



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

Alaska Workers' Compensation Board Meeting

Public Meeting Packet

October 15 - 16, 2026

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

TABLE OF CONTENTS

<u>TAB 1</u> Page 4	Agenda
<u>TAB 2</u> Page 7	Board Minutes May 14, 2026
<u>TAB 3</u> Page 10	Board Member Roster
<u>TAB 4</u> Page 12	Board Designees
<u>TAB 5</u> Page 14 Page 22 Page 23	Director's Report Director's Report Organization Staffing Chart FY2026 Budget Sheets
<u>TAB 6</u> Page 30	Annual Report
<u>TAB 7</u> Page 126	Case Summaries
<u>TAB 8</u> Page 128	Medical Fee Schedule
<u>TAB 9</u> Page 199 Page 200 Page 236	Regulations 8 AAC 45.083 January 2026 Reg Package 8 AAC 45.220
<u>TAB 10</u> Page 241	Public Comment

TAB 1

ALASKA WORKERS' COMPENSATION BOARD MEETING AGENDA

October 15-16, 2026

**ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

Zoom Video Conference: <https://us02web.zoom.us/j/83666166455>

To participate telephonically: call 833-548-0282, Webinar ID: 836 6616 6455

Thursday, October 15, 2026

- 9:00am** Call to order
Roll call establishment of quorum
Introduction of new Board members
Introduction of Senior Staff
- 9:10am** Approval of Agenda
- 9:15am** Reading and approval of minutes from May 14, 2026, Board meeting
- 9:30am** Director's Report
- Division Update
 - Approval of Board Designees
 - AWCB 2027 Hearing Calendar?
 - Legislative Audit updates
- 10:00am** Break
- 10:15am** Public Comment Period
- Public comments
- 11:15am** Budget & Staffing Update – Alexis Hildebrand, Admin Officer
- 11:30am** 2025 Annual Report
- 12:00pm** Lunch Break
- 1:30pm** 2025 Annual Report - continued
- 3:30pm** Adjournment

Friday, October 16, 2026

- 9:00am** Call to order
Roll call establishment of quorum
- 9:10am** Court Case Review
- 9:40am** Old Business
- Regulation proposals adoption of 8 AAC 45.083 amendment
 - Regulation proposals from past Board meetings
- 10:30am** Break
- 10:45am** New Business
- Regulation proposals 8 AAC 45.220
- 11:50pm** Lunch Break
- 1:30pm** New Business Continued if needed
- 3:30pm** Break
- 3:45pm** New Business Continued
- 5:00pm** Adjournment



TAB 2

Alaska Workers' Compensation Board
Meeting Minutes
May 14, 2026

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:01 a.m. in Juneau, Alaska. Participation was available in person and via Zoom videoconference.

II. ROLL CALL

The following Board members were present, constituting a quorum:

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

Member Randall McLellan was absent. Member Dennis arrived at 9:05 a.m.

III. AGENDA APPROVAL

Member Lefebvre moved to approve the agenda; Member White seconded. Member Lefebvre noted that the January meeting was held on January 8 only, not January 8-9 as stated in the agenda. Member Lefebvre also noted that the Board had moved for the Division to draft a bulletin and that the item should be included under Old Business. Member White accepted the amendments. The agenda, as amended, passed unanimously.

IV. APPROVAL OF JANUARY 8, 2026 AND FEBRUARY 19, 2026 MEETING MINUTES

Member Lefebvre moved to approve the January 8, 2026 minutes; Member White seconded. The motion passed unanimously.

Member Lefebvre moved to approve the February 19, 2026 minutes; Member White seconded. The motion passed unanimously.

V. DIRECTOR'S REPORT

Director Collins provided a legislative update on pending bills that may affect workers' compensation benefits, Division operations, funding, electronic service, and the Workers' Compensation Appeals Commission. He stated that the Division continues to monitor legislation that could directly or indirectly affect the workers' compensation system. Director Collins also provided updates on the Board's regulation package.

Member Lefebvre moved to approve the list of Board Designees; Member White seconded. The motion passed unanimously.

Director Collins reported that the Division received written comment from Carson Honeycutt regarding mandatory mediation in disputed claims. Director Collins and Chief Wright discussed the Division's current mediation practices, potential benefits and challenges of mandatory mediation, mediator training needs, staffing capacity, and due process considerations. No action was taken.

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

Jackie Doerner, self-employed rehabilitation specialist

- Commented on recent regulation changes. Stated that extending the timeframe for reemployment eligibility evaluations from 30 days to 60 days has been helpful.
- Commented on the transition to O*NET for job descriptions. Stated that O*NET has been useful, particularly when identifying appropriate job titles, but noted that the longer job descriptions may present challenges for medical providers.
- Stated that the increased reemployment benefit amount is beneficial, but noted that its usefulness depends on approval of retraining plans at the higher amount.

Carrie Guthrie-Whitlow, vocational rehabilitation counselor

- Submitted written public comment.
- Commented on her experience with the Stay at Work program and stated that early involvement by vocational rehabilitation counselors can support communication, reduce uncertainty, and assist with return-to-work efforts.
- Identified delays in communication from adjusters and employers as an area for improvement.

VII. OLD BUSINESS

In response to the Board's motion at the February 19, 2026 meeting, Director Collins reported that the Division issued Bulletin 26-02 to clarify application of the medical fee schedule following the delayed adoption of the updated fee schedule and newly adopted CMS resource materials. The bulletin is posted online and clarifies that the 2025 medical fee schedule remained in effect through March 31, 2026, and that the updated fee schedule took effect April 1, 2026.

VIII. NEW BUSINESS

Member Lefebvre moved to adopt the 2027 hearing calendar; Member Zematis seconded. Member Cline noted that the Juneau and Fairbanks calendars incorrectly included an additional Board meeting on May 13. Member Lefebvre amended the motion to exclude that date, and Member Zematis accepted the amendment. The motion, as amended, passed unanimously.

Lunch 12:00 p.m. - 1:30 p.m.

IX. ETHICS TRAINING

Matthew Stinson, Department of Law, provided Executive Branch Ethics Act training to the Board and staff.

X. ADJOURNMENT

Member Lefebvre moved to adjourn; Member Dennis seconded. The motion passed unanimously.

Adjourn 2:27 p.m.

TAB 3

ALASKA WORKERS' COMPENSATION BOARD

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

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

TAB 4



BOARD DESIGNEES – OCTOBER 2026

The following staff members are appointed as Board designees to act on the Board's behalf in accordance with the Alaska Workers' Compensation Act and Regulations. (For example, the Board designee may conduct prehearing conferences, take action in connection with Board-ordered second independent medical examinations, and decide whether to continue or cancel scheduled Board hearings.)

<u>NAME</u>	<u>LOCATION</u>	<u>POSITION TITLE</u>
Charles Collins	Juneau	Director
Janel Wright	Anchorage	Chief of Adjudications
Kyle Reding	Anchorage	WC Hearing Officer II
William Soule	Anchorage	WC Hearing Officer II
Kyle Ruschell	Anchorage	WC Hearing Officer I
Vacant	Anchorage	WC Hearing Officer I/II
Kathryn Setzer	Juneau	WC Hearing Officer II
Robert Vollmer	Fairbanks	WC Hearing Officer II
Vacant	Fairbanks	WC Hearing Officer I/II
Elizabeth Pleitez	Anchorage	WC Officer II
Harvey Pullen	Anchorage	WC Officer II
Vacant	Anchorage	WC Officer II
Carrie Craig	Anchorage	WC Officer II
Rochelle Comer	Anchorage	WC Officer I
Vacant	Juneau	WC Officer II
Vacant	Fairbanks	WC Officer II

TAB 5



WORKERS' COMPENSATION DIVISION

OCTOBER 2026 ALASKA WORKERS' COMPENSATION
DIRECTOR'S REPORT

...to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers...

ALASKA WORKERS COMPENSATION BOARD NEWS

It is with great pleasure to report that the Board is almost fully staffed. Recent appointments this summer have provided a much-needed injection of life to the Board. Currently we have only one vacancy, an industry seat from District 3, and have welcomed a new member last month.

Name	Panel	Affiliation	Term Date
Brad Austin	Southern	Labor	2028
Debbie White	Southern	Industry	2027
Randy Beltz	Southcentral	Industry	2028
Mike Dennis	Southcentral	Industry	2028
Sara Faulkner	Southcentral	Industry	2028
Rebecca Tamaki	Southcentral	Industry	2028
Vacant	Southcentral	Industry	2028
Bronson Frye	Southcentral	Labor	2027
Pam Cline	Southcentral	Labor	2027
Anthony Ladd	Southcentral	Labor	2029
Randall McLellan II	Southcentral	Labor	2029
Shayne Wescott	Southcentral	Labor	2027
Sarah LeFebvre	Northern	Industry	2028
Samuel Moore	Northern	Industry	2028
Lake Williams	Northern	Labor	2029
John Corbett	Northern	Labor	2027
Amy Bender	At Large	Industry	2027
Brian Zematis	At Large	Labor	2029

REGULATIONS

I am delighted to share that both Regulation packages have been reviewed and approved by the Department of Law, sent out for public comment and now are back in the Board's control to be considered for adoption. The large packet worked on in the January Board meeting has undergone some edits by LAW but are substantially unchanged and all edits were made in conjunction with Workers' Compensation Hearing Officers in working sessions with attorneys from LAW. The Medical Fee Schedule Package is also included without changes. One note on 8 AAC 45.083, Fees for medical services, we once again are adding a subparagraph in the long list of annual fee schedule adoption paragraph. There is reason for optimism, as the Department of Law has identified a potential solution.

Governor's Administrative Order 360 directed all Departments to look for ways to "improve the quality, transparency, and efficiency of the State's regulatory environment." To ensure all regulations are clearly written, legally sound, and supported by a demonstrated need. Regularly evaluating existing regulations for effectiveness, redundancy, clarity, and impact to reduce the regulatory burden on all Alaskans.

Further regulation work will be required to meet the intent of the Administrative Order, the Division is currently researching the regulatory code for further improving efficiency and quality.

LEGISLATION

With Alaska currently between legislative sessions, no bills are pending. However, several recurring or emerging policy areas are expected to materialize as bill concepts once the next session convenes. These issues reflect long-standing debates within Alaska as well as national trends influencing workers' compensation, employment classification, and sector-specific presumptions.

1. Repeal of the Workers' Compensation Appeals Commission

A proposal to repeal the Workers' Compensation Appeals Commission consistently returns each legislative session and is expected to reappear. The typical intent is to dissolve the Commission and transfer appeals to another judicial body, such as the Superior Court.

If advanced, this change would have operational impacts on appeals processing, workload distribution, and procedural timelines. It should be noted that this proposal has passed both sides of the legislative body in the past but never advanced to the Governor's desk.

2. Workers' Compensation Funding Structure and Electronic Service

To maintain operations aligned with legislative intent, the workers' compensation system will require adjustments to its revenue model and continued refinements to operating procedures. Any upgrade / modernization of the claims database, implementation of AI technology, or additional work groups will require Legislative action.

Potential mechanisms under consideration include:

- Increasing the premium levy to raise revenue.
- Implementing a tax on hours worked by employees.
- Establishing an annual fee on employers.
- These mechanisms are used in other states and may be evaluated for suitability in Alaska.

Continued modernization—such as expanding electronic service—may also require statutory updates.

3. Anticipated Bills Emerging from National Trends

Several policy themes active in other states are likely to surface in Alaska, including:

- Agricultural cooperative updates
- Coverage frameworks for gig workers and non-traditional employment models
- Firefighter occupational presumptions
- PTSD-related reforms or clarifications
- Attorney fee reforms in workers' compensation cases
- Additional modernization or compliance-driven adjustments

These issues typically reach Alaska after gaining traction elsewhere and can be expected to appear in future legislative proposals.

While the state is between sessions, the policy areas outlined above represent potential bill concepts for the upcoming legislative cycle. Many are recurring efforts, while others reflect evolving national trends that eventually converge in Alaska's legislative environment.

CURRENT WORK

The AWCB will be voting on the adoption regulation of a New Medical Fee Schedule for 2027 at the October Board meeting. National Council on Comprehensive Insurance, Inc. (NCCI), has just released the Medical Data Report for Alaska on the 2025 medical data, this report is available to the Board and will be referenced in several statistics this winter. The big news is that Alaska's Fee Schedule has become a reference for many other jurisdictions and I receive a number of questions on our process and success.

NCCI monitors changes in CMS reimbursement rules and rates that impact WC medical costs. The impacts of these changes on WC medical costs vary by state. The major changes that affected Alaska were contemplated by the MSRC and incorporated in the 2027 Alaska Medical Fee Schedule. The major findings were:

- The 2026 physician conversion factor increased by 3.3% from the 2025 conversion factor, marking the first increase following five years of declines
- The 2026 physician Relative Value Units (RVUs) were rebalanced, resulting in increased payment rates for Evaluation and Management services and decreased payment rates for Surgical services
- Facility base rates saw moderate increases that were in line with the changes seen in prior years
- The 2.0% increase to the CMS DMEPOS update factor in 2026 is in line with the increase from last year

Physician Payments as a Percentage of Medicare

Service Year 2025

Physician Service Category	Alaska	Countrywide
Anesthesia	297%	325%
Evaluation and Management	191%	161%
Physical and General Medicine	174%	152%
Surgery	279%	268%
Radiology	325%	247%
All Physician Services	210%	180%

While participating in the recent IAIABC Conference, the Alaska Fee Schedule was highlighted several times on our progressive work of controlling costs while working with providers. The recent work on Durable Medical Devices, DME, to provide direction for proper billing on new types of therapeutic devices was highlighted by vendors as the preferred option as this allows providers to prescribe those devices and be reimbursed without delays. The work that several states, including Alaska, on controlling compounded drugs and topical ointments was also praised by providers and other jurisdictions as this issue is a current hot topic for the workers' compensation industry.

DIRECTOR THOUGHTS

We began the year concerned that a budget deficiency would negatively impact the Division and the Board, potentially hindering workers' compensation operations through inefficiency. The Division has been operating with a significant vacancy factor, which has affected our ability to fully meet the demands of the industry.

The good news is that, despite these challenges, we have continued to meet our key performance metrics. Additionally, the FY2027 budget directly addresses these issues, positioning us to restore capacity and improve operational efficiency moving forward.

My objectives:

- Fill the positions with the largest operational return.
- Reduce adjudication delays and enforcement backlog.
- Rebuild statewide footprint via Fairbanks staffing.

To facilitate this process, I have put into action some initiatives:

- Reclassification and market-based compensation adjustments for hearing officers.
- Fill Investigator III position to reduce uninsured employer cases and fraud exposure.
- Restore Fairbanks office staffing to improve statewide coverage and access.
- Develop a recruitment pipeline with UAA, law schools, and paralegal programs.

The goal for the Division is to:

- Hearing officer vacancy duration reduced 50%.
- Investigator III position filled by FY2027 Q2.
- Fairbanks office operating with full minimum staffing by FY2027 Q3.
- Average adjudication processing time reduced 10% year-over-year.

MODERNIZATION

Technology gaps and deferred equipment upgrades continue to pose a substantial operational risk. To address these risks, the Division is developing a plan to replace legacy systems, improve workflow efficiency, expand digital data exchange, and ensure continuity of specialized programs through in-house training..

The Workers' Compensation Division will be refining its data-driven management evaluation system with a renewed focus on leveraging new technology to enhance customer service and improve claim-handling processes. As part of this effort, we are developing a plan to increase both the speed and accuracy of annual claim reporting from our trading partners, ensuring greater usability and more reliable data reporting. New practices and procedures are being written into policy and each task is undergoing testing before implementation.

In addition, the Division will reinstate scheduled upgrades to digital equipment this year. This practice is essential for supporting staff performance and ensuring we continue to meet statutory requirements related to communication with constituents.

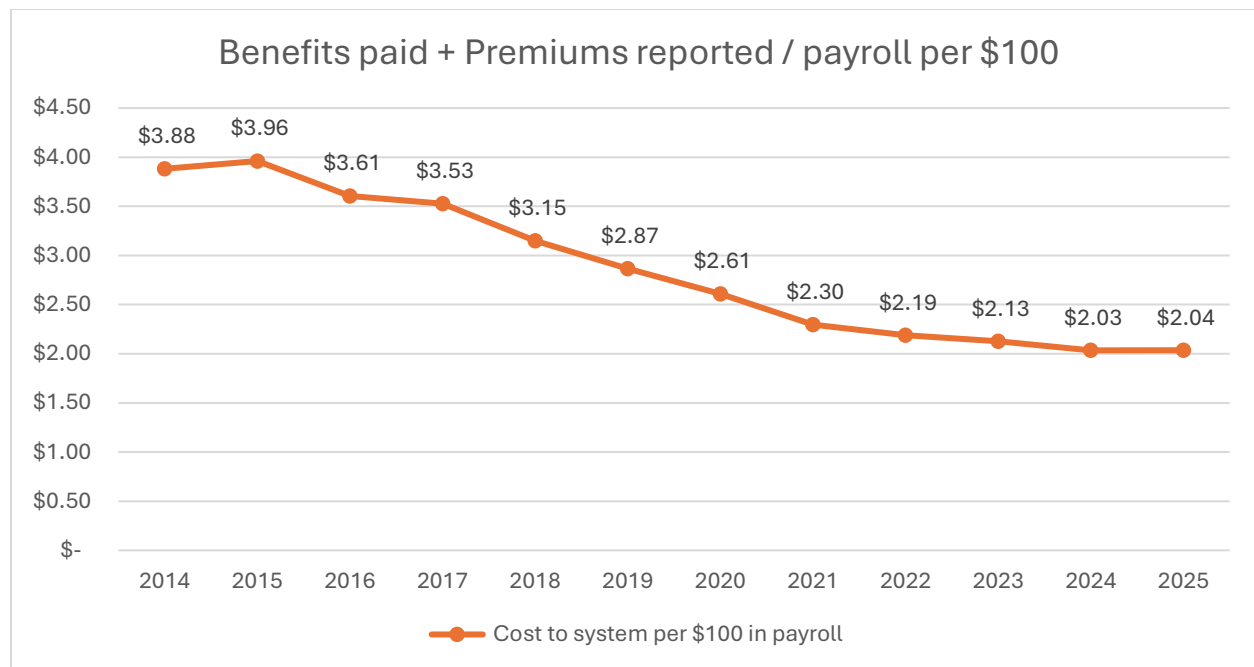
The largest impediment facing the Board and the Division is the replacement of the ICERS program, the claims database currently in use. Upgrading to a modern claims system is critical. A new platform will allow all parties to access claim files, submit documents directly, and monitor claim progress in real time. It will also enable Division staff to shift their focus from repetitive data entry to providing meaningful assistance to parties, resolving issues more efficiently and improving

overall service delivery. This project will require a capital funding request from the Legislature after the specifications are decided on. I anticipate that a project plan will be implemented in 2028, and, depending on the selected vendor, the project could be completed and operational within two years of initiation. The current estimated cost is over \$15 million.

With the continued successes that the Board has accomplished by streamlining the workers' compensation processes to ease the burden on all parties, we can provide a strong argument for continuing that success. To enhance the transaction of business with the Division, the modernization of our database is imperative. The Alaska Workers' Compensation Board will be essential to request and obtaining funds for this project.

TOTAL COSTS TO WORKERS COMPENSATION IN ALASKA

Alaska continues to work diligently to carefully control costs and partner with providers and payers to improve outcomes for injured workers



This is an average cost of all Alaskan employers reporting under Alaska Workers' Compensation.

Using the Alaska Department of Labor QCEW annual wage data for both years, and the CPI-U to put 2015 wages into 2025 dollars, the comparison is:

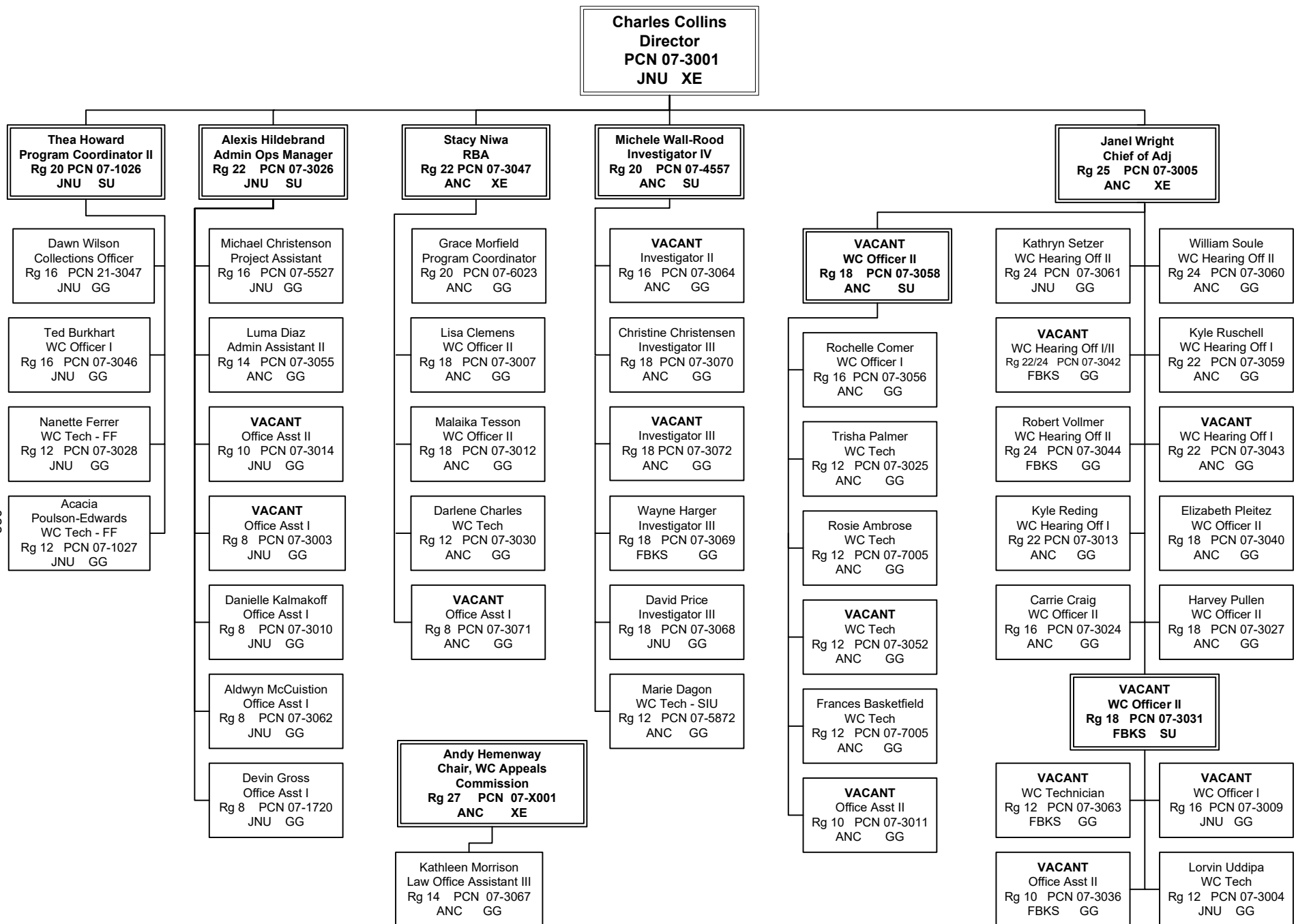
Measure	2015	2025	Change 2015–2025
Average annual salary/wage	\$54,180	\$74,640	+\$20,460 (+37.8%)
2015 salary in 2025 dollars	\$73,593	—	—
Real wage change after inflation	—	—	+\$1,047 (+1.4%)
Inflation, 2015–2025	—	—	35.8%
Workers' compensation cost per \$100 payroll	\$3.96	\$2.04*	-\$1.92 (-48.6%)

While nominal wages increased 37.8% between 2015 and 2025, inflation cut the purchasing power of the increase by 35.8%, making the real increase a mere 1.4%. But workers' compensation costs fell approximately 48.6% during the same time period assisting Alaskan employers to control costs. In other words, wages essentially kept pace with inflation, while the workers' compensation cost burden declined substantially.

MINOR CONCERNS

In the annual report we will be sharing some new data that was recently researched and shared with us by NCCI. This data exhibits the number of workers' compensation insurance policies sold annually compared to the number of employers reporting employee wages annually. In the past the Division worked under the assumption that 700 to 800 businesses neglected to provide coverage annually. The findings not only surprised us but are a worry for the Director. This not only has the possible risk of workers being injured with no coverage and relying on the Benefits Guarantee Fund but also reduces the possible funding of the Division.

The only incentive the AWCB / WCD has to ensure employers cover employees is our SIU team performing follow-up contacts from the tip line, working a list from the Division of Insurance for known businesses that may have let a policy lapse, or checking on our reoccurring offenders. My goal is to increase the Board's awareness of the size and scope of the problem. Our SIU team is equipped to assist employers in becoming compliant with the law. However, additional Board support is needed to develop effective strategies for motivating employers to obtain and maintain required workers' compensation coverage.



Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/22/2026	Q3	FY2026
-----------	----	--------

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 7/5/2026

Summary:

Program	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/22/2026		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Workers' Compensation	7,071,900	0	0	0	7,071,900	6,020,070.25	0.00	1,051,830	0	0	6,020,070	1,051,830	85.1%
WC Appeals Commission	503,300	0	0	0	503,300	476,538.36	0.00	26,762	0	0	476,538	26,762	94.7%
WC Benefits Guaranty Fund	805,100	0	0	0	805,100	694,923.31	0.00	110,177	0	0	694,923	110,177	86.3%
Second Injury Fund	2,902,500	0	0	0	2,902,500	1,638,228	0	1,264,272	0	0	1,638,228	1,264,272	56.4%
Fishermen's Fund	1,475,400	0	0	0	1,475,400	1,325,018	0	150,382	0	0	1,325,018	150,382	89.8%
Division Total	12,758,200	0	0	0	12,758,200	10,154,778	0	2,603,422	0	0	10,154,778	2,603,422	79.6%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Workers' Safety	7,525,300	0	0	0	7,525,300
General Funds	49,900	0	0	0	49,900
Benefits Guaranty Fund	805,100	0	0	0	805,100
Second Injury Fund	2,902,500	0	0	0	2,902,500
Fishermen's Fund	1,475,400	0	0	0	1,475,400
Total Program Funding	12,758,200	0	0	0	12,758,200

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: 9/22/2026 Q3 FY2026

Pay Periods processed	26	PPE: 7/5/2026
Pay Periods Remaining	0	
Total	26	

Workers' Compensation

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/22/2026		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To Date
						Expend	Encumb						
Personal Services	5,869,300.00	19,255.30	0.00	0.00	5,888,555.30	4,924,148.92	0.00	964,406.38	0.00	0.00	4,924,148.92	964,406.38	83.6%
Travel	70,400.00	-36,600.00	0.00	0.00	33,800.00	28,610.66	0.00	5,189.34	0.00	0.00	28,610.66	5,189.34	84.6%
Services	1,045,800.00	17,344.70	0.00	0.00	1,063,144.70	995,731.53	0.00	67,413.17	0.00	0.00	995,731.53	67,413.17	93.7%
Commodities	74,800.00	0.00	0.00	0.00	74,800.00	60,034.06	0.00	14,765.94	0.00	0.00	60,034.06	14,765.94	80.3%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	1,191,000.00	-19,255.30	0.00	0.00	1,171,744.70	1,084,376.25	0.00	87,368.45	0.00	0.00	1,084,376.25	87,368.45	92.5%
Grants	11,600.00	0.00	0.00	0.00	11,600.00	11,545.08	0.00	54.92	0.00	0.00	11,545.08	54.92	99.5%
Total Program Expenditures	7,071,900.00	0.00	0.00	0.00	7,071,900.00	6,020,070.25	0.00	1,051,829.75	0.00	0.00	6,020,070.25	1,051,829.75	85.1%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
General Funds	24,600.0				24,600.00
Workers' Safety	7,047,300.00				7,047,300.00
Total Program Funding	7,071,900.00	0.00	0.00	0.00	7,071,900.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/22/2026	Q3	FY2026
-----------	----	--------

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 7/5/2026

WC Appeals Commission

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/22/2026		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	387,200.00	7,511.34	0.00	0.00	394,711.34	391,712.23	0.00	2,999.11	0.00	0.00	391,712.23	2,999.11	99.2%
Travel	0.00	5,400.00	0.00	0.00	5,400.00	0.00	0.00	5,400.00	0.00	0.00	0.00	5,400.00	0.0%
Services	111,100.00	-30,911.34	0.00	0.00	80,188.66	62,119.64	0.00	18,069.02	0.00	0.00	62,119.64	18,069.02	77.5%
Commodities	5,000.00	18,000.00	0.00	0.00	23,000.00	22,706.49	0.00	293.51	0.00	0.00	22,706.49	293.51	98.7%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	116,100.00	-7,511.34	0.00	0.00	108,588.66	84,826.13	0.00	23,762.53	0.00	0.00	84,826.13	23,762.53	78.1%
Grants	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00		0.00	0.0%
Total Program Expenditures	503,300.00	0.00	0.00	0.00	503,300.00	476,538.36	0.00	26,761.64	0.00	0.00	476,538.36	26,761.64	94.7%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
General Funds	25,300.0				25,300.00
Workers' Safety	478,000.00				478,000.00
Total Program Funding	503,300.00	0.00	0.00	0.00	503,300.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/22/2026	Q3	FY2026
-----------	----	--------

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 7/5/2026

Benefits Guaranty Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/22/2026		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	138,800.00	489.58	0.00	0.00	139,289.58	139,289.58	0.00	0.00	0.00	0.00	139,289.58	0.00	100.0%
Travel	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
Services	231,600.00	-40,489.58	0.00	0.00	191,110.42	95,007.51	0.00	96,102.91	0.00	0.00	95,007.51	96,102.91	49.7%
Commodities	2,000.00	0.00	0.00	0.00	2,000.00	171.80	0.00	1,828.20	0.00	0.00	171.80	1,828.20	8.6%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	233,600.00	-40,489.58	0.00	0.00	193,110.42	95,179.31	0.00	97,931.11	0.00	0.00	95,179.31	97,931.11	49.3%
Grants	432,700.00	40,000.00	0.00	0.00	472,700.00	460,454.42	0.00	12,245.58	0.00	0.00	460,454.42	12,245.58	97.4%
Total Program Expenditures	805,100.00	0.00	0.00	0.00	805,100.00	694,923.31	0.00	110,176.69	0.00	0.00	694,923.31	110,176.69	86.3%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Benefits Guaranty Fund	805,100.00				805,100.00
Total Program Funding	805,100.00	0.00	0.00	0.00	805,100.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/22/2026	Q3	FY2026
-----------	----	--------

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 7/5/2026

Second Injury Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/22/2026		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	264,200.00	32,400.00	0.00	0.00	296,600.00	287,843.19	0.00	8,756.81	0.00	0.00	287,843.19	8,756.81	97.0%
Travel	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
Services	65,700.00	-2,000.00	0.00	0.00	63,700.00	39,410.78	0.00	24,289.22	0.00	0.00	39,410.78	24,289.22	61.9%
Commodities	4,300.00	2,000.00	0.00	0.00	6,300.00	6,176.39	0.00	123.61	0.00	0.00	6,176.39	123.61	98.0%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	70,000.00	0.00	0.00	0.00	70,000.00	45,587.17	0.00	24,412.83	0.00	0.00	45,587.17	24,412.83	65.1%
Grants	2,568,300.00	-32,400.00	0.00	0.00	2,535,900.00	1,304,797.29	0.00	1,231,102.71	0.00	0.00	1,304,797.29	1,231,102.71	51.5%
Total Program Expenditures	2,902,500.00	0.00	0.00	0.00	2,902,500.00	1,638,227.65	0.00	1,264,272.35	0.00	0.00	1,638,227.65	1,264,272.35	56.4%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Second Injury Fund	2,902,500.00				2,902,500.00
Total Program Funding	2,902,500.00	0.00	0.00	0.00	2,902,500.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/22/2026	Q3	FY2026
-----------	----	--------

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 7/5/2026

Fishermen's Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/22/2026		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	338,800.00	500.00	0.00	0.00	339,300.00	343,914.44	0.00	-4,614.44	0.00	0.00	343,914.44	-4,614.44	101.4%
Travel	28,000.00	-6,900.00	0.00	0.00	21,100.00	10,930.51	0.00	10,169.49	0.00	0.00	10,930.51	10,169.49	51.8%
Services	322,500.00	6,400.00	0.00	0.00	328,900.00	329,542.21	0.00	-642.21	0.00	0.00	329,542.21	-642.21	100.2%
Commodities	41,400.00	0.00	0.00	0.00	41,400.00	453.64	0.00	40,946.36	0.00	0.00	453.64	40,946.36	1.1%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	391,900.00	-500.00	0.00	0.00	391,400.00	340,926.36	0.00	50,473.64	0.00	0.00	340,926.36	50,473.64	87.1%
Grants	744,700.00	0.00	0.00	0.00	744,700.00	640,177.54	0.00	104,522.46	0.00	0.00	640,177.54	104,522.46	86.0%
Total Program Expenditures	1,475,400.00	0.00	0.00	0.00	1,475,400.00	1,325,018.34	0.00	150,381.66	0.00	0.00	1,325,018.34	150,381.66	89.8%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Fishermen's Fund	1,475,400.00				1,475,400.00
Total Program Funding	1,475,400.00	0.00	0.00	0.00	1,475,400.00

TAB 6



Alaska Workers' Compensation Board

2025 Annual Report

030



ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Cathy Muñoz, Commissioner

Workers' Compensation 2026





Alaska Workers' Compensation Board

Table of Contents

031

Alaska Workers' Compensation Board "to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers" AS 23.30.001 The Alaska Division of Workers' Compensation (WCD)—part of the Department of Labor & Workforce Development—is the administrative agency responsible for implementing the Alaska Workers' Compensation Act. Alaska requires employers or their insurers to provide medical, disability, and reemployment benefits to workers injured on the job, including benefits for dependents in work-related fatalities.	Alaska Workers' Compensation Board 2025 Annual Report Adjudications	Alaska Workers' Compensation Board 2025 Annual Report Benefits Guaranty Fund Thea Howard	Alaska Workers' Compensation Board 2025 Annual Report Second Injury Fund Thea Howard																											
Alaska Workers' Compensation Board 2025 Annual Report Special Investigations Unit	Alaska Workers' Compensation Board 2025 Annual Report Reemployment Benefits Unit	Alaska Workers' Compensation Board 2025 Annual Report Second Independent Medical Evaluations SIME Carrie Craig, Workers' Compensation Officer II	Alaska Workers' Compensation Board Index of Topics <table><tr><td>STATUTE</td><td>REGULATION</td><td>HEARING</td></tr><tr><td>MEDIATION</td><td>FALL</td><td>DEPOSITION</td></tr><tr><td>CONTROVERSION</td><td>SLIP</td><td>DIAGNOSIS</td></tr><tr><td>COMBATIVE</td><td>PINCH</td><td>EMPLOYEE</td></tr><tr><td>SAFE</td><td>SIME</td><td>EMPLOYER</td></tr><tr><td>WORKPLACE</td><td>IMPAIRMENT</td><td>OCCUPATION</td></tr><tr><td>THERAPY</td><td>DISABILITY</td><td>MEDICAL</td></tr><tr><td>REHABILITATION</td><td>COMPENSATION</td><td></td></tr><tr><td>FRAUD</td><td>INDEMNITY</td><td></td></tr></table>	STATUTE	REGULATION	HEARING	MEDIATION	FALL	DEPOSITION	CONTROVERSION	SLIP	DIAGNOSIS	COMBATIVE	PINCH	EMPLOYEE	SAFE	SIME	EMPLOYER	WORKPLACE	IMPAIRMENT	OCCUPATION	THERAPY	DISABILITY	MEDICAL	REHABILITATION	COMPENSATION		FRAUD	INDEMNITY	
STATUTE	REGULATION	HEARING																												
MEDIATION	FALL	DEPOSITION																												
CONTROVERSION	SLIP	DIAGNOSIS																												
COMBATIVE	PINCH	EMPLOYEE																												
SAFE	SIME	EMPLOYER																												
WORKPLACE	IMPAIRMENT	OCCUPATION																												
THERAPY	DISABILITY	MEDICAL																												
REHABILITATION	COMPENSATION																													
FRAUD	INDEMNITY																													





Alaska Workers' Compensation Board

“to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers” AS 23.30.001

032

The Alaska Division of Workers' Compensation (WCD)—part of the Department of Labor & Workforce Development—is the administrative agency responsible for implementing the Alaska Workers' Compensation Act.

Alaska requires employers or their insurers to provide medical, disability, and reemployment benefits to workers injured on the job, including benefits for dependents in work-related fatalities.





Alaska Workers' Compensation Board

Kids' Chance Alaska



Susan Daniels,
President

Misty Steed,
Vice President

Michelle Meshke,
Secretary

Andrew Wilson,
Treasurer

Stacey Stone,
Director

Alizon White,
Director

Janel Wright,
Director

Amber-Rae
McCampbell,
Director

Cheryl Wika,
Director





Alaska Workers' Compensation Board

News from Workers' Compensation

034



Hon. Janel L. Wright

Alaska Workers' Compensation Division

Anchorage, Alaska

Adjudicator

Janel Wright has been with Alaska' Workers' Compensation Division since 2004. Initially, she served as a Hearing Officer and was appointed as the Chief of Adjudications in 2008; she served until 2015. She returned to being Hearing Officer and in 2023 was again appointed as Chief of Adjudications. Prior to immersing herself in workers' compensation law, she was a civil rights attorney and Legal Director for Alaska's Disability Law Center.

