ALASKA WORKERS' COMPENSATION BOARD MEETING

October 13-14, 2022

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TAB 1

ALASKA WORKERS' COMPENSATION BOARD MEETING AGENDA

OCT 13-14, 2022

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

DIVISION OF WORKERS' COMPENSATION

Zoom Video Conference: https://us02web.zoom.us/j/83453516981

To participate telephonically: 888-788-0099, Webinar ID: 834 5351 6981

Thursday, Oct 13, 2022

9:00am Call to order
Roll call establishment of quorum
Introduction of Senior Staff

9:10am Approval of Agenda

9:15am Reading and approval of minutes from May 13, 2021, Board meeting

9:30am Director's Report

- Division Update
- Legislative Update
- Approval of Board Designees

10:00am Break

10:15am Public Comment Period

- Public comments

11:15am Budget & Staffing Update – Alexis Hildebrand, Admin Officer

11:30am Old Business

- Adoption of Regulations
  - 8 AAC 45.083 Medical Treatment Fee Schedule for 2023

12:00pm Lunch Break

1:30pm 2021 Annual Report

- Workers' Compensation – Velma Thomas, Program Coordinator
- Special Programs - Velma Thomas, Program Coordinator
- Reemployment Benefits Overview – Stacy Niwa, Reemployment Benefits Administrator
- Workers' Compensation SIU Overview - Rhonda Gerharz, Chief Investigator of Special Investigations Unit
- Annual Report Workers' Compensation Case Review - William Soule, Acting Chief of Adjudications
- SIME Annual Report - Dani Byers, SIME Coordinator

3:00pm Break

3:15pm 2021 Annual Report Continued

5:00pm Adjournment

Friday, Oct 14, 2022

9:00am	Call to order
	Roll call establishment of quorum
9:10am	New Business
	• Proposed Regulation Updates
	• Report from RBA on Rehabilitation Specialists meetings
10:30am	Break
10:45am	New Business – Open
12:00pm	Lunch Break
1:30pm	New Business – Open
3:30pm	Break
3:45pm	New Business - Open
5:00pm	Adjournment

TAB 2

Workers' Compensation Board
Meeting Minutes
May 12, 2022

Thursday, May 12, 2022

I. Call to Order

Workers' Compensation Director Charles Collins called the Board to order at 9:09 am on Thursday, May 12, 2022. The meeting was held in Anchorage, Alaska, and by video conference.

II. Ethics Training

Assistant Attorney General Kevin Higgins provided ethics training to the board members.

Break 10:00am-10:16am

III. Roll call

Director Collins conducted a roll call. The following Board members were present:

Bradley Austin	Randy Beltz	Pamela Cline	Christopher Dean
Sara Faulkner	Bronson Frye	Christina Gilbert	Anthony Ladd
Sarah Lefebvre	Jason Motyka	Robert Weel	

Director Collins noted that member Matthew Barth was excused, and member Anthony Ladd arrived after the roll call. Members Micheal Dennis, Nancy Shaw, and Lake Williams were absent. A quorum was established. Director Collins introduced the senior staff present.

IV. Public Comment Period 10:15 am- 11:15 am

Janice Shipman –

- Oppose 8 AAC 45.500(D), which requires Reemployment Specialists to submit a copy of their billing to the Reemployment Benefits Administrator (RBA).
- This was proposed in 2009, and the board did not vote to approve it.
- Reemployment Specialists operate private practices, and this amendment would allow the RBA to dictate private practices. It would allow the administration to determine what is or is not considered fraudulent billing. There is currently no definition for fraudulent billing.
- Reemployment Specialists hold a Masters's level education and national certification.

Norman Silta – Representing Redoubt Vocational Services

- Agreed with comments made by Janice Shipman.
- Proposed changes are a bit too vague. Too subjective. More detail is needed.

- Requested a workgroup of rehabilitation specialists, RBA, and Division staff to review the regulations.
- Requested the RBA provide training.

Josetta Cranston – Representing
- Provided written public comment.
- Agreed with comments made by Janice Shipman.
- Opposed proposed regulations as written.

Dan LaBrosse – Representing DAL Enterprises
- Provided written public comment.
- Opposed proposed regulations as written.

Karen Davis – Representing Davis Vocational Services
- Provided written public comment.
- Agreed with comments made by Janice Shipman.
- Requested the RBA provide training.
- Requested that the Division establish an annual meeting of the rehabilitation specialists.

