2014 Meeting the MSRC discussed whether status payment codes should be incorporated, but reached no decision. On January 15 and 16, 2015, an Optum representative pointed out that the committee needed to make a decision on how to address status codes, and at the February 23, 2015 meeting they discussed status codes in the context of medical facilities. At its April 20, 2015 meeting the committee approved rules relating to the physician fee schedule that make no reference to status codes. In its June 1, 2015 report to the Commissioner, the committee found that it needed to make payment rules for unvalued services and gaps where CMS did not produce relative values. It also found that while CMS payment rules were well established, certain status codes required state specific rules. However, its recommended physician fee schedule, again made no reference to status codes. The MRSC's recommendation was adopted by the board as 8 AAC 45.083.

The MSRC's minutes after the adoption of 8 AAC 45.083 also raise questions as to its intent. On July 15, 2016, one member stated it had not been the committee's intent to adopt all CMS rules, and the committee discussed the problem of CPT codes with a relative value of zero. A member of the public testified clarification was needed on chiropractic codes, including 98943; however the committed made no decision but asked Optum to provide more evidence for review. Again on July 29 2016, a different member stated it was his belief that the committee was not adopting all Medicare rules, only those related to billing and coding. At its August 12, 2016 meeting, a member requested "carve outs" for status code N items as well as some chiropractic CPT codes, including 98943. There is, as yet, no final MSRC statement as to its intention regarding status code N items.

The legislative history of HB 316 provides some guidance, however. Committee testimony indicates the intent of the bill was to reduce worker's compensation medical costs by enacting a new fee schedule. It was not intended to include evidence based best practices or utilization review. Certainly, nothing suggests the bill was intended to reduce the benefits available to injured workers or change or override other provisions of the act.

A hearing panel does not have jurisdiction to find a regulation conflicts with the Act; under AS 23.62.300, (a), only the courts have that authority. This case does not require a determination as to the validity of 8 AAC 45.083, but when faced with two conflicting interpretations of the regulation, the same factors considered by the courts in determining whether a regulation is valid come into play. It must be assumed that the MSRC was aware of the bill's intent, and that it did not intend to exceed its statutory authority or to make the recommendations that conflict with other portions of the Act.

Two examples illustrate why the MSRC cannot have intended to preclude payment for status code N items in the physician fee schedule. First, under AS 23.30.095 and several board cases, hearing aids, and hearing aid exams, are compensable if the employment caused the hearing loss. Additionally, under AS 23.30.395(24), the definition of "injury" includes breakage or damage to hearing aids caused by work, regardless of whether the employee suffered any physical injury. Under the CMS physician's fee schedule, hearing aid exams, CPT code 92591, are a status code N item and thus not covered. Second, and more closely related to this case, the Act's definition of "physician" includes chiropractors, with no limitations as to the body parts or treatment a chiropractor can provide. AS 23.30.395(32). However, under Medicare's definition, a chiropractor is only considered a physician if the treatment is limited to manual manipulation of the spine for a specific purpose. Consequently, CPT code 98943, for chiropractic manipulation other than to the spine, is a status code N item and is not covered.

The practical effect of a fee schedule that does not provide payment for mandated benefits is the elimination of those benefits. Under AS 23.30.097(f), an employee may not be required to pay for medical treatment for a work injury, and medical providers cannot be expected to treat injured workers for free. Similarly, incorporating CMS's limit on chiropractors as physicians is

incompatible with the Act's definition of "physician," which includes no such limitation. The physician fee schedule is best harmonized with the Act if does not include the status code N payment restrictions.[5]

## CONCLUSION OF LAW

Extra-spinal manipulation is compensable under the fees schedule.

## ORDER

Claimant's claims are granted.

Dated in Anchorage, Alaska on December 16, 2016.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Ronald Nalikak, Member

/s/
Mark Talbert, Member

[5] This is not to suggest the MSRC cannot make status code N items noncompensable in general if it makes some provision for items required by the Act. It may well be that many of the status code N items have no application in the workers' compensation context.

## 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 JOSHUA KASTELLE, employee; JAMES F. HESTON, D.C., claimant; v. NOMAR, LLC, employer; OHIO CASUALTY INSURANCE COMPANY, insurer / defendants; MOLLY KENNEDY, employee; JAMES F. HESTON, D.C., claimant; v. SOUTH PENINSULA BEHAVIORAL HEALTH SERVICES, employer; ALASKA NATIONAL INSURANCE COMPANY, insurer / defendants; and NANCY MARTIN, employee; JAMES F. HESTON, D.C., claimant; v. HOMER SENIOR CARE, employer; ALASKA NATIONAL INSURANCE COMPANY, insurer / defendants; Case Nos. 201602586, 201602666, and 201519138, respectively; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on December ___, 2016.

/s/
Vera James, Office Assistant