 (907) 869-4982

 janel.wright@alaska.gov

National Workers' Compensation College Fellow
Janel Wright
Chief of Adjudications, Alaska Division of Workers' Compensation



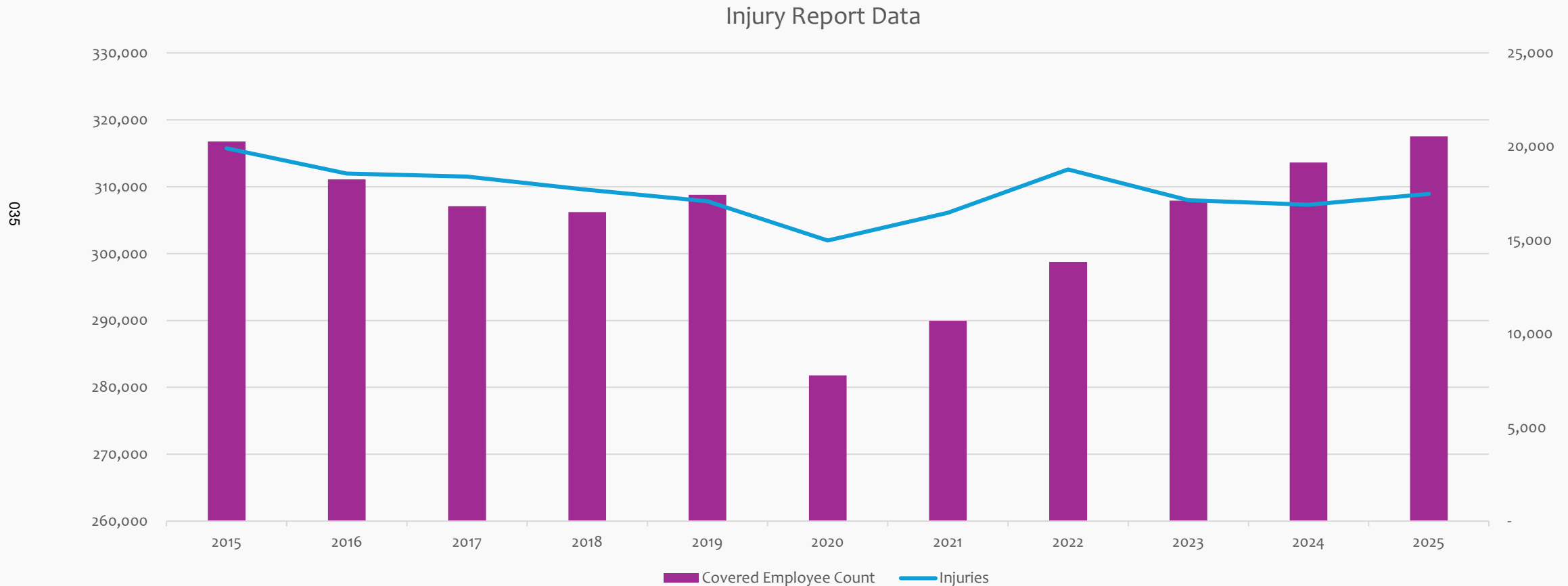
NextGen Award Winner
Alexis Hildebrand
Administrative Operations Manager, Alaska Division of Workers' Compensation





Alaska Workers' Compensation Board

Increased Employment – Injury Report Flat





Alaska Workers' Compensation Board

Notes from the Director



Adjudications



Investigations



Reemployment

036

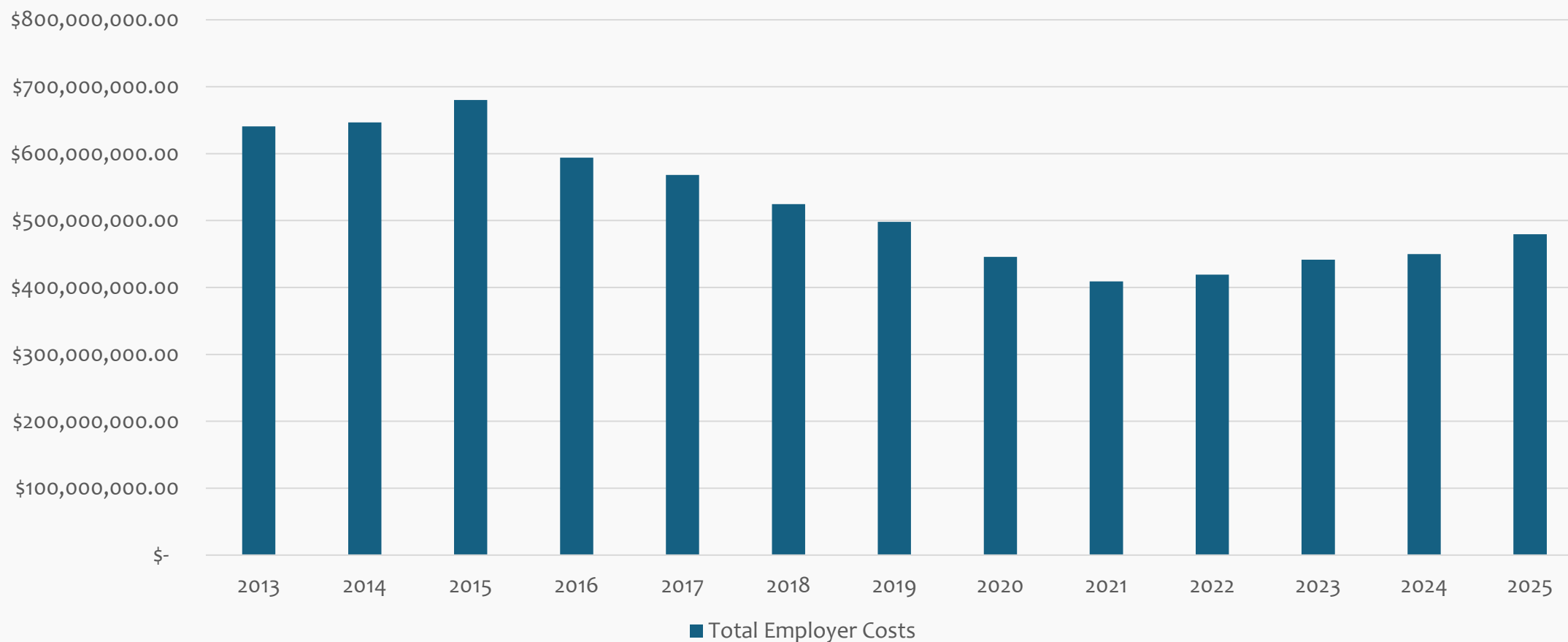




Alaska Workers' Compensation Board

Total Workers' Compensation Costs

037





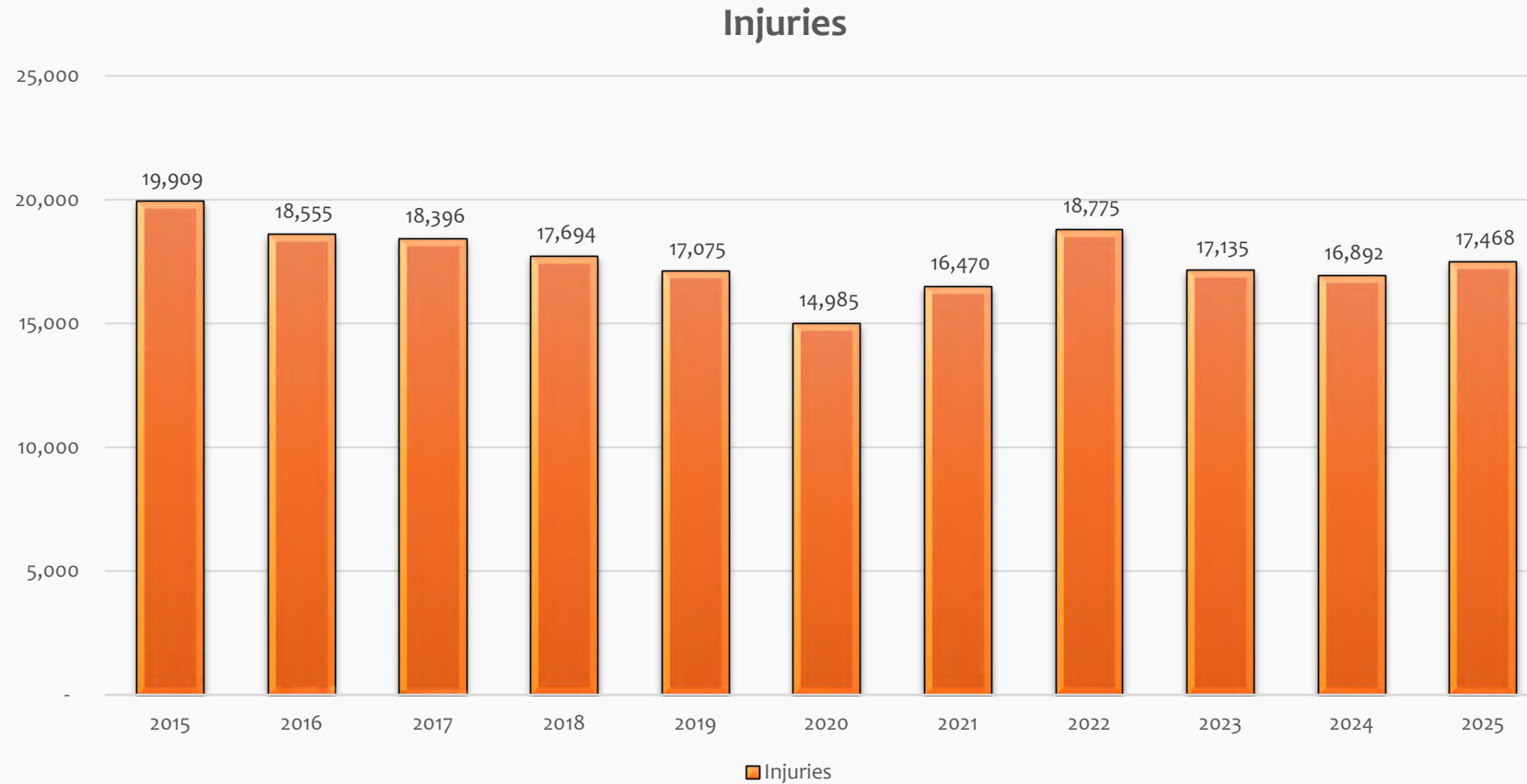
2025 Annual Report Adjudications

038





Reports of Injury



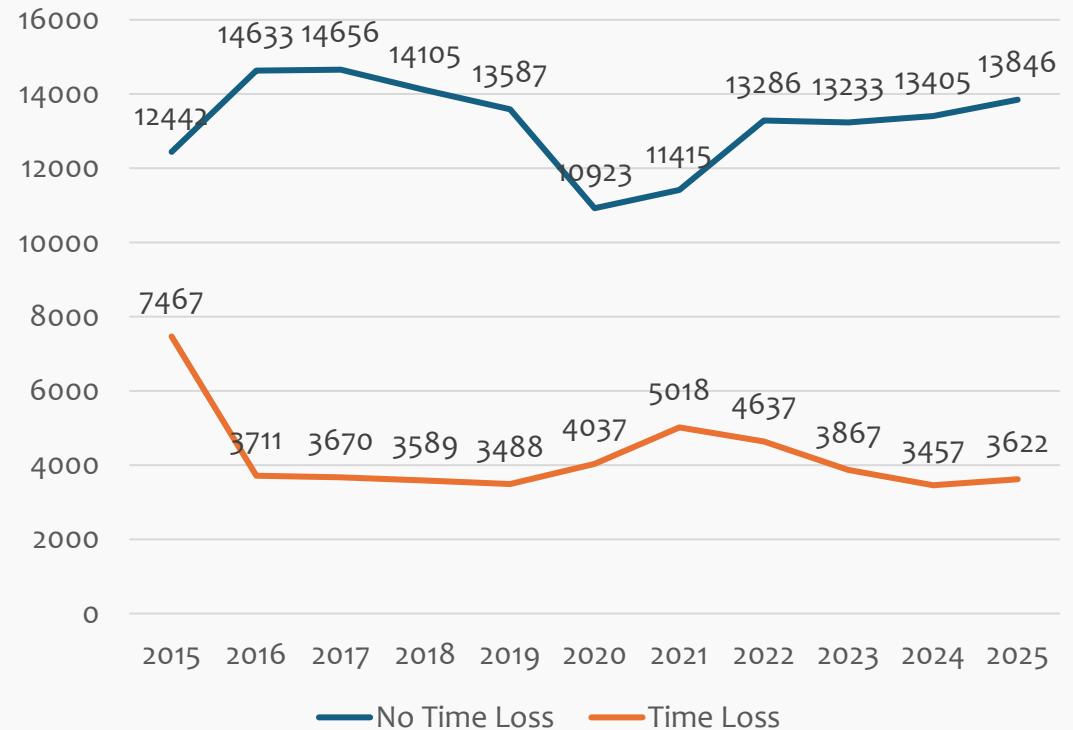
Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data

Case Files

- An increase of 576 First Reports of Injury
- 17,468 total files
- 13,846 No Time Loss cases.
- 3,622 Time Loss Cases
- 42 Fatalities reported

ROIs Filed



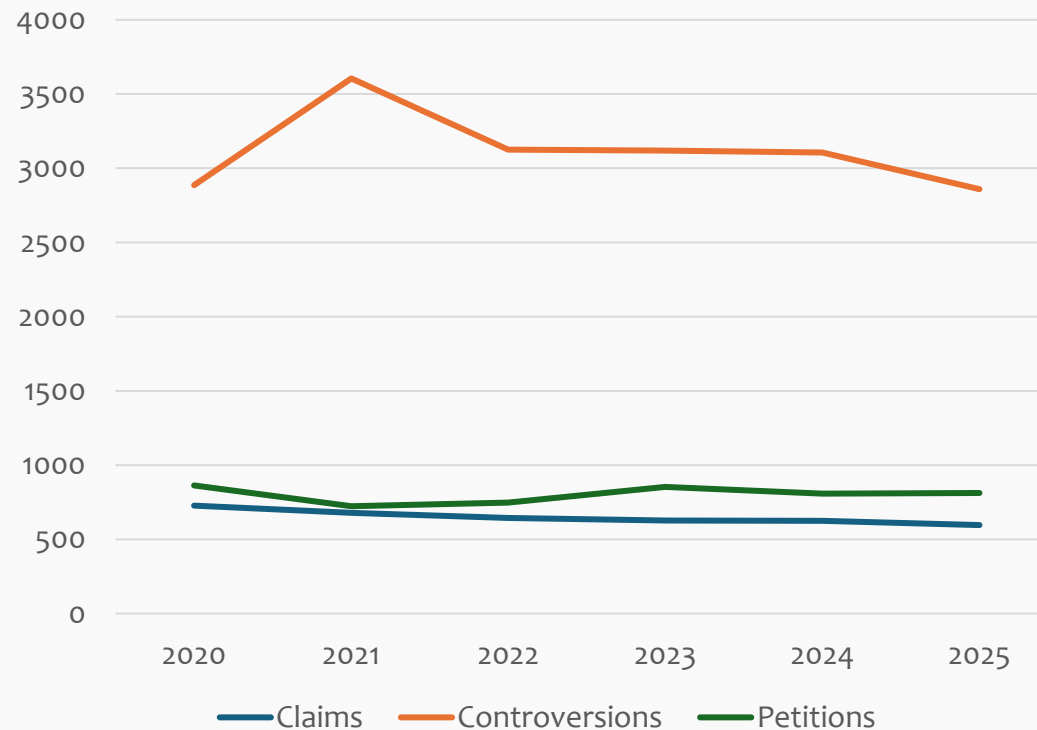
Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data

Historical numbers

	2020	2021	2022	2023	2024	2025
Claims	727	678	643	627	625	596
Controversions	2886	3605	3126	3118	3105	2859
Petitions	863	723	747	853	807	813

Claims, Controversions, and Petitions



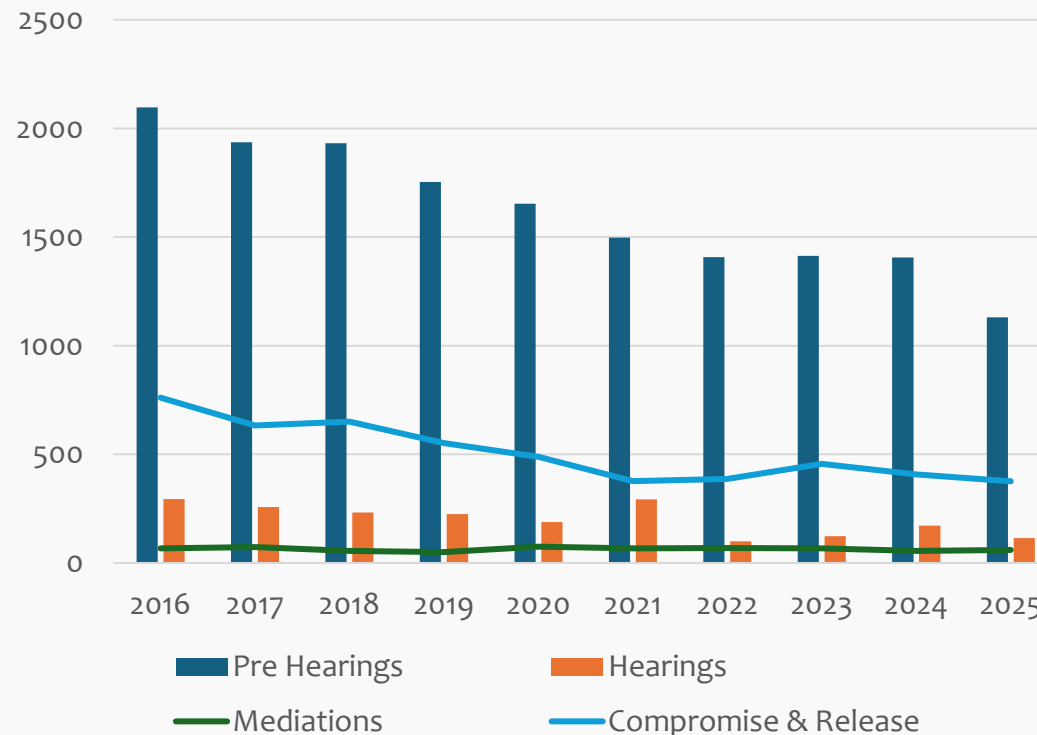
Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data

Judicial Action

Calendar Year	2020	2021	2022	2023	2024	2025
Pre Hearings	1,653	1,498	1,408	1,413	1,406	1,131
Hearings	188	292	99	123	172	115
Mediations	75	67	69	68	55	60
Compromise & Release	488	377	387	456	408	376

Hearings, Mediations, Compromise & Release, and Prehearing Conferences





Alaska Workers' Compensation Board

Most Frequent Body Part Injured

Body Part	Count	Percent of ROI
Fingers	1564	9.00%
Lower Back	1421	8.18%
Knee	1408	8.10%
Hand	1256	7.23%
Multiple Body Parts	1089	6.27%
Shoulder	1024	5.86%
Ankle	764	4.40%
Soft Tissue	703	4.04%
Eye (s)	680	3.91%
Foot	570	3.28%

043

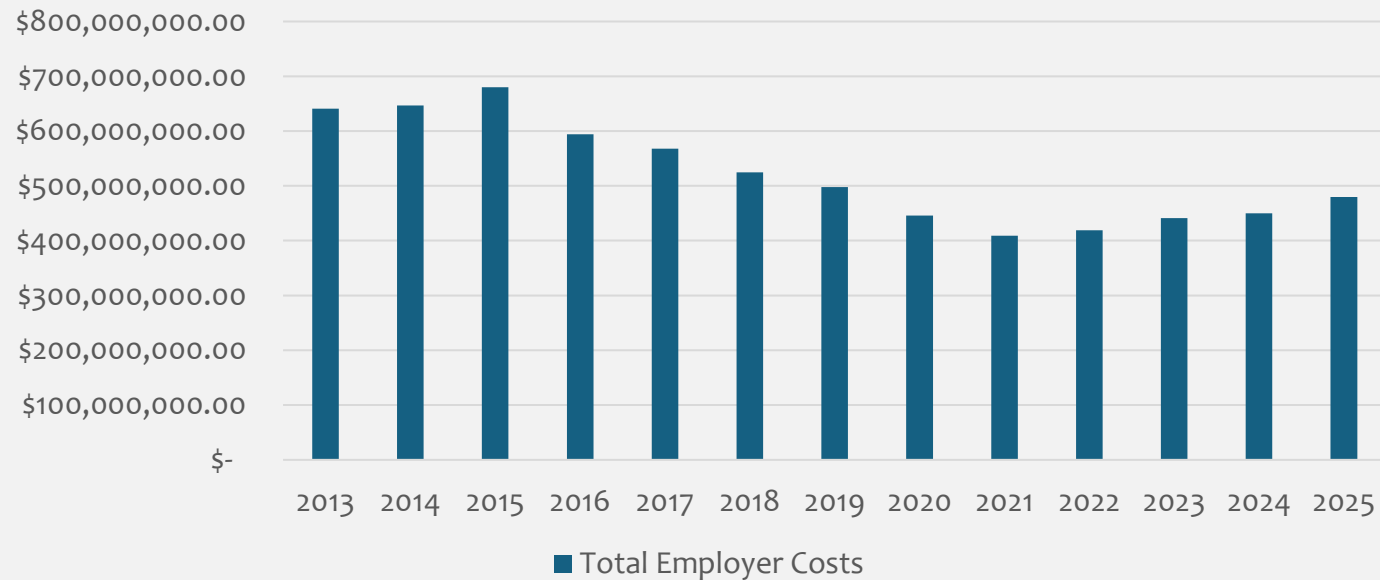




Alaska Workers' Compensation Board

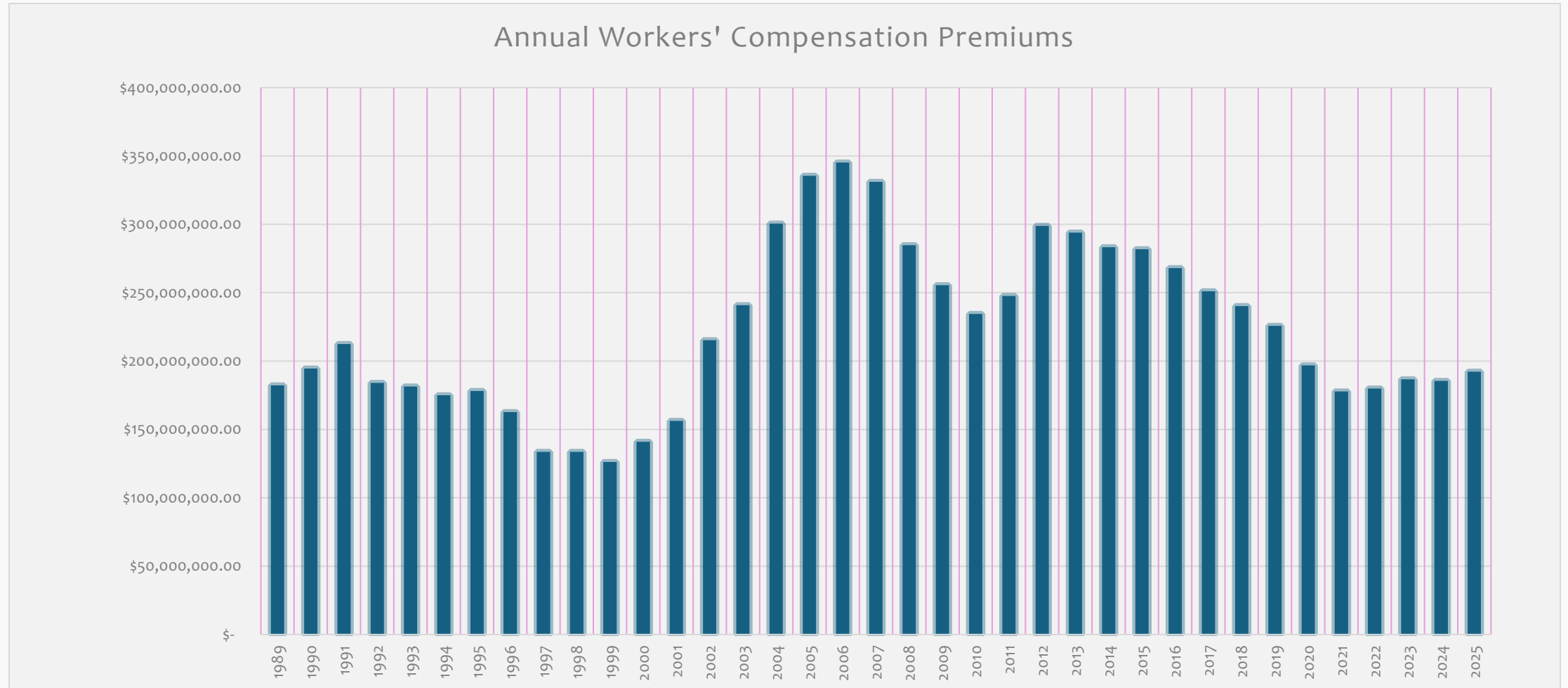
044

2025 shows an increase in costs over 2024. Costs have risen since a low of 2020 but remain below the total of 2019.