Jackie Doerner – Representing OSC Vocational Systems, Inc.
- Agreed with comments made by others.
- Requested that the Division establish a work group and annual meetings of the rehabilitation specialists.

V. Agenda Approval

A motion to approve the agenda was made by member Frye and seconded by member Lefebvre. The agenda was approved by a unanimous vote.

VI. Approval of Meeting Minutes

A motion to adopt the minutes from the January 13-14, 2022 regular Board Meeting was made by member Austin and seconded by member Weel. The minutes were adopted without objection.

VII. Director's Report

Director Collins discussed board member changes and active legislation.

Director Collins reviewed the list of Board Designees. A motion to accept the board designees was made by Member Frye seconded by member Lefebvre. The motion passed unanimously.

Administrative Officer Alexis Hildebrand provided an overview of Division staffing and the FY22 budget performance year-to-date.

A motion to accept the 2023 Hearing Calendar was made by member Frye and seconded by member Lefebvre. The motion passed unanimously.

VIII. Reemployment Benefits 2021 Annual Report

Reemployment Benefits Administrator Stacy Niwa presented the 2021 Reemployment Benefits Annual Report.

Lunch Break 11:46am-1:15pm

IX. Old Business

A vote to take up old business was made by member Frye and seconded by member Weel. The motion was rescinded by member Frye and member Weel seconded the recension.

X. New Business

Member Lefebvre motioned that the Division revisit the body of regulations in tandem with Dept of Law and rehab spec community, and member Frye seconded. The motion passed unanimously.

Motion to adjourn was made by member Frye and seconded by member Lefebvre. The motion passed unanimously.

Meeting Adjourned 5:00 pm

TAB 3

ALASKA WORKERS' COMPENSATION BOARD

Chair, Commissioner Dr. Tamika L. Ledbetter
Alaska Department of Labor and Workforce Development

Name	Seat	District	Affiliation
Charles Collins	Commissioner's Designee		
Brad Austin	Labor	1st Judicial District	Plumbers and Pipe Fitters Local 262
Vacant	Industry	1st Judicial District	
Randy Beltz	Industry	3rd Judicial District	
Pamela Cline	Labor	3rd Judicial District	Intl. Brotherhood of Electrical Workers LU 1547
Micheal Dennis	Industry	3rd Judicial District	
Sara Faulkner	Industry	3rd Judicial District	
Bronson Frye	Labor	3rd Judicial District	Painters and Allied Trades Local 1959
Anthony Ladd	Labor	3rd Judicial District	
Jason Motyka	Industry	3rd Judicial District	
Nancy Shaw	Labor	3rd Judicial District	
Vacant	Industry	3rd Judicial District	
Vacant	Industry	3rd Judicial District	
Sarah Lefebvre	Industry	4th Judicial District	Colaska dba Exclusive Paving / University Redi-Mix
Lake Williams	Labor	4th Judicial District	Operating Engineers Local 302
Vacant	Industry	4th Judicial District	
Vacant	Labor	4th Judicial District	
Mathew Barth	Labor	At Large	
Bob Weel	Industry	At Large	

TAB 4

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Labor and Workforce Development

DIVISION OF WORKERS' COMPENSATION

P.O. BOX 115512
Juneau, Alaska 99811-5512
Main: 907.465.2790
Fax: 907.465.2797

BOARD DESIGNEES – October 2022

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.)

NAME	LOCATION	POSITION TITLE
Charles Collins	Juneau	Director
William Soule	Anchorage	Acting Chief of Adjudications
William Soule	Anchorage	WC Hearing Officer II
Janel Wright	Anchorage	WC Hearing Officer II
Vacant	Anchorage	WC Hearing Officer II
Vacant	Anchorage	WC Hearing Officer II
Kathryn Setzer	Juneau	WC Hearing Officer II
Robert Vollmer	Fairbanks	WC Hearing Officer II
Vacant	Fairbanks	WC Hearing Officer II
Kyle Reding	Anchorage	WC Hearing Officer I
Grace Morfield	Anchorage	WC Officer II
Elizabeth Pleitez	Anchorage	WC Officer II
Harvey Pullen	Anchorage	WC Officer II
Shannon Sanderson	Anchorage	WC Officer II
Dani Byers	Juneau	WC Officer II
Melody Kokrine	Fairbanks	WC Officer II
Rosanna Mallari	Anchorage	WC Officer I
Vacant	Anchorage	WC Officer I

TAB 5

Workers Compensation Division

The Division of Workers' Compensation is the agency charged with the administration of the Alaska Workers' Compensation Act (Act).

Board News

AWCB has no new members since our last meeting, we lost Christopher Dean from Fairbanks due to relocating out of state. Vacancies are Industry in District 1, Juneau; in the 2nd and 4th District or Fairbanks we have two vacancies, one labor and one industry; finally in the 3rd District or Anchorage area, we have two vacancies one labor and one industry.

As information the Alaska Workers Compensation Appeals Commission has a vacancy as Stephan Hagedorn has resigned.

Legislative News

Senate Bill 131, "An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters."

This bill was signed into law on July 30 and goes into effect on January 1 of 2023. The bill was expanded at the end of the legislative session to include changes to death and permanent partial impairment benefits. This will increase the amount of compensation injured workers receive upon PPI rating. NCCI has forecast a 3% rise in costs due the imposed changes.

House Bill 265, "An Act relating to telehealth; relating to the practice of medicine and the practice of nursing; relating to medical assistance coverage for services provided by telehealth; and providing for an effective date."

This bill also was signed and becomes effective upon various dates as directed by section. The effects on workers' compensation are included in the newest Fee Schedule to become effective in 2023 as telehealth will continue to be allowed without a special order from the Commissioner of Health. The MSRC applauded this continuation of the practice of telehealth as routine follow ups are included in this law which enhances the process of providing service to injured employees.

Division News

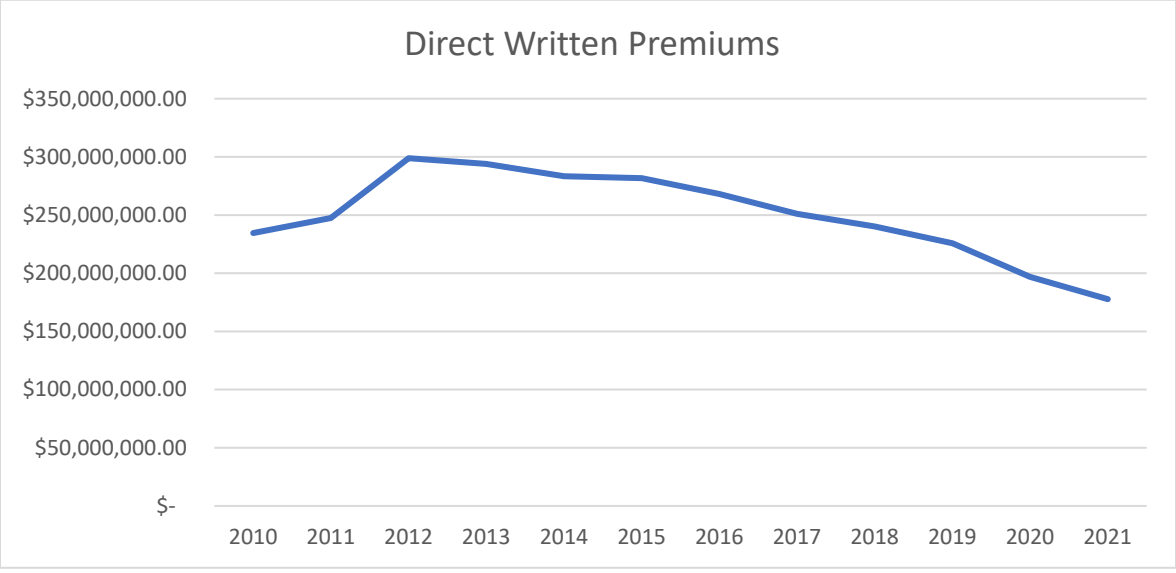
Currently the Division is searching for a permanent Chief of Adjudications and the position is being actively advertised. As a specialized position with minimum qualifications requiring several years of experience, the candidate list is very limited.

The Division is also concurrently advertising for Hearing Officer positions to fill the openings in Anchorage and Fairbanks. Currently we are three positions down.

Upgrades to the Anchorage hearing room are **still** ongoing. As the hearing room is used for multiple hearings Department wide and doubles as a conference room, technological upgrades are being investigated.