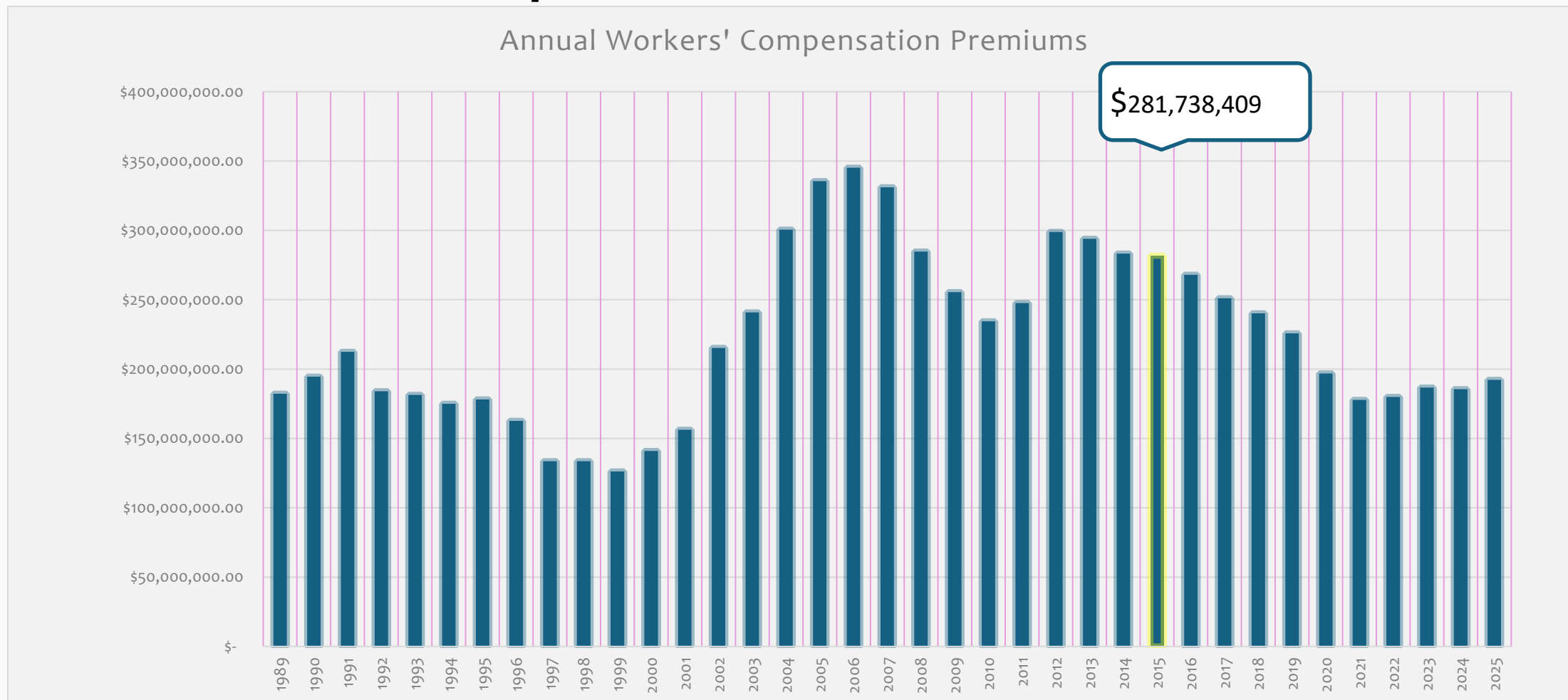


Workers' Compensation Insurance Premiums



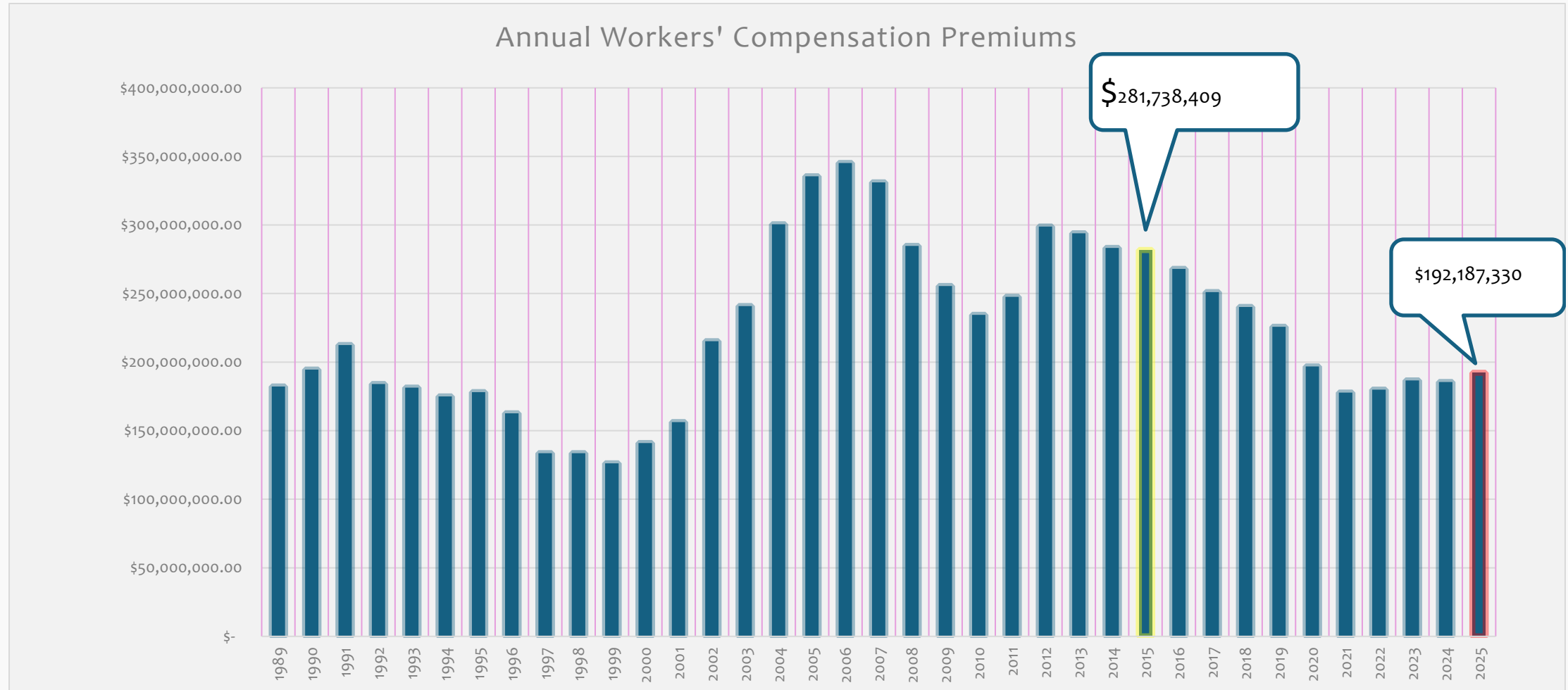


Workers' Compensation Insurance Premiums



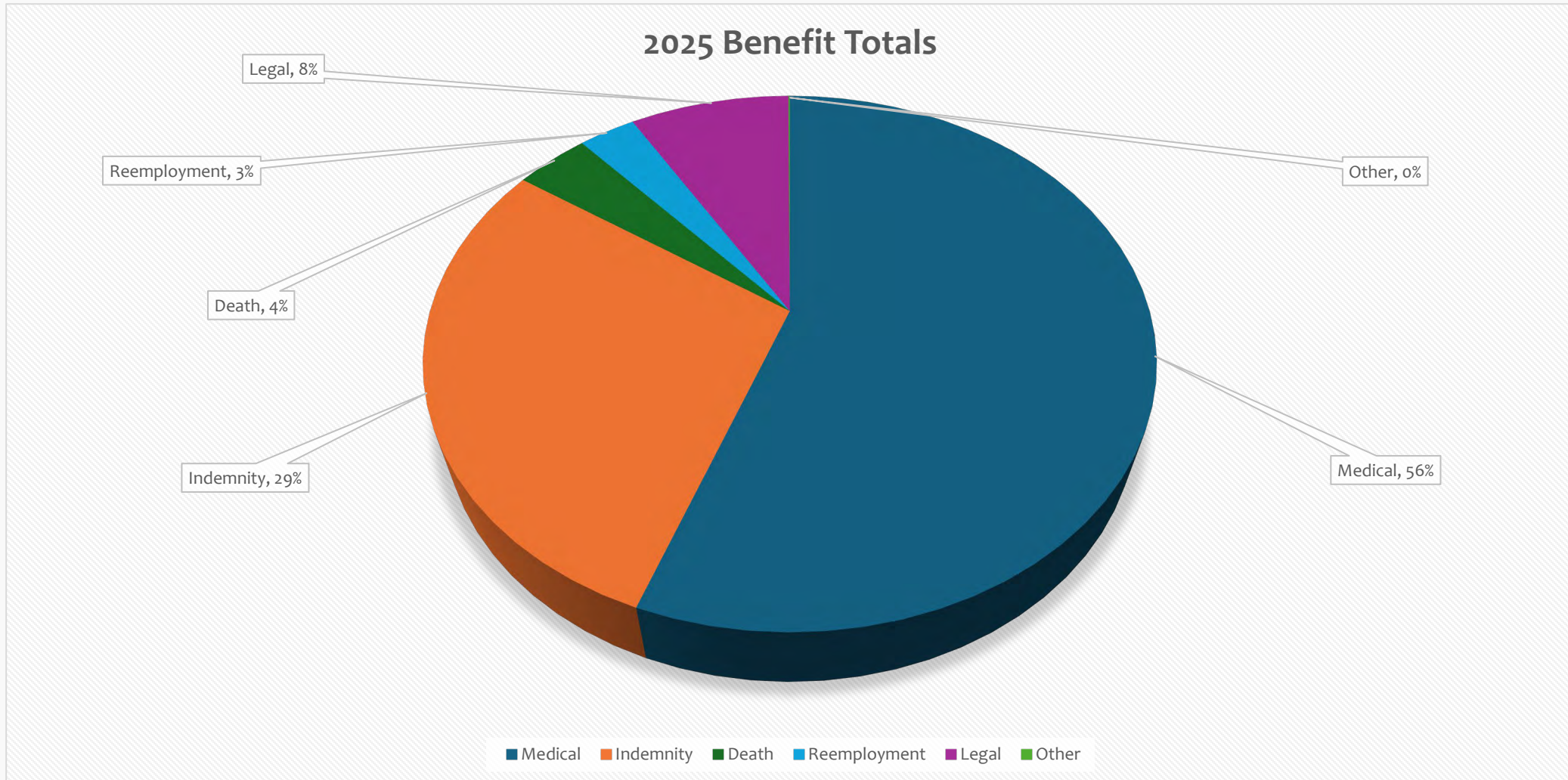


Workers' Compensation Insurance Premiums





Alaska Workers' Compensation Board



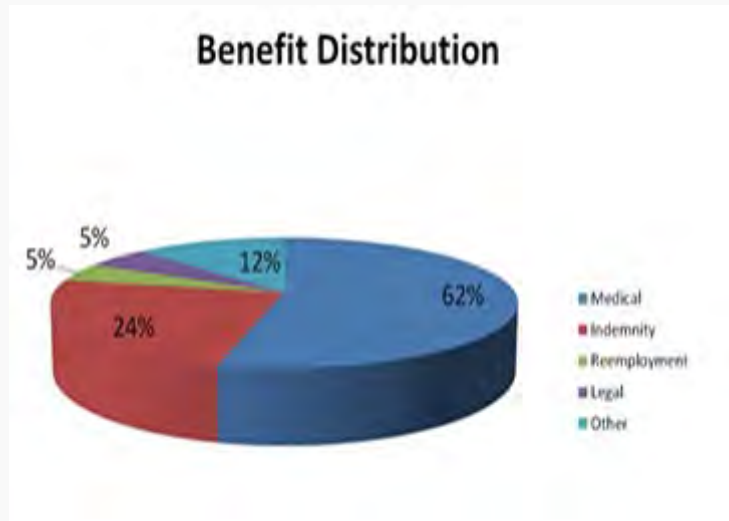
048





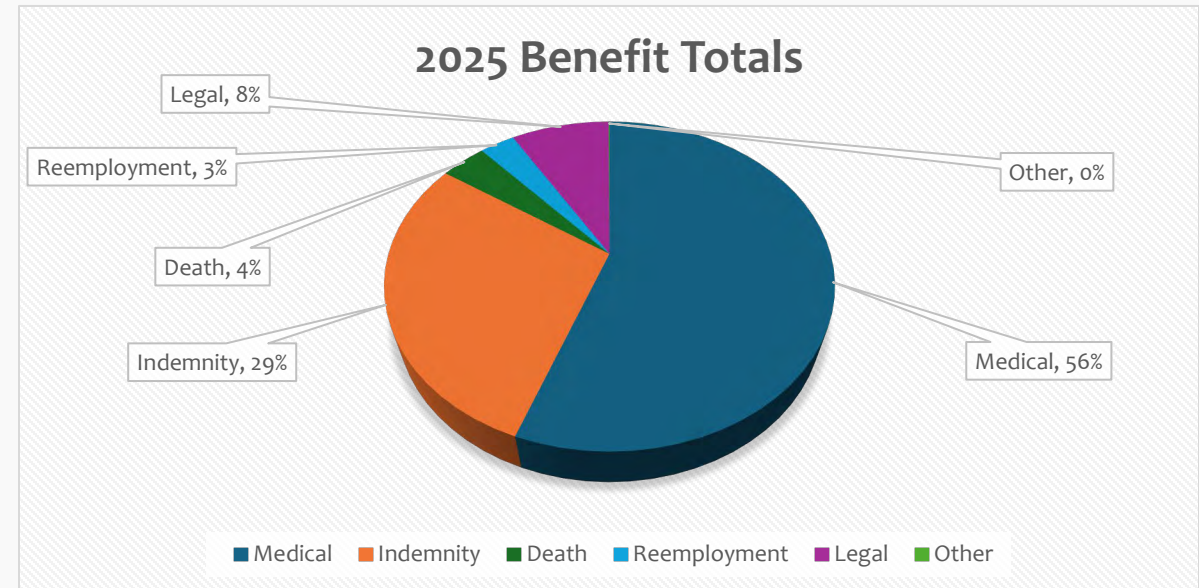
Alaska Workers' Compensation Board

2015



Medical was 62% of total benefit costs – \$186.1 million

2025

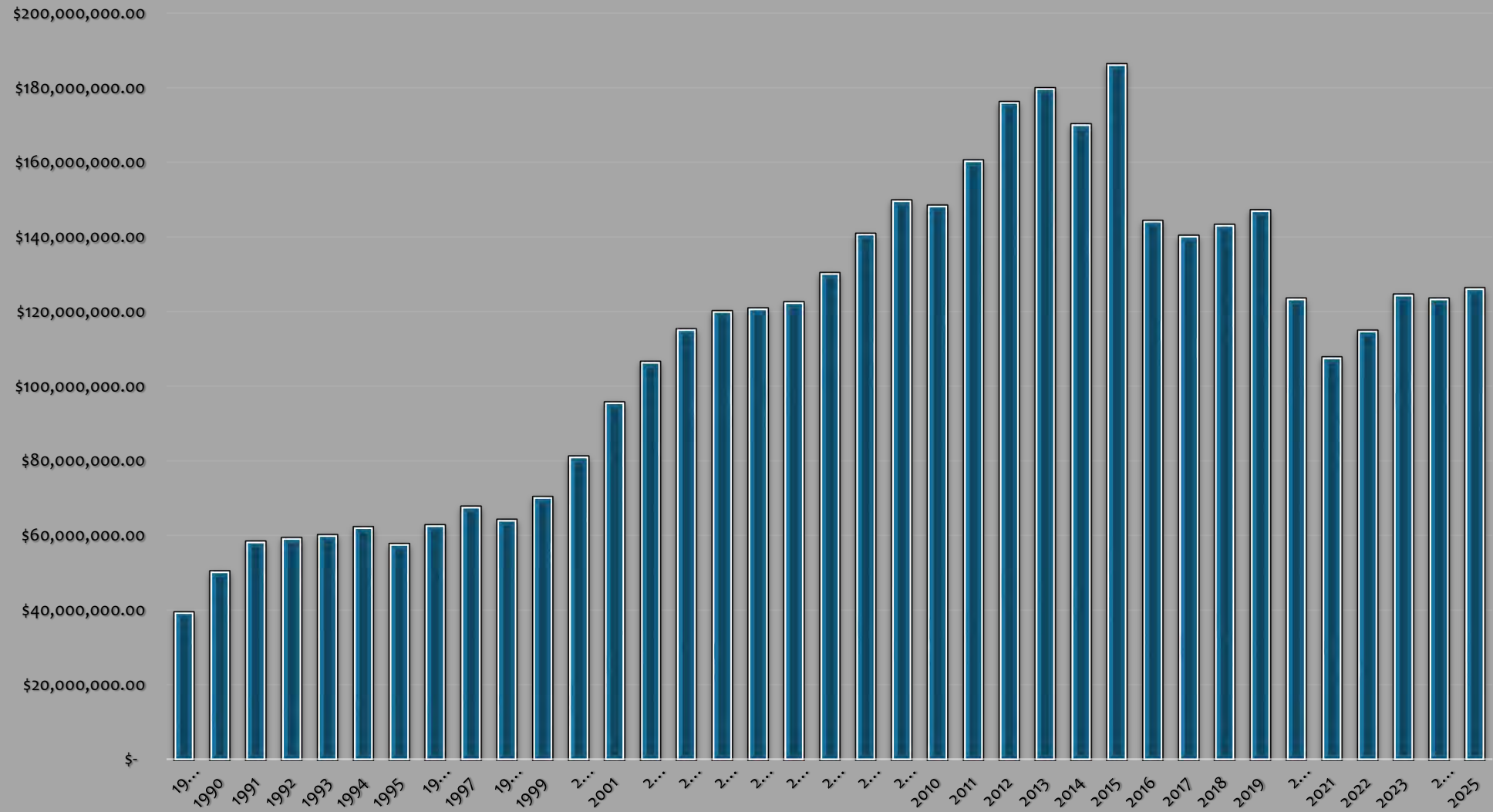


Medical now 56% of total benefit costs - \$126.1 million



Alaska Workers' Compensation Board

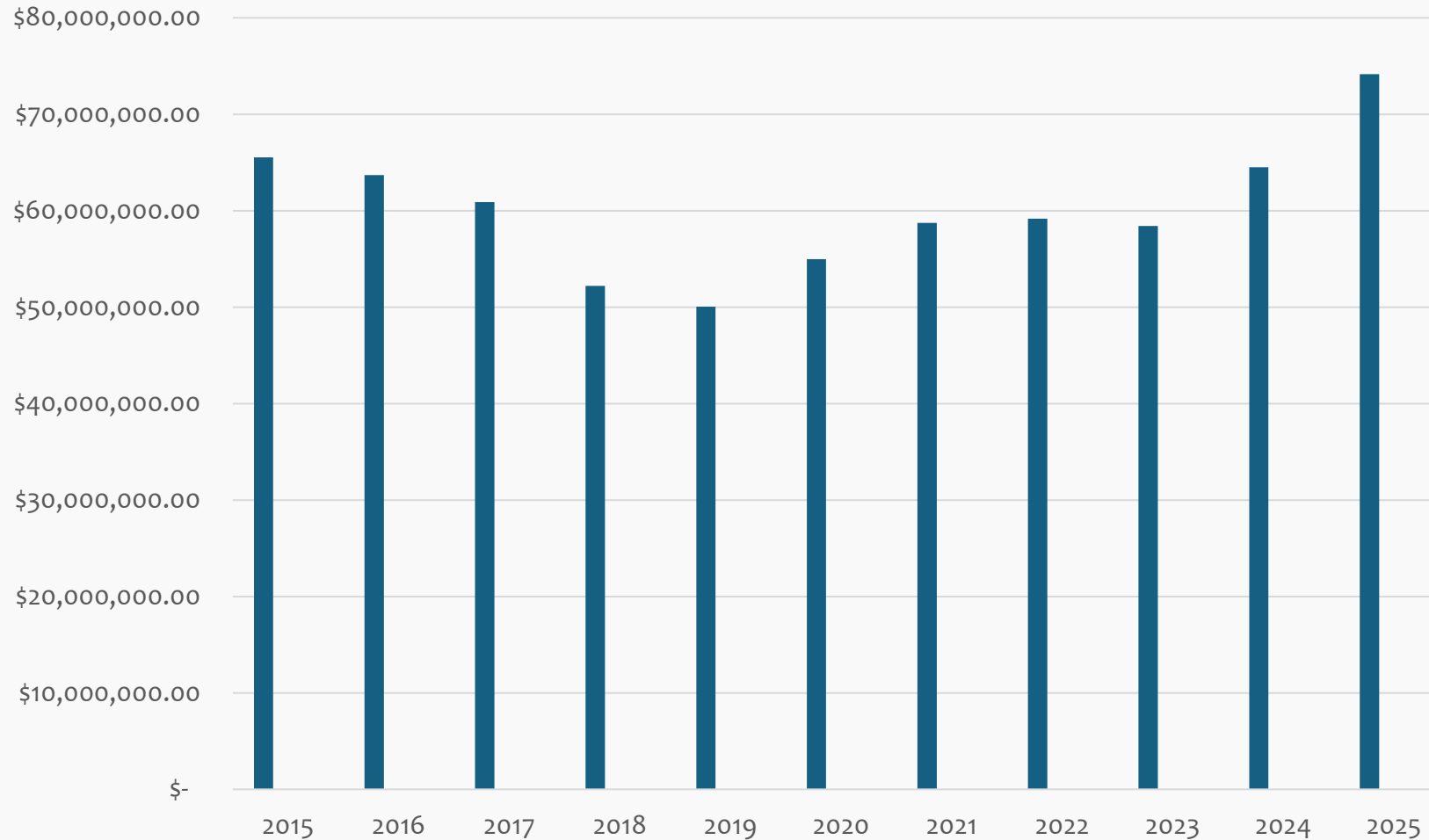
Medical Benefits





Alaska Workers' Compensation Board

Indemnity Benefit Payments



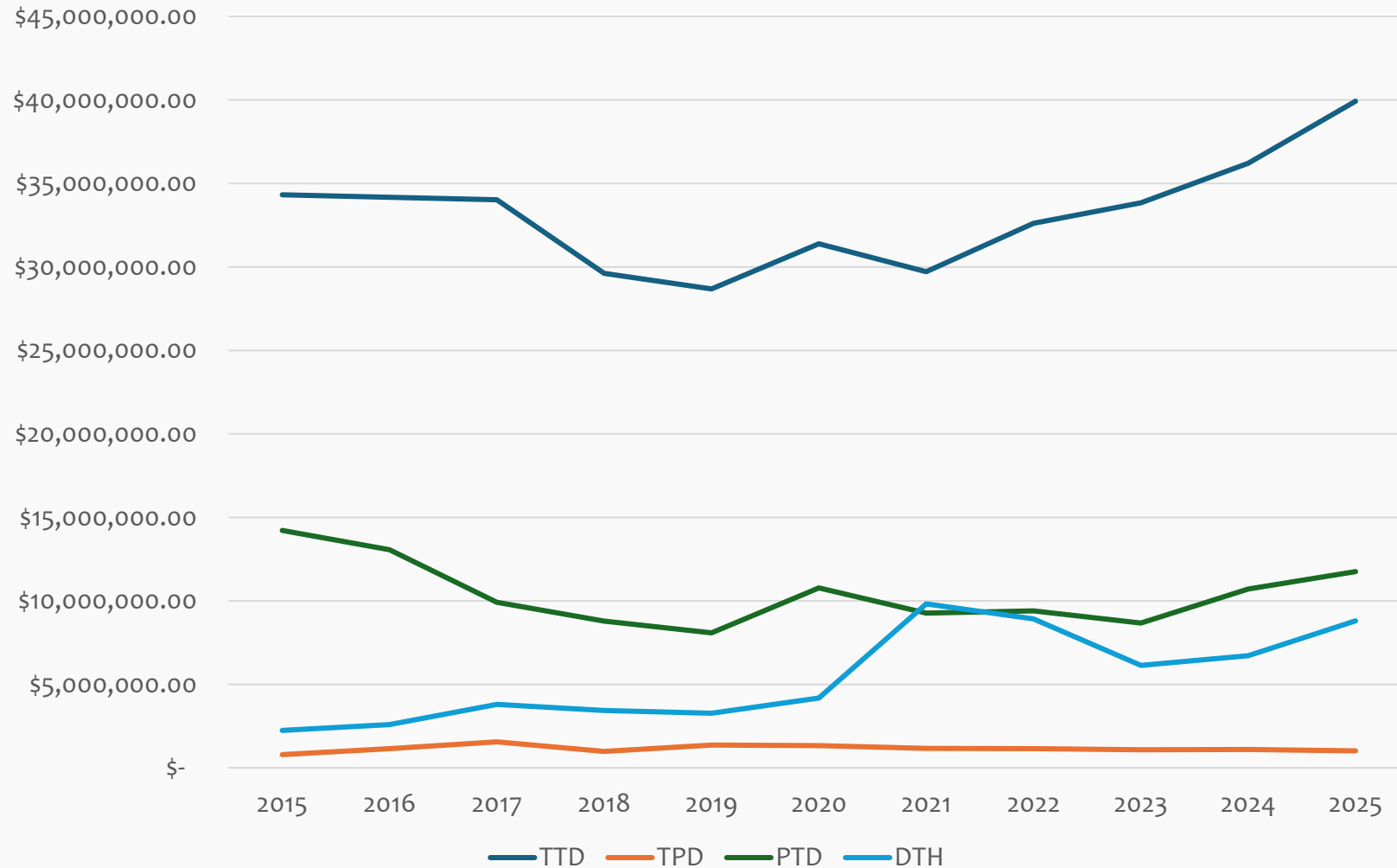
051





Alaska Workers' Compensation Board

Indemnity Benefit Payments Distribution – 10 Year Review



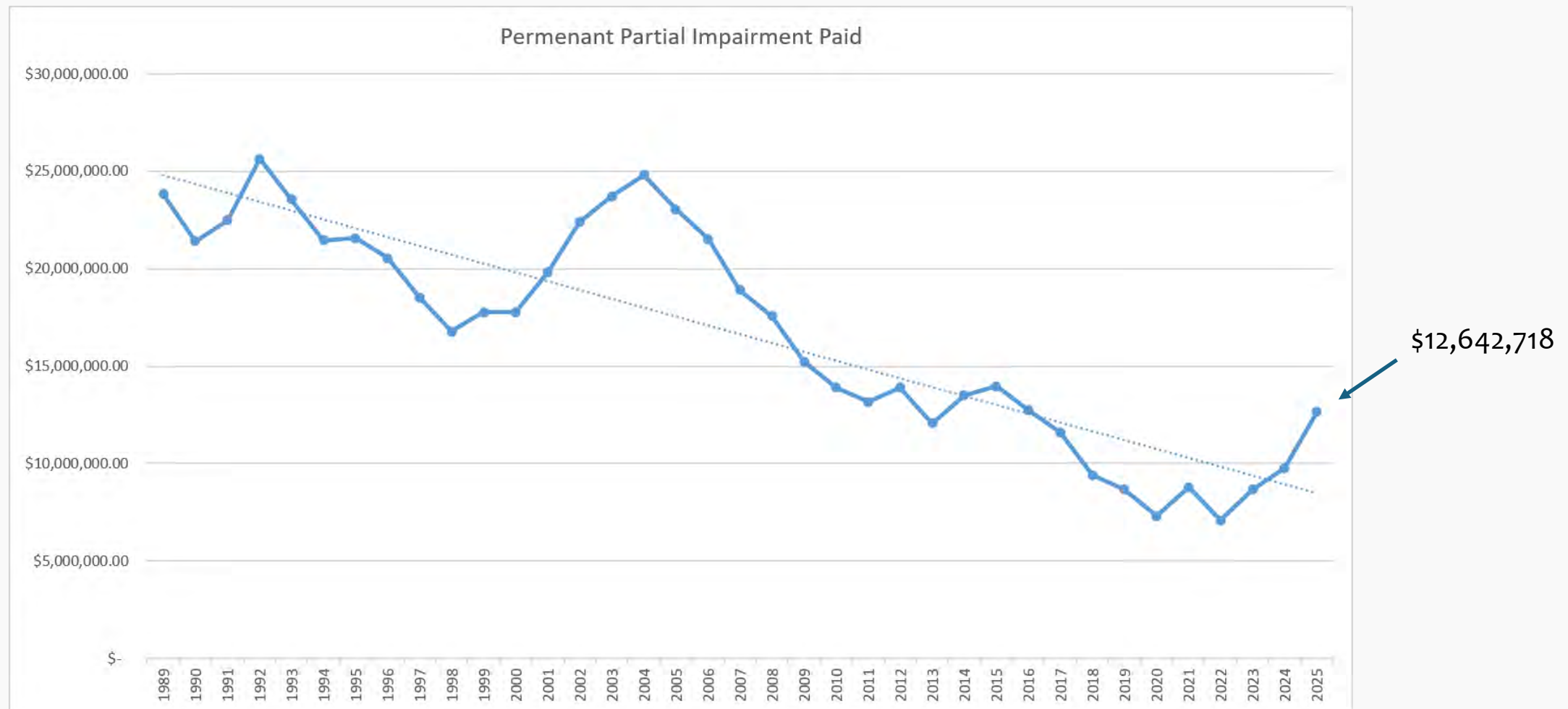
052





Alaska Workers' Compensation Board

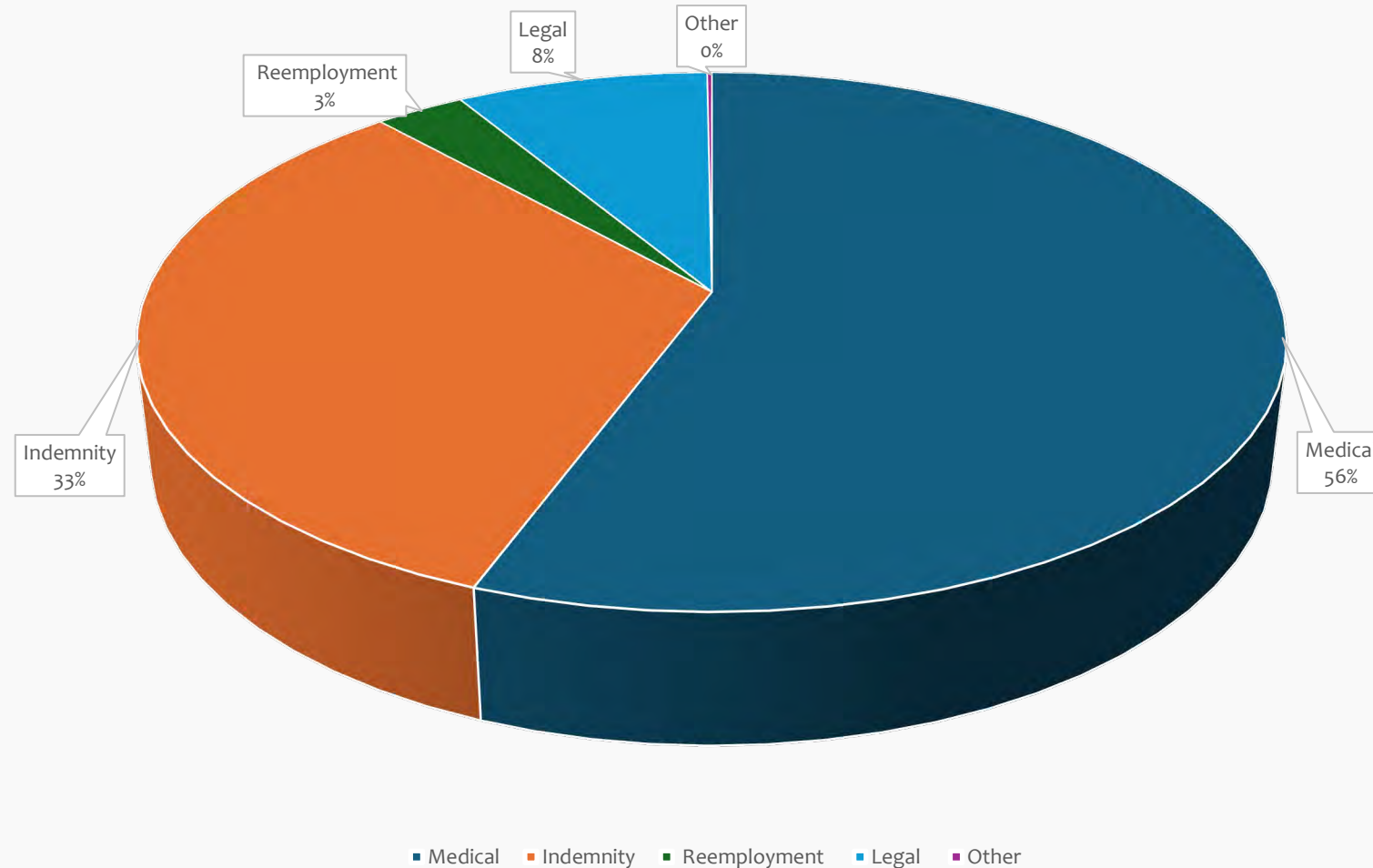
Indemnity Benefit Payments Permanent Partial Impairment





Alaska Workers' Compensation Board

Total Compensation Benefits Payment Distribution



054





Alaska Workers' Compensation Board

Total Compensation Benefits Payment Distribution

Benefit Type	Amount Paid	% of Total Cost
Medical	\$126,167,353	55.7%
Indemnity	\$74,148,996	32.7%
Reemployment	\$6,819,813	3.0%
Legal	\$19,196,406	8.5%
Other*	\$363,777	0.2%
Total	\$226,696,345	

*Other costs include interest and penalty.





Alaska Workers' Compensation Board

Alaska Injury Frequency

Year	Reported Injuries	Average Monthly Employment	Injury Frequency Rate
2025	17,468	317,542	5.50
2024	16,892	313,630	5.39
2023	17,135	307,926	5.56
2022	18,775	298,762	6.28
2021	16,470	289,946	5.68
2020	14,985	281,976	5.32
2019	17,075	308,796	5.53
2018	17,694	306,211	5.78
2017	18,396	307,063	5.99
2016	18,555	311,091	5.96
2015	19,909	316,757	6.29

In 2025, 17,468 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees of 5.50%. The nationwide number is 1.76%.

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment totaled 317,542 in 2025, compared to 313,630 in 2024, 307,926 in 2023, and 298,762 in 2022.

Employment has grown in Alaska since 2020, with the highest number of covered employees* in the past decade.

*This is less Federal employment which is not covered under Alaska Workers' Compensation or Commercial Fishermen, also not covered.

Injury frequency rate = Reported Cases of Injury/ Statewide Average Monthly Employment (less Federal wages)*100.





Alaska Workers' Compensation Board

Alaska Workplace Fatalities

Fatal event or exposure

- Transportation incidents (15) were the most frequent type of fatal event in Alaska, accounting for 63 percent of all fatal work injuries in the state. Nationally the share was 38 percent. Worker deaths from transportation incidents were down from 18 over the year. (See [chart 2](#) and [table 1](#).)
- Contact incidents (5) accounted for 21 percent of Alaska worker fatalities; nationally the share was 15 percent.

Chart 2. Percent distribution of total fatal occupational injuries by event, United States and Alaska, 2024



Note: Percents may not add to total due to rounding.
Source: U.S. Bureau of Labor Statistics.

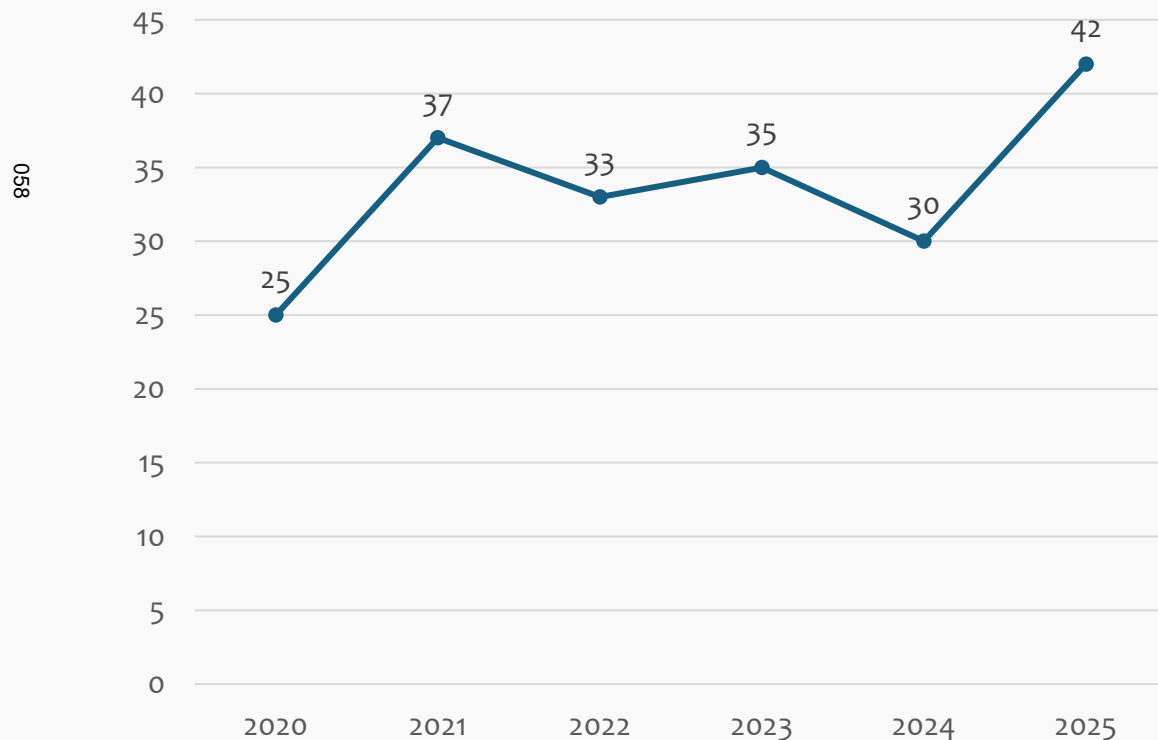
057



Alaska Workers' Compensation Board

Alaska Workplace Fatalities

All 2025 Workplace Fatalities



Workers' Compensation Covered Fatalities

Incident Description	Count
Plane / Helio Crash	10
Fall	4
Cancer	2
Cardiac Arrest	2
ATV Crash	2
Electrocution	2
Crush / Pinch / Struck	1 / 1 / 1
Gunshot / Assault	1 / 1
Total WC covered	28



Litigation



059

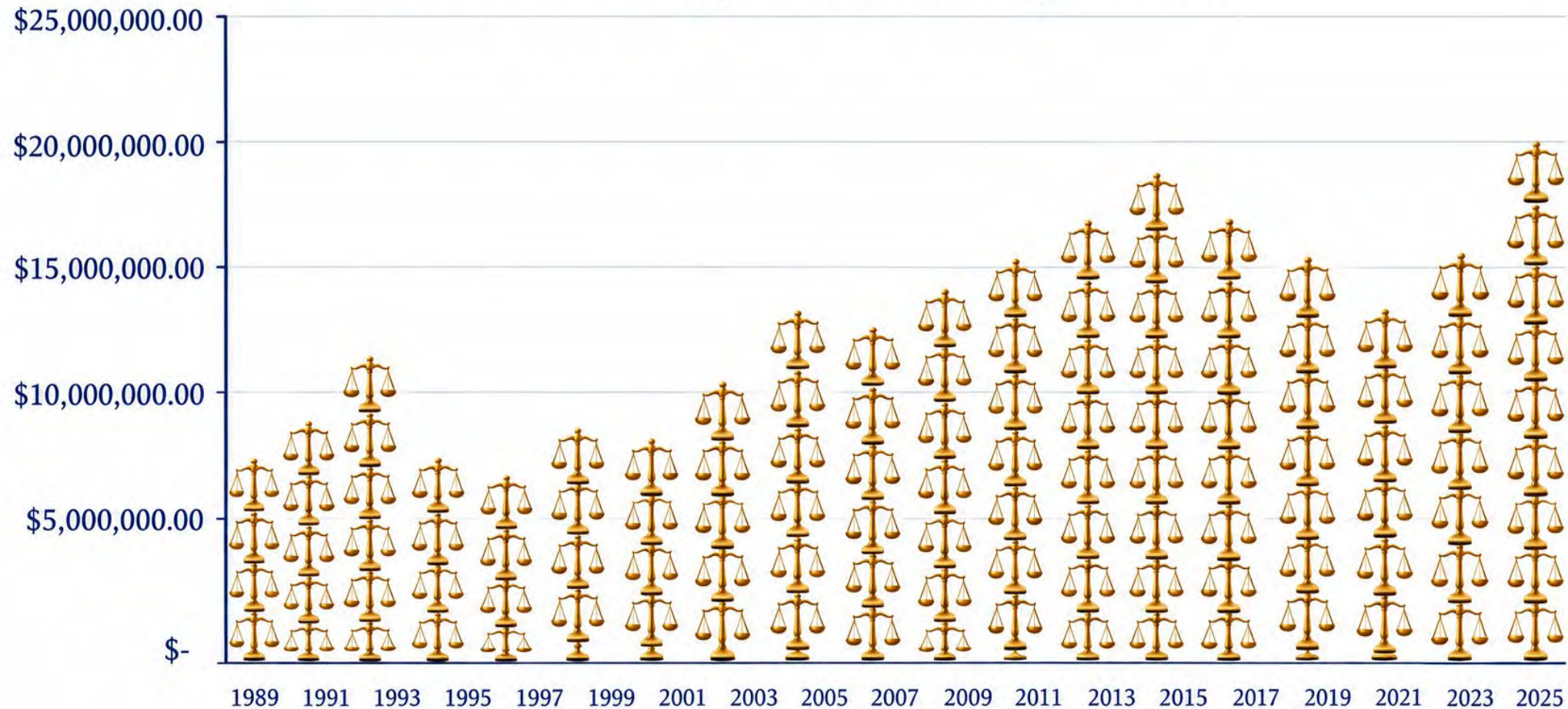




Alaska Workers' Compensation Board

Claim Litigation Expense

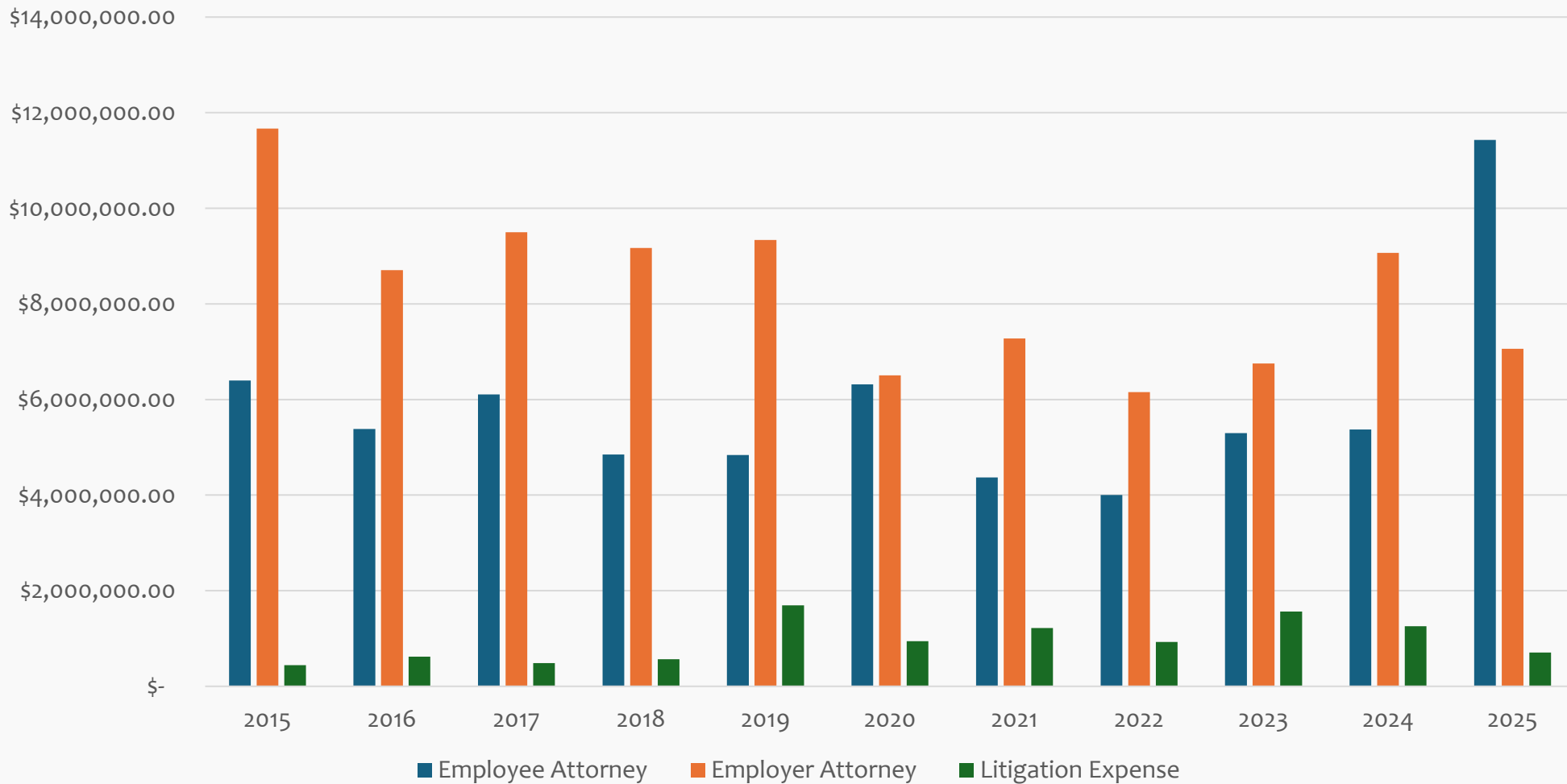
000





Alaska Workers' Compensation Board

Reported Attorney Expense Breakdown



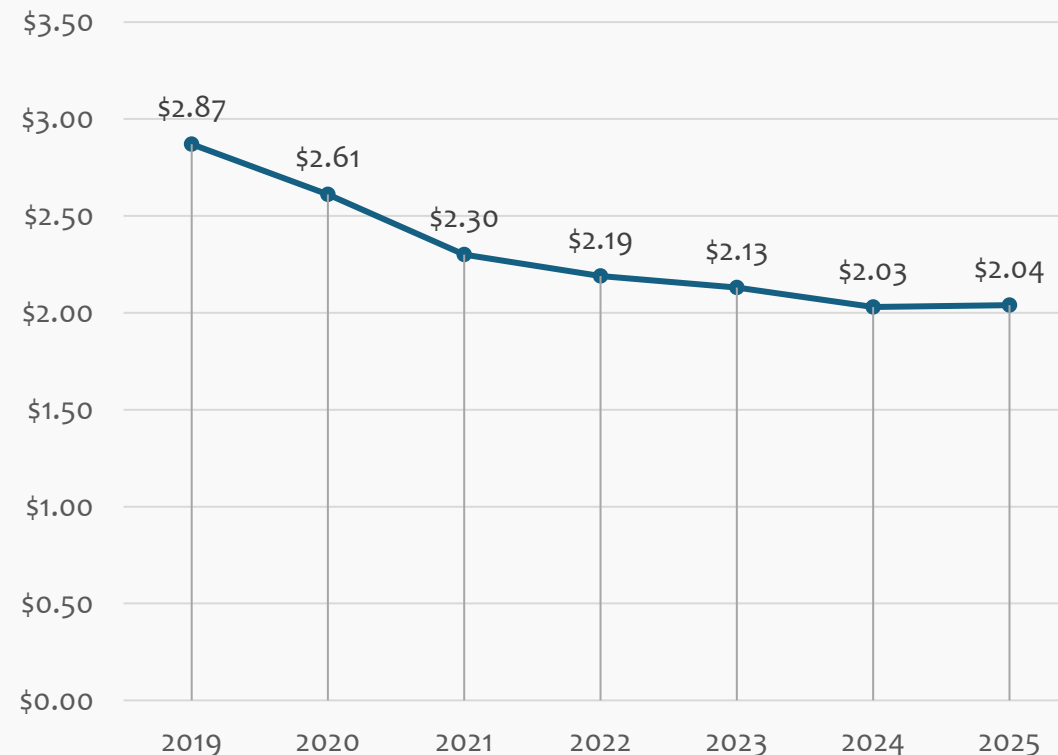


Alaska Workers' Compensation Board

Employer's Costs

Department of Labor and Workforce Development's Research and Analysis team shows \$23.5 billion in wages for employees covered by workers' compensation in 2025. That is an increase of over 35% while premiums* decreased by 15%.

ER Costs per \$100 payroll



* includes self-insured costs.

A decrease of 83 cents.





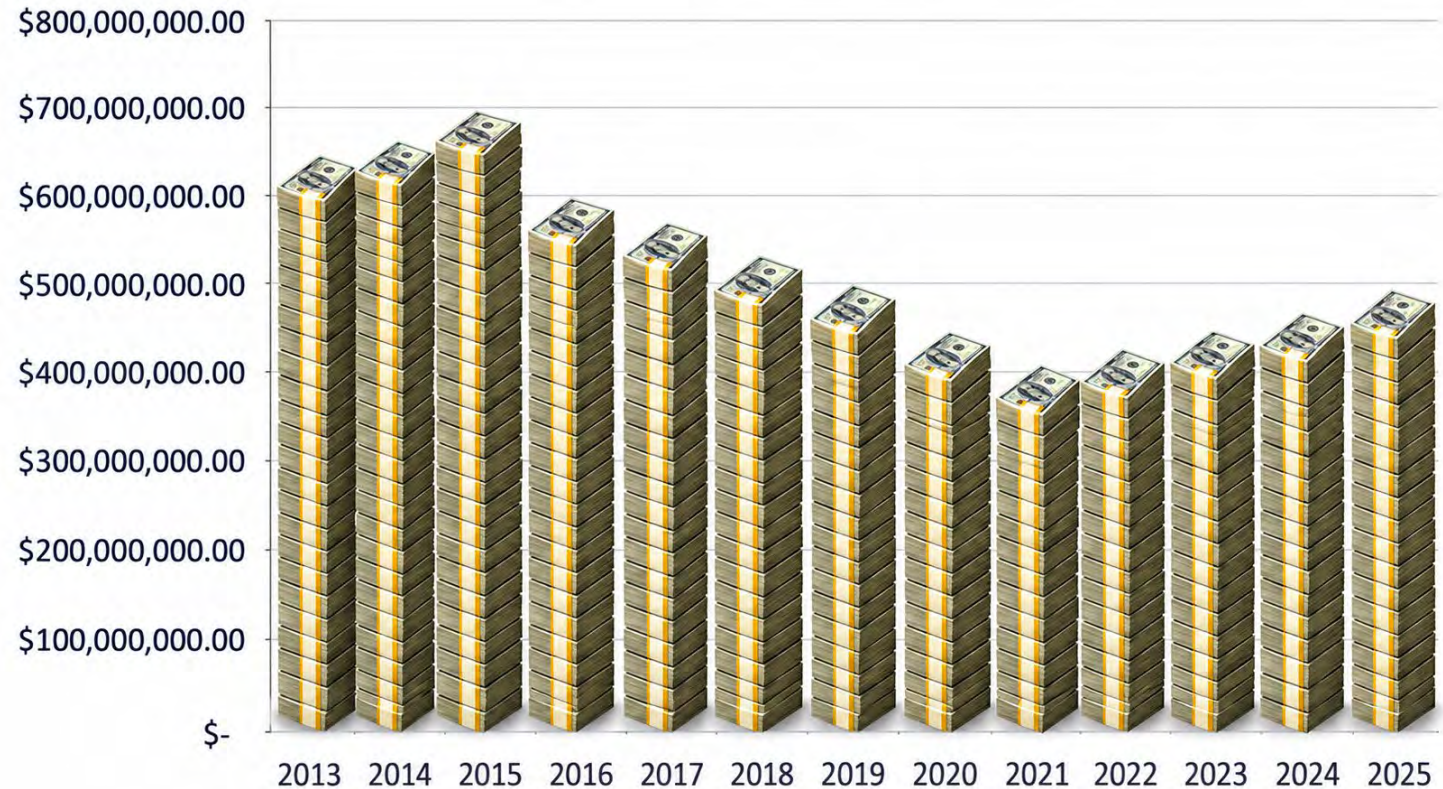
Alaska Workers' Compensation Board

Employer's Costs

Since 2019, employers in Alaska have saved an average of \$142,779,275.75 annually on workers' compensation costs compared to the previous four years.

063

This results in an overall reduction in costs to employers this decade of \$999,454,903.25.





Strategic Priorities

- Stabilize the Funding Model
- Restore Critical Staffing
- Replace ICERS
- Refine our Data-Driven Management Evaluation System
- Reevaluate High-Cost Programs
- Formalize Succession Planning

064





Alaska Workers' Compensation Board

Workers' Compensation Appeals Commission

The Commission docketed eight new cases in 2025, five fewer than in 2024. Six of the new cases were appeals and two were petitions for review.

Employees filed five of the eight new cases in 2025, with four filed by unrepresented employees.

Fifteen cases appeared on the 2025 docket, a decrease of four cases from 2024.

At the end of 2025, the Commission had seven cases on its docket: a 2024 case due to a pending decision on reconsideration, and six cases filed in 2025.

Of the ten cases on the 2025 docket that were closed, three resulted in published final decisions on the merits of appeals, one was dismissed on motion by the appealing party, one was dismissed for failure to prosecute, two petitions for review were denied, two were settled after remand from the Alaska Supreme Court, and one remand order was issued after a Court opinion was issued.

Of the three published final decisions issued on the merits of appeals, one affirmed the Board's decision, one vacated and remanded the Board's decision, and one affirmed in part, vacated in part, and remanded the Board's decision.





Alaska Workers' Compensation Board

Workers' Compensation Appeals Commission

A total of five Commission decisions await Court rulings: one issued in 2024, and four issued in 2025.

In 2025, the Court decided two appeals of Commission decisions, which created legal precedent:

- 1) *Rusch v. Southeast Alaska Regional Health Consortium and Dockter v. Southeast Alaska Regional Health Consortium*, 563 P.3d 2 (Alaska 2025), were consolidated. Each case involved appeals of attorney fees awarded by the Commission. The Court vacated the Commission's order and remanded.
- 2) *Woodell v. Alaska Regional Hospital*, 576 P.3d 62 (Alaska 2025), reversed in part the Commission's 2021 decision, vacated the Commission's 2023 decision, and remanded to the Commission to remand to the Board with instructions to reinstate the Board's 2020 award of compensation.

On April 23, 2025, the Court also issued one memorandum opinion and judgment, *Fletcher v. Pike's on the River, Inc.*, 2025 WL 1179443 (Alaska App., April 23, 2025) which does not create legal precedent, but may have persuasive value. The Court affirmed the Commission's decision because substantial evidence supported the Board's decision and any procedural errors the agencies may have made were harmless.





Alaska Workers' Compensation Board

QUESTIONS?

067





2025 Annual Report Benefits Guaranty Fund

Thea Howard

860





Alaska Workers' Compensation Board

Alaska Workers' Compensation Benefits Guaranty Fund

The Alaska Workers' Compensation Benefits Guaranty Fund was established by the Alaska Legislature in 2005 and is applicable to injuries occurring on or after November 7, 2005. The Fund was created to assist injured workers who were injured while working for an uninsured employer under the authority of AS 23.30.082

Fund revenues come from civil penalties assessed against uninsured employers.

Staffing:

Thea Howard, Fund Administrator

Dawn Wilson, Collections Officer I

690





Alaska Workers' Compensation Board

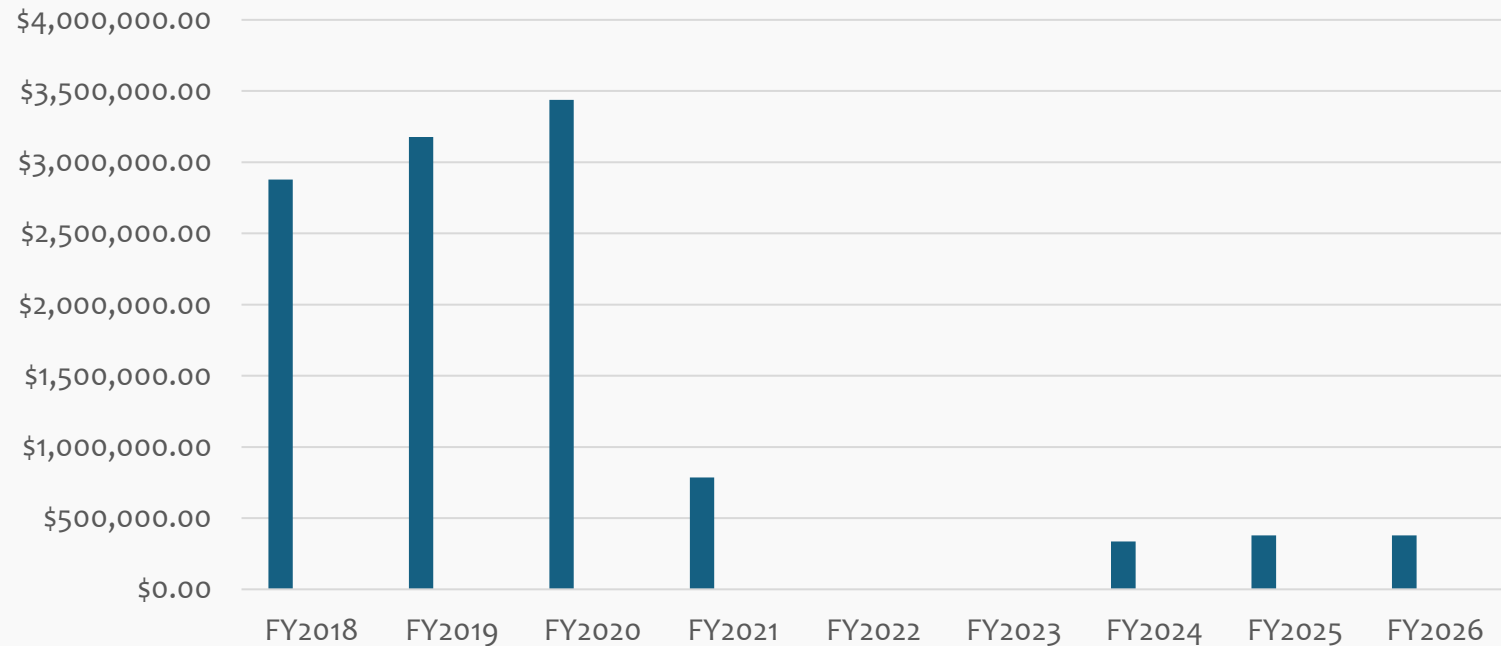
Alaska Workers' Compensation Benefits Guaranty Fund

Sec. 23.30.082. Workers' compensation benefits guaranty fund.

(a) The workers' compensation benefits guaranty fund is established as a **separate fund** in the state treasury to carry out the purposes of this section. The fund is composed of civil penalty payments made by employers under AS 23.30.080, income earned on investment of the money in the fund, money deposited in the fund by the department, and appropriations to the fund, if any. However, money appropriated to the fund does not lapse. Amounts in the fund may be appropriated for claims against the fund, for expenses directly related to fund operations and claims, and for legal expenses.

For FYE 2026, fund balance was \$379,360.

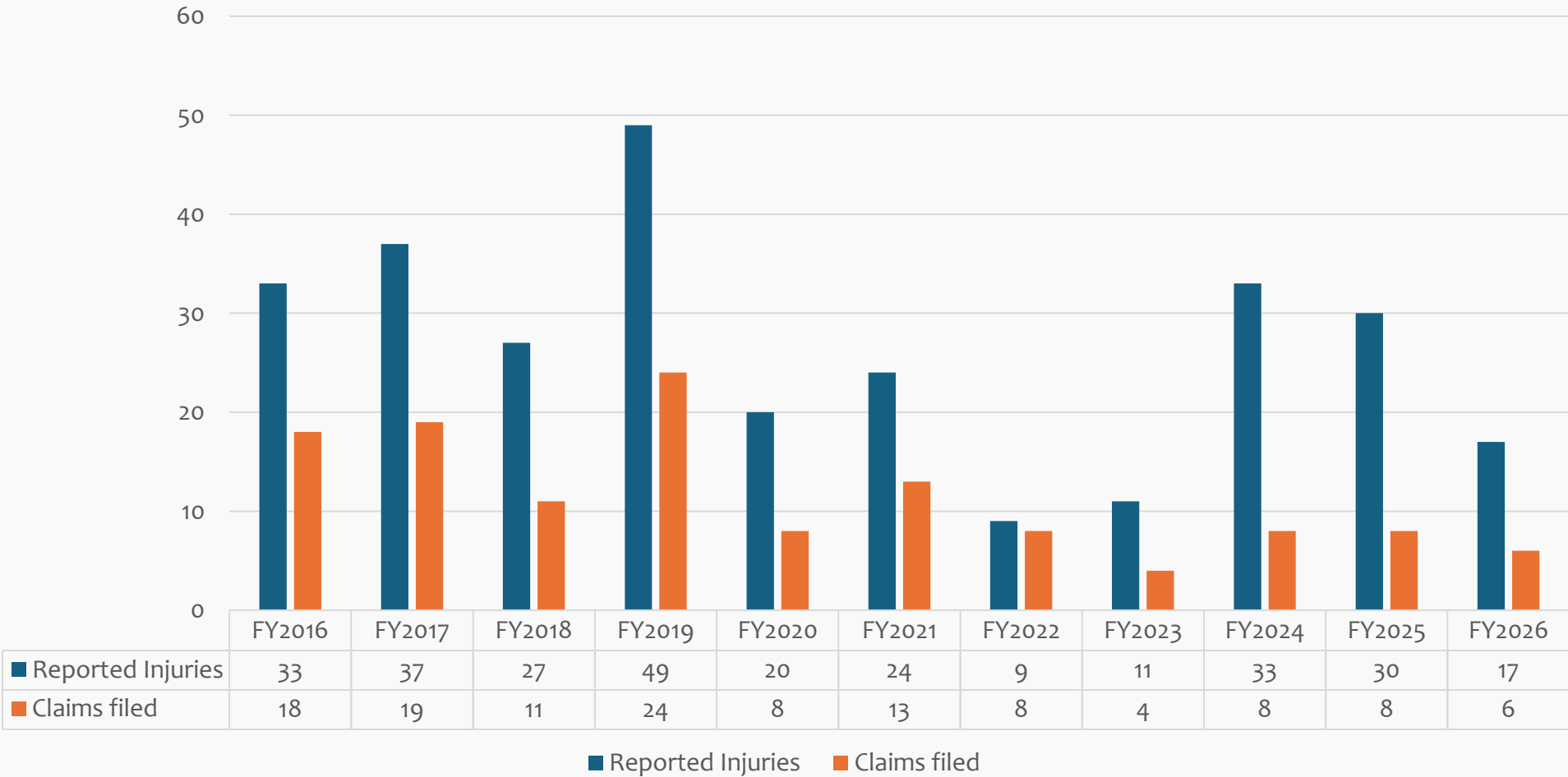
Decrease for FY 2021, FY 2022, and FY 2023 was \$3.1 million, 1.3 million and \$268,091, respectively, attributed to sweeps into the unassigned repayment of the Constitutional Budget Reserve Fund (CBRF). There are no provisions to move funds back into designated accounts.