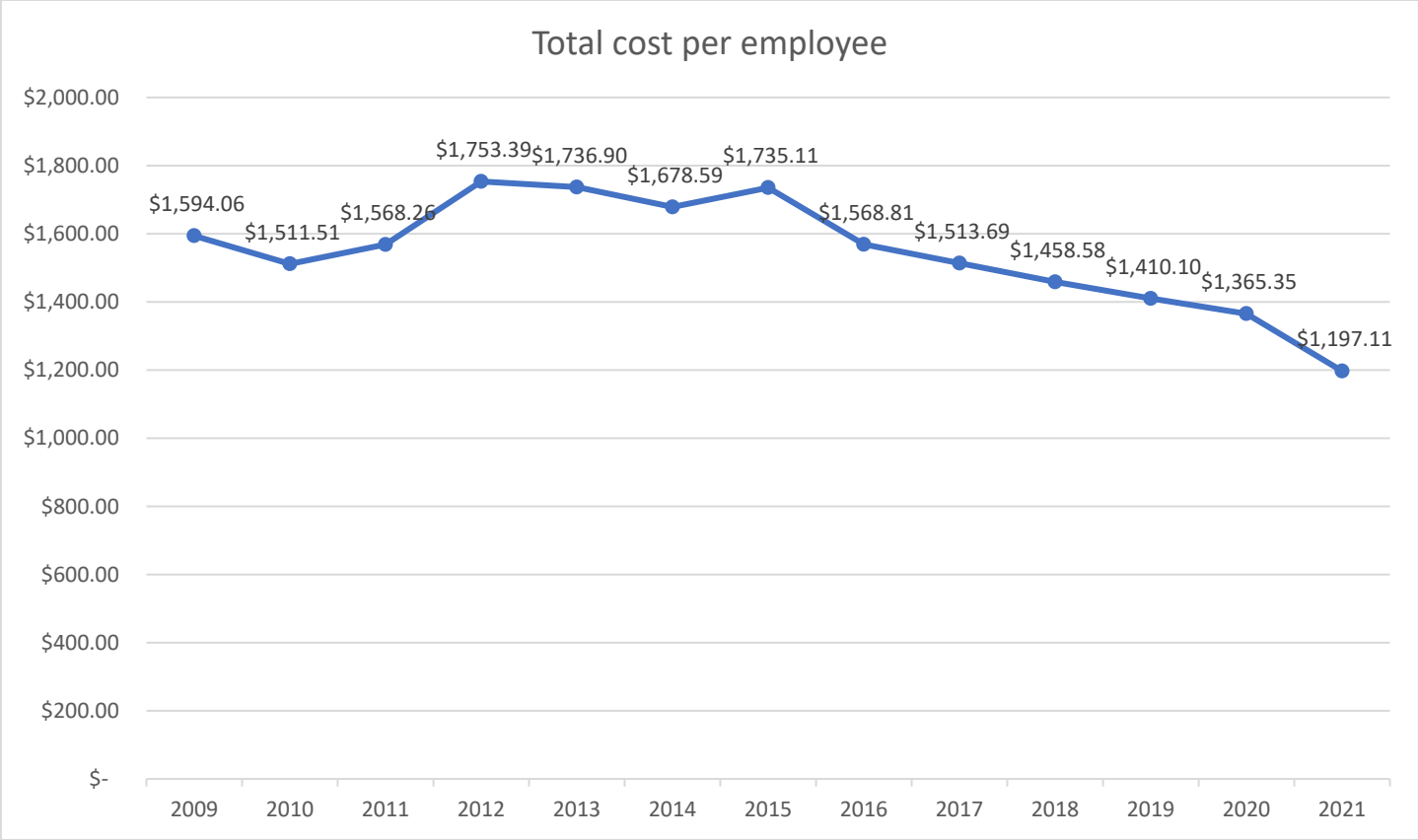
Continued monitoring and researching budget ideas to enhance the longevity of the WSCAA fund. WCD has an established history of budget frugality and rarely if ever has overspent the amount authorized during a fiscal year.

Carefully monitoring the decision by Division of Insurance regarding workers' compensation premiums. The National Council on Compensation Insurance, (NCCI), has recommended a -6.5% reduction in the voluntary market and a -4.1% reduction in the assigned risk market for 2023. This will make the fourteenth year of consecutive rate reductions for the voluntary market. This does not mean that a certain business will pay less than the preceding year in premiums as this is only one part of the components that make up the cost of insurance. Classification rates, experience modules, payroll amount, and even payment plans all impact the premium and influence the actual amount a business may pay annually. However, the big picture shows an improvement in costs to employers.



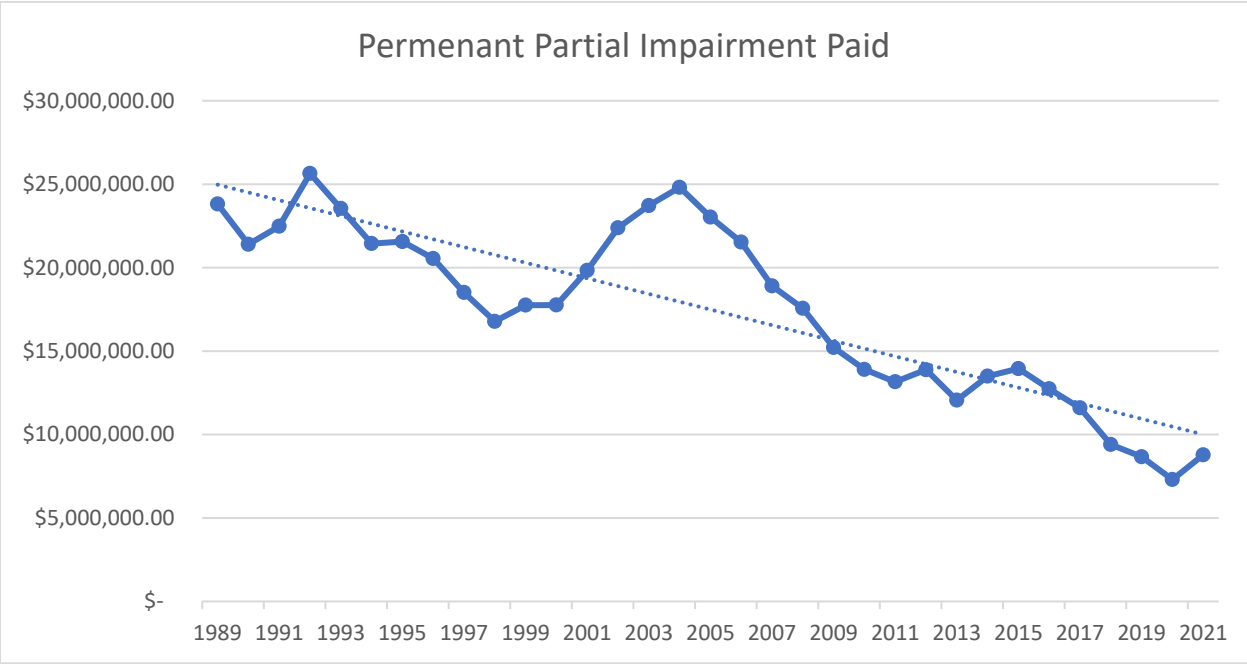
How does affect the division and of course the Workers, Safety and Compensation Administrative Account, (WSCAA)? AS 23.05.067(a)(2) sets a 2.5% service fee on all premiums annually, as premiums decrease the divisional revenue also decreases. WCD is a victim of our success, by saving the system money we also hinder our revenue stream and must continue to budget prudently.

A business might ask if it truly is less expensive to provide benefits and insurance in the workers' compensation system then years back. If we add all the insurance premiums recorded to the total amount of self-insured payments, add in all litigation costs, medical costs and indemnity costs, all payments that impact employers. Then divide that by the **covered** employees, federal government and self-employed entities that opt out are not covered, we come up with a cost per employee.



This cost per employee might not reflect all costs, as some employers elect to direct pay injured employees with normal payroll which is not reported. However, the facts show that the cost of providing benefits and coverage for Alaskan employees has declined considerable these last six years.

The forecast for recent changes in benefit amounts for permanent partial impairment, (ppi), and death benefits may impact the decline in costs to the system. NCCI has forecasted that for 2023, the impact on the system wide costs due to SB 131 becoming law will be 3%. The biggest impact is the base rate for ppi rises from $177,000 currently to $273,000 on January 1, 2023. The following chart demonstrates the history of the costs of ppi which have trended downward for many years.



Further cost impacts may manifest with the large infrastructure plans being implemented in the state. With a forecast of more projects requiring heavy labor and trade positions, a workforce that is aging and a possibility of more workers engaging in new careers, the costs to the system and the premiums purchased to cover workers are forecasted to rise. Alaska is not alone in this as many of our sister states are carefully considering how to best meet the opportunities that are before us.

Changes that may appear before the legislature next session currently consist of a variety of issues that have been considered before. The division has been successful in sharing the concerns we have with AS 23.30.041 with both the Governor and a few Legislators. As this is an election year, I am watching the races closely. It is my hope that each of you will exercise your right to vote in November.