Alaska Workers' Compensation Board

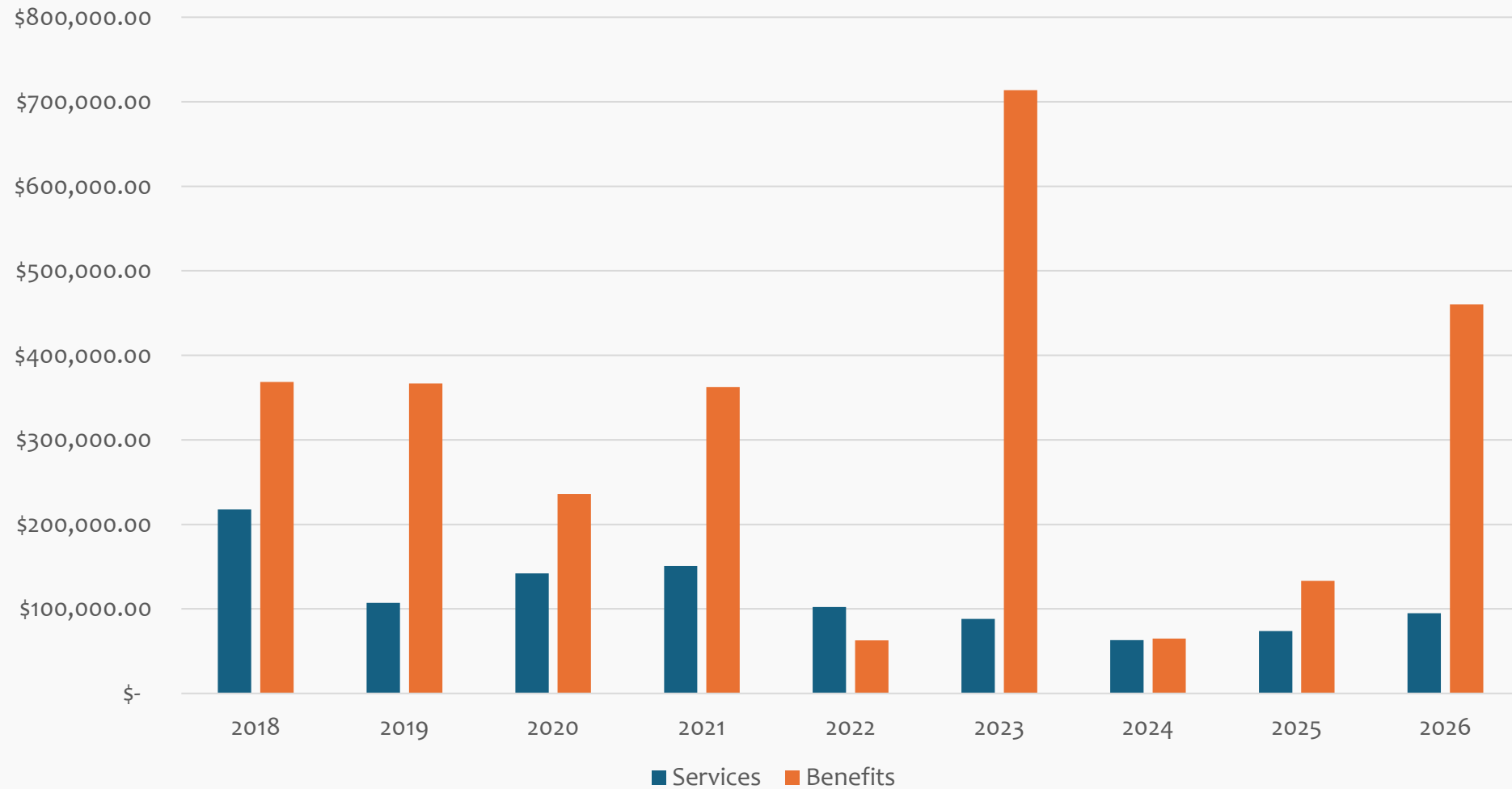
Benefits Guaranty Fund Claim Data





Alaska Workers' Compensation Board

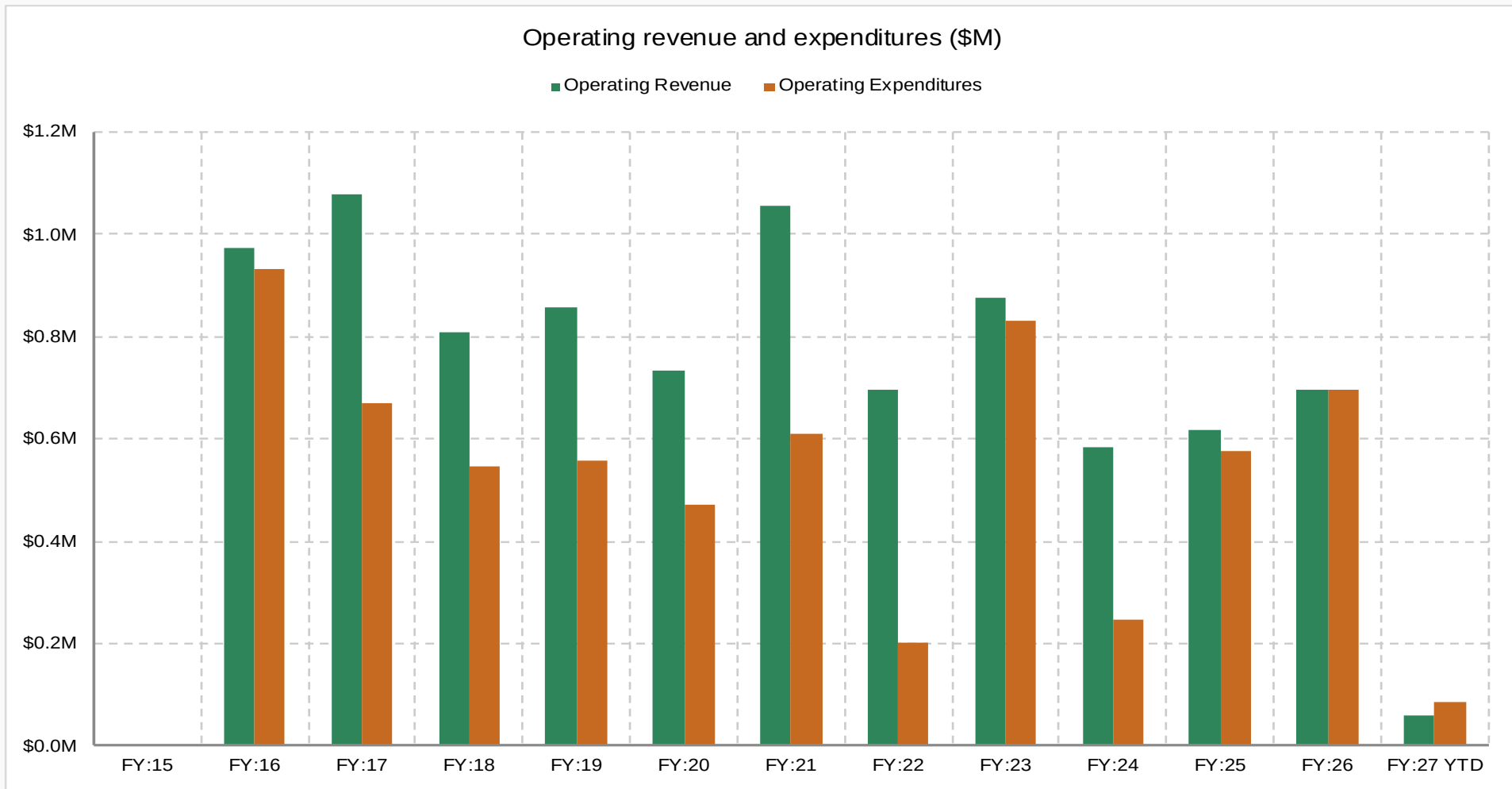
Benefits Guaranty Fund Claim Expense Data





Alaska Workers' Compensation Board

Benefits Guaranty Fund Revenue Data





Alaska Workers' Compensation Board

QUESTIONS?

074





2025 Annual Report Second Injury Fund

Thea Howard

075





Alaska Workers' Compensation Board

Second Injury Fund

Established in 1959, the Second Injury Fund is a dedicated fund that provides a system of reimbursement to the employer of a person with a qualifying pre-existing condition. The fund was established to remove obstacles to the employment of the disabled. It is meant to provide a financial incentive to encourage employers to hire or retain physically impaired workers. The SIF also distributes the risk and cost of employing the disabled equally among all employers.

Revenue is collected from each insurer, adjuster, and uninsured employer every March 1; when they file their annual reports. They must pay a percentage of annual compensation payments.

The workers' compensation reforms passed by the State of Alaska Legislature on May 11, 2018 (SCS CSHB 79(FIN)) provided for the closure of the Second Injury Fund. The Department of Labor and Workforce Development shall continue to administer the Second Injury Fund and payment of its remaining liabilities.

Authority: AS 23.05.067, AS 23.30.040, 23.30.155, AS 23.30.205 & 8 AAC 45.136

Staffing:

Thea Howard, Fund Administrator

Ted Burkhardt, Workers' Compensation Officer I

076



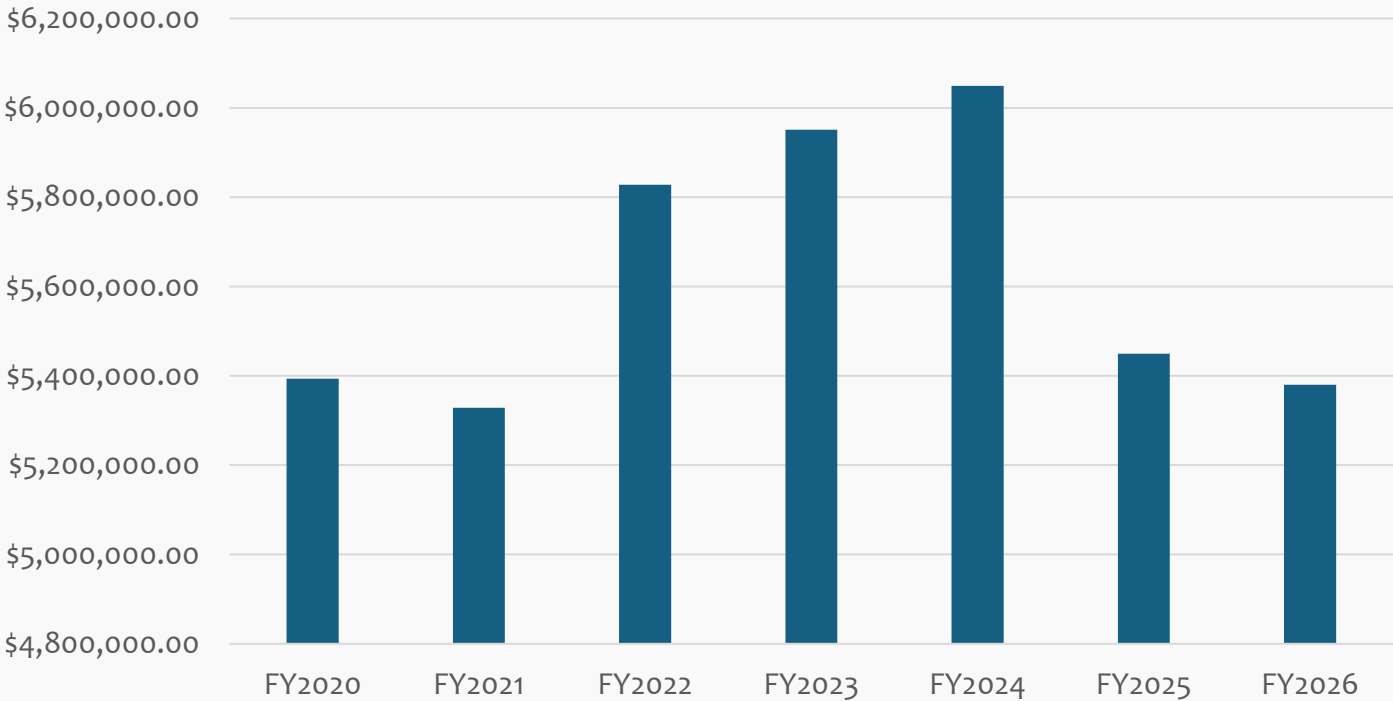


Alaska Workers' Compensation Board

Second Injury Fund

Second Injury Fund Balance

Fiscal Year	Revenues
2026	\$1,568,732
2025	\$1,806,174
2024	\$1,999,079
2023	\$2,456,080
2022	\$2,591,282
2021	\$2,593,928
2020	\$2,452,494



077





Alaska Workers' Compensation Board

Second Injury Fund

Fiscal Year	Revenue	Expense
2026	\$1,568,732	\$1,638,228
2025	\$1,806,174	\$2,405,477
2024	\$1,999,079	\$1,901,240
2023	\$2,456,080	\$2,332,979
2022	\$2,591,282	\$2,091,991

There are 51 active SIF claims.

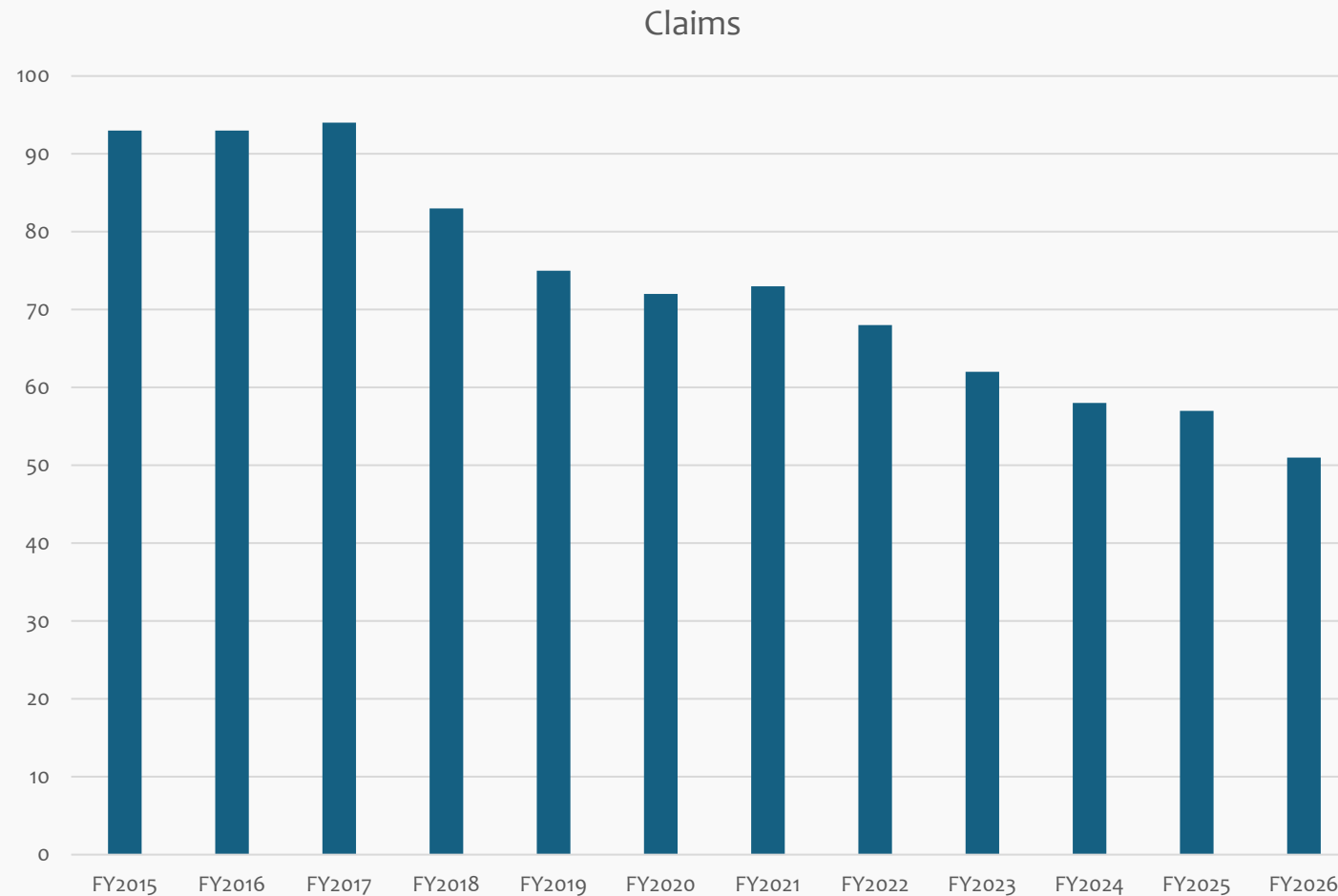
078





Alaska Workers' Compensation Board

Second Injury Fund Claims



51 claims received benefits* in 2025.

679

* There are active claims that are not currently receiving benefits.





Alaska Workers' Compensation Board

QUESTIONS?

080





2025 Annual Report Special Investigations Unit

081





Special Investigations Unit

- Established by the Alaska Legislature in 2005, AS 23.30.280
- Staffing:
 - Michele Wall-Rood, Chief Investigator-Anchorage (10/2021)
 - Christine Christensen, Investigator 3-Anchorage (10/2007)
 - Wayne Harger, Investigator 3-Fairbanks (4/2011)
 - David Price, Investigator 3-Juneau (3/2014)
 - Vacant, Investigator 1/2/3-Anchorage (since 07/25)
 - Vacant, Investigator 3-Anchorage (since 08/26)
 - Marie Dagon, WC Technician-Anchorage (4/2024)

082





Mission Statement and Core Values

- **Mission Statement:** The Alaska Division of Workers' Compensation Special Investigations Unit is dedicated to enforcing compliance with the Alaska Workers' Compensation Act. SIU conducts thorough and fair fraud investigations, holds violators accountable, and strives to prevent uninsured injuries through proactive public education.
- **Integrity** — We act with honesty, honor, impartiality, fairness, and transparency. We never compromise the truth.
- **Respect** — We treat others with dignity and compassion. We operate in the spirit of cooperation with our fellow team members, our colleagues inside and outside the state, and our community. We embrace diversity and each other's unique talents.
- **Dedication/Commitment** — We serve the people of Alaska by going above and beyond, while staying within the scope of our own division duties and program boundaries.
- **Accountability** — We are each responsible for our words, our actions, and our results. We pursue excellence.
- **Family** — We support each other in creating an exceptional work environment and encourage a healthy work-life balance.

083





Challenges

- Staffing (29% vacancy rate) impacts proactive outreach
- Recruiting Issues
- Criminal Fraud Prosecution
- Employers without Records
- Legal Opinions
- Case Management System and Technical Support (ICERS)

084





Actions Completed

- 81 Settlements; One Decision and Order
- 475 FTI Investigations Worked; 335 Opened, 391 Closed
- 255 Onsite Outreach visits to Businesses and Communities
- 25 Public Speaking Engagements for Education and WC Information
- 47 Cases Referred to other Agencies; Multi-Agency Collaboration
- 4,259 Compliance Checks

085





Alaska Workers' Compensation Board

Fraud Hotline and Email Tips

	FY2024	FY2025	FY2026	Year-to-Date First Quarter FY2027 (7/1/2026-9/30/2026)
Total Fraud Tip Calls and Emails	105	126	1,128	142
Claimant/Injured Worker Tips	16	15	28	5
Employer Tips	25	26	45	11
Care Providers	0	3	0	0
Attorneys/Non-Attorney Reps	1	3	4	
Insurance Companies/Agents	6	0	0	1
WC Injury Claim Process			915 (Five IW filed multiple complaints)	91
Law Enforcement Agency Assistance Requests	57	81	120	26
Other/Non-Related	0	1	16	8

086





Alaska Workers' Compensation Board

Failure to Insure Statistics

Investigations Opened/Re-Opened	Investigations Closed	Uninsured Injury Referrals Received	Uninsured Injuries Confirmed	Employers With Uninsured Injuries Petitioned
335	391	17	10	6

Assessed By	Total Assessed	Discounted	Suspended	Ordered to Pay
81 Settlements (22 with payment plans)	\$1,277,335.40	\$268,566.26	\$404,240.94	\$604,528.20
One Decision & Order	\$20,000.00	n/a	\$8,000.00	\$12,000.00
TOTALS	\$1,297,335.40	\$268.566.26	\$412,240.94	\$616,528.20

087





Additional SIU Statistics

ACTIVITY	FY2024	FY2025	FY2026	Year-to-Date First Quarter FY2027 07/01/26 to 09/30/26
Pending Cases Carried Forward	107	175	140	84
New Cases Opened	380	424	335	51
Cases Closed	313	465	391	53
Total Cases Worked	487	599	475	135
Petitions	95	98	63	18
Prehearings Attended	124	139	15	1
Compliance Checks	4,620	6,576	4,259 + 255 (on-sites) Total = 4,514	685 + 3 (on-sites) Total 688
Public Inquiries	332	363	311	54
Formal Hearings	5	6	1	0
Warning Letters	37	63	60	6
Investigation Only	197	277	226	23
Percentage Closed in 6 Months	77% (242 of 313)	81% (378 of 465)	75% (291 of 391)	74% (39 of 53)
Uninsured Injuries	33	9	11	5
Interagency Referrals	17	18	47	11

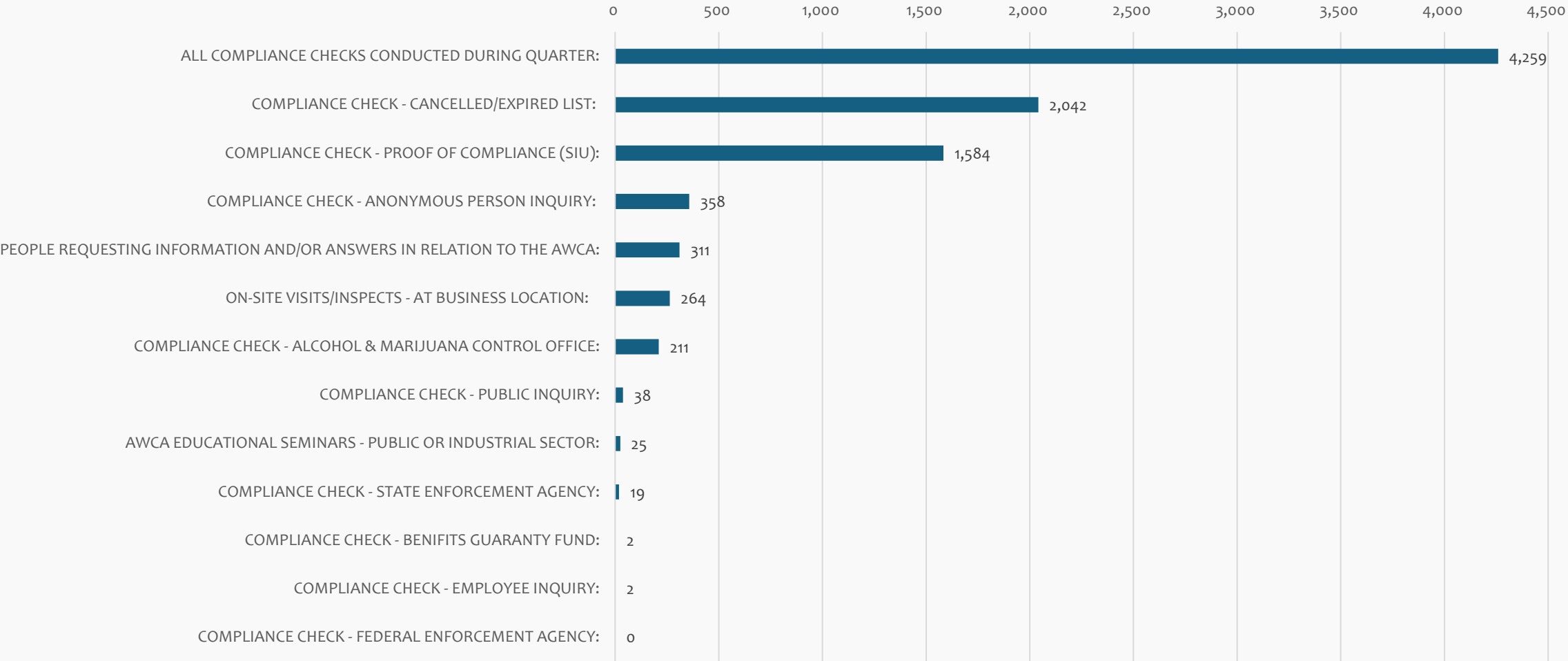
088





Compliance Reviews

680

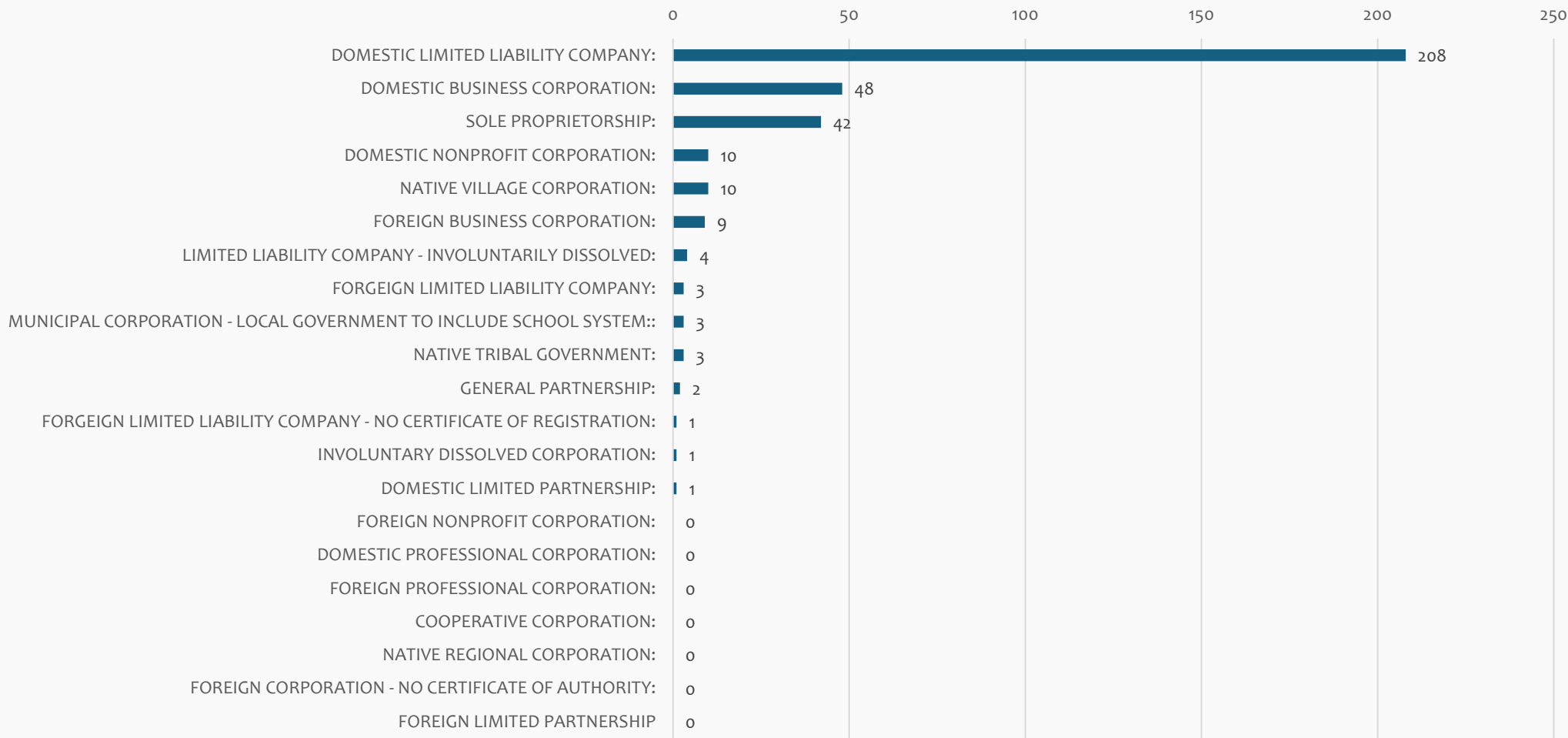




Alaska Workers' Compensation Board

Entity Types for FTI Investigations

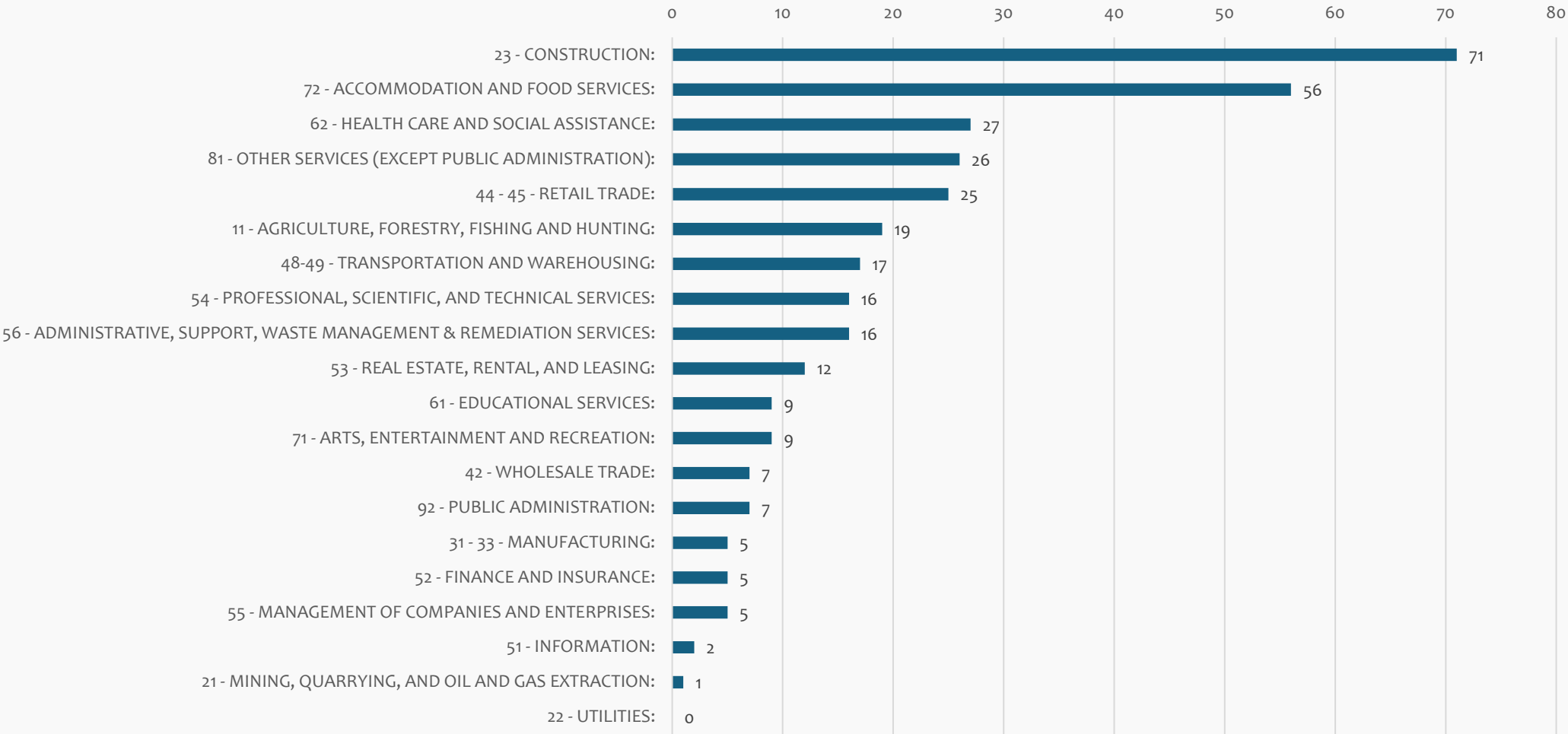
000





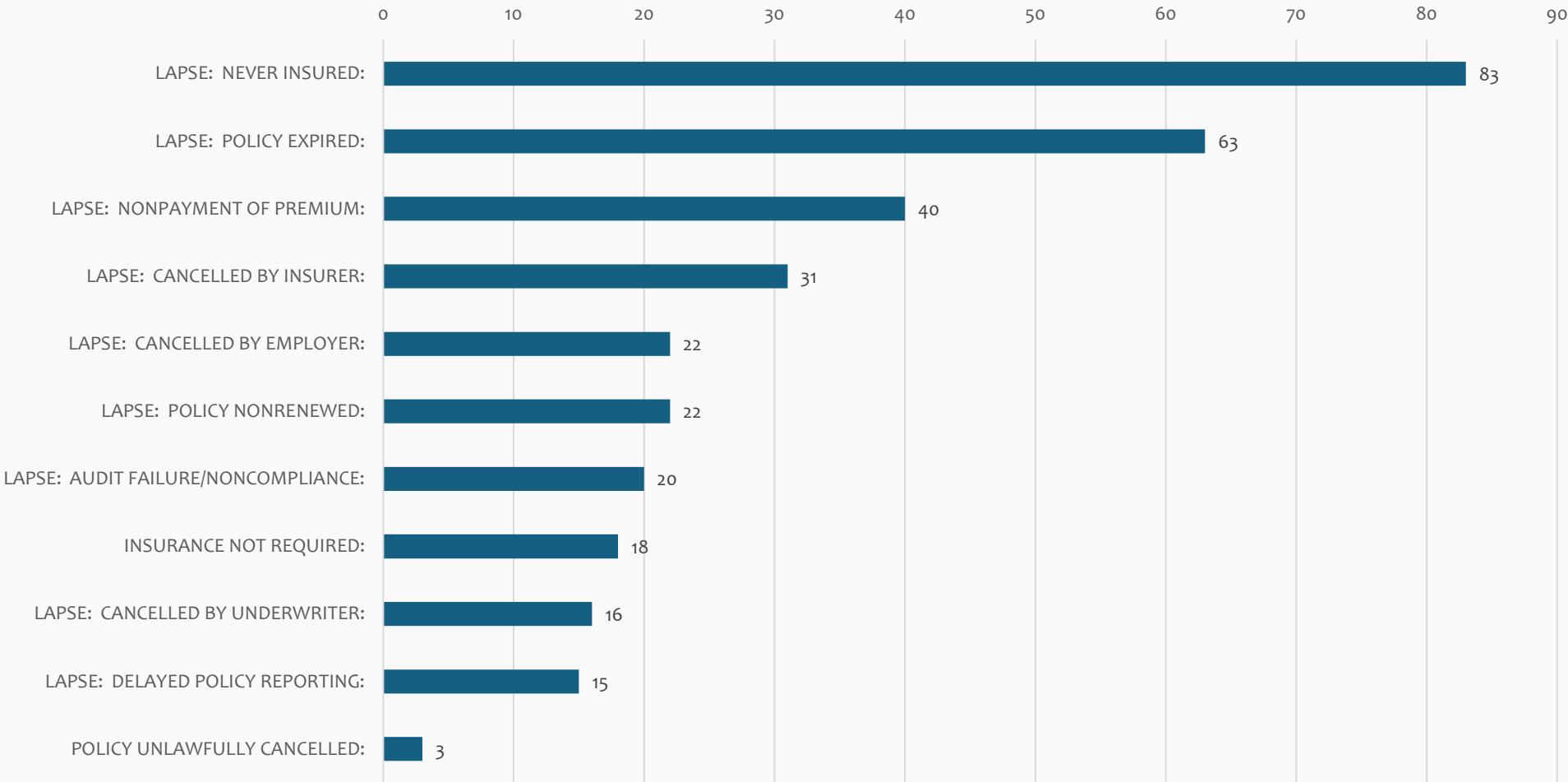
Alaska Industry Classification for FTI Investigations

091





Lapse Reasons for FTI Investigations

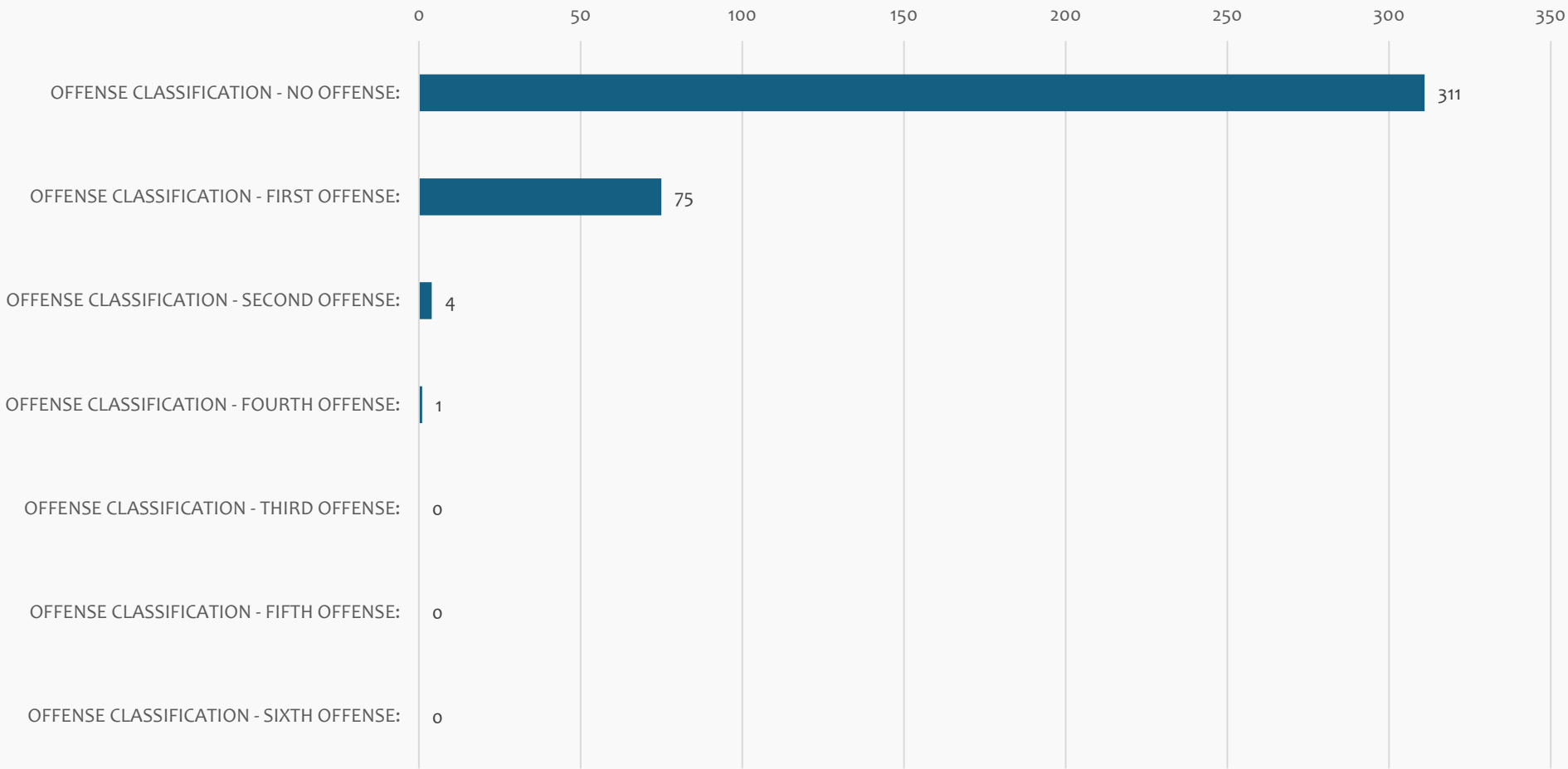


092





Misclassified/Repeat Offender/Debarment



093





NCCI Estimated Uninsured Employers

Effective Date Range:	Policy Count	Employer Count
1/1/2025 to 12/31/2025	22,779	28,812
1/1/2024 to 12/31/2024	22,513	28,226
1/1/2023 to 12/31/2023	22,122	27,348
1/1/2022 to 12/31/2022	21,513	26,288
1/1/2021 to 12/31/2021	20,753	25,277
1/1/2020 to 12/31/2020	19,757	23,767
In 2025 Unemployment Insurance reported 2,811 employer accounts with zero payroll. $28,812 - 22,779 = 6033 - 2811 = 3,222$ potentially uninsured employers (This Chart does not include employers without a payroll account)		
©2026 National Council on Compensation Insurance, Inc. All rights reserved.		

094





Goals and Priorities

- Staffing Level Commensurate with Workload
- Recruit and fill Investigator 3 and Investigator 1/2/3 Positions
- Continued Targeted, Proactive and Collaborative Engagement with other Agencies and Employers
- Expanded Fraud Investigations

095





Alaska Workers' Compensation Board

QUESTIONS?

096





2025 Annual Report Reemployment Benefits Unit

097





Alaska Workers' Compensation Board

STATE OF ALASKA DIVISION OF WORKERS' COMPENSATION

REEMPLOYMENT BENEFITS ANNUAL REPORT Calendar Year 2025

Stacy Niwa
Reemployment Benefits Administrator

008





Alaska Workers' Compensation Board

Reemployment Benefits Section

- Provides information about reemployment and stay-at-work benefits
- Notifies employees of their reemployment and stay-at-work benefits rights
- Processes requests for, and stipulations to, eligibility evaluations
- Makes eligibility determinations after review of rehabilitation specialist recommendations
- Processes and serves employee elections of reemployment benefits or job dislocation benefits
- Processes assignment of eligible employees to rehabilitation specialists for plan development
- Reviews reemployment and stay-at-work benefits plans

660





Alaska Workers' Compensation Board

2025 By the Numbers

- 605 reemployment/stay-at-work employee rights and election forms were served.
- 192 reemployment election forms were received.
- 84 injured workers elected to enter the Stay-at-Work process.
- 151 employer opt out of stay-at-work program notices were received.
- 57 referrals were made to 6 rehabilitation specialists to develop stay-at-work plans.
- 41 Stay-at-Work plans could not be developed for various reasons.
- At the end of CY2025 we had 16 stay-at-work plans in the development process.

100





Alaska Workers' Compensation Board

2025 By the Numbers

- 476 injured workers were referred for evaluations for eligibility for reemployment benefits.
- 999 eligibility evaluation reports were reviewed.
- 108 suspension letters were issued.
- 501 eligibility determinations were made.
- 89 injured workers were found eligible for reemployment benefits.
- 25 injured workers elected to receive a job dislocation benefit.

101





Alaska Workers' Compensation Board

2025 By the Numbers, cont.

- 45 injured workers selected to pursue reemployment benefits.
- 43 reemployment plans were submitted.
- 12 plans were signed by all parties and moved forward.
- 4 plan reviews were completed.
- 12 informal rehabilitation conferences were held to assist the parties in moving forward with reemployment benefits.
- 4 injured workers completed reemployment plans.
- In summary, we experienced a 25% decrease in the number of eligibility evaluation referrals, a 24% increase in eligibility determinations, a 13% increase in elections for plan development and a 50% increase in approved plans since CY2024.

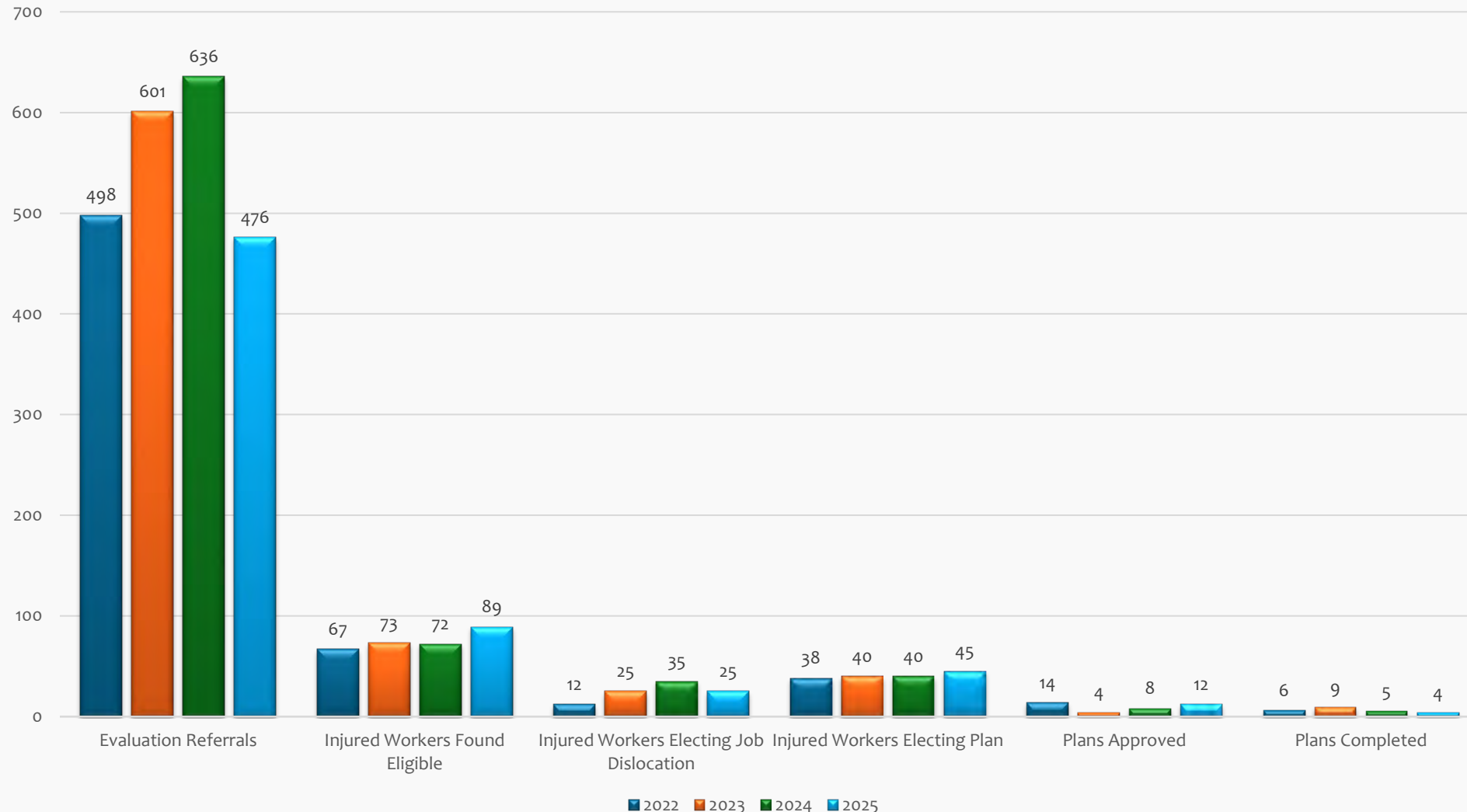
102





Alaska Workers' Compensation Board

2025 By the Numbers, cont.





Alaska Workers' Compensation Board

Reemployment Benefit Plans

- 90 injured workers were in the plan process at some point during 2025.
- 43 injured workers were referred for plan development in 2025.
- 20 injured workers exited the process through a Compromise and Release after plan referral and before plan completion.
- 15 injured workers were in an approved plan at year end.
- 29 injured workers were in plan development, and 12 plans were pending approval at year end.
- 4 injured workers successfully completed plans with an average plan length of 15 months from plan approval to plan completion.

104





Alaska Workers' Compensation Board

Reemployment Benefit Plans, cont.

46 plans were stalled or exited for the following reasons.

- Pending approval by the parties
- Medical suspension
- Compromise and Release agreement
- Non-participation of the injured worker
- Rehabilitation specialist unable to develop plan that meets statute or regulations

105





Alaska Workers' Compensation Board

Outcomes for Workers Completing Plans

- 14 injured workers responded.
- 11 injured workers had returned to the workforce.
- 3 injured workers reported they had not returned to work.
- 1 reported medically disabled.
- 1 reported continuing their education.
- 1 reported as retired.

106





Alaska Workers' Compensation Board

Reemployment Benefits Costs

	2023	2024	2025
Evaluation Costs	\$1,646,132	\$1,745,174	\$1,599,025
Reemployment Specialist Plan Fees	\$615,758	\$684,179	\$437,702
Plan Costs	\$435,966	\$515,940	\$577,216
Wage Benefits (AS 23.30.041(k))	\$3,083,339	\$2,763,301	\$2,309,235
Job Dislocation Benefits (AS 23.30.041(g))	\$1,264,092	\$2,044,222	\$1,896,634
TOTALS	\$7,045,287	\$7,752,817	\$6,819,813
% Change	8.22%	10.04%	-12.03%

107





Alaska Workers' Compensation Board

Reemployment Benefits in Settlements

- 115 injured workers exited the reemployment benefits process through Compromise and Release agreements during the reemployment benefits process.
- 26 injured workers had funds designated for reemployment benefits included in settlements approved in 2025, increasing reemployment benefit costs.
- 71 injured workers exited the reemployment process through a settlement after a determination of eligibility, significantly reducing the number of injured workers available for plan completion.

108





Alaska Workers' Compensation Board

Rehabilitation Specialists Performance

- 12 Alaska Rehabilitation Specialists accepted 344 referrals for eligibility evaluations; 127 evaluations were referred to 30 specialists out of state.
- For Alaska Based Specialists:
 - 296 or 85% of the first reports were submitted within 60 days of the referral.
 - 284 or 81% of the evaluations were completed on the first report submission or prior to a suspension letter from a Reemployment Benefits Administrator Designee.
 - 61 reports did not meet statutory/regulatory requirements.
- Continued improvements in our process are being made to ensure work is in compliance with statutory and regulatory requirements through suspension letters, discussions, plans of correction and disqualification from providing services under AS 23.30.041 and 23.30.043.

109





Alaska Workers' Compensation Board

Alaska Rehabilitation Specialist Performance, cont. 2025 Reemployment Benefits Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1 st report	% complete on 1 st report or w/o suspension letter	% of late 1 st reports	% of 1 st reports rcvd in 60 days	# reports not meeting stat/reg	Median # days to determ
J. Cranston	13	49	54%	62%	77%	8	185
K. Davis	19	51	89%	32%	68%	6	91
J. Doerner	40	42	60%	1%	98%	1	78
R. Hoover	38	29	64%	0%	100%	2	85
T. Hutto	38	39	95%	1%	97%	3	75
S. Krier	38	33	95%	53%	97%	2	71
D. LaBrosse	35	33	83%	1%	97%	1	112
N. Peterson	36	46	100%	25%	86%	9	85

110





Alaska Workers' Compensation Board

Alaska Rehabilitation Specialist Performance, cont. 2025 Reemployment Benefits Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1 st report	% complete on 1 st report or w/o suspension letter	% of late 1 st reports	% of 1 st reports rcvd in 60 days	# reports not meeting stat/reg	Median # days to determ
C. Robbins	37	50	86%	54%	76%	22	84
J. Shipman	5	32	80%	20%	80%	1	61
N. Silta	33	39	82%	0%	100%	1	87
P. Vargas	12	38	91%	41%	92%	5	65

111





Alaska Workers' Compensation Board

QUESTIONS?

112





2025 Annual Report Second Independent Medical Evaluations

SIME

Carrie Craig, Workers' Compensation Officer II

113





Alaska Workers' Compensation Board

Second Independent Medical Evaluations (SIME)

AS 23.30.095
8 AAC 45.092

Carrie Craig
Workers' Compensation Officer II

114





Alaska Workers' Compensation Board

2026 SIME Selection Panel

Panel Members:

Adam Franklin, Employee Attorney

Keenan Powell, Employee Attorney

Jeffrey Holloway, Employer Attorney

Aaron Sandone, Employer Attorney

Division Support Staff:

Janel Wright, Chief of Adjudications

Alexis Hildebrand, Administrative Operations Manager

Amanda Johnson, Workers' Compensation Officer II

Carrie Craig, Workers' Compensation Officer II

115





Alaska Workers' Compensation Board

2026 SIME Selection Panel Decisions per 8 AAC 45.092(b)(6):

2023 SIME Physicians NOT Re-Selected

Rajeev Saggar, MD Internal Medicine

2023 SIME Physicians Re-Selected:

William Faloon Jr., MD Orthopedic Surgery

Peter E. Diamond, MD Orthopedic Surgery

Maria B. Patten, DO Physical Medicine & Rehabilitation

Jon H. Scarpino, MD Orthopedic Surgery

John Shuster, MD Orthopedic Surgery

Frank W. Uhr, MD Orthopedic Surgery

Sidney H. Levine, MD Orthopedic Surgery

Ori Levy, DDS Dentistry, Periodontics

Jay N. Schapira, MD Cardiology, Internal Medicine

Sushil M. Sethi, MD Occupational Medicine

Leon D. Zeitzer, MD Otolaryngology (ENT)

Martina Ziegenbein, MD Rheumatology, Internal Medicine

Ryan Davis, MD Psychiatry

Based on the information provided for the above physicians, the total SIME cost (including addendums & depositions)
is: **\$236,394.66**

There were no 2023 SIME Physicians Considered for Removal by a Majority Vote, per 8 AAC 45.092(b)(6)(A).





Alaska Workers' Compensation Board

2026 SIME Selection Panel Decisions per 8 AAC 45.092(b)(5):

NEW SIME Physicians Selected by a Majority Vote:

Mark Borsody MD, PhD Neurology

Benjamin DuBois MD Orthopedic Surgery

Pouriya Ghayoumi MD Orthopedic Surgery

Daniel Gittings MD Orthopedic Surgery

Gregg Hartman MD Orthopedic Surgery

H. Paco Kang MD Orthopedic Surgery

Michael Lim MD Orthopedic Surgery

Steven Lin MD Orthopedic Surgery

Roshan Melvani MD Orthopedic Surgery

Behnam Sharareh MD Orthopedic Surgery

Swapnil Shah MD Orthopedic Surgery

Carlos Uquillas MD Orthopedic Surgery

Farid Kia MD PM&R

Christopher Ornelas MD PM&R

Keith Happawana PsyD Psychology

Mehran Movassaghi MD, MBA Urology

Kian Raiszadeh MD Orthopedic Surgery

117





Alaska Workers' Compensation Board

2026 SIME Physician Non-Renewals:

The panel members did not suggest any SIME physicians be considered for removal by a majority vote.

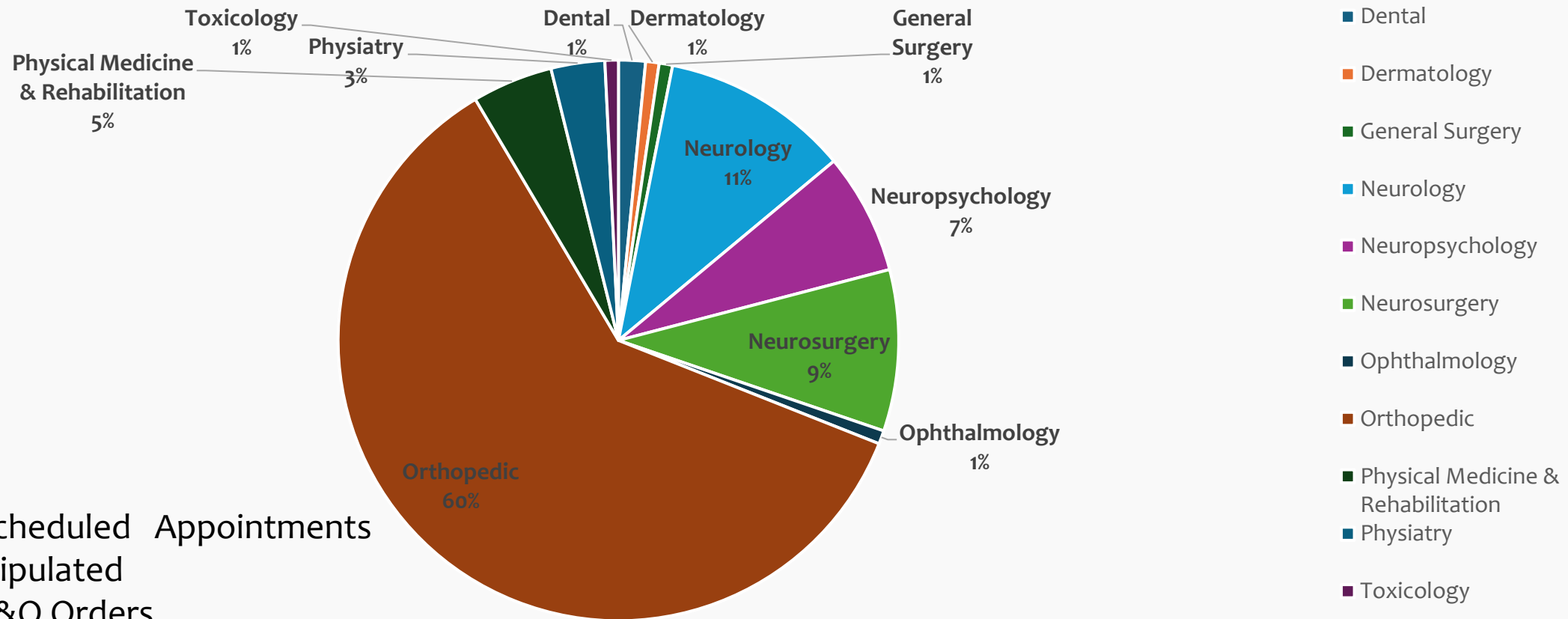
118





Alaska Workers' Compensation Board

2026 SIME Specialties Utilized



133 Scheduled Appointments
113 Stipulated
20 D&O Orders
10 Settled prior to appointment

119

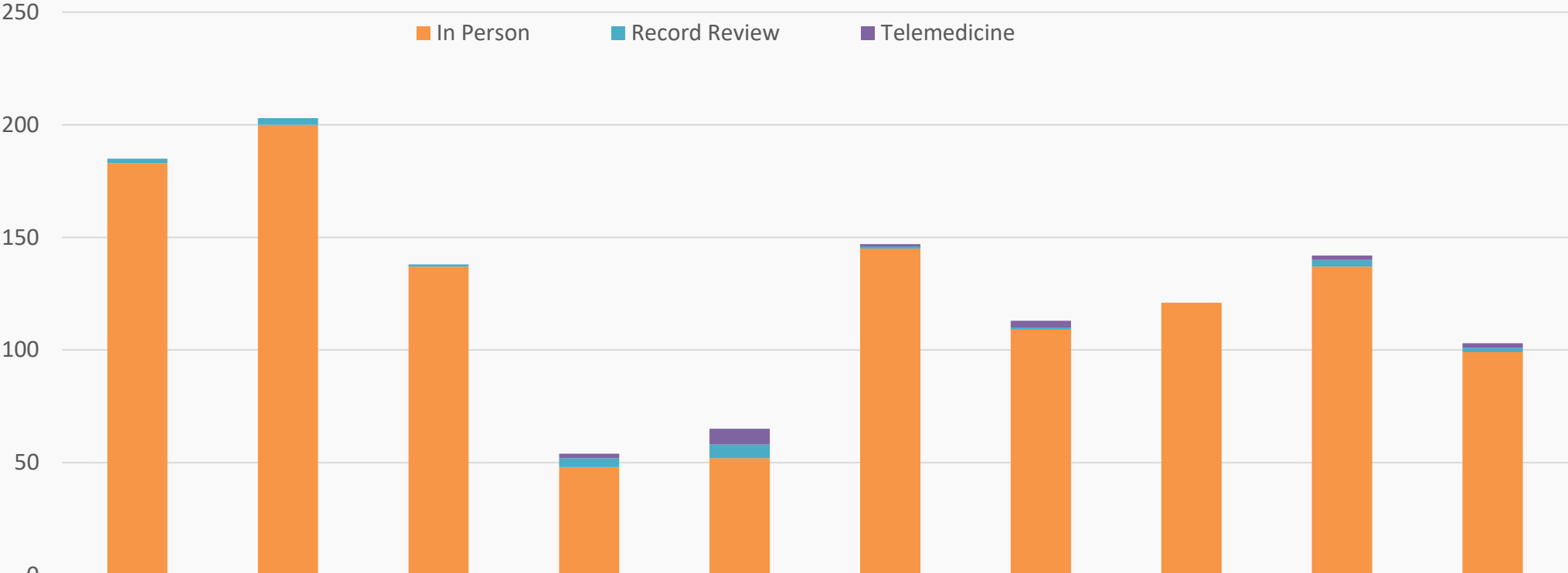




Alaska Workers' Compensation Board

2026 SIME Totals and Methods last 10 Year Comparison:

120



	11/1/2016 - 10/31/2017	11/1/2017 - 10/31/2018	11/1/2018 - 10/31/2019	11/1/2019 - 10/31/2020	11/1/2020 - 10/31/2021	11/1/2021 - 10/31/2022	11/1/2022 - 10/31/2023	11/1/2023 - 10/31/2024	11/1/2024 - 10/31/2025	11/1/2025 - 10/31/2026
Telemedicine	0	0	0	2	7	1	3	0	2	2
Record Review	2	3	1	4	6	1	1	0	3	2
In Person	183	200	137	48	52	145	109	121	137	99





Alaska Workers' Compensation Board

QUESTIONS?

121





Alaska Workers' Compensation Board

Find all 25 words. Words may run horizontally, vertically, diagonally, forward, or backward.

V	Q	Y	S	Y	A	S	F	B	Z	D	Z	V	F	X	N	G	B	F	D	B	A	D	T	K
W	G	I	Y	C	S	F	A	T	N	O	I	T	A	T	I	L	I	B	A	H	E	R	E	I
T	M	R	G	L	G	D	C	X	C	D	H	E	A	R	I	N	G	F	I	X	N	Q	V	A
E	N	H	G	I	L	Y	P	X	O	T	V	H	C	Y	J	N	M	A	I	O	U	M	U	C
T	L	E	G	V	P	A	A	R	M	O	Z	E	E	H	Q	O	A	X	Q	C	O	J	Y	A
I	A	G	M	A	L	X	F	T	P	D	G	H	J	K	N	I	C	N	C	C	Y	T	T	U
R	G	L	R	R	O	J	C	Y	E	I	P	J	E	Y	E	S	A	P	F	U	C	L	Y	O
Q	F	E	O	Q	I	W	Q	A	N	A	I	A	X	X	W	R	C	I	Q	P	N	J	K	Z
M	H	Y	K	X	N	A	Q	J	S	G	Y	A	G	I	M	E	K	L	J	A	S	G	J	Z
T	C	T	M	P	V	E	P	Z	A	N	G	J	M	J	E	V	O	S	Q	T	S	B	X	W
G	U	E	M	Q	C	E	F	M	T	O	A	Q	I	E	D	O	P	P	P	I	R	B	Y	T
U	G	U	S	D	K	R	U	K	I	S	Q	N	N	D	I	R	L	E	I	O	E	S	E	Z
H	R	S	G	M	U	E	D	C	O	I	I	Z	E	C	A	T	X	V	A	N	T	A	Q	O
A	P	M	J	V	X	G	O	H	N	S	O	P	G	E	T	N	R	I	X	F	U	D	X	O
O	T	F	R	Q	D	U	F	T	V	C	O	R	U	S	I	O	Y	T	S	K	T	E	K	X
N	J	O	J	J	I	L	U	I	L	S	J	H	K	M	O	C	T	A	D	J	A	O	J	D
C	F	F	E	D	N	A	U	I	I	G	L	O	E	A	N	X	I	B	I	Z	T	I	U	Y
H	L	K	M	F	A	T	K	T	Y	M	E	D	G	P	N	O	N	M	S	L	S	A	I	Q
H	N	G	P	G	S	I	I	A	M	W	I	M	K	T	A	V	M	O	A	R	R	J	Y	E
X	N	P	L	Z	N	O	M	Q	I	C	U	T	P	K	N	O	E	C	B	F	B	D	G	Z
Y	U	P	O	E	N	N	S	F	A	F	H	S	S	L	F	Q	D	B	I	F	N	W	W	N
E	I	B	Y	S	A	F	E	L	Z	R	C	P	Z	D	O	J	N	J	L	H	C	N	I	P
O	D	E	E	W	U	W	W	O	R	K	P	L	A	C	E	Y	I	Z	I	K	V	E	Q	C
L	E	P	E	V	G	S	V	C	K	T	A	K	P	L	X	B	E	C	T	C	H	W	G	R
C	E	V	K	I	M	W	O	Q	C	O	Q	R	X	X	D	A	P	R	Y	K	O	Y	R	W

STATUTE	REGULATION	HEARING
MEDIATION	FALL	DEPOSITION
CONTROVERSION	SLIP	DIAGNOSIS
COMBATIVE	PINCH	EMPLOYEE
SAFE	SIME	EMPLOYER
WORKPLACE	IMPAIRMENT	OCCUPATION
THERAPY	DISABILITY	MEDICAL
REHABILITATION	COMPENSATION	
FRAUD	INDEMNITY	





Alaska Workers' Compensation Board

Cathy Muñoz, Commissioner

Email: Commissioner.Labor@alaska.gov

Phone: (907) 465-2702

Charles Collins, Director

Email: Charles.Collins@alaska.gov

Phone: (907) 465-6060



123





Alaska Workers' Compensation Board

2025 Annual Report

124



ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Cathy Muñoz, Commissioner

Workers' Compensation 2026



TAB 7

Humphrey v. Reges, 591 P.3d 868 (Alaska 2026)

Opinion by: Chief Justice Carney

Representatives: Dion Humphrey, self-represented Appellant
Robert Reges for Appellees

Issue:

Did the superior court abuse its discretion by removing a disruptive self-represented civil litigant from trial?

Result: No.

Discussion:

This is not a workers' compensation case, but it should apply in Board proceedings when a party becomes disruptive at hearing. In *Humphrey*, a self-represented landowner sued his neighbors over a property dispute. The neighbor is a lawyer.

The plaintiff repeatedly interrupted the court and opposing party, argued after rulings, spoke over the judge, and disregarded repeated instructions from the court. The judge explained courtroom procedure and gave multiple warnings. It then moved the plaintiff to Zoom. When he continued to interrupt over Zoom, including unmuting himself, the court removed him from the trial but allowed him to submit written closing materials.

The Supreme Court affirmed the removal. This was the Court's first decision addressing whether a trial court may remove a disruptive civil litigant from trial. The Court applied an abuse-of-discretion standard because the trial court is best positioned to evaluate courtroom disruption.

The Court held that a civil litigant has a due process right to be present, but that right is not absolute. Criminal defendants receive greater protection, yet even they may be removed after repeated disruptive conduct according to US Supreme Court precedent. A self-represented civil litigant receives less protection because the case does not involve the same constitutional concern as a criminal trial.

The controlling and practical rule is that removal must follow "fair warning and reasonable efforts to preserve participation." The superior court gave repeated instructions: litigant was warned of consequences, moved to Zoom, unmuted himself to interrupt, and was removed only after each measure failed to contain him. The Court emphasized that his behavior interfered with the opposing party's right to a fair trial. Because the trial court acted gradually and preserved a later opportunity to submit a written argument, removal was not an abuse of discretion.

Humphrey may support maintaining Board hearing decorum when a party disrupts proceedings. A hearing officer should explain expectations, warn the party of consequences, consider lesser measures such as Zoom participation or muting, and create a clear record showing the conduct prevented a fair and orderly hearing. If those steps fail, exclusion from the proceeding may be justified. But the party must have an opportunity to submit a written argument.

TAB 8



Official

ALASKA

WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2027



STATE OF ALASKA DISCLAIMER

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

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

NOTICE

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

QUESTIONS ABOUT THE OFFICIAL WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

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

GENERAL QUESTIONS ABOUT WORKERS' COMPENSATION

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

AMERICAN MEDICAL ASSOCIATION NOTICE

CPT © 2026 American Medical Association. All rights reserved.

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

CPT is a registered trademark of the American Medical Association.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS NOTICE

Relative Value Guide © 2026 American Society of Anesthesiologists. All Rights Reserved.

Relative Value Guide is a relative value study and not a fee schedule. It is intended only as a guide. ASA does not directly or indirectly practice medicine or dispense medical services. ASA assumes no liability for data contained or not contained herein.

Relative Value Guide is a registered trademark of the American Society of Anesthesiologists.

Contents

Introduction.....	1	Category II.....	39
Organization of the Fee Schedule.....	1	Category III.....	41
Scope of Practice Limits and provider Schedule.....	2	Category III Modifiers	41
Services by Out-of-State Providers.....	2	HCPCS Level II	43
Drugs and Pharmaceuticals	2	General Information and Guidelines.....	43
HCPCS Level II	3	Medicare Part B Drugs.....	43
Outpatient Facility.....	4	Durable Medical Equipment.....	43
Inpatient Hospital.....	4	Modifiers	44
Definitions.....	4	Ambulance Services.....	45
General Information and Guidelines.....	7	Outpatient Facility	47
Billing and Payment Guidelines.....	7	General Information and Guidelines.....	47
Modifiers	12	Surgical Services	50
Evaluation and Management	15	Drugs and Biologicals.....	50
General Information and Guidelines.....	15	Equipment, Devices, Appliances, and Supplies	51
Billing and Payment Guidelines.....	15	Specialty and Limited-Supply Items.....	51
Modifiers	20	Durable Medical Equipment (DME).....	51
Anesthesia.....	21	Use of Outpatient Facility and Ancillary Services.....	51
General Information and Guidelines.....	21	Nursing and Related Technical Personnel Services.....	51
Billing and Payment Guidelines.....	21	Surgical Dressings, Splinting, and Casting Materials	51
Anesthesia Modifiers.....	22	Inpatient Hospital	53
Surgery.....	25	General Information and Guidelines.....	53
General Information and Guidelines.....	25	Exempt from the MS-DRG	53
Billing and Payment Guidelines.....	25	Services and Supplies in the Facility Setting.....	53
Modifiers	27	Preparing to Determine a Payment.....	54
Radiology	29	Date of Service Recommendation.....	54
General Information and Guidelines.....	29	Example.....	54
Billing and Payment Guidelines.....	29	Critical Access Hospital, Rehabilitation Hospital,	
Modifiers	30	Long-term Acute Care Hospital	61
Pathology and Laboratory	31	General Information and Guidelines.....	61
General Information and Guidelines.....	31	“Physicians Report” Example Appendix A.....	63
Billing and Payment Guidelines.....	31	Acronyms Appendix B.....	66
Modifiers	32		
Medicine (Physical Therapy).....	33		
General Information and Guidelines.....	33		
Billing and Payment Guidelines.....	33		
Modifiers	38		

DRAFT

Introduction

The Alaska Division of Workers' Compensation (ADWC) is pleased to announce the implementation of the *Official Alaska Workers' Compensation Medical Fee Schedule*, which provides guidelines and the methodology for calculating rates for provider and non-provider services.

Fees and charges for medical services are subject to Alaska Statute 23.30.097(a).

Insurance carriers, self-insured employers, bill review organizations, and other payer organizations shall use these guidelines for approving and paying medical charges of physicians and surgeons and other health care providers for services rendered under the Alaska Workers' Compensation Act. In the event of a discrepancy or conflict between the Alaska Workers' Compensation Act (the Act) and these guidelines, the Act governs.

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

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

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

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

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

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

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

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

ORGANIZATION OF THE FEE SCHEDULE

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

- Introduction
- General Information and Guidelines
- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine (Physical Medicine)
- Category II
- Category III
- HCPCS Level II
- Outpatient Facility
- Inpatient Hospital

- Critical Access Hospital, Rehabilitation Hospital, Long-term Acute Care Hospital

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

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

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

SCOPE OF PRACTICE LIMITS AND PROVIDER SCHEDULE

The amounts allowed in the Provider Schedule represent the physician portion of a service or procedure and apply to physicians and other certified or licensed providers that do not meet the definition of an outpatient facility. Fees for services performed outside a licensed medical provider's scope of practice, as defined by Alaska's professional licensing laws and applicable regulatory boards, are not reimbursable.

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

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

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total relative value units (RVUs) are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total RVUs are used for services performed in a practitioner's office, patient's home, or other non-hospital settings such as a residential care facility. For these services, the practitioner typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the practitioner's service. Where the RVU is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

SERVICES BY OUT-OF-STATE PROVIDERS

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

DRUGS AND PHARMACEUTICALS

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

The maximum allowable reimbursement for prescription drugs dispensed and billed by a pharmacy is as follows:

1. Brand name drugs shall be reimbursed at the manufacturer's average wholesale price plus a \$5 dispensing fee;
2. Generic drugs shall be reimbursed at the manufacturer's average wholesale price plus a \$10 dispensing fee;

Over-the-counter (OTC) medications are drugs available for purchase by the general public without a prescription. Reimbursement for OTC medications shall be the lowest average wholesale price (AWP)

among therapeutically equivalent products, based on the original manufacturer’s national drug code (NDC). OTC medications shall not be eligible for a dispensing fee.

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

PHYSICIAN-DISPENSED DRUGS

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

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

TOPICALS AND TOPICAL COMPOUNDS

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

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

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

be \$10.00 for a compound containing three (3) or fewer ingredients and \$20.00 for a compound containing more than three (3) ingredients.

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

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

NON-TOPICAL COMPOUNDED DRUGS

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

HCPCS LEVEL II

DURABLE MEDICAL EQUIPMENT

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

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

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

AMBULANCE SERVICES

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

OUTPATIENT FACILITY

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

INPATIENT HOSPITAL

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

DEFINITIONS

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

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

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

Board — the Alaska Workers' Compensation Board.

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

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

Covered injury — accidental injury, an occupational disease or infection, or death arising out of and in the

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

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

Day — a continuous 24-hour period.

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

Drugs — a controlled substance as defined by law.

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

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

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

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

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

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

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

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

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

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

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

Modifier — a two-character alphanumeric code used in conjunction with the procedure code to describe any unusual circumstances arising in the treatment of an injured or ill employee.

Operative report — the provider's written or dictated description of the surgery and includes all of the following:

- Preoperative diagnosis
- Postoperative diagnosis
- A step-by-step description of the surgery
- Identification of problems that occurred during surgery
- Condition of the patient when leaving the operating room, the provider's office, or the health care organization.

Optometrist — an individual licensed to practice optometry.

Orthotic equipment — orthopedic apparatus designed to support, align, prevent or correct deformities, or improve the function of a moveable body part.

Orthotist — a person skilled and certified in the construction and application of orthotic equipment.

Outpatient service — services provided to patients who do not require hospitalization as inpatients. This includes outpatient ambulatory services, hospital-based emergency room services, or outpatient ancillary services that are based on the hospital premises. Refer to the Inpatient Hospital section of this fee schedule for reimbursement of hospital services.

Payer — the employer/insurer or self-insured employer, or third-party administrator (TPA) who pays the provider billings.

Pharmacy — the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Physician — under AS 23.30.395(32) and Thoeni v. Consumer Electronic Services, 151 P.3d 1249, 1258 (Alaska 2007), "physician" includes doctors of medicine, surgeons, chiropractors, osteopaths, dentists, optometrists, and psychologists.

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

Primary procedure — the therapeutic procedure most closely related to the principal diagnosis and, for billing purposes, the highest valued procedure.

Procedure — a unit of health service.

Procedure code — a five-digit numerical or alpha-numerical sequence that identifies the service performed and billed.

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

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

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

Prosthesis — an artificial substitute for a missing body part.

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

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

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

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

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

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

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

General Information and Guidelines

This section contains information that applies to all providers billing independently, regardless of site of service. The guidelines listed herein apply only to providers' services, evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, medicine, and durable medical equipment.

Insurers and payers are required to use the *Official Alaska Workers' Compensation Medical Fee Schedule* for payment of workers' compensation claims.

BILLING AND PAYMENT GUIDELINES

FEES FOR MEDICAL TREATMENT

Providers should bill their normal charges for services. The fee reimbursement may not exceed the physician's actual fee or the maximum allowable reimbursement (MAR), whichever is lower. The MAR for **physician services** except anesthesia is calculated using the Resourced-Based Relative Value Scale (RBRVS) relative value units (RVU) produced by the Centers for Medicare and Medicaid Services (CMS) and the Geographic Practice Cost Index (GPCI) for Alaska based on the following formula:

$$(\text{Work RVUs} \times \text{Work GPCI}) + (\text{Practice Expense RVUs} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVUs} \times \text{Malpractice GPCI}) = \text{Total RVU}$$

The Alaska MAR payment is determined by multiplying the total RVU by the applicable Alaska conversion factor, which is rounded to two decimals after the conversion factor is applied.

Example data for CPT code 10021 with the Alaska GPCI using the non-facility RVUs:

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.03	1.500	1.545
Non-facility Practice Expense RVU x Practice Expense GPCI	1.84	1.065	1.9596
Malpractice RVU x Malpractice GPCI	0.15	0.551	0.08265
Total RVU			3.58725

Data for the purpose of example only

Calculation using example data:

$$1.03 \times 1.500 = 1.545$$

$$+ 1.84 \times 1.065 = 1.9596$$

$$+ 0.15 \times 0.551 = 0.08265$$

$$= 3.58725$$

$$3.58725 \times \$119.00 \text{ (CF)} = 426.88275$$

Payment is rounded to \$426.88

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

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

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total RVUs are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total RVUs are used for services performed in a practitioner's office, patient's home, or other non-hospital settings such as a residential care facility. For these services, the practitioner typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the practitioner's service. Where the RVU is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

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

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

An employer or group of employers may negotiate and establish a list of preferred providers for the treatment of its employees under the Act; however, the employees' right to choose their own attending physician is not impaired.

All providers may report and be reimbursed the lesser of billed charge or MAR for codes 97014 and 97810–97814.

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

RBRVS STATUS CODES

The Centers for Medicare and Medicaid Services (CMS) RBRVS Status Codes are listed below. The CMS guidelines apply except where superseded by Alaska guidelines.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
A	<u>Active Code</u> . These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status.	The maximum fee for this service is calculated as described in Fees for Medical Treatment.
B	<u>Bundled Code</u> . Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.	No separate payment is made for these services even if an RVU is listed.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
C	<u>Contractors price the code</u> . Contractors will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
D	<u>Deleted Codes</u> . These codes are deleted effective with the beginning of the applicable year.	Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .
E	<u>Excluded from Physician Fee Schedule by regulation</u> . These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
F	<u>Deleted/Discontinued Codes</u> . (Code not subject to a 90 day grace period).	Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .
G	<u>Not valid for Medicare purposes</u> . Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.)	Not in current RBRVS. Not payable under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .
H	<u>Deleted Modifier</u> . This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H."	Not in current RBRVS. Not payable with modifiers TC and/or 26 under the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .
I	<u>Not valid for Medicare purposes</u> . Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
J	<u>Anesthesia Services</u> . There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.	Alaska recognizes the anesthesia base units in the <i>Relative Value Guide</i> published by the American Society of Anesthesiologists. See the <i>Relative Value Guide</i> or Anesthesia Section.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
M	<u>Measurement Codes</u> . Used for reporting purposes only.	These codes are supplemental to other covered services and for informational purposes only.
N	<u>Non-covered Services</u> . These services are not covered by Medicare.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
P	<u>Bundled/Excluded Codes</u> . There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. - If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) - If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
R	<u>Restricted Coverage</u> . Special coverage instructions apply. If covered, the service is contractor priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D." We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
T	<u>T = Injections</u> . There are RVUs and payment amounts for these services, but they are paid only if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> .
X	<u>Statutory Exclusion</u> . These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)	The service may be a covered service of the <i>Official Alaska Workers' Compensation Medical Fee Schedule</i> . The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider. For ambulance services see HCPCS Level II section of this guideline.

ADD-ON PROCEDURES

The CPT book identifies procedures that are always performed in addition to the primary procedure and designates them with a + symbol. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. Specific language is used to identify add-on procedures such as "each additional" or "(List separately in addition to primary procedure)."

The same physician or other provider that performed the primary service/procedure must perform the add-on service/procedure. Add-on codes describe additional intra-service work associated with the primary service/procedure (e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)). Add-on codes are not subject to reduction and should be reimbursed at the lower of the billed charges or 100 percent of MAR. Do not append modifier 51 to a code identified as an add-on procedure. Designated add-on codes are identified in Appendix D of the CPT book. Please reference the CPT book for the most current list of add-on codes.

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

EXEMPT FROM MODIFIER 51 CODES

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

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

PROFESSIONAL AND TECHNICAL COMPONENTS

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

GLOBAL DAYS

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

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

- MMM Designates services furnished in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care.
- XXX Designates services where the global concept does not apply.

- YYY Designates services where the payer must assign a follow-up period based on documentation submitted with the claim. Procedures designated as YYY include unlisted procedure codes.
- ZZZ Designates services that are add-on procedures and as such have a global period that is determined by the primary procedure.

TELEHEALTH SERVICES

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

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

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

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

SUPPLIES AND MATERIALS

Supplies and materials provided by the physician (e.g., sterile trays, supplies, drugs, etc.) over and above those usually included with the office visit may be charged separately.

MEDICAL REPORTS

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

A medical provider may not charge a separate fee for medical reports or treatment plans that are required to substantiate the medical necessity of a service. Provider medical reports are furnished to the payer/employer within 14 days after the encounter or service.

CPT code 99080 is not to be used to complete required workers' compensation insurance forms or to complete required documentation to substantiate medical necessity. CPT code 99080 is not to be used for signing affidavits or certifying medical records forms. CPT code 99080 is appropriate for billing only after receiving a request for a special report from the employer or payer.

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

TREATMENT PLANS

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

- A) three treatments per week during the first month;
- B) two treatments per week during the second and third months;
- C) one treatment per week during the fourth and fifth months; or
- D) one treatment per month during the sixth through twelfth months.

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

MEDICAL EVALUATIONS

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

OFF-LABEL USE OF MEDICAL SERVICES

All medications, treatments, experimental procedures, devices, or other medical services should be medically necessary, having a reasonable expectation of cure or significant relief of a covered condition and supported by medical record documentation, and, where appropriate, should be provided consistent with the approval of the Food and Drug Administration (FDA). Off-label medical services must include submission of medical record documentation and comprehensive medical literature review including at least two reliable prospective, randomized, placebo-controlled, or double-blind trials. The Alaska Division of Workers' Compensation (ADWC) will consider the quality of the submitted documents and determine medical necessity for off-label medical services.

Off-label use of medical services will be reviewed annually by the Alaska Workers' Compensation Medical Services Review Committee (MSRC).

PAYMENT OF MEDICAL BILLS

Medical bills for treatment are due and payable within 30 days of receipt of both the medical provider's bill, and the completed medical report, that complies with regulation 8 AAC 45.086, as prescribed by the Board under Alaska Statute 23.30.097. If the medical provider's bill and medical report are not submitted at the same

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

A provider whose bill has been denied or reduced by the employer or appropriate payer may file an appeal with the Board within 60 days after receiving notice of the denial or reduction. A provider who fails to file an appeal of a denial or reduction of a bill within the 60-day period waives the right to contest the denial or reduction. See AS 23.30.097(i).

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

SCOPE OF PRACTICE LIMITS

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

HOME HEALTH AND IN-HOME CARE SERVICES

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

REIMBURSEMENT BY AGREEMENT

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

by CMS coding methodology and therefore must be reimbursed based on a separate agreement between the payer and the provider.

REIMBURSEMENT BY FEE SCHEDULE

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

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

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

BOARD FORMS

All board bulletins and forms can be downloaded from the Alaska Workers' Compensation Division website: www.labor.state.ak.us/wc.

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific modifiers shall be reimbursed as follows:

Modifier 26—Reimbursement is calculated according to the RVU amount for the appropriate code and modifier 26.

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued, then both sides

are reported with modifiers 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

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

Consistent with the Centers for Medicare and Medicaid Services (CMS) guidelines, code-specific multiple procedure reduction guidelines apply to endoscopic procedures, and certain other procedures including radiology, diagnostic cardiology, diagnostic ophthalmology, and therapy services.

Modifiers 80, 81, and 82— Reimbursement is the lower of the billed charge or 20 percent of the MAR for the surgical procedure.

APPLICABLE HCPCS MODIFIERS

MODIFIER AS—PHYSICIAN ASSISTANT OR NURSE PRACTITIONER ASSISTANT AT SURGERY SERVICES

When assistant at surgery services are performed by a physician assistant or nurse practitioner, the service is reported by appending modifier AS in addition to modifier 80, 81, or 82.

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

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

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

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

Data for the purpose of example only

MODIFIER TC—TECHNICAL COMPONENT

Certain procedures are a combination of a physician component and a technical component. When the

technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure code. Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure code with modifier TC.

MODIFIER QZ—CRNA WITHOUT MEDICAL DIRECTION BY A PHYSICIAN

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

STATE-SPECIFIC MODIFIERS

MODIFIER PE—PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

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

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

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

Data for the purpose of example only

DRAFT

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

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

The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Consultation codes are linked to location.

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

BILLING AND PAYMENT GUIDELINES

TELEHEALTH SERVICES

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

with codes 98000–98015. Telehealth services should be reported with modifier 93 or 95 appended.

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

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

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

MEDICAL EVALUATIONS

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

NEW AND ESTABLISHED PATIENT SERVICE

Several code subcategories in the Evaluation and Management (E/M) section are based on the patient's status as being either new or established. CPT guidelines clarify this distinction by providing the following time references:

“A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

“An established patient is one who has received professional services from the physician or other qualified health care professional, or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

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

E/M SERVICE COMPONENTS

E/M COMPONENT GUIDELINES FOR CPT CODES

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

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

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

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

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

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

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

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

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

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

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

PROBLEM

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

SUBCATEGORIES OF EVALUATION AND MANAGEMENT

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

TELEHEALTH SERVICES (98000-98016)

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

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

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

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

OFFICE OR OTHER OUTPATIENT SERVICES (99202–99215)

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

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

The codes for hospital inpatient and observation care services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge-day management. Per CPT guidelines for inpatient and observation care, the time component includes both face-to-face time and non-face-to-face time spent on the date of service on or off the unit. This time may include family counseling or discussing the patient’s condition with the family; establishing and reviewing the patient’s record; documenting within the chart; and communicating with other health care professionals such as other physicians, nursing staff, respiratory therapists, and so on.

If the patient is admitted to a facility on the same day as another encounter (office, emergency department, nursing facility, etc.), report the service in the initial site separately with a modifier 25 to indicate that a significant, separately identifiable service was performed by the same physician or other qualified health care professional.

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

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

CONSULTATIONS (99242–99245, 99252–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient or Observation Consultations. Follow-up visits by the consultant in an office or other outpatient facility are reported with established patient office codes 99212–99215 or home or residence codes 99347–99350. For follow-up consultation services during the same admission as the initial consultation, see Subsequent Hospital Inpatient or Observation Care codes 99231–99233 and Subsequent Nursing Facility Care codes 99307–99310. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate E/M code for the site of service (office, home or residence, hospital inpatient or observation). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99242–99245 or Initial Inpatient Consultations 99252–99255). The general rules and requirements of a consultation are defined by the CPT book as follows:

- A consultation is “a type of evaluation and management service provided at the request of another physician, or other qualified healthcare professional, or appropriate source to recommend care for a specific condition or problem.”
- Most requests for consultation come from an attending physician or other appropriate source, and the necessity for this service must be documented in the patient’s record. Include the name of the requesting physician on the claim form or electronic billing.

- The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.
- The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.
- Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.
- When the consultant assumes responsibility for the management of any or all of the patient's care, consultation codes are no longer appropriate. Report the appropriate code for the site of service (office, home or residence, hospital inpatient or observation).
- Follow-up visits with the consultant should be reported with the appropriate subsequent or established patient codes, depending on the location.

EMERGENCY DEPARTMENT SERVICES (99281–99288)

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

CRITICAL CARE SERVICES (99291–99292)

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

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

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

NURSING FACILITY SERVICES (99304–99316)

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

HOME OR RESIDENCE SERVICES (99341–99350)

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

PROLONGED SERVICES (99358–99360, 99415–99418)

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

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

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

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

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

These prolonged physician services without direct (face-to-face) patient contact may include review of extensive records and tests, and communication (other than telephone calls) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided. This prolonged service is provided on a different date than the face-to-face E/M encounter with the patient and/or family/caregiver. Use 99358 to report the first hour and 99359 for each additional 30 minutes. Services lasting less than 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable.

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

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

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

Physician Standby Services

Code 99360 reports the circumstances of a physician who is requested by another physician to be on standby, and the standby physician has no direct patient contact. The standby physician may not

provide services to other patients or be proctoring another physician for the time to be reportable. Also, if the standby physician ultimately provides services subject to a surgical package, the standby is not separately reportable.

This code reports cumulative standby time by date of service. Less than 30 minutes is not reportable, and a full 30 minutes must be spent for each unit of service reported. For example, 25 minutes is not reportable, and 50 minutes is reported as one unit (99360 x 1).

CASE MANAGEMENT SERVICES (99366–99368)

Physician case management is the process of physician-directed care. This includes coordinating and controlling access to the patient or initiating and/or supervising other necessary health care services.

CARE PLAN OVERSIGHT SERVICES (99374–99380)

These codes report the services of a physician providing ongoing review and revision of a patient’s care plan involving complex or multidisciplinary care modalities. Only one physician may report this code per patient per 30-day period, and only if 15 minutes or more are spent during the 30 days. Do not use this code for supervision of patients in nursing facilities or under the care of home health agencies unless the patient requires recurrent supervision of therapy. Also, low intensity and infrequent supervision services are not reported separately.

TELEPHONE SERVICES

(See Telehealth Services 98000-98016)

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

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

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

99455	10.63
99456	21.25

OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

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

MODIFIERS

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

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

STATE-SPECIFIC MODIFIER

**MODIFIER PE: PHYSICIAN ASSISTANTS AND
ADVANCED PRACTICE REGISTERED NURSES**

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

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

Anesthesia

GENERAL INFORMATION AND GUIDELINES

This schedule utilizes the relative values for anesthesia services from the current *Relative Value Guide*® published by the American Society of Anesthesiologists (ASA). No relative values are published in this schedule—only the conversion factors and rules for anesthesia reimbursement.

Report services involving administration of anesthesia by the surgeon, the anesthesiologist, or other authorized provider by using the CPT five-digit anesthesia procedure code(s) (00100–01999), physical status modifier codes, qualifying circumstances codes (99100–99140), and modifier codes (defined under Anesthesia Modifiers later in these ground rules).

BILLING AND PAYMENT GUIDELINES

Anesthesia services include the usual preoperative and postoperative visits, the administration of the anesthetic, and the administration of fluids and/or blood incident to the anesthesia or surgery. Local infiltration, digital block, topical, or Bier block anesthesia administered by the operating surgeon are included in the surgical services as listed.

When multiple operative procedures are performed on the same patient at the same operative session, the anesthesia value is that of the major procedure only (e.g., anesthesia base of the major procedure plus total time).

Anesthesia values consist of the sum of anesthesia base units, time units, physical status modifiers, and the value of qualifying circumstances multiplied by the specific anesthesia conversion factor \$100.00. Relative values for anesthesia procedures (00100–01999, 99100–99140) are as specified in the current *Relative Value Guide* published by the American Society of Anesthesiologists.

TIME FOR ANESTHESIA PROCEDURES

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

CALCULATING ANESTHESIA CHARGES

The following scenario is for the purpose of example only:

01382 Anesthesia for diagnostic arthroscopic procedure of knee joint

Dollar Conversion Unit = \$100.00

Base Unit Value = 3

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

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

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

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

ANESTHESIA SUPERVISION

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

ANESTHESIA MONITORING

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

OTHER ANESTHESIA

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

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

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

ANESTHESIA MODIFIERS

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

PHYSICAL STATUS MODIFIERS

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

MODIFIER	DESCRIPTION
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

These physical status modifiers are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

QUALIFYING CIRCUMSTANCES

Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly impact the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedures to qualify an anesthesia procedure or service. More than one qualifying circumstance may apply to a procedure or service. See the ASA *Relative Value Guide* for units allowed for each code.

CODE	DESCRIPTION
99100	Anesthesia for patient of extreme age: younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

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

MODIFIERS

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

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

APPLICABLE HCPCS MODIFIERS

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

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

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

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

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

Modifier QS Monitored anesthesia care service—This modifier should be used by either the anesthesiologist or the CRNA to indicate that the type of anesthesia performed was monitored anesthesiology care (MAC). Payment is the lower of billed charges or the MAR. No payment reductions are made for MAC; this modifier is for information purposes only.

Modifier QX CRNA service: with medical direction by a physician—This modifier is appended to CRNA or anesthesiologist assistant (AA) claims. This informs a payer that a CRNA or AA provided the service with direction by an anesthesiologist. Payment is the lower of billed charges or 50 percent of the MAR.

Modifier QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist—This modifier is used by the anesthesiologist when directing a CRNA in a single case.

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

DRAFT

GENERAL INFORMATION AND GUIDELINES

DEFINITIONS OF SURGICAL REPAIR

The definition of surgical repair of simple, intermediate, and complex wounds is defined in the CPT book and applies to codes used to report these services.

BILLING AND PAYMENT GUIDELINES

CONVERSION FACTOR

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

GLOBAL REIMBURSEMENT

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

In addition to the surgical procedure, global reimbursement includes:

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

- The allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. The day of surgery is day one when counting follow-up days

FOLLOW-UP CARE FOR DIAGNOSTIC PROCEDURES

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

FOLLOW-UP CARE FOR THERAPEUTIC SURGICAL PROCEDURES

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

ADDITIONAL SURGICAL PROCEDURE(S)

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

INCIDENTAL PROCEDURE(S)

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

SUTURE REMOVAL

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

ASPIRATIONS AND INJECTIONS

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

SURGICAL ASSISTANTS

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

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

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

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

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

Data for the purpose of example only

Payment will be made to the physician assistant or nurse practitioner's employer (the physician).

Note: If the physician assistant or nurse practitioner is acting as the surgeon or sole provider of a procedure, he or she will be paid at a maximum of the lower of the billed charge or 85 percent of the MAR.

PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

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

Data for the purpose of example only

ANESTHESIA BY SURGEON

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

MULTIPLE OR BILATERAL PROCEDURES

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

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

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

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

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

Example of two procedures during same surgical session:

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

Data for the purpose of example only

ENDOSCOPIC PROCEDURES

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

Example:

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

Data for the purpose of example only

ARTHROSCOPY

Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific modifiers shall be reimbursed as follows:

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued, then both sides are reported with modifier 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

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

For multiple endoscopic procedures please see the Endoscopic Procedures section above.

Modifiers 80, 81, and 82— Reimbursement is the lower of the billed charge or 20 percent of the MAR for the surgical procedure when performed by a physician. See modifier AS for physician assistant or nurse practitioner.

APPLICABLE HCPCS MODIFIERS

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

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

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

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

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

Data for the purpose of example only

STATE-SPECIFIC MODIFIERS

MODIFIER PE—PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

must be properly certified and licensed by the State of Alaska and/or licensed or certified in the state where services are provided.

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

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

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

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

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

CONVERSION FACTOR

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

PROFESSIONAL COMPONENT

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

TECHNICAL COMPONENT

The technical component includes the charges for personnel, materials (including usual contrast media and drugs), film or xerography, space, equipment and other facilities, but excludes the cost of radioisotopes and non-ionic contrast media such as the use of gadolinium in MRI procedures. (Report using modifier TC.)

REVIEW OF DIAGNOSTIC STUDIES

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical provider or other medical personnel. Neither the professional component value (modifier 26) nor the radiologic consultation code (76140) is reimbursable

under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

WRITTEN REPORTS

A written report, signed by the interpreting physician, should be considered an integral part of a radiologic procedure or interpretation.

MULTIPLE RADIOLOGY PROCEDURES

CMS multiple procedure payment reduction (MPPR) guidelines for the professional component (PC) and technical component (TC) of diagnostic imaging procedures apply if a procedure is billed with a subsequent diagnostic imaging procedure performed by the same physician (including physicians in a group practice) to the same patient in the same session on the same day.

The MPPR on diagnostic imaging services applies to the TC services. It applies to both TC-only services and to the TC portion of global services. The service with the highest TC payment under the MAR is paid at the lower of billed charges or the MAR, subsequent services are paid at the lower of billed amount or 50 percent of the TC MAR when furnished by the same physician (including physicians in a group practice) to the same patient in the same session on the same day.

The MPPR also applies to the PC services. Full payment is the lower of billed charges or the MAR for each PC and TC service with the highest MAR. For subsequent procedures furnished by the same physician (including physicians in a group practice) to the same patient in the same session on the same day payment is made at the lower of billed charges or 95 percent of the MAR.

See example below under Reimbursement Guidelines for CPT Modifiers.

Alaska MAR:

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

Data for the purpose of example only

If codes 72142 and 72147 were reported on the same date for the same patient:

Technical Component:

72142-TC	\$762.10	100% of the TC
72147-TC	\$377.13	(50% of the TC for the second procedure)
Total	\$1,139.23	

Professional Component:

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

Global Reimbursement:

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific CPT modifiers shall be reimbursed as follows:

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

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

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

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT—

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

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

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

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

Data for the purpose of example only

Calculation using example data:

$$0.43 \times 1.500 = .645$$

$$+ 0.36 \times 1.065 = 0.3834$$

$$+ 0.02 \times 0.551 = 0.01102$$

$$= 1.03942$$

$$1.03942 \times \$122.00 \text{ (CF)} = 126.80924$$

Payment is rounded to \$126.81

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

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

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

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

BILLING AND PAYMENT GUIDELINES

PROFESSIONAL COMPONENT

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

TECHNICAL COMPONENT

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

ORGAN OR DISEASE ORIENTED PANELS

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

DRUG SCREENING

Drug screening is reported with CPT codes 80305–80307. These services are reported once per patient encounter. These codes are used to report urine, blood, serum, or other appropriate specimen. Drug confirmation is reported with codes G0480–G0483 dependent upon the number of drug classes tested. These codes are valued in the CLAB schedule and the multiplier is 4.43.

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT

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

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

Medicine (Physical Therapy)

GENERAL INFORMATION AND GUIDELINES

Visits, examinations, consultations, and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or in health supervision. The maximum allowable fees apply only when a licensed health care provider is performing those services within the scope of practice for which the provider is licensed; or when performed by a non-licensed individual rendering care under the direct supervision of a physician.

BILLING AND PAYMENT GUIDELINES

All providers may report and be reimbursed at the lesser of billed charges or the maximum allowable reimbursement (MAR) for codes 97014 and 97810-97814.

CONVERSION FACTOR

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

MEDICAL REPORTS

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

A medical provider may not charge a separate fee for medical reports or treatment plans that are required to substantiate the medical necessity of a service. Provider medical reports are furnished to the payer/employer within 14 days after the encounter or service.

CPT code 99080 is not to be used to complete required workers' compensation insurance forms or to complete required documentation to substantiate medical necessity. CPT code 99080 is not to be used for signing affidavits or certifying medical records forms. CPT code 99080 is appropriate for billing only after receiving a request for a special report from the employer or payer.

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

TREATMENT PLANS

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

- A) three treatments per week during the first month;
- B) two treatments per week during the second and third months;
- C) one treatment per week during the fourth and fifth months; or
- D) one treatment per month during the sixth through twelfth months.

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

MEDICAL EVALUATIONS

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

Ophthalmology services—Full payment is made for the TC service with the highest MAR. Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a “7” in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

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

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

MULTIPLE PROCEDURES

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

See below for examples of the reduction calculations.

Cardiovascular services—Full payment is made for the TC service with the highest MAR. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day. These services are identified with a “6” in the multiple procedure column of the RBRVS. The MPPRs do not apply to PC services.

Alaska MAR:

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

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

SEPARATE PROCEDURES

Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate reimbursement. When, however, such a procedure is performed independently of, and is not immediately related to the other services, it may be listed as a separate procedure. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

MATERIALS SUPPLIED BY PHYSICIAN

Supplies and materials provided by the physician (e.g., sterile trays, supplies, drugs, etc.), over and above those usually included with the office visit or other services rendered, may be charged for separately. List drugs, trays, supplies, and materials provided and identify using the CPT or HCPCS Level II codes with a copy of the manufacturer/supplier's invoice for supplies.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes and the Alaska value in effect at the time of treatment in the Medicare DMEPOS fee schedule multiplied by 1.66.

TELEHEALTH SERVICES

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

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

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

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

PHYSICAL MEDICINE

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

The initial evaluation of a patient is reimbursable when performed with physical medicine services. Follow-up evaluations for physical medicine are covered based on the conditions listed below. Physicians should use the

appropriate code for the evaluation and management section, other providers should use the appropriate physical medicine codes for initial and subsequent evaluation of the patient. Physical medicine procedures include setting up the patient for any and all therapy services and an E/M service is not warranted unless reassessment of the treatment program is necessary or another physician in the same office where the physical therapy services are being rendered is seeing the patient.

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

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

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

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

MULTIPLE PROCEDURES

Therapy services—For the practitioner and the office or institutional setting, all therapy services are subject to MPPR. These services are identified with a “5” in the multiple procedure column of the RBRVS. The Practice Expense (PE) portion of the service is reduced by 50 percent for the second and subsequent services provided on a date of service.

Alaska MAR:

97016	\$36.52
[(.18 x 1.5) + (.017 x 1.065) + (.01 x .551)] x 80	
97024	\$20.42
[(.06 x 1.5) + (.015 x 1.065) + (.01 x .551)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

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

Example:

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

TENS UNITS

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

PUBLICATIONS, BOOKS, AND VIDEOS

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

FUNCTIONAL CAPACITY EVALUATION

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

WORK HARDENING/CONDITIONING

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

97545	3.41
97546	1.36

OSTEOPATHIC MANIPULATIVE TREATMENT

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

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

CHIROPRACTIC MANIPULATIVE TREATMENT

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

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

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

REMOTE THERAPEUTIC MONITORING (RTM)

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

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

REMOTE MONITORING THERAPY SETUP AND DEVICE SUPPLY

To support billing these codes, the documentation should include:

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

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

Medical necessity related to the compensable injury.

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

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

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

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

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

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

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

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

REMOTE MONITORING TREATMENT MANAGEMENT
To support billing these codes, the documentation should include:

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

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

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

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

REIMBURSEMENT BY FEE SCHEDULE

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

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

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

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

Specific modifiers shall be reimbursed as follows:

Modifier 50—Reimbursement is the lower of the billed charge or 100 percent of the MAR for the procedure on

the first side; reimbursement is the lower of the billed charge or 50 percent of the MAR for the procedure for the second side. If another procedure performed at the same operative session is higher valued, then both sides are reported with modifier 51 and 50 and reimbursed at the lower of the billed charge or 50 percent of the MAR.

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

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

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT

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

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

Category II

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

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

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

DRAFT

Category III

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

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

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

CATEGORY III MODIFIERS

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

DRAFT

DRAFT

GENERAL INFORMATION AND GUIDELINES

The CPT coding system was designed by the American Medical Association to report physician services and is, therefore, lacking when it comes to reporting durable medical equipment (DME) and medical supplies. In response, the Centers for Medicare and Medicaid Services (CMS) developed a secondary coding system, HCPCS Level II, to meet the reporting needs of the Medicare program and other sectors of the health care industry.

HCPCS (pronounced “hick-picks”) is an acronym for Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book.

MEDICARE PART B DRUGS

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

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

DURABLE MEDICAL EQUIPMENT

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

DME items that are unvalued (i.e., \$0.00) in the DMEPOS fee schedule are still reported with the correct HCPCS code. An original invoice is required for items without a stated value and reimbursement shall be the lower of the submitted original manufacturer/supplier’s

invoice plus 20 percent or billed charges. Rental items are reported with modifier RR. The monthly reimbursement is the value as calculated using the invoice multiplied by 0.10. Only those DME rental items calculated using the invoice may be reimbursed at a daily rate based on the monthly reimbursement divided by 30 (multiplied by 0.0333). In no event shall the total accumulated rental reimbursement for an item exceed its purchase price; when cumulative rental payments equal the purchase price, the item is considered purchased and no further rental is payable.

Example:
Invoice amount E0218

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

Data for the purpose of example only

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

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

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

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

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

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

HEARING AIDS

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

related testing, dispensing, evaluations, and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V5110, V5160, V5240, and V5241 are not separately reimbursed services. All accessories and supplies are reimbursed at 20 percent above manufacturer's/supplier's submitted invoice.

HEARING AID SERVICES

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

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

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

- NU New equipment
- RR Rental (use the RR modifier when DME is to be rented)
- UE Used durable medical equipment

AMBULANCE SERVICES

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

- (1) for air ambulance services provided **entirely in this state** that are not provided under a certificate issued under 49 U.S.C. 41102 or that are provided under a certificate issued under 49 U.S.C. 41102 for charter air transportation by a charter air carrier, the maximum allowable reimbursements are as follows:
 - (A) a fixed wing lift off fee may not exceed \$11,500;
 - (B) a fixed wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;
 - (C) a rotary wing lift off fee may not exceed \$13,500;
 - (D) a rotary wing air mile rate may not exceed 400 percent of the Centers for Medicare and Medicaid Services ambulance fee schedule rate in effect at the time of service;

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

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

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

DRAFT

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

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

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

A revenue code is defined by CMS as a code that identifies a specific accommodation, ancillary service or billing calculation. Revenue codes are used by outpatient facilities to specify the type and place of service being billed and to reflect charges for items and services provided. A substantial number of outpatient facilities use both CPT codes and revenue codes to bill private payers for outpatient facility services. The outpatient facility fees are driven by CPT code rather than revenue code. Common revenue codes are reported for components of the comprehensive surgical outpatient facility charge, as well as pathology and laboratory services, radiology

services, and medicine services. The CMS guidelines applicable to status indicators are followed unless otherwise superseded by Alaska state guidelines. The following billing and payment rules apply for medical treatment or services provided by hospital outpatient clinics, and ambulatory surgical centers:

- (1) medical services or procedures without an APC weight
 - (a) where a payment rate is available the allowable is calculated using the multiplier of 2.08 for ASCs and 2.75 for outpatient facilities;
 - (b) when no weight or payment rate is listed reimburse at the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (2) status indicator codes C, E1, E2, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;
- (3) two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;
- (4) a payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.

Status indicators determine how payments are calculated, whether items are paid, and which reimbursement methodology is used. The *Official Alaska Workers' Compensation Medical Fee Schedule* guidelines supersede the CMS guidelines as described below.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: - Ambulance services - Separately payable clinical diagnostic laboratory services - Separately payable non-implantable prosthetic and orthotic - Physical, occupational, and speech therapy - Diagnostic mammography - Screening mammography - Unclassified drugs and biologicals reportable under HCPCS code C9399	Not paid under OPPS. See the appropriate section under the provider fee schedule. Unclassified drugs and biologicals priced at 95 percent of drug or biological's average wholesale price (AWP) using Red Book or an equivalent recognized compendium and paid under OPPS. <i>Alaska Specific Guideline: Drugs and biologicals are paid at the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges.</i>
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient. <i>Alaska Specific Guideline: May be performed in the outpatient or ASC setting if beneficial to the patient and as negotiated by the payer and providers. Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i>
D	Discontinued codes	Not paid under OPPS or any other Medicare payment system.
E1	Items, codes, and services not covered by any Medicare outpatient benefit category; statutorily excluded; not reasonable and necessary	Not paid under OPPS. <i>Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i> <i>Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.</i>

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
E2	Items and services for which pricing information and claims data are not available	Not paid under OPPS. <i>Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i>
F	Corneal tissue acquisition; certain CRNA services	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	Pass-through device categories	Separate cost-based pass-through payment. <i>Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.</i>
H1	Non-opioid medical devices for post-surgical pain relief	Separate payment based on hospital's charges adjusted to cost. Subject to criteria and payment limitation under Section 4135 of the CAA, 2023 <i>Alaska Specific Guideline: A payer shall subtract non-opioid medical devices from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 20 percent</i>
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, H1, K1 [SEE ADDENDUM J], L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products).

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
J2	Hospital Part B services that may be paid through a comprehensive APC	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI = F, G, H, H1, K1 [SEE ADDENDUM J], L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services, services assigned to a new technology APC, self-administered drugs, all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products). (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1. (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radio pharmaceuticals	Paid under OPPS; separate APC payment.
K1	Non-opioid drugs and biologicals for post-surgical pain relief	Paid under OPPS; Separate APC payment. Subject to criteria and payment limitation under Section 4135 of the CAA, 2023. <i>Alaska Specific Guideline: Payment allowance limits for Drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges.</i>
L	Influenza vaccine; pneumococcal pneumonia vaccine; Hepatitis B vaccine; Covid-19 Vaccine, Monoclonal Antibody Therapy Product	Not paid under OPPS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. <i>Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.</i>
01	Software as a Medical Service	Paid under OPPS; separate APC payment. (Pending adoption of CMS Proposed Rule 1850-P for 2027).
P	Partial hospitalization or Intensive Outpatient Program	Paid under OPPS; per diem APC payment. <i>Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.</i>
Q1	STV packaged codes	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI of S, T, or V. (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
Q2	T packaged codes	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
Q3	Codes that may be paid through a composite APC	Paid under OPPS; addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments. (1) Composite APC payment on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS). (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published OPSI J1, J2, S, T, V, Q1, Q2, or Q3. (2) In other circumstances, laboratory tests should have an OPSI = A and payment is made under the CLFS.
R	Blood and blood products	Paid under OPPS; separate APC payment.
S	Procedure or service, not discounted when multiple	Paid under OPPS; separate APC payment.
S1	Skin substitute product paid separately	Paid under OPPS; separate APC payment. Subject to payment based on FDA regulatory pathway.
T	Procedure or service, multiple reduction applies	Paid under OPPS; separate APC payment. <i>Alaska Specific Guideline: Two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classification's calculated amount and all other status indicator code T items paid at 50 percent.</i>
U	Brachytherapy sources	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPPS; separate APC payment.
Y	Non-implantable durable medical equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC. <i>Alaska Specific Guideline: Not separately paid in ASC/OPPS. Equipment sent home with the patient may be separately reported by the DME supplier and paid under the DME guidelines of this fee schedule.</i>

SURGICAL SERVICES

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

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

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

DRUGS AND BIOLOGICALS

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

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

For drugs and injections coded under the HCPCS, including non-opioid drugs and biologicals for post-surgical pain relief, the payment allowance limits for drugs is the lower of the CMS Medicare Part B Drug Average Sales Price Drug Pricing File payment limit in effect at the time of treatment or service multiplied by 3.375 or billed charges.

EQUIPMENT, DEVICES, APPLIANCES, AND SUPPLIES

All equipment, devices, appliances, and general supplies commonly furnished by an outpatient facility for a surgical procedure are incorporated into the comprehensive outpatient facility fee allowance.

Example:

- Syringe for drug administration
- Patient gown
- IV pump

SPECIALTY AND LIMITED-SUPPLY ITEMS

Particular surgical techniques or procedures performed in an outpatient facility require certain specialty and limited-supply items that may or may not be included in the comprehensive outpatient facility fee allowance. This is because the billing patterns vary for different outpatient facilities.

These items should be supported by the appropriate HCPCS codes listed on the billing and a manufacturer/supplier's invoice showing the actual cost incurred by the outpatient facility for the purchase of the supply items or devices.

DURABLE MEDICAL EQUIPMENT (DME)

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

Example:

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

See the HCPCS section for DME reporting guidelines.

USE OF OUTPATIENT FACILITY AND ANCILLARY SERVICES

The comprehensive surgical outpatient fee allowance includes outpatient facility patient preparation areas, the operating room, recovery room, and any ancillary areas of the outpatient facility such as a waiting room or other area used for patient care. Specialized treatment areas, such as a GI (gastrointestinal) lab, cast room, freestanding clinic, treatment or observation room, or other facility areas used for outpatient care are also included. Other outpatient facility and ancillary service areas included as an integral portion of the comprehensive surgical outpatient facility fee allowance are all general administrative functions necessary to run and maintain the outpatient facility. These functions include, but are not limited to, administration and record keeping, security, housekeeping, and plant operations.

NURSING AND RELATED TECHNICAL PERSONNEL SERVICES

Patient care provided by nurses and other related technical personnel is included in the comprehensive surgical outpatient facility fee allowance. This category includes services performed by licensed nurses, nurses' aides, orderlies, technologists, and other related technical personnel employed by the outpatient facility.

SURGICAL DRESSINGS, SPLINTING, AND CASTING MATERIALS

Certain outpatient facility procedures involve the application of a surgical dressing, splint, or cast in the operating room or similar area by the physician. The types of surgical dressings, splinting, and casting materials commonly furnished by an outpatient facility are considered part of the comprehensive surgical outpatient facility fee allowance.

DRAFT

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

- (1) the IPPS Web Pricer amount for Providence Alaska Medical Center is multiplied by 2.38;
 - (2) the IPPS Web Pricer amount for Mat-Su Regional Medical Center is multiplied by 1.84;
 - (3) the IPPS Web Pricer amount for Bartlett Regional Hospital is multiplied by 1.79;
 - (4) the IPPS Web Pricer amount for Fairbanks Memorial Hospital is multiplied by 1.48;
 - (5) the IPPS Web Pricer amount for Alaska Regional Hospital is multiplied by 2.32;
 - (6) the IPPS Web Pricer amount for Yukon Kuskokwim Delta Regional Hospital is multiplied by 2.63;
 - (7) the IPPS Web Pricer amount for Central Peninsula General Hospital is multiplied by 1.38;
 - (8) the IPPS Web Pricer amount for Alaska Native Medical Center is multiplied by 2.53;
 - (9) except as otherwise provided by Alaska law, the IPPS Web Pricer amount for all other inpatient acute care hospitals is multiplied by 2.02;
- Note:** Mt. Edgecumbe is now a critical access hospital.
- (10) hospitals may seek additional payment for unusually expensive implantable devices if the manufacturer/supplier's invoice cost of the device or devices was more than \$25,000. Manufacturer/supplier's invoices are required to be submitted for payment. Payment will be the manufacturer/supplier's invoice cost minus \$25,000 plus 10 percent of the difference.

Example of Implant Outlier:

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

Implant invoice	\$28,000
Less threshold	<u>(\$25,000)</u>
Outlier amount	= \$ 3,000
	<u>x 110%</u>
Implant reimbursement	= \$ 3,300

In possible outlier cases, implantable device charges should be subtracted from the total charge amount before the outlier calculation, and implantable devices should be reimbursed separately using the above methodology.

Any additional payments for high-cost acute care inpatient admissions are to be made following the methodology described in the Centers for Medicare and Medicaid Services (CMS) final rule and updated with federal fiscal year values current at the time of the patient discharge.

EXEMPT FROM THE MS-DRG

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

SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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

PREPARING TO DETERMINE A PAYMENT

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

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

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

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

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

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

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

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

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

<https://webpricer.cms.gov/#/pricer/ipp>

DATE OF SERVICE RECOMMENDATION

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

EXAMPLE

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

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

Enter claim

Estimate

Clear

1. Required Fields

Provider number (Required)

between 6 - 13 characters, for example: 01W234.

020001

Admit date (Required)

For example: 04/01/2020.

01/25/2026

Discharge date (Required)

Discharge date must be on or after 10/01/2019.

01/28/2026

Covered charges (Required)

For example: \$50,000.00.

\$35,000.00

Covered days (Required)

Must be greater than lifetime reserve days.

3

Diagnosis related group (DRG) (Required)

3 digit code, for example: 123

462

2. Additional Codes

National drug code (NDC)

9 to 11 digit code

NDC #1

NDC #2

Procedure Code #1

Procedure Code #2

Diagnosis Code

Click the (+) to add diagnosis codes

Diagnosis Code #1

Diagnosis Code #2

Condition Code

Click the (+) to add condition codes

Condition Code #1

Condition Code #2

3. Additional Fields

Lifetime reserve days

Number, 0 to 60.

Transfer status

Indicates covered transfer status:

☒

No transfer

☐

Short-term acute transfer

☐

Post-acute transfer

Cost outlier threshold

Yes shows outlier threshold for provider.

☒

No

☐

Yes

HMO paid claim

Used by MA plans for out of network claims

☒

No

☐

Yes

The IPPS Web Pricer instructions are included below:

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

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

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

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

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

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

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

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

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

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

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

CONDITION CODE – Enter the condition code when required

LIFETIME RESERVE DAYS – not required to be entered.

TRANSFER STATUS – Select the correct option from

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

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

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

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

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

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

Review results

[Edit Claim](#)[Clear](#)

Summary

Calculation version	2026 1
Return code	14
Description: PAID DRG WITH PERDIEM	
Key claim information	
Provider number	020001
Effective date	10/15/2025
Diagnosis related group (DRG)	462
Claim estimate	
Claim estimate with provider adjustments	\$25,449.88
Outlier calculation	\$0.00
Grand total amount	\$25,449.88

The estimate is based on submitted claim info

[Download CSV](#)

Provider details

Provider type	00
Geographic CBSA	11260
Reclassification CBSA	—

Capital amounts

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

Claim information

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

Operating amounts

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

Review results

[Edit Claim](#)[Clear](#)

PPS factors & adjustments

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

Pass-through amounts

Capital	—
Direct medical education	\$28.82
Organ acquisition	\$0.00
Allogeneic Stem Cell Acquisition	\$0.00
Supply Chain Costs	—
Total pass-through & miscellaneous	\$28.82
Estimated total pass-through amount	\$66.46

Other PPS amounts

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

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

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

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

DETERMINING THE FINAL MAXIMUM ALLOWABLE REIMBURSEMENT (MAR)

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

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

DRAFT

Critical Access Hospital, Rehabilitation Hospital, Long-term Acute Care Hospital

GENERAL INFORMATION AND GUIDELINES

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

For a list of critical access hospitals in Alaska, please contact the Alaska Department of Health, Division of Health Care Services.

DRAFT

DRAFT

“Physicians Report” Example

Appendix A

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

DRAFT

PHYSICIAN'S REPORT

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

- ☐ **INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
☐ **PROGRESS** Physician: Sections 1 & 4
☐ **TREATMENT PLAN** Employee: Sections 1 & 2/ Physician: Sections 3 & 4

AWCB Case Number:

SECTION 1	1. Employee's Name (Last, First, Middle Initial)		2. Insurer Claim Number		3. Date of Injury				
	4. Address		5. Sex ☐ Male ☐ Female		6. Social Security Number				
	City	State	Zip Code	Telephone	7. Date of Birth				
	8. Employer		9. Insurer						
	10. Address		11. Address						
	City	State	Zip Code	Telephone	City	State	Zip Code	Telephone	
SECTION 2	12. Date Last Worked		13. Was Body Part Injured Before? ☐ No ☐ Yes If yes, when and describe:						
	14. Describe Injury and Tell How It Happened:								
	15. Have You Seen Any Other Doctor for This Injury? ☐ No ☐ Yes If yes, list name and address:				16. Hospitalized As Inpatient? ☐ No ☐ Yes Name of Hospital:				
SECTION 3	17. Your First Treatment Date		18. Describe Complaints:						
	19. Fully Describe Findings on First Examination (Specify Right or Left):								
	20. Diagnosis:								
	21. X-Rays? ☐ No ☐ Yes X-Ray Diagnosis:								
	22. Is Condition Work Related? ☐ No ☐ Yes Explain: ☐ Undetermined (Explain):								
SECTION 4	23. Treatment Date(s) Since Last Report		24. Next Treatment Date		25. Estimate Length of Further Treatment Days Weeks Months				
	26. Medically Stable? ☐ No ☐ Yes		27. Date of Medical Stability		28. Injury May Permanently Preclude Return to Job at Time of Injury ☐ No ☐ Yes ☐ Undetermined				
	29. Will Injury Result in Permanent Impairment? ☐ No ☐ Yes ☐ Undetermined								
	30. Impairment Rating		31. Factors on Which Rating is Based						
	32. Released for Work ☐ No ☐ Yes Estimate Length of Disability ☐ 1-3 Days ☐ 4-7 Days ☐ 8-14 Days ☐ 15-21 Days ☐ 22-28 Days ☐ More ____ Weeks ____ Months ☐ Regular Work (Date): ☐ Modified Work (Date): Give Limitations:								
	33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.								
	34. Describe Treatment (and/or Attach Notes)								
	35. If Case Referred to Another Physician, State Name and Address:								
	36. IRS I.D. Number								
	37. Physician's Name and Degree (Print or Type)				38. Physician's Signature				
39. Report Date									
40. Address		City		State		Zip Code		41. Telephone	

SEE INSTRUCTIONS ON BACK

Form 07-6102 (Rev 01/2013)

INSTRUCTIONS TO PHYSICIANS:

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

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

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

INSTRUCTIONS TO EMPLOYEE:

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

[illegible]

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

Form 07-6102 (Rev 01/2013)

Acronyms Appendix B

Workers' Compensation Medical Fee Schedule Acronyms

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

TAB 9

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

8 AAC 45.083. Fees for medical treatment and services.

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

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

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

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

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

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

8 AAC 45.020 is repealed and readopted to read:

8 AAC 45.020. Transaction of business. (a) The division will transact business during the hours prescribed by law.

(b) A document may be filed in person at the division's offices, by mail, by facsimile transmission, or by electronic mail.

(c) A document is considered filed upon receipt, except a document received on a Saturday, Sunday, a day the division is closed due to a state-recognized closure, or after 5:00 p.m. Alaska time, is considered filed the next working day.

(d) A document filed in person or by mail is considered received when it is stamped "received" at the division's office. An electronic mail or facsimile transmission filing is considered received upon receipt of the entire document at the electronic mail address or by the facsimile machine of the division or administrator, respectively.

(e) The division, the board, and the administrator are not responsible for verifying that a document filed by any method is received correctly, that all pages are filed or transmitted, that the document is legible, or that receipt is correct in any other respect, and are not responsible for technological problems that occur as a party tries to transmit a document electronically. Electronic mail that is identified as potentially harmful to the state's electronic mail system will not be considered filed.

(f) The division may require a party filing a document by electronic mail to use a third-party secure web-based file transfer and drop-off system to share files that are too large for the division's standard electronic mail.

(g) A party filing a document by facsimile transmission or by electronic mail

(1) shall, for a document filed by electronic mail with the division, file the

document by sending it as an attachment in portable document format (PDF) to the division's electronic mail address;

(2) shall, for a document filed by electronic mail with the administrator, file the document by sending it as an attachment in PDF to the administrator's electronic mail address;

(3) may not file a document by facsimile transmission to the division or administrator that exceeds 50 pages;

(4) shall provide proof of service as required by 8 AAC 45.060(c) and (d) by including the proof of service on, or attaching it to, the filed document;

(5) shall, for documents filed by electronic mail, include in the subject line of the transmitting message

(A) the division's case number for the attached documents; and

(B) a brief description of the documents to be filed;

(6) shall, for documents filed by facsimile, include a cover sheet with the division's case number and identify the documents to be filed; and

(7) may not provide extraneous narrative or explanation in the body of the transmitting electronic mail message or on the facsimile cover sheet; information in the electronic mail message or on the facsimile cover sheet shall be limited to the division's case number and title of each document that is attached for filing.

(h) A party shall keep the original of copies of documents filed by the party to resolve questions pertaining to authenticity.

(i) Failure to adhere to (g) of this section may result in rejection of the submitted documents. (In effect before 7/28/59; am 5/28/83, Register 86; am 4/9/2016, Register 218; am 5/12/2019, Register 230; am ____/____/____, Register ____)

Authority: AS 23.30.005

8 AAC 45.025 is repealed and readopted to read:

8 AAC 45.025. Forms. The division may require the use of a form for reporting any information required by this chapter or by AS 23.30. A person may obtain a form on the division's website at https://www.labor.alaska.gov/wc/pdf_list.htm or by making a request to the division. (Eff. 5/28/83, Register 86; am 3/16/90, Register 113; am 5/12/2019, Register 230; am 6/11/2023, Register 246; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.041 AS 23.30.107
 AS 23.30.012 AS 23.30.085

8 AAC 45.030 is repealed and readopted to read:

8 AAC 45.030. Fees. (a) The division may charge reasonable fees for duplicating division files, records, or hearing recordings.

(b) The division will not prepare transcripts of proceedings. A party seeking a transcript of a proceeding under this chapter is responsible for preparing the transcript and paying all transcription costs. (In effect before 7/28/59; am 5/28/83, Register 86; am 12/23/2021, Register 240; am ____/____/____, Register ____)

Authority: AS 23.30.005

8 AAC 45.032 is repealed and readopted to read:

8 AAC 45.032. Files. Upon receiving written notice of an injury or death, or when a failure-to-insure investigation is initiated, the division will establish a case file and notify the

parties in writing of the case number. (Eff. 7/20/97, Register 143; am 2/27/2000, Register 153; am 4/9/2016, Register 218; am 12/23/2021, Register 240; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.100 AS 23.30.105
 AS 23.30.070

8 AAC 45.040 is repealed and readopted to read:

8 AAC 45.040. Parties and joinder. (a) A person other than the employee filing a claim for benefits is not eligible to receive a benefit related to the claim unless they join the injured or deceased employee as a party and

(1) prove that the employee has a compensable injury; or

(2) the adverse parties stipulate or admit to facts from which the board can find the employee's injury is compensable.

(b) When a request for joinder is filed,

(1) any person who may have a right to relief in respect to or arising out of the same transaction or series of transactions may be joined;

(2) any person against whom a right to relief may exist in respect to or arising out of the same transaction or series of transactions may be joined;

(3) if the employer was not insured at the time of the injury, the Alaska workers' compensation benefits guaranty fund shall be joined; and

(4) in death cases, all persons who may be the deceased employee's dependents or beneficiaries shall be joined.

(c) A proceeding to join a person to an existing claim is begun by

(1) a party filing with the division a petition to join another person and serving the

petition and a copy of the claim for which joinder is sought on the person to be joined and all parties; or

(2) the board or its designee serving notice to join a person to the claim and a copy of the claim for which joinder is sought on all parties and the person to be joined.

(d) A party filing a petition to join a person to an existing claim need not file a new claim against the person to be joined.

(e) A petition or a notice to join must state that the person will be joined as a party to an existing claim unless, within 20 days of service under (c) of this section, the person or a party files an objection with the division and serves it on the petitioner and on all parties.

(f) A petition to join that does not conform to the requirements of this section will be denied.

(g) If the person against whom joinder is sought or a party fails to timely object to a petition to join, that person or party waives the right to object to joinder and the division may join the person without further board action.

(h) In determining whether to join a person to an existing claim, the board or its designee will consider whether the person is subject to joinder under (b) of this section and any timely filed objections. (In effect before 7/28/59; am 5/28/83, Register 86; am 7/20/97, Register 143; am 6/11/2023, Register 246; am 3/23/2025, Register 253; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.110

 AS 23.30.010 AS 23.30.135

8 AAC 45 is amended by adding a new section to read:

8 AAC 45.045. Consolidation. If a single incident injures two or more employees, regardless of whether the employers are the same, two or more cases may be consolidated for the purpose of taking evidence. A party may ask for consolidation by filing a petition. The board or its designee may consolidate claims on their own initiative. To consolidate cases at a hearing or prehearing, the board or its designee must determine the injuries or issues in the cases are similar or closely related. (Eff. ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.110
 AS 23.30.010 AS 23.30.135

8 AAC 45.050 is repealed and readopted to read:

8 AAC 45.050. Pleadings. (a) A person may start a proceeding before the board by filing a written claim or petition. A minor child's claim must be filed by the surviving parent or other authorized representative.

(b) For claims and petitions,

(1) except for a petition for a self-insurance certificate, a complete claim or petition must include

(A) the names and addresses of all parties;

(B) the date of injury;

(C) the general nature of the dispute between the parties; and

(D) the signature of the claimant, petitioner or authorized representative;

(2) the board or its designee will not act on a petition or claim that does not meet the requirements of this section and the division will return an incomplete petition or claim to the filer;

(3) a petition to terminate benefits must include the date on which the petitioner claims the disability or need for medical treatment ended.

(c) For answers to claims and petitions,

(1) an answer to a claim or petition must be filed not later than 20 days after the date of service of the pleading and served upon all parties; on a party's petition or on its own motion, the board may extend or postpone the time for filing an answer; if an answer is not timely filed, default will not be entered, but statements in the claim or petition will be deemed admitted; however, failure of a party to deny a fact alleged in a claim or petition does not preclude the board from requiring proof of the fact;

(2) a general denial is not an answer; an answer must be simple in form and language and state the admitted and disputed claims briefly and clearly so that a lay person can determine what proof will be required at the hearing; when applicable, an answer must state

(A) any reason why the claim or dispute cannot be heard completely at the first hearing;

(B) whether the claim is barred under AS 23.30.022, 23.30.100, 23.30.105, or 23.30.110, or otherwise barred by law or equity;

(C) whether the injury was proximately caused by the employee's willful intent to injure or kill any person;

(D) whether the injury was proximately caused by the employee being intoxicated or under the influence of a drug or combination of drugs;

(E) whether the party filing the answer contends that successive work contributed to the employee's disability or need for treatment, and liability should be imposed on the employer at the time of the most recent injury that caused a disability or

need for medical treatment;

(F) whether the employee failed to minimize the disability, and how;

(G) whether the employee has been overpaid, and why;

(H) whether the employee's compensation rate should be adjusted under AS 23.30.175(b).

(d) No party is required to file a reply to an answer, but a party who chooses to file a reply shall do so not later than seven days after the answer was served upon the parties.

(e) A pleading may be amended at any time before a decision on the pleading. If the amendment arose out of the conduct, transaction, or occurrence set out or attempted to be set out in the original pleading, the amendment relates back to the date of the original pleading, subject to all defenses.

(f) For stipulations,

(1) a stipulation signed by all parties to the stipulation may be filed if the stipulating parties agree that there is no dispute as to any material fact and agree to the dismissal of a claim or petition or the dismissal of a party; by filing a stipulation under this paragraph, the parties agree to the immediate filing of an order based upon the stipulation;

(2) a stipulation between parties may be made in writing at any time or may be made orally in the course of a hearing or a prehearing;

(3) a stipulation is binding upon the parties to the stipulation and has the effect of an order unless the board, for good cause, relieves a stipulating party from the terms of the stipulation;

(4) a stipulation waiving an employee's right to benefits under AS 23.30 must conform to AS 23.30.012 and 8 AAC 45.160, and be approved by the board;

(5) a stipulation may be used to resolve attorney fees provided the stipulating parties serve the stipulation on the employee; a party who objects to the stipulation must file with the division and serve on all other parties to the case a written objection, stating all grounds upon which the party objects, not later than seven days after service of the fee stipulation;

(6) if an objection to an attorney fees stipulation is filed, the commissioner's designee may make findings of fact based on available evidence, may cause further evidence or testimony to be taken, may order an investigation into the matter as prescribed by AS 23.30, and issue a decision. (In effect before 7/28/59; am 5/28/83, Register 86; am 12/14/86, Register 100; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 6/11/2023, Register 246; am ____/____/____, Register ____)

Authority:	AS 23.30.005	AS 23.30.105	AS 23.30.175
	AS 23.30.012	AS 23.30.110	AS 23.30.190
	AS 23.30.022	AS 23.30.135	AS 23.30.235
	AS 23.30.100		

8 AAC 45.052 is repealed and readopted to read:

8 AAC 45.052. Medical summary. (a) Parties may use form 07-6103 or a substantially equivalent form to comply with AS 23.30.095(h). A form is substantially equivalent to form 07-6103 if it contains the information requested by form 07-6103.

(b) A medical summary is not required for a claim or petition requesting only

- (1) a compensation rate adjustment or a determination of gross weekly earnings;
- (2) additional compensation under AS 23.30.155;
- (3) a determination that the employer or its insurer frivolously or unfairly

controverted benefits;

(4) attorney fees or costs;

(5) a determination of dependency in death cases;

(6) reimbursement under AS 23.30.155(j);

(7) an offset under AS 23.30.225; or

(8) a self-insurance certificate. (Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 3/16/90, Register 113; am 7/2/98, Register 146; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.070 AS 23.30.095

8 AAC 45.054(a) is amended to read:

(a) **A** [THE TESTIMONY OF A MATERIAL WITNESS, INCLUDING A PARTY, MAY BE TAKEN BY WRITTEN OR ORAL DEPOSITION IN ACCORDANCE WITH THE ALASKA RULES OF CIVIL PROCEDURE. IN ADDITION, THE PARTIES MAY AGREE OR, UPON A PARTY'S PETITION, THE BOARD OR DESIGNEE WILL EXERCISE DISCRETION AND DIRECT THAT THE DEPOSITION TESTIMONY OF A WITNESS BE TAKEN BY TELEPHONE CONFERENCE CALL. THE] party seeking to introduce a **witness's** [WITNESS'] testimony by deposition shall pay the initial **costs** [COST] of the deposition **and transcript.**

8 AAC 45.054(c) is amended to read:

(c) The board or **its designee may** [DIVISION WILL] issue subpoenas and subpoenas duces tecum in accordance with the Act. The person requesting the subpoena shall serve the

subpoena at the person's expense. Neither the board nor the division will serve subpoenas on behalf of a party.

8 AAC 45.054(e) is repealed:

(e) Repealed. (Eff. 5/28/83, Register 86; am 7/20/97, Register 143; am 4/1/2017, Register 221; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.108 AS 23.30.135
 AS 23.30.080 AS 23.30.115

8 AAC 45 is amended by adding a new section to read:

8 AAC 45.055. Requests for cross-examination. (a) A party may request the right to cross-examine the author of a written document filed on a medical summary or notice of intent to rely before an affidavit of readiness for hearing is served as follows:

(1) if the party filing an affidavit of readiness for hearing wants the opportunity to cross-examine an author, the party shall file with the division, and serve upon all parties, a completed request for cross-examination on form 07-6174 or its substantial equivalent, together with the affidavit of readiness for hearing, an updated medical summary, and copies of the medical reports listed on the medical summary; a form is substantially equivalent to form 07-6174 if it contains the information requested by form 07-6174;

(2) if a party served with an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a document, and a request for cross-examination of the author of that document has not already been filed and served upon all parties, a request for cross-examination must be filed with the division and served upon all parties not later than 10

days after service of the affidavit of readiness for hearing;

(b) After an affidavit of readiness for hearing has been served, and until the claim is heard or otherwise resolved,

(1) all documents filed for the first time after the affidavit of readiness for hearing is served must be accompanied by a request for cross-examination if the party filing the new document wants the opportunity to cross-examine the document's author; and

(2) if a party served with a document filed for the first time after the affidavit of readiness for hearing is served wants the opportunity to cross-examine the author of the document, a request for cross-examination must be filed with the division and served upon all parties not later than 10 days after service of the new document;

(c) If a new medical record or documentary evidence is filed and served less than 20 days before a hearing, the board may rely upon the evidence only if the parties expressly waive the right to cross-examination, or if the board determines that the document is not hearsay or is admissible under a hearsay exception of the Alaska Rules of Evidence;

(d) If a request for cross-examination is not filed in accordance with this section, the party waives the right to request cross-examination of the author of a document. If a party waives the right to request cross-examination, the party may still call the author as a witness at hearing, at the party's expense.

(e) A request for cross-examination filed under this section must

(1) specifically identify the document by date and author, and generally describe the type of document; and

(2) state the specific reason why cross-examination is being requested.

(f) If a request for cross-examination is filed in accordance with this section, an

opportunity for cross-examination must be provided unless the request is withdrawn or the board determines that

(1) the document is admissible under the Alaska Rules of Evidence; or

(2) the document is a report of an examination performed by a physician chosen by the board under AS 23.30.095(k) or AS 23.30.110(g).

(g) If a party receives a request for cross-examination of the author of a document the party wishes to rely on at hearing, the party may satisfy the request for cross-examination by making the author available for cross-examination at hearing or at deposition.

(h) If a party files a valid written request to cross-examine the author of a document, the party seeking to rely on the document at hearing does not provide an opportunity to cross-examine the author, and the document is not hearsay or admissible under a hearsay exception of the Alaska Rules of Evidence, the document will be excluded as evidence. (Eff.

____/____/____, Register _____)

Authority: AS 23.30.005 AS 23.30.108 AS 23.30.135
 AS 23.30.080 AS 23.30.115

8 AAC 45.060(a) is amended to read:

(a) **The board may serve a claim by electronic mail, certified mail, personal service, or other means in accordance with due process. A party filing a petition shall** [THE BOARD WILL] serve **the petition and provide proof of service of the petition** [A COPY OF THE CLAIM BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED,] upon **all parties** [EACH PARTY OR THE PARTY'S REPRESENTATIVE OF RECORD].

8 AAC 45.060(b) is amended to read:

(b) A party may file a document with the **division** [BOARD, OTHER THAN THE ANNUAL REPORT UNDER AS 23.30.155(m), PERSONALLY, BY MAIL, OR BY ELECTRONIC FILING THROUGH FACSIMILE TRANSMISSION OR ELECTRONIC MAIL] in compliance with **8 AAC 45.020** [8 AAC 45.020(d)]. Except for a claim, a party shall serve a copy of a document filed with the **division** [BOARD] upon all parties or, if a party is represented, upon the party's representative. Service must be done personally, by facsimile, by electronic mail, or by mail, in accordance with due process. Service by mail is complete when deposited in the mail if mailed with sufficient postage and properly addressed to the party at the party's last known address. If a right may be exercised or an act is to be done, three days must be added to the prescribed period when a document is served by mail.

The introductory language of 8 AAC 45.060(c) is amended to read:

(c) A party shall file proof of service with the **division** [BOARD]. Proof of service may be made by

...

8 AAC 45.060(d) is amended to read:

(d) **Proof** [A PROOF] of service must set out the names of the persons served, method and date of service, place of personal service or the address to which it was mailed or sent by facsimile or electronically, and verification of successful sending if required. The board will, in its discretion, refuse to consider a document when proof of its service does not conform to the requirements of this section.

8 AAC 45.060(e) is repealed:

(e) Repealed ____/____/____.

8 AAC 45.060(f) is amended to read:

(f) Immediately upon a change of address for service, a party or a party's representative **shall** [MUST] file with the **division** [BOARD] and serve on the opposing party a written notice of the change. Until a party or the **division** [BOARD] receives written notice of a change of address, documents must be served upon a party at the party's last known address.

8 AAC 45.060(g) is amended to read:

(g) If, after due diligence, service cannot be done personally, electronically, by facsimile, or by mail, **the board or its designee may** [THE BOARD WILL, IN ITS DISCRETION,] find a party has been served if service was done **in accordance with due process** [BY A METHOD OR PROCEDURE ALLOWED BY THE ALASKA RULES OF CIVIL PROCEDURE]. (In effect before 7/28/59; am 5/28/83, Register 86; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 4/9/2016, Register 218; am 5/12/2019, Register 230; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.110 AS 23.30.135

8 AAC 45.065 is repealed and readopted to read:

8 AAC 45.065. Prehearings. (a) After a claim or petition has been filed, a party may file a written request for a prehearing, and the division will schedule a prehearing conference. Even

if a claim, petition, or request for prehearing conference has not been filed, the board or its designee may direct the parties or their representatives to appear for a prehearing conference.

The division will give notice of at least 10 days of the prehearing conference by electronic mail or first-class mail. At the prehearing conference, the board's designee

(1) may identify and simplify the issues;

(2) may amend the pleadings and require parties to file additional documents;

(3) may accept stipulations, including stipulations of fact or stipulations to

provide other documents that may avoid presenting unnecessary evidence at hearing;

(4) may limit the number of witnesses, identify witnesses, and require a witness

list in accordance with 8 AAC 45.112;

(5) may set briefing requirements that differ from the requirements set out in 8

AAC 45.114, including modified page limitations or service requirements;

(6) shall decide the relevance of information requested under AS 23.30.107(a) and

AS 23.30.108;

(7) may decide petitions to join a person;

(8) may consolidate two or more cases, even if a petition for consolidation has not

been filed;

(9) may discuss settlement or the use of mediation to resolve the dispute;

(10) shall decide discovery requests;

(11) may set the closing date for discovery;

(12) may set the closing date for serving and filing evidence;

(13) may determine if a party intends at the time of hearing to seek recusal of a

hearing panel member;

(14) may extend the time for the parties' opening and closing arguments; and

(15) may decide and issue orders on other matters that may aid in the disposition of the case.

(b) After a prehearing, the board's designee will issue a summary of the discussions and actions taken at the prehearing. Unless modified, the summary governs and limits the issues and the course of the hearing.

(c) Not later than 10 days after service of a prehearing summary issued under (b) of this section, a party may file and serve a request to modify a prehearing summary. If a party's request to modify is not timely filed or lacks proof of service on all parties, the designee may not act on the request. Not later than 10 days after the division receives a party's request to amend a prehearing summary, the designee will approve or deny the request and give notice of the decision to the parties. If the designee denies a request to modify a prehearing summary to add an issue for hearing, the party requesting modification must request a new prehearing if it wants to add the issue for hearing.

(d) The board's designee may set a hearing date at a prehearing. The designee will set the hearing for the first possible date on the board's hearing calendar unless good cause exists to set a later date.

(e) A party may audio record the prehearing at the party's expense. If a party audio records the prehearing and transcribes the recording and wishes to rely on that recording as evidence at a hearing, the party shall file the recording and a certified transcript with the division and serve a copy on all parties at least 10 days before a scheduled hearing. If a party fails to timely file and serve the audio recording and certified transcript, the board will exclude the transcript and audio recording from consideration.

(f) Notwithstanding (c) of this section, only the board designee who entered a discovery order at a prehearing conference may reconsider that discovery order under AS 23.30.108. The discovery order may be reconsidered on the board designee's own motion or on petition of a party under AS 44.62.540. A petition for reconsideration must set out the specific grounds for reconsideration. Not later than 15 days after the division receives a party's request for reconsideration, the designee will either grant or deny the request and give notice of the decision to the parties. If a party seeks the board's review of the designee's reconsideration decision, the party must file a petition for appeal not later than 10 days after service of the reconsideration decision.

(g) Notwithstanding (c) of this section, a party may appeal a discovery order entered by a board designee under AS 23.30.108 by filing with the division a petition in accordance with 8 AAC 45.050. Unless a petition is filed under this subsection not later than 10 days after service of a board designee's discovery order, the discovery order is final. (Eff. 5/28/83, Register 86; am 7/20/97, Register 143; am 7/2/98, Register 146; am 2/3/2001, Register 157; am 7/9/2011, Register 199; am 12/2/2012, Register 204; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.108 AS 23.30.135
 AS 23.30.107 AS 23.30.110

8 AAC 45.070 is repealed and readopted to read:

8 AAC 45.070. Hearings. (a) Hearings will be held at the time and place fixed by notice served by the division. A hearing may be postponed or continued by the board or its designee, and in accordance with the Act and this chapter.

(b) If a party wants a hearing on a claim but is not fully prepared for a hearing, the party shall petition for an extension of time to request a hearing under AS 23.30.110(c).

(c) Except as provided in (d)(1), (d)(4), and (f) of this section and 8 AAC 45.074(c), the division will not schedule a hearing unless a claim or petition has been filed, an affidavit of readiness for hearing has been filed, and the division has not returned the affidavit. The division has available an affidavit of readiness for hearing form that a party may use. The division will return an affidavit of readiness for hearing and a hearing will not be set if the affidavit lacks proof of service upon all other parties or if the affiant fails to state that the party has completed all necessary discovery, has all the necessary evidence, and is fully prepared for the hearing.

(d) A hearing is requested by using the following procedures:

(1) for review of an administrator's decision issued under AS 23.30.041 or AS 23.30.043, a party shall file a petition for review of the administrator's decision under 8 AAC 45.150; an affidavit of readiness for hearing form is not required;

(2) for a written record hearing based on the division's file on a claim or petition, or an in-person hearing on a claim or petition, a party shall file an affidavit of readiness for hearing in accordance with (e) of this section;

(3) for a default hearing under AS 23.30.170, a party shall file a petition together with an affidavit of readiness for hearing;

(4) to resolve a medical dispute under AS 23.30.095(k) or to request the board order a physical examination under AS 23.30.110(g), a party shall file with the division and serve on opposing parties a petition asking the board to order a second independent medical evaluation, a completed second independent medical evaluation form signed by the party that filed the petition, and medical records reflecting the medical disputes; if the parties do not

stipulate to the second independent medical evaluation within 20 days of service of the documents, the board or its designee will schedule a hearing, the board will hold a hearing on the written record with briefs, and the board will issue its decision and order within 60 days of the date the documents were filed with the division and served on the opposing party; an affidavit of readiness for hearing form is not required;

(5) for a venue dispute, a party shall file a petition to change venue and an affidavit of readiness for hearing on the written record; an in-person hearing will not be held.

(e) Except as provided in (d) of this section, a party may not file an affidavit of readiness for hearing on a claim or petition before the opposing party files an answer to the claim or petition or 20 days after the service of the claim or petition, whichever occurs first. If an affidavit of readiness for hearing is filed before the time set by this subsection, no action will be taken by the division or board or its designee until the 20 days have passed.

(f) If the board or its designee determines that a hearing should be scheduled even though a party has not filed an affidavit of readiness for hearing, the division will give notice of the hearing in accordance with AS 23.30.110.

(g) To oppose a hearing, a party shall file an affidavit of opposition. If an affidavit of opposition to a hearing is filed in accordance with this subsection, the board's designee will, within 30 days after the filing of the affidavit of opposition, hold a prehearing conference. At the prehearing conference, the board's designee may schedule a hearing date within 60 days or schedule a hearing under (a) of this section on a date stipulated by all the parties. If the affidavit of opposition is not filed in accordance with this subsection, and unless the parties stipulate to the contrary, the board's designee will schedule a hearing within 60 days and may hold a prehearing conference before scheduling a hearing. An affidavit of opposition must

- (1) be filed with the division office nearest the requested hearing location;
- (2) be filed not later than 10 days after service of the affidavit of readiness for hearing that is being opposed;
- (3) include proof of service upon the other parties;
- (4) include the case number and list the parties' names and the date of the affidavit of readiness for hearing that is being opposed; and
- (5) state the specific reason, and not a general allegation, why the case should not be heard, a party is not ready, or a hearing is not appropriate.

(h) The board or designee will not schedule a hearing until the requesting party has complied with this section unless the parties stipulate otherwise, the board's designee or the board determines that a hearing should be scheduled, or an affidavit of readiness for hearing is not required under (d) of this section.

(i) If an agreed settlement is reached less than 14 days before a scheduled hearing and

- (1) it conforms to AS 23.30.012 and 8 AAC 45.160, and is filed with the division not less than two working days before the scheduled hearing, the parties shall appear at the scheduled hearing to request board action under AS 23.30.012 on the agreed settlement; if the board does not approve the agreed settlement, the hearing will proceed as scheduled; or

- (2) it is not in accordance with AS 23.30.012 and 8 AAC 45.160, the parties shall appear before the board's designee at the scheduled hearing time to state the terms of the settlement agreement; after the parties have stated the terms of the settlement, the hearing will be continued.

(j) If a settlement is reached more than 14 days before a scheduled hearing, but it is not written and signed by the parties and approved by the board, the hearing will proceed as scheduled.

(k) If the board finds that a party was served with notice of hearing and is not present at the hearing, the board may

(1) proceed with the hearing in the party's absence and, after taking evidence, decide the issues in the claim or petition;

(2) dismiss the claim or petition without prejudice; or

(3) adjourn, postpone, or continue the hearing.

(l) Except when the board determines that unusual and extenuating circumstances exist, the prehearing summary, if a prehearing was conducted and if applicable, governs the issues and the course of the hearing.

(m) If the hearing is not completed on the scheduled hearing date and the board determines that good cause exists to continue the hearing for further evidence, legal memoranda, or oral arguments, the board will set a date for the completion of the hearing.

(n) The board may permit a member

(1) to attend a hearing by electronic means; or

(2) who did not attend a hearing to review the written record, evidence, and hearing recording to deliberate with

(A) a deadlocked two-member panel to decide the case; or

(B) the remaining member of a two-member panel if, before a decision is filed on a case heard by a two-member panel, a member's term expires or a member dies, resigns, or is replaced by the governor.

(o) Before a member is added to the panel under (n) of this section, the board will notify the parties of the new member's name and give the parties an opportunity to request the member's disqualification from the panel in accordance with AS 44.62.450(c). (In effect before 7/28/59; am 5/28/83, Register 86; am 12/14/86, Register 100; am 7/1/88, Register 107; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 3/31/2002, Register 161; am 5/12/2019, Register 230; am 7/7/2024, Register 251; am 3/23/2025, Register 253; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.110 AS 23.30.135

8 AAC 45.072(2) is amended to read:

(2) after receiving a party's **petition to change venue** [REQUEST IN ACCORDANCE WITH 8 AAC 45.070(b)(4)] and based on the documents filed with the **division** [BOARD] and the parties' written arguments, the board orders the venue changed for the convenience of the parties and the witnesses; the board's panel in the city with the initial venue will decide the **petition** [REQUEST] to change [THE] venue [FILED UNDER 8 AAC 45.070(b)(4)]; or

8 AAC 45.072(3) is amended to read:

(3) the board or its designee **changes** [, IN ITS DISCRETION, CHANGED] the venue for the board's convenience or to assure a speedy remedy. (Eff. 5/28/83, Register 86; am 7/20/97, Register 143; am 7/2/98, Register 146; am 6/11/2023, Register 246; am 3/23/2025, Register 253; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.110 AS 23.30.135

8 AAC 45.074(b)(1)(M) is amended to read:

(M) **the parties reach a settlement less than 14 days before a scheduled hearing and comply with the requirements of 8 AAC 45.070(i)(1)** [AN AGREED SETTLEMENT HAS BEEN REACHED BY THE PARTIES LESS THAN 14 DAYS BEFORE THE SCHEDULED HEARING, THE AGREED SETTLEMENT HAS NOT BEEN PUT INTO WRITING, SIGNED BY THE PARTIES, AND FILED WITH THE BOARD IN ACCORDANCE WITH 8 AAC 45.070(d)(1), THE PROPOSED SETTLEMENT RESOLVES ALL DISPUTED ISSUES SET TO BE HEARD, AND THE PARTIES APPEAR AT THE SCHEDULED HEARING TO STATE THE TERMS OF THE SETTLEMENT ON THE RECORD]; or

(Eff. 5/28/83, Register 86; am 7/1/88, Register 107; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 7/9/2011, Register 199; am 3/28/2012, Register 201; am 3/23/2025, Register 253; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.110 AS 23.30.135

8 AAC 45.092(b) is amended to read:

(b) The list of physicians will be created as follows:

(1) **not later than January 15, the board's** [THE BOARD OR ITS] designee will **provide a copy of the second independent medical examiners list in effect and** ask the Alaska Chiropractic Society, Alaska Dental Society, **the Alaska Society of Eye Physicians and Surgeons** [ALASKA OPTOMETRIC ASSOCIATION], and Alaska State Medical Association to make recommendations; **the** [FROM WITHIN THEIR RESPECTIVE SPECIALTY. THE]

recommendations must be received by the board on or before **May 1** [NOVEMBER 1, 1989
AND ON OR BEFORE NOVEMBER 1] of each year; [AFTER THAT.]

(2) **not** [NOT] later than **June** [DECEMBER] 15 of each year, the board will
provide [PUBLISH A BULLETIN LISTING] the names of the physicians recommended by the
Alaska Chiropractic Society, the Alaska Dental Society, **the Alaska Society of Eye Physicians
and Surgeons** [THE ALASKA OPTOMETRIC ASSOCIATION], and the Alaska State Medical
Association **to the volunteer panel members chosen by the commissioner;** [AS WELL AS
THE NAMES OF SECOND INDEPENDENT MEDICAL EXAMINERS.]

(3) **an** [AN] attorney who meets the following criteria may, not later than **April**
[MARCH] 1 of each year, submit a letter to the commissioner volunteering to serve on a panel to
select physicians for inclusion on the board's **second independent medical examiners** list; **the**
[AS DESCRIBED IN (5) OF THIS SUBSECTION. THE] attorney must

(A) be admitted to the practice of law in this or another state;

(B) have personally **represented parties either at workers'**
compensation mediations or hearings in at least [PRESENTED A TOTAL OF] three
cases [, NO MORE THAN ONE OF WHICH WAS RESOLVED BY AGREED
SETTLEMENTS, FOR BOARD DECISION] during the calendar year preceding
volunteering to serve on a panel; and

(C) in the calendar year preceding volunteering, have represented one
class of litigants, either employee or employer, 90 percent of the time; based on the class
of litigant that was represented 90 percent of the time, the commissioner will classify the
attorney as either an employee or employer attorney; [.]

(4) **the panel shall consider letters of interest from physicians interested in serving as second independent medical examiners if the letters are received on or before June 1 of each year; the panel may consider letters of interest received after June 1 of other physicians identified by the panel at its regular meetings;**

(5) **by June** [BY MAY] 1 of each year, the commissioner shall choose, from the attorneys who volunteered in accordance with (3) of this subsection, two employee attorneys and two employer attorneys to serve on a panel to select physicians for inclusion on the board's list of physicians; **the** [. THE] panel shall meet and select physicians by **September** [AUGUST] 1 of each year; **the** [. THE] commissioner shall provide staff to schedule the panel's meetings, publish notice of the meetings, and arrange facilities or other support for the meeting to assist the panel, but the panel members may not be paid for their work or expenses for participating on the panel;

(6) **the** [. (5) THE] panel members shall vote, or abstain from voting, upon the physicians **recommended by the Alaska Chiropractic Society, the Alaska Dental Society, the Alaska Society of Eye Physicians and Surgeons, and the Alaska State Medical Association** [WHOSE NAMES WERE LISTED IN THE BULLETIN PUBLISHED UNDER (2) OF THIS SUBSECTION] or [ARE] suggested by a panel member, even if the physician's name **was not provided to the volunteer panel under (2) of this subsection** [DID NOT APPEAR IN THE BULLETIN]; [. A PHYSICIAN WHO RECEIVES THREE AFFIRMATIVE VOTES WILL BE SENT BY] the **board's** [BOARD OR ITS] designee **will send** an application and a letter **to a physician who receives three affirmative votes** asking if the physician is interested in performing second independent medical examinations; **unless** [. UNLESS] the [BOARD] **designee** determines that good cause exists to extend the time, not later than 60 days after the date of the board's letter the physician **shall** [MUST] submit

(A) a completed application listing the physician's education, training, work experience, specialty, and the particular discipline in which the physician is licensed, as well as the names and addresses of professional organizations that have certified the physician or in which the physician is an active member;

(B) a copy or proof of the physician's current license from the appropriate licensing agency in the state in which the physician practices;

(C) a certificate of insurance for the physician's current and enforceable professional liability insurance for the services performed; and

(D) a certificate of insurance for the physician's workers' compensation insurance if the physician has employees;

(7) if [. (6) If] the physician complies with **(6)** [5] of this subsection, the physician's name will be added to the board's list of second independent medical examiners, effective **January** [NOVEMBER] 1 of **the next** [THAT] year; **the division will publish a bulletin listing the names of the second independent medical examiners not later than December 15 of each year; except** [. EXCEPT] as provided in **(8)** [7] of this subsection and (c) of this section, the physician's name will remain on the list for three years; **after** [. AFTER] three years, the physician must be reselected in accordance with **(6)** [5] of this subsection; **if** [. IF] reselected, the physician will remain on the list unless

(A) three members of the panel described in **(5)** [(4)] of this subsection recommend that the physician be removed from the list and the department determines that the removal of the physician is not inconsistent with this chapter; or

(B) the physician is removed from the list under **(8)** [(7)] of this subsection or (c) of this section;

(8) notwithstanding [. (7) NOTWITHSTANDING] (d) of this section, the board may remove a physician's name from the list compiled in accordance with **(7)** [(6)] of this subsection

(A) upon receipt of the physician's written notification that the physician no longer wants to perform second independent medical evaluations; or

(B) if, within 30 days after receipt of a written request, the physician does not annually submit a copy of or proof of licensing by the appropriate state agency, a certificate of insurance for professional liability insurance and, if required under AS 23.30, workers' compensation insurance.

8 AAC 45.092(h) is amended to read:

(h) In an evaluation under AS 23.30.095(k), the board or the board's designee will identify the medical disputes at issue and prepare and submit questions addressing the medical disputes to the medical examiners selected under this section. The board **or the board's designee** may direct

(1) a party to **organize and digitize a first set of** [MAKE A COPY OF] all medical records, including **transcripts of** medical providers' depositions, regarding the employee in the party's possession, put the **records** [COPY] in chronological order by date of treatment with the initial report **first** [ON TOP], **and** number the records consecutively [, AND PUT THE RECORDS IN A BINDER];

(2) **a** [THE] party [MAKING THE COPY] to **electronically** serve the **first set of digitized** [BINDER OF] medical records upon the opposing party together with an affidavit

verifying that [THE BINDER CONTAINS COPIES OF] all the medical reports relating to the employee in the party's possession **have been digitized and organized chronologically;**

(3) **a** [THE] party served with the **first set of digitized medical records** [BINDER] to review **and** [THE COPIES OF THE MEDICAL RECORDS TO] determine if [THE BINDER CONTAINS COPIES OF] all the employee's medical records in that party's possession **are included in the first set of digitized medical records;** the party served with **those digitized medical records shall** [THE BINDER MUST] file **them electronically** [THE BINDER] with the **division** [BOARD] not later than 10 days after receipt and, if the **those digitized medical records are** [BINDER IS]

(A) complete, the party served with the **first set of digitized medical records shall** [BINDER MUST] file **them with** the [BINDER UPON] **division** [BOARD] together with an affidavit verifying that the **first set of digitized medical records contain** [BINDER CONTAINS] copies of all the employee's medical records in the party's possession; or

(B) incomplete, the party served with the **first set of digitized medical records shall** [BINDER MUST] file **them with** [THE BINDER UPON] the **division** [BOARD] together with [A] supplemental **digitized** [BINDER WITH COPIES OF THE] medical records in that party's possession that were missing from the **first set of digitized medical records** [BINDER] and an affidavit verifying that the **first set of medical records along with the supplemental digitized medical records** [BINDERS] contain [COPIES OF] all **the employee's** medical records in the party's possession; the [COPIES OF THE] medical records in the supplemental **digitized medical records** [BINDER] must be placed in chronological order by date of treatment, with the initial report **first**

[ON TOP], and numbered consecutively; the party **shall** [MUST] also serve the party who prepared the first **set of digitized medical records** [BINDER] with [A COPY OF] the supplemental **digitized medical records** [BINDER] together with an affidavit verifying that the **supplemental digitized medical records are** [BINDER IS] identical to the supplemental **records** [BINDER] filed with the **division** [BOARD];

(4) **a** [THE] party [, WHO] **that** receives additional medical records after the **first set of digitized medical records and supplemental digitized medical records have** [BINDER HAS] been **organized** [PREPARED] and filed with the **division** [BOARD], to **digitize** [MAKE TWO COPIES OF] the additional medical records **and organize them** [, PUT THE COPIES IN TWO SEPARATE BINDERS] in chronological order by date of treatment, with the initial report **first** [ON TOP], and number the copies consecutively; the party **shall electronically** [MUST] file **the additional medical records with the division and on the opposing party** [ONE BINDER WITH THE BOARD] not later than seven days after receiving the medical records [; THE PARTY MUST SERVE THE OTHER ADDITIONAL BINDER ON THE OPPOSING PARTY], together with an affidavit stating the **additional digitized medical records are** [BINDER IS] identical to the **records** [BINDER] filed with the **division** [BOARD, NOT LATER THAN SEVEN DAYS AFTER RECEIVING THE MEDICAL RECORDS];

(5) REPEALED 5/12/2019].

(Eff. 7/1/88, Register 107; am 10/28/88, Register 108; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 2/27/2000, Register 153; am 3/13/2004, Register 169; am 2/28/2010, Register 193; am 4/1/2017, Register 221; am 7/27/2017, Register 223; am 5/12/2019, Register 230; am 12/23/2021, Register 240; am ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.095 AS 23.30.110

8 AAC 45.120 is repealed and readopted to read

8 AAC 45.120. Evidence. (a) The provisions of AS 44.62.460 apply in workers' compensation cases.

(b) If the board determines that a party is indigent and cannot afford to pay a transcription fee, the board will rely upon the audio or visual recording of the deposition without a transcript.

(c) The board may determine the order and manner of evidence and argument at a hearing unless otherwise expressly provided by law.

(d) A party who does not testify may be called and examined by any party as if under cross-examination.

(e) Any document that is served upon the parties, accompanied by proof of service, and in the division's possession 20 or more days before hearing may be relied upon by the board in reaching a decision unless a valid written request for an opportunity to cross-examine the document's author is filed with the division and served upon all parties under 8 AAC 45.055.

(f) The provisions of 8 AAC 45.055 do not limit the parties' right to object to the introduction of documents on other grounds.

(g) The board favors the production of written medical reports and may give less weight to written reports that do not include

- (1) the patient's complaints;
- (2) the history of the injury;
- (3) the source of all facts set out in the history and complaints;
- (4) the findings on examination;
- (5) the medical treatment indicated and provided;

(6) the relationship of the impairment or injury to the employment;

(7) the medical provider's opinion concerning the employee's working ability and reasons for that opinion;

(8) the likelihood of permanent impairment; and

(9) the medical provider's opinion as to whether the impairment, if permanent, is ready for rating, the extent of the impairment, and detailed factors upon which the rating is based.

(h) A duplicate is admissible to the same extent as original evidence unless the board determines a genuine issue is raised as to its authenticity or reliability.

(i) To rely on a deposition transcript, a party shall file it at least two days before the hearing. The board will not rely on late-filed depositions transcripts unless it finds unusual and extenuating circumstances exist.

(j) The board will not consider evidence or legal memoranda filed after the board closes the hearing record unless the board, upon its motion, determines that the hearing was not completed and reopens the hearing record for additional evidence or legal memoranda. The board will give the parties written notice of reopening the hearing record, specify what additional documents are to be filed, and provide the deadline for filing the documents. (In effect before 7/28/59; am 5/28/83, Register 86; am 12/14/86, Register 100; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am ____/____/____, Register ____)

Authority: AS 23.30.005(h) **AS 23.30.110** AS 23.30.135

AS 23.30.095 [AS 23.30.110(c)]

8 AAC 45.170 is repealed:

8 AAC 45.170. Listing of injuries. Repealed. (In effect before 7/28/59; am 5/28/83, Register 86; am 2/27/2000, Register 153; repealed ____/____/____, Register ____)

8 AAC 45.176(d)(3) is amended to read:

(3) a violation of AS 23.30.075 that exceeds 180 **consecutive** calendar days;
(Eff. 2/28/2010, Register 193; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.080

8 AAC 45.180(b) is amended to read:

(b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant **shall** [MUST] apply to the board for approval of the fee. **The** [; THE] attorney may **file a** [SUBMIT AN APPLICATION FOR ADJUSTMENT OF] claim [OR A PETITION]. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) **shall, at least three working days before a hearing on a claim or petition for which services were rendered,** [MUST (1)] file an affidavit itemizing the hours expended **in 1/10 of an hour increments for each task, describing** [, AS WELL AS] the extent and character of the work performed, **and addressing each factor in Rule 1.5(a) of the Alaska Rules of Professional Conduct. An affidavit filed under this subsection may not provide for block billing or for only the total time for all tasks performed. An attorney may supplement a fee affidavit filed in accordance with this subsection by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If a fee affidavit is not**

filed in accordance with this subsection, the board will deny a request for a fee in excess of the statutory minimum [AND (2) IF A HEARING IS SCHEDULED, FILE AN AFFIDAVIT AT LEAST THREE WORKING DAYS BEFORE THE HEARING ON THE CLAIM FOR WHICH THE SERVICES WERE RENDERED; AT THE HEARING, THE ATTORNEY MAY SUPPLEMENT THE AFFIDAVIT BY TESTIFYING ABOUT THE HORUS EXPENDED AND THE EXTENT AND CHARACTER OF THE WORK PERFORMED AFTER THE AFFIDAVIT WAS FILED. IF THE REQUEST AND AFFIDAIVT ARE NOT IN ACCORDANCE WITH THIS SUBSECTION, THE BOARD WILL DENY THE REQUEST FOR A FEE IN EXCESS OF THE STATUTORY MINIMUM FEE, AND WILL AWARD THE MINIMUM STATUTORY FEE].

(Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 3/16/90, Register 113; am

____/____/____, Register _____)

Authority: AS 23.30.005(h) AS 23.30.115 AS 23.30.145

AS 23.30.110

8 AAC 45.188 is repealed:

8 AAC 45.188. Third party claim. Repealed. (Eff. 7/20/97, Register 143; repealed

____/____/____, Register _____)

8 AAC 45.510(b) is amended to read:

(b) The administrator shall consider a written request for an eligibility evaluation for reemployment benefits, unless the employer controverts on grounds the employee's injury did not arise out of and in the course of employment, on grounds the employee's total inability to

return to the employee's employment at the time of injury is not a result of the injury, or on grounds identified under AS 23.30.022, 23.30.100, 23.30.105, or 23.30.250. If reemployment benefits have been controverted on any of these grounds, the administrator shall forward the matter to the board to conduct a prehearing conference regarding the controversion not later than 30 days after the board receives the matter. If a claim is filed and if requested by the employee, the board will conduct a hearing no later than 90 days after the prehearing conference in accordance with **8 AAC 45.070(f)** [8 AAC 45.060(e) AND 8 AAC 45.070(b)(8)], limited to the grounds set out in this subsection.

(Eff. 7/2/98, Register 146; am 7/9/2011, Register 199; am 3/23/2025, Register 253; am ____/____/____, Register ____)

Authority: AS 23.30.005 AS 23.30.041 AS 23.30.043

8 AAC 45.900(a)(5) is amended to read:

(5) "claim" **is a written request for benefits** [INCLUDES ANY MATTER OVER WHICH THE BOARD HAS JURISDICTION];

8 AAC 45.900(a) is amended by adding a new paragraph to read:

(17) "petition" means a written request for action other than a claim for benefits.
(((Publisher: please replace the period at the end of 8 AAC 45.900(a)(16) with a semicolon.)))

8 AAC 45.900(j) is amended to read:

(j) **"Previously** [FOR AN INJURY OCCURRING AFTER DECEMBER 22, 2011,"PREVIOUSLY] rehabilitated" under AS 23.30.041(f)(3) means having [(1)] completed a

reemployment benefits plan under AS 23.30.041 or a substantially similar law in another jurisdiction [; OR (2) DONE BOTH OF THE FOLLOWING: (A) HAVING STIPULATED TO ELIGIBILITY, HAVING AN ELIGIBILITY REQUEST APPROVED, OR HAVING AN ELIGIBILITY EVALUATION ORDERED UNDER AS 23.30.041(c); (B) HAVING WAIVED REEMPLOYMENT BENEFITS UNDER AS 23.30.041(q), 23.30.012, OR A SUBSTANTIALLY SIMILAR LAW IN ANOTHER JURISDICTION].

(Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 7/1/88, Register 107; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 4/16/2010, Register 194; am 12/22/2011, Register 200; am 12/1/2015, Register 216; am 7/27/2017, Register 223; am 12/23/2021, Register 240; am 3/23/2025, Register 253; am ____/____/____, Register ____)

Authority:	AS 23.30.005	AS 23.30.090	AS 23.30.230
	AS 23.30.030	AS 23.30.097	AS 23.30.240
	AS 23.30.041	AS 23.30.175	AS 23.30.395
	AS 23.30.043	AS 23.30.220	

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

8 AAC 45.220. Gross weekly earnings.

8 AAC 45.220 is amended to read:

8 AAC 45.220. Gross weekly earnings. (a) [AFTER] **When** calculating the employee’s gross weekly earnings [LESS THE PAYROLL TAX DEDUCTIONS] under AS 23.30.220, [THE RESULT WILL BE ROUNDED TO THE NEAREST DOLLAR], **also apply AS 23.30.395 (22) to determine the “Gross Weekly Wage” to enter into the Division’s Benefit Calculator at <https://labor.alaska.gov/wc/benefitcalculator.htm>.**

[(b) THE CALCULATION OF AN EMPLOYEE’S GROSS WEEKLY EARNINGS SET OUT
IN (c) OF THIS SECTION APPLIES TO EACH OF THE FOLLOWING PERIODIC
PAYMENTS:

- (1) “WEEKLY AMOUNT” UNDER AS 23.30.220(a)(1);
- (2) “MONTHLY EARNINGS” UNDER AS 23.30.220(a)(2);
- (3) “YEARLY EARNINGS” UNDER AS 23.30.220(a)(3);
- (4) “EARNINGS” UNDER AS 23.30.220(a)(4)(A);
- (5) “AMOUNT THAT THE EMPLOYEE WOULD HAVE EARNED” UNDER AS
23.30.220(a)(4)(B);
- (6) “USUAL WAGE” UNDER AS 23.30.220(a)(5);
- (7) “TOTAL WAGES” UNDER AS 23.30.220(a)(6); OR
- (8) “EARNINGS” UNDER AS 23.30.220(a)(7).

(c) IN CALCULATING AN EMPLOYEE’S GROSS WEEKLY EARNINGS, EACH OF THE
TERMS SET OUT IN (b) OF THIS SECTION MEANS PERIODIC PAYMENTS MADE BY

AN EMPLOYER TO AN EMPLOYEE FOR EMPLOYMENT BEFORE ANY AUTHORIZED OR LAWFULLY REQUIRED DEDUCTION OR WITHHOLDING OF MONEY BY THE EMPLOYER; FOR PURPOSES OF THIS SUBSECTION,

(1) COMPENSATION THAT IS DEFERRED AT THE OPTION OF THE EMPLOYEE IS A PERIODIC PAYMENT;

(2) THE VALUE OF ROOM AND BOARD IS A PERIODIC PAYMENT IF TAXABLE TO THE EMPLOYEE[,] ; BUT THE VALUE OF ROOM AND BOARD THAT WOULD RAISE AN EMPLOYEE'S GROSS WEEKLY EARNINGS ABOVE THE STATE'S AVERAGE WEEKLY WAGE AT THE TIME OF INJURY MAY NOT BE CONSIDERED A PERIODIC PAYMENT;

(3) THE TERMS SET OUT IN (b) OF THIS SECTION DO NOT INCLUDE AS PERIODIC PAYMENTS:

(A) IRREGULAR BONUSES, REIMBURSEMENT OF EXPENSES, AND EXPENSE ALLOWANCES;

(B) A BENEFIT OR PAYMENT TO THE EMPLOYEE THAT IS NOT FULLY TAXABLE TO THE EMPLOYEE DURING THE PAY PERIOD, EXCEPT THAT THE AMOUNT AN EMPLOYER CONTRIBUTED TO PROVIDE HEALTH OR LIFE INSURANCE COVERAGE FOR THE EMPLOYEE OR EMPLOYEE'S BENEFICIARIES MUST BE INCLUDED AS A PERIODIC PAYMENT.

(d) FOR PURPOSES OF CALCULATING THE GROSS WEEKLY EARNINGS UNDER AS 23.30.220 AND (c) OF THIS SECTION FOR AN INJURY THAT OCCURRED BEFORE JULY 1, 2000,

(1) "OVERTIME" PAY MEANS ONLY THE RATE OF PAY FOR HOURS WORKED IN EXCESS OF 40 HOURS PER WEEK AND EIGHT HOURS A DAY IF THAT RATE OF PAY IS DIFFERENT THAN THE REGULAR RATE OF PAY FOR THE HOURS THE EMPLOYEE WORKED THAT WERE NOT IN EXCESS OF 40 HOURS A WEEK OR EIGHT HOURS A DAY; THE HOURS WORKED IN EXCESS OF 40 HOURS IN A WEEK OR EIGHT HOURS A DAY ARE INCLUDED IN THE GROSS WEEKLY EARNINGS, BUT AT THE REGULAR RATE OF PAY; AND

(2) "PREMIUM" PAY MEANS ONLY THE HOURLY RATE OF PAY FOR WORKING A HOLIDAY, A GRAVEYARD SHIFT, OR OTHER SHIFT DIFFERENTIAL, IF THAT RATE OF PAY IS DIFFERENT THAN THE REGULAR RATE OF PAY FOR THE EMPLOYEE'S USUAL WORK WEEK.

[EXAMPLE

1. AN EMPLOYEE WORKS 48 HOURS IN A WEEK AND DOES NOT RECEIVE CONTRIBUTIONS THAT WOULD BE ADDED UNDER THIS SECTION. THE EMPLOYEE'S REGULAR RATE OF PAY FOR THE FIRST 40 HOURS IS \$10 AN HOUR OR \$400 ($\$10 \times 40 = \400); THE RATE OF PAY FOR THE EXCESS 8 HOURS IS \$15 AN HOUR OR \$120 ($\$15 \times 8 = \120). THE ACTUAL WEEKLY TOTAL EARNINGS ARE \$520 ($\$400 + \120). FOR PURPOSES OF COMPUTING THE GROSS WEEKLY EARNINGS, THE EMPLOYEE'S WEEKLY EARNINGS WOULD BE \$480 (48 HOURS TIMES \$10 AN HOUR).

2. AN EMPLOYEE IS PAID \$8 PER HOUR AND THERE ARE NO CONTRIBUTIONS THAT WOULD BE ADDED UNDER THIS SECTION. THE EMPLOYEE NEVER WORKED MORE THAN 8 HOURS PER DAY OR 40 HOURS PER WEEK. THE EARNINGS PERIOD USED

Register _____, _____ 2026 LABOR AND WORKFORCE DEV.

TO COMPUTE THE GROSS WEEKLY EARNINGS INCLUDED NEW YEAR'S DAY.

BECAUSE THE EMPLOYEE WORKED NEW YEAR'S DAY, A HOLIDAY, THE
EMPLOYEE WAS PAID "PREMIUM PAY" OF AN ADDITIONAL \$2 PER HOUR, OR \$10
PER HOUR. IN COMPUTING THE GROSS WEEKLY EARNINGS, THE WEEKLY
EARNINGS FOR THAT WEEK ARE \$320 (40 HOURS AT \$8 PER HOUR), AND NOT THE
ACTUAL WEEKLY EARNINGS OF \$336 (32 HOURS AT \$8 PER HOUR AND 8 HOURS AT
\$10 PER HOUR).]

(Eff. 12/14/86, Register 100; am 7/2/98, Register 146; am 2/3/2001, Register 157; am ___ / ___ /
____, Register ___)

Authority: AS 23.30.005 AS 23.30.220 **AS 23.30.395**

TAB 10

October 8, 2026

Alaska Department of Labor and Workforce Development

Division of Workers' Compensation

P.O. Box 115512, Juneau, AK 99811-5512

Attn: Mr. Charles Collins, Director and Ms. Alexis Hildebrand, Admin Operations Manager

Submitted by Electronic Mail to: workerscomp@alaska.gov

Re: 2027 Proposed Workers' Compensation Medical Fee Schedule

Dear Mr. Collins, Ms. Hildebrand, and Respected Colleagues:

On behalf of the American Association of Payers, Administrators, and Networks (AAPAN), we appreciate the opportunity to provide feedback in support of the proposed updates to the 2027 Alaska Workers' Compensation Medical Fee Schedule. AAPAN is the only national association providing a unified, integrated voice for payers, administrators, networks, and care management organizations operating in the commercial and government health and workers' compensation markets.

We commend the Division and the Medical Services Review Committee (MSRC) for their continued work reviewing and refining the medical fee schedule (the "Draft")¹, and we offer the following comments, including one targeted language recommendation, for your consideration:

Overall Support for the Proposed Pharmacy and Ancillary Reimbursement Updates

AAPAN supports the proposed changes addressing repackaged and physician-dispensed drugs [Draft, "Drugs and Pharmaceuticals" and "Physician-Dispensed Drugs," p. 4], topicals and compounded medications [*id.*, "Topicals and Topical Compounds" and "Non-Topical Compounded Drugs," p. 4], and durable medical equipment [*id.*, "Durable Medical Equipment," p. 4]. Taken together, these updates provide greater clarity around reimbursement for pharmacy and ancillary services and give the stakeholders responsible for administering medical benefits within Alaska's workers' compensation system a clearer, more consistent set of standards to apply.

One Compounding Fee per Compounded Prescription

We particularly appreciate the MSRC's acceptance of an AAPAN member recommendation, offered during the Committee's discussions on compounded medications, clarifying that only one compounding fee may be reimbursed per compounded prescription [Draft, "Topical compounds" and "Non-Topical

¹ Proposed Draft Alaska Fee Schedule, located at <https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=163927>

Compounded Drugs,” p. 4]. This clarification establishes a clear and consistent reimbursement standard and helps reduce the potential for duplicative or excessive fees. AAPAN supports its inclusion in the proposed fee schedule as drafted.

Recommended Clarification: “Lowest” Cost Equivalent for Non-Compounded Topicals

In addition to our overall support, AAPAN respectfully recommends one specific language amendment to the proposed reimbursement provision for non-compounded topicals. Elsewhere in the proposed language, the provisions for OTC medications, compounded topicals, and non-topical compounds refer to reimbursement at the “lowest” cost generic or therapeutic equivalent rate [Draft, OTC medications, pp. 3–4; “Topical compounds” and “Non-Topical Compounded Drugs,” p. 4]. The provision specific to “Topicals (non-compounded),” however, refers to reimbursement at “a lower-cost” therapeutic or OTC equivalent [Draft, “Topicals (non-compounded),” p. 4]. We believe this difference is likely an oversight in the drafting process and, for reasons of consistency, cost control, and reduced ambiguity, recommend that the language be amended as follows (deletions shown in strikethrough; additions underlined):

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

Aligning this provision with the “lowest” cost standard used throughout the rest of the pharmacy section would avoid differing interpretations among payers and dispensers about which equivalent applies, and ensure that non-compounded topicals are treated consistently with comparable products under the fee schedule.

Once again, we thank you for the opportunity to provide comments on the proposed 2027 Alaska Workers’ Compensation Medical Fee Schedule. Should you have any questions regarding the comments I have outlined, please do not hesitate to reach out to me.

Sincerely,



Lisa Anne Hurt-Forsythe

Vice President, Government Affairs

American Association of Payers Administrators and Networks (AAPAN)

Direct: (916) 224-1163/**Email:** lahurt-forsythe@aapan.org

cc: Mr. Julian Roberts, President, AAPAN

Mr. Charles Collins, State of AK at charles.collins@alaska.gov

Ms. Alexis Hildebrand, State of AK at alexis.hildebrand@alaska.gov

Alaska Department of Labor and Workforce Development
Division of Workers' Compensation
Submitted via email to workerscomp@alaska.gov



October 8, 2026

Re: 2027 edition of Official Alaska Workers' Compensation Medical Fee Schedule

MyMatrixx, an Evernorth Company, appreciates the opportunity to submit comments in response to the Division of Workers' Compensation's proposed updates to the Official Alaska Workers' Compensation Medical Fee Schedule for 2027. By way of background, MyMatrixx provides pharmacy benefit management services to insurers, self-insured employers and third-party administrators specifically in the workers' compensation market in Alaska and throughout the country. Given that, our comments are limited to proposed updates to the "Drugs and Pharmaceuticals" section in the fee schedule.

Support

MyMatrixx supports the Division's proposed updates to the "Drugs and Pharmaceuticals" section in the fee schedule. MyMatrixx attended several of the Workers' Compensation Medical Services Review Committee meetings earlier this year, where draft changes were presented and worked on, and was called upon to provide our feedback on the language and background on what some other states have done in terms of subjects like topical medications, compounds, and over-the-counter (OTC) medications. Through that open and constructive process, we believe several important amendments were recommended and now proposed in this formal rulemaking effort. We are very appreciative of members of the committee, the Division, and the Division's fee schedule publication vendor for their willingness to work with stakeholders like us to develop this language. We also appreciate the Alaska Workers' Compensation Board approving the recommendations of the committee to move forward to this formal proposal stage.

While we support the updates to the "Drugs and Pharmaceuticals" section generally, more specifically, we particularly support the following provisions:

- New reimbursement caps on non-compounded and compounded topicals: We have continued to see escalated charges for certain topical medications being dispensed from non-traditional pharmacies or directly from physicians' offices at substantially higher rates even though they often use the same ingredients as other widely available and less costly products. The charges from these channels, at times, can reflect gaps in existing state regulatory controls. The Workers' Compensation Research

Institute reported that reimbursement caps for topical medications adopted in certain states over the last several years have reduced payments for topicals significantly.¹

- Added language clarifying reimbursement for OTC medications: Many may believe OTC medications are lower cost and injured workers just pay for them out of pocket and seek reimbursement through their insurance carrier/self-insured employer. However, workers' compensation regulations can at times overlook the importance of OTC medications that may be ordered by treating physicians for use by injured workers and billed directly to employers, workers' compensation insurers, and their PBMs. While most OTC medications are available at low or reasonable retail prices, some are not, and we have seen this being exploited in some cases where a particular national drug code (NDC) for an OTC medication available from multiple manufacturers may carry with it a significantly higher average wholesale price than comparable equivalents. Clear fee schedule controls on this category, like those proposed by the Division, should add more certainty to the system and help contain unnecessary costs while still ensuring access to needed OTC medications for injured workers.
- Clarification on billing and reimbursement of physician dispensed and repackaged medications: While existing workers' compensation statutes (Alaska Stat. §23.30.097) address physician dispensed medications to some extent and reference use of the original manufacturer's NDC for repackaged medications, we appreciate the additional language proposed here for the fee schedule, including clarity around additional fees and application of the proposed caps to physician-dispensed topicals.

Additional recommendation

In addition to our overall support noted above, MyMatrixx would also like to recommend one specific language amendment to what is being proposed for reimbursement for non-compounded topicals. While other references in the proposed language for OTC medications, topical compounds, and non-topical compounds refer to reimbursement at the "lowest" cost generic or therapeutical equivalent rate, the proposed language specific to "Topicals (non-compounded)" refers to reimbursement at a "lower" cost therapeutic or OTC equivalent. We believe this may just be an oversight in the drafting process over time and recommend for that reason, and for reasons of consistency, cost control, and less ambiguity, that this language be amended as follows (our language edits are noted below with strikethrough and underlined text):

Topicals (non-compounded). A topical drug, such as (but not limited to) a cream, gel, ointment, lotion, or patch, is reimbursed at the lowest ~~a lower~~-cost therapeutic or over-the-counter (OTC) equivalent when available.

¹ Interstate Variation and Trends in Workers' Compensation Drug Payments, 6th Edition: A WCRI FlashReport. Workers Compensation Research Institute; May 2026. <https://www.wcrinet.org/reports/interstate-variation-and-trends-in-workers-compensation-drug-payments-6th-editiona-wcri-flashreport/>

Reimbursement is based on that equivalent and shall not exceed the lesser of the applicable cap or the equivalent's average wholesale price.



Conclusion

MyMatrixx thanks the Division for seeking stakeholder input at this point in the process, and we again are very appreciative for your involvement of MyMatrixx and other stakeholders during the earlier development of this language. Thank you for your consideration of our comments. If you have any questions regarding them, please contact me for further discussion.

Sincerely,

Adam Fowler

Director, Workers' Compensation Regulatory Affairs

MyMatrixx by Evernorth

[MyMatrixx.com](https://www.mymatrixx.com)

Adam.Fowler@MyMatrixx.com



Outlook

FW: NOTICE OF PROPOSED CHANGES ON WORKERS COMPENSATION FEES FOR MEDICAL TREATMENT AND SERVICES

From Compensation, Workers' (DOL sponsored) <workerscomp@alaska.gov>

Date Mon 9/14/2026 3:14 PM

To Collins, Charles M (DOL) <charles.collins@alaska.gov>

From: Jessica Pyatt <admin@alpineptsitka.com>

Sent: Monday, September 14, 2026 2:27 PM

To: Compensation, Workers' (DOL sponsored) <workerscomp@alaska.gov>

Subject: RE: NOTICE OF PROPOSED CHANGES ON WORKERS COMPENSATION FEES FOR MEDICAL TREATMENT AND SERVICES

You don't often get email from admin@alpineptsitka.com. [Learn why this is important](#)

CAUTION: This email originated from outside the State of Alaska mail system. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear Workers Comp Board -

I am writing regarding physical therapy payment and code changes.

I do not agree with beginning MPPRS for physical therapy services. This was meant to be a temporary budget consideration in 2011 and congress never reversed it.

Did you know that only 25% of licensed PTs work in full time patient care? The late night and weekend documentation requirements, hours, and doctorate level profession where one earns less year over year, not more, leads to most changing professions.

When you add MPPRS to reimbursement you shut down the small one person clinics and force those providers either out of the profession or into the hospitals. The formulas pay the hospitals more, most of the money leaving the state with temporary staff and travelers, and increase the cost of care. Two major insurances are cutting reimbursement in Alaska this year and it will mean fewer PT providers in the state to serve our neighbors.

I DO AGREE with any consideration to eliminate pay for RTM for orthopedic services. I believe it should be used for blood pressure, blood sugar etc. However I am seeing from the orthopedic surgery world significant abuse of the system. I am seeing post op folks being charged \$5,000 for remotely controlled bikes, CPMs, and iPads with exercise programs. All of which have made these post op patients do too much too soon, add too much resistance, do exercises that are too high level for being 1 week post op, and lead to prolonged rehab and recovery with excessive swelling, blood clots etc. Please eliminate all payment for RTM for physical therapy / orthopedic services. It is all a scam to make technology companies large amounts of money. The State of Alaska has

fallen for this by paying Hinge Health 1 MILLION dollars a year for a service advertised as "free" that also makes people do inappropriate activity for their body or diagnosis. These folks still access in person physical therapy and I often have to undo and change what the Hinge Health app has had them perform.

Thank you for considering,
Jessica Pyatt PT



CONFIDENTIALITY NOTICE: This email/fax may contain information that is privileged, confidential or otherwise protected from disclosure. It is intended only for the use of the authorized individual as indicated in the email/fax. If you are not the intended recipient of this email, please notify the sender immediately by return e-mail or fax, purge it and do not disseminate or copy it.

BIRCH VIEW VOCATIONAL SERVICES

May 19, 2026

Director Charles Collins (charles.collins@alaska.gov)

Department of Labor and Workforce Development – Workers’ Compensation

Re: May 14, 2026 Board Meeting – Public Comment

Greetings Director Collins:

I wanted to add to my statement at the recent Board meeting regarding the 2025 changes in regulations, and specifically the use of ONET.

ONET is a great resource, but it’s just that – a resource; thus I am concerned with the manner in which we are being asked to use it when performing Eligibility Evaluations. As you are likely aware, we are still required to use the SCODRDOT to document the physical demands; thus, I don’t believe the use of ONET has added anything to the overall evaluation process.

The purpose of presenting a job description to a physician is for that physician to make a determination (or prediction) that an injured worker will be able to perform the physical demands as described. As I stated in public comment, sometimes there are only 1-2 statements in a list of 20+ “Activities or Tasks” for one occupation that are applicable to the injured worker’s job. I am concerned that this may be too much information and/or confusing to the physician.

As a Vocational Rehabilitation Counselor (VRC) in WA State for 15+ years using a job analysis was the standard practice to present to physician’s for review when inquiring about an injured workers ability to work in any job (i.e. the job of injury, prior employment held, or for a retraining goal). A job analysis is different from a job description, in that a job analysis provides details regarding the physical demands of an occupation. Whereas a job description is generally a brief overview of the occupation and duties performed.

As an example, I have attached a copy of what we are now required to submit to a physician for review using ONET and the SCODRDOT. I have also attached an example of a job analysis I currently use to represent a retraining goal for injured worker’s during the Reemployment Benefit Plan process (and as noted above, was standard practice for any job being considered in a WA State workers’ compensation claim). As you will note, the job analysis provides much more detail regarding the physical demands; which per the Alaska Statute is the whole purpose of presenting this information to a doctor – to inquire as to whether or not the physician predicts the injured worker will be able to perform the physical demands as described.

As you can see from my example, a job analysis can be developed using ONET, the SCODRDOT and direct employer contact (or via information obtained from current job listings or employer website). In my experience, the resulting job analysis is valid for 18 months; thus,

189 E. Nelson Ave. #238

Wasilla, AK 99654

FAX: 1.833.625.1141

birchviewvoc@gmail.com

as a VRC it was standard practice to build a database for these documents, which overall reduced the time and cost for a claim.

The concern I have for using ONET as a stand-alone job description is that it is somewhat unprofessional in its presentation as it is simply “print to pdf” and the physical demands are cut/paste from the SCODRDOT. Yes this is simple and very easy to do; however, I for one do not consider this final product as being reflective of someone that has a Master of Education degree and is a Certified Rehabilitation Counselor. As I stated above, ONET is a great resource but I don’t believe it was intended to be used in the manner in which we as Rehabilitation Specialists are being asked to do.

I understand sometimes the initial idea and proposal for a regulation change may not be what the actual outcome is and/or intent of the original idea. These types of changes seems to be the usual bureaucratic process, which unfortunately includes people that have absolutely no idea how this information is used and/or what a Rehabilitation Specialist (or VRC) does.

I am very appreciative of the efforts you and the Reemployment Benefits Administrator have made to the regulations. Other than the concern I have voiced regarding ONET, I have no complaints and/or concerns regarding the other regulation changes.

Thank you for your time and please feel free to share this letter/attachments with the Board and/or whomever you deem appropriate.

Respectfully,



Jackie Doerner, M.Ed., CRC
Rehabilitation Specialist

Enclosures: ONET Job Description
Job Analysis

cc: RBA – Stacy Niwa (stacy.niwa@alaska.gov)



Heavy and Tractor-Trailer Truck Drivers

53-3032.00

Bright Outlook

Updated 2026

Drive a tractor-trailer combination or a truck with a capacity of at least 26,001 pounds Gross Vehicle Weight (GVW). May be required to unload truck. Requires commercial drivers' license. Includes tow truck drivers.

Sample of reported job titles: CDL Driver (Commercial Driver's License Driver), Driver, Line Haul Driver, Log Truck Driver, Over the Road Driver (OTR Driver), Production Truck Driver, Road Driver, Semi Truck Driver, Tractor Trailer Driver, Truck Driver

Summary

Details

Custom

Easy Read

Veterans

Español

Contents

Occupation-Specific Information

Tasks

Save Table: XLSX CSV

^ All 29 displayed

Importance	Category	Task
91	Core	Check all load-related documentation for completeness and accuracy.
91	Core	Inspect loads to ensure that cargo is secure.
90	Core	Check vehicles to ensure that mechanical, safety, and emergency equipment is in good working order.
90	Core	Crank trailer landing gear up or down to safely secure vehicles.
90	Core	Obtain receipts or signatures for delivered goods and collect payment for services when required.

Importance	Category	Task
89	Core	+ Maintain logs of working hours or of vehicle service or repair status, following applicable state and federal regulations.
89	Core	+ Read bills of lading to determine assignment details.
89	Core	+ Report vehicle defects, accidents, traffic violations, or damage to the vehicles.
88	Core	+ Perform basic vehicle maintenance tasks, such as adding oil, fuel, or radiator fluid, performing minor repairs, or washing trucks.
88	Core	+ Couple or uncouple trailers by changing trailer jack positions, connecting or disconnecting air or electrical lines, or manipulating fifth-wheel locks.
88	Core	+ Maneuver trucks into loading or unloading positions, following signals from loading crew and checking that vehicle and loading equipment are properly positioned.
87	Core	+ Collect delivery instructions from appropriate sources, verifying instructions and routes.
87	Core	+ Drive trucks with capacities greater than 13 tons, including tractor-trailer combinations, to transport and deliver products, livestock, or other materials.
85	Core	+ Read and interpret maps to determine vehicle routes.
84	Core	+ Check conditions of trailers after contents have been unloaded to ensure that there has been no damage.
83	Core	+ Operate equipment, such as truck cab computers, CB radios, phones, or global positioning systems (GPS) equipment to exchange necessary information with bases, supervisors, or other drivers.
83	Core	+ Drive trucks to weigh stations before and after loading and along routes in compliance with state regulations.
80	Core	+ Load or unload trucks or help others with loading or unloading, using special loading-related equipment or other equipment as necessary.

Importance	Category	Task
78	Core	+ Plan or adjust routes based on changing conditions, using computer equipment, global positioning systems (GPS) equipment, or other navigation devices, to minimize fuel consumption and carbon emissions.
74	Core	+ Perform emergency roadside repairs, such as changing tires or installing light bulbs, tire chains, or spark plugs.
69	Core	+ Remove debris from loaded trailers.
92	Supplemental	+ Secure cargo for transport, using ropes, blocks, chain, binders, or covers.
92	Supplemental	+ Follow appropriate safety procedures for transporting dangerous goods.
82	Supplemental	+ Inventory and inspect goods to be moved to determine quantities and conditions.
78	Supplemental	+ Follow special cargo-related procedures, such as checking refrigeration systems for frozen foods or providing food or water for livestock.
78	Supplemental	+ Install or remove special equipment, such as tire chains, grader blades, plow blades, or sanders.
74	Supplemental	+ Wrap and secure goods using pads, packing paper, containers, or straps.
71	Supplemental	+ Operate idle reduction systems or auxiliary power systems to generate power from alternative sources, such as fuel cells, to reduce idling time, to heat or cool truck cabins, or to provide power for other equipment.
66	Supplemental	+ Give directions to laborers who are packing goods and moving them onto trailers.

Find occupations related to multiple tasks

Occupational Requirements

Work Activities

Save Table: [XLSX](#) [CSV](#)

^ All 41 displayed

Importance	Work Activity
91	Operating Vehicles, Mechanized Devices, or Equipment — Running, maneuvering, navigating, or driving vehicles or mechanized equipment, such as forklifts, passenger vehicles, aircraft, or watercraft.
86	Inspecting Equipment, Structures, or Materials — Inspecting equipment, structures, or materials to identify the cause of errors or other problems or defects.
82	Getting Information — Observing, receiving, and otherwise obtaining information from all relevant sources.
72	Identifying Objects, Actions, and Events — Identifying information by categorizing, estimating, recognizing differences or similarities, and detecting changes in circumstances or events.
72	Monitoring Processes, Materials, or Surroundings — Monitoring and reviewing information from materials, events, or the environment, to detect or assess problems.
68	Communicating with Supervisors, Peers, or Subordinates — Providing information to supervisors, co-workers, and subordinates by telephone, in written form, e-mail, or in person.
67	Evaluating Information to Determine Compliance with Standards — Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.
62	Performing General Physical Activities — Performing general physical activities includes doing activities that require considerable use of your arms and legs and moving your whole body, such as climbing, lifting, balancing, walking, stooping, and handling materials.
58	Repairing and Maintaining Mechanical Equipment — Servicing, repairing, adjusting, and testing machines, devices, moving parts, and equipment that operate primarily on the basis of mechanical (not electronic) principles.
57	Communicating with People Outside the Organization — Communicating with people outside the organization, representing the organization to

Importance	Work Activity
	customers, the public, government, and other external sources. This information can be exchanged in person, in writing, or by telephone or e-mail.
57	➤ Documenting/Recording Information — Entering, transcribing, recording, storing, or maintaining information in written or electronic/magnetic form.
54	➤ Handling and Moving Objects — Using hands and arms in handling, installing, positioning, and moving materials, and manipulating things.
53	➤ Estimating the Quantifiable Characteristics of Products, Events, or Information — Estimating sizes, distances, and quantities; or determining time, costs, resources, or materials needed to perform a work activity.
52	➤ Making Decisions and Solving Problems — Analyzing information and evaluating results to choose the best solution and solve problems.
51	➤ Processing Information — Compiling, coding, categorizing, calculating, tabulating, auditing, or verifying information or data.
50	➤ Updating and Using Relevant Knowledge — Keeping up-to-date technically and applying new knowledge to your job.
49	➤ Controlling Machines and Processes — Using either control mechanisms or direct physical activity to operate machines or processes (not including computers or vehicles).
49	➤ Judging the Qualities of Objects, Services, or People — Assessing the value, importance, or quality of things or people.
49	➤ Organizing, Planning, and Prioritizing Work — Developing specific goals and plans to prioritize, organize, and accomplish your work.
46	➤ Performing for or Working Directly with the Public — Performing for people or dealing directly with the public. This includes serving customers in restaurants and stores, and receiving clients or guests.
46	➤ Working with Computers — Using computers and computer systems (including hardware and software) to program, write software, set up functions, enter data, or process information.
44	➤ Establishing and Maintaining Interpersonal Relationships — Developing constructive and cooperative working relationships with others, and maintaining them over time.

Importance	Work Activity
40	➤ Scheduling Work and Activities — Scheduling events, programs, and activities, as well as the work of others.
39	➤ Resolving Conflicts and Negotiating with Others — Handling complaints, settling disputes, and resolving grievances and conflicts, or otherwise negotiating with others.
37	➤ Analyzing Data or Information — Identifying the underlying principles, reasons, or facts of information by breaking down information or data into separate parts.
37	➤ Thinking Creatively — Developing, designing, or creating new applications, ideas, relationships, systems, or products, including artistic contributions.
34	➤ Training and Teaching Others — Identifying the educational needs of others, developing formal educational or training programs or classes, and teaching or instructing others.
31	➤ Assisting and Caring for Others — Providing personal assistance, medical attention, emotional support, or other personal care to others such as coworkers, customers, or patients.
31	➤ Coaching and Developing Others — Identifying the developmental needs of others and coaching, mentoring, or otherwise helping others to improve their knowledge or skills.
30	➤ Coordinating the Work and Activities of Others — Getting members of a group to work together to accomplish tasks.
28	➤ Developing Objectives and Strategies — Establishing long-range objectives and specifying the strategies and actions to achieve them.
27	➤ Developing and Building Teams — Encouraging and building mutual trust, respect, and cooperation among team members.
27	➤ Monitoring and Controlling Resources — Monitoring and controlling resources and overseeing the spending of money.
26	➤ Interpreting the Meaning of Information for Others — Translating or explaining what information means and how it can be used.
25	➤ Guiding, Directing, and Motivating Subordinates — Providing guidance and direction to subordinates, including setting performance standards and monitoring performance.

Importance	Work Activity
24	➤ Repairing and Maintaining Electronic Equipment — Servicing, repairing, calibrating, regulating, fine-tuning, or testing machines, devices, and equipment that operate primarily on the basis of electrical or electronic (not mechanical) principles.
23	➤ Providing Consultation and Advice to Others — Providing guidance and expert advice to management or other groups on technical, systems-, or process-related topics.
22	➤ Performing Administrative Activities — Performing day-to-day administrative tasks such as maintaining information files and processing paperwork.
18	➤ Selling or Influencing Others — Convincing others to buy merchandise/ goods or to otherwise change their minds or actions.
16	➤ Drafting, Laying Out, and Specifying Technical Devices, Parts, and Equipment — Providing documentation, detailed instructions, drawings, or specifications to tell others about how devices, parts, equipment, or structures are to be fabricated, constructed, assembled, modified, maintained, or used.
16	➤ Staffing Organizational Units — Recruiting, interviewing, selecting, hiring, and promoting employees in an organization.

Experience Requirements

Job Zone

Save Table:  [XLSX](#)  [CSV](#)

Title	Job Zone 1-2: Very Little to Some Preparation Needed
Education	Usually requires a high school diploma or GED, though some occupations may not.
Related Experience	Some occupations may need little or no previous experience; others require several months to a year of experience. For example, landscaping and groundskeeping workers might require very little training or previous experience, while agricultural equipment operators can benefit from on-the-job training.
Job Training	Ranges from a few days to one year of on-the-job training.
Job Zone Examples	These occupations involve following instructions and often involve using your knowledge and skills to help others. Examples include dishwashers, landscaping and groundskeeping workers, counter and rental clerks, dental

laboratory technicians, and security guards.

SVP Range (Below 6.0)

904.383-010 TRACTOR-TRAILER-TRUCK DRIVER

SPECIFIC VOCATIONAL PREPARATION: SVP = 4
(Education, Training, and/or Experience)
Semi-Skilled - Three to six months

STRENGTH: Medium

Exert force of 20-50 lbs. occasionally, 10-25 lbs. frequently, or up to 10 lbs. constantly.

OTHER PHYSICAL DEMANDS:

CL - Climbing - Occasional
BA - Balancing - Occasional
ST - Stooping - Occasional
KN - Kneeling - Not Present
CR - Crouching - Occasional
CW - Crawling - Not Present
RE - Reaching - Frequent
HA - Handling - Frequent
FI - Fingering - Frequent
FE - Feeling - Not Present
TA - Talking - Not Present
HE - Hearing - Occasional
TS - Tasting/Smelling - Not Present

FV - Field of Vision - Frequent

COMMON ENVIRONMENTAL WORKING
CONDITIONS (to which the worker is exposed):

WE - Exposure to weather - Occasional
CO - Extreme cold - Not Present
HO - Extreme heat - Not Present
WT - Wet and/or Humid - Not Present
NO - Noise Intensity Level - Loud
VI - Vibration - Not Present
AT - Atmospheric Conditions - Not Present
MV - Moving Mechanical Parts Hazard - Not
Present

VISION:

NE - Near Acuity - Frequent
FA - Far Acuity - Frequent
DE - Depth Perception - Frequent
AC - Accommodation - Not Present
CV - Color Vision - Frequent

EL - Electrical Shock Hazard - Not Present
HI - High, Exposed Place Hazard - Not Present
RA - Exposure to Radiation - Not Present
EX - Explosion Hazard - Not Present
TX - Toxic/Caustic Chemical Hazard - Not
Present
OT - Other Environmental Conditions -
Occasional

DATA SOURCES: U.S. Dept. of Labor, Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (1993). (electronic files contain all, not just selected characteristics.) U.S. Dept. of Labor, *The Revised Handbook for Analyzing Jobs*, (1991).

Worker:
AWCB#:

Vocational Firm: Birch View Vocational Services	Worker Name:
Address: 189 E. Nelson Ave. #238 Wasilla, AK 99654 Email: birchviewvoc@gmail.com Fax: 1.833.625.1141	Claim Number:
Phone Number: 907.232.7295	Involved Body Part(s):

Job Title: Truck Driver	SCODRDOT Title: Tractor-Trailer-Truck Driver
SVP: 4 (3 to 6 months)	SCODRDOT Number: 904.383-010
O*Net Title/Code: Heavy and Tractor-Trailer Truck Drivers / 53.3032.00	Type of Industry: Any

Analyst / Rehabilitation Specialist: Jackie Doerner, M.Ed., CRC	Source: SCODRDOT, O*Net, Labor Market Research
Date: 07/01/2025 Updated 02/04/2026	

Note: The information for this job analysis was obtained from standardized industry resources such as the DOT, GOE, COJ, OOH, and O*NET. On occasion, practicality and feasibility prevent direct observation and/or gathering of objective, quantifiable data. For this reason, a "best estimate" may have been used.

Type of Analysis: ☐ On-Site ☐ Interview ☒ Representative
Essential Functions: Drives gasoline or diesel-powered tractor-trailer combination, usually long distances, to transport and deliver products, livestock, or materials in liquid, loose, or packaged form: Drives truck to destination, applying knowledge of commercial driving regulations and skill in maneuvering vehicle in difficult situations, such as narrow passageways. Inspects truck for defects before and after trips and submits report indicating truck condition. Maintains driver log according to I.C.C. regulations. May assist workers in loading and unloading truck.

Job Qualifications and Skills: Must possess a valid Commercial Driver's License – Class A.
Machines, Tools, Special Equipment, Personal Protective Equipment Used: Tractor-trailer combination, CB-Radio, cell phone and driver's log book.

1
Worker:
Claim #:

Physical Requirements		
Frequency Scale	Strength	Work Pattern
N = Never	☐ Sedentary	☒ Full-Time
S = Seldom (1% — 10%; up to 1 hour)	☐ Light	☐ Part-Time
O = Occasional (11% — 33%; 1 — 3 hours)	☒ Medium	☐ Seasonal
F = Frequent (34% — 66%; 3 — 6 hours)	☐ Heavy	8 Hours Per Day
C = Constant (67% — 100%; Not Restricted)	☐ Very Heavy	5 Days Per Week

Frequency			Activity Description			
	N	S	O	F	C	
Sitting	☐	☐	☐	☐	☒	Must sit for long periods of time. May stand/walk for brief periods of time throughout the day.
Standing	☐	☒	☐	☐	☐	Intermittent with sitting and walking at employee discretion.
Walking	☐	☒	☒	☐	☐	Intermittent throughout the day.

Job Demand	Frequency & Weight					Activity Description
	N	S	O	F	C	
Lift	☐		*Up to 50 lbs.	lbs.	lbs.	Lifting/carrying of up to 50 lbs. generally only occurs if the employee works in a delivery driver capacity. *If driving long-haul, lifting/carrying is generally not required as trailers are loaded/unloaded by other workers.
Carry Distance/Surface	☐	Up to 50 lbs.		lbs.	lbs.	See above. Forklift, dollies and/or pallet jacks are generally used to move items into/out of the trailer.
Pushing/Pulling	☐	X	lbs.	lbs.	lbs.	Negligible force to open/close doors, shift and/or if moving product in/out of trailer.

Job Demand	Frequency					Activity Description
	N	S	O	F	C	
Climb Stairs/Steps	☐	☒	☐	☐	☐	Will climb steps into/out of tractor.
Twisting at Neck/Waist	☐	☐	☒	☐	☐	As needed when driving and performing inspections.
Stooping/Bending	☐	☐	☒	☐	☐	When performing tractor-trailer inspections.
Squatting/Kneeling	☒	☐	☐	☐	☐	May choose to squat/kneel in lieu of stoop/bend.
Crawling	☒	☐	☐	☐	☐	Not an essential requirement of this position

Job Demand	Frequency					Activity Description
	N	S	O	F	C	
Reach	☐			X		At chest level when driving. Will also reach with right arm to shift (if applicable to the vehicle driving as some tractors are equipped with an automatic shift)
Handle/Grasp	☐			X		Steering wheel, radio, etc.
Fine Finger Manipulation	☐			X		When operating CB radio, completing paperwork, etc.
Foot Controls	☐				X	Using both feet when driving.
Vibratory Tasks — Low	☐			X		Steering wheel when driving.

2
Worker:
Claim #:

Job Demand	Frequency					Activity Description
	N	S	O	F	C	
Talking	☐	☒	☐	☐	☐	As needed throughout the day.
Hearing	☐	☐	☒	☐	☐	As needed throughout the day.
Visual — Near Acuity	☐	☐	☐	☒	☐	When driving.
Visual — Far Acuity	☐	☐	☐	☒	☐	When driving.
Visual — Depth Perception	☐	☐	☐	☒	☐	When driving.
Visual — Color Discrimination	☐	☐	☐	☒	☐	When driving.
Visual — Accommodation	☐	☐	☐	☒	☐	When driving.
Visual — Field of Vision	☐	☐	☐	☒	☐	When driving.

Environmental Conditions	Frequency					Activity Description
	N	S	O	F	C	
Exposure to Weather	☐	☐	☒	☐	☐	When entering/exiting the tractor
Extreme Cold	☒	☐	☐	☐	☐	Not an essential requirement of this position
Extreme Hot	☒	☐	☐	☐	☐	Not an essential requirement of this position
Wet and/or Humidity	☒	☐	☐	☐	☐	Not an essential requirement of this position
Proximity to Moving Mechanical Parts	☒	☐	☐	☐	☐	Not an essential requirement of this position
Exposure to Explosives	☒	☐	☐	☐	☐	Not an essential requirement of this position
Noise Intensity (see scale below)	4					
1 = Very Quiet 2 = Quiet 3 = Moderate 4 = Loud 5 = Very Loud						
Atmospheric Conditions	☒	☐	☐	☐	☐	Not an essential requirement of this position
Exposed Heights	☒	☐	☐	☐	☐	Not an essential requirement of this position
Exposure to Electricity	☒	☐	☐	☐	☐	Not an essential requirement of this position
Exposure to Toxic/Caustic Chemicals	☒	☐	☐	☐	☐	Not an essential requirement of this position
Exposure to Radiation	☒	☐	☐	☐	☐	Not an essential requirement of this position