WCD Goals

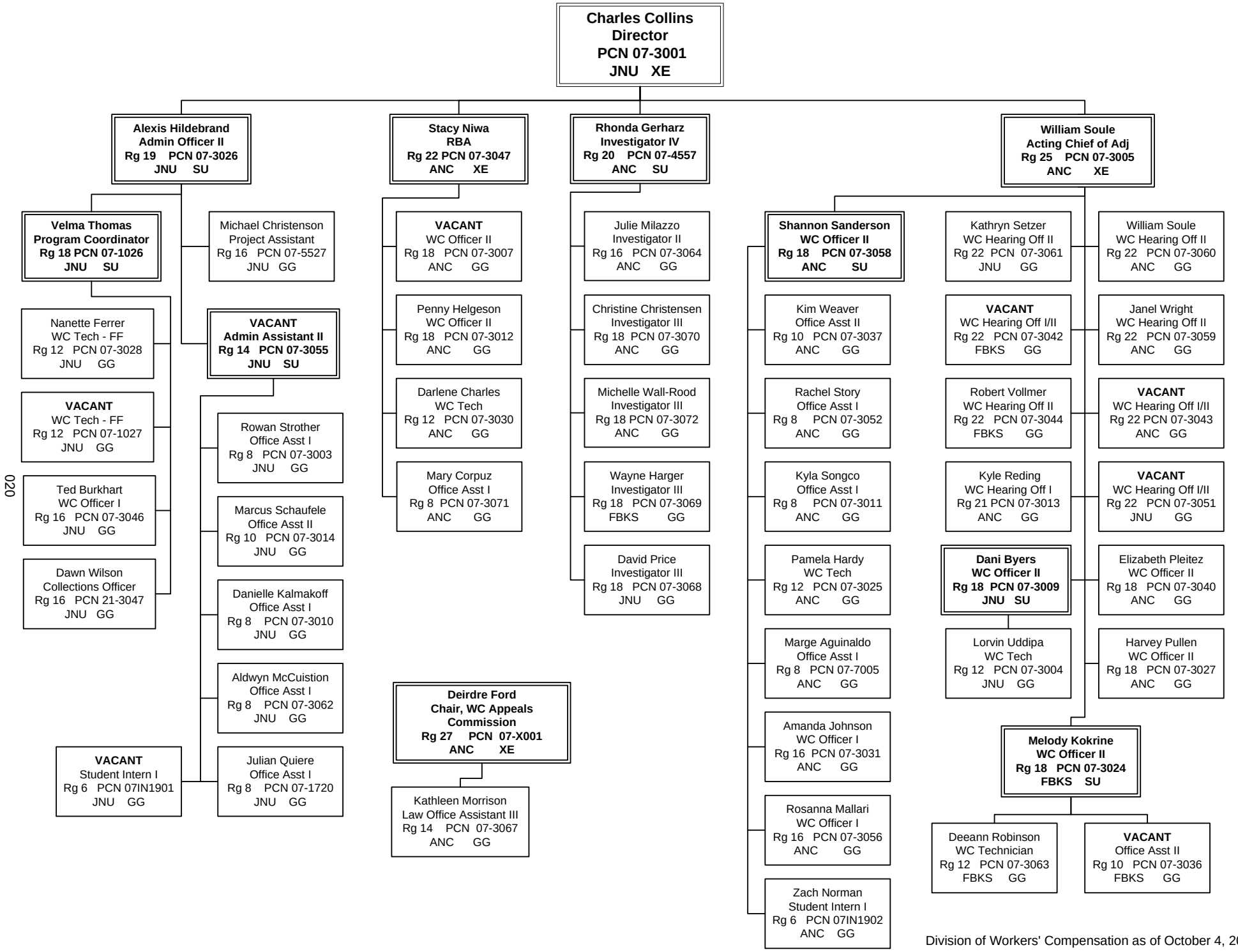
Improvement of Rehabilitation and Reemployment of injured workers is my foremost focus. A change in the process to a return to work/stay at work program that holistically assists injured workers in retention and return to the workforce. At the same time shortening the turnaround in claims and reducing the financial burden on employers.

Upgrades to the database to enhance data availability. This includes a new “Proof of Coverage” module for use by the division to insure all employees are covered by an active workers’ compensation policy

Enhance the reporting that the WCD produces from claims to better analyze trends in the system. Annual reports are very complex, and the database is built to follow claims but does a poor job of producing reports.

Continue the scanning of historical files that are stored in physical format. A concerted effort to scan and catalog files for safe keeping and ease of search by digital means.

Internally to the Department I am researching the process to enhance the ability to work with our sister Divisions to offer injured workers the resources that the entire Department offers.



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Division of Workers' Compensation as of October 4, 2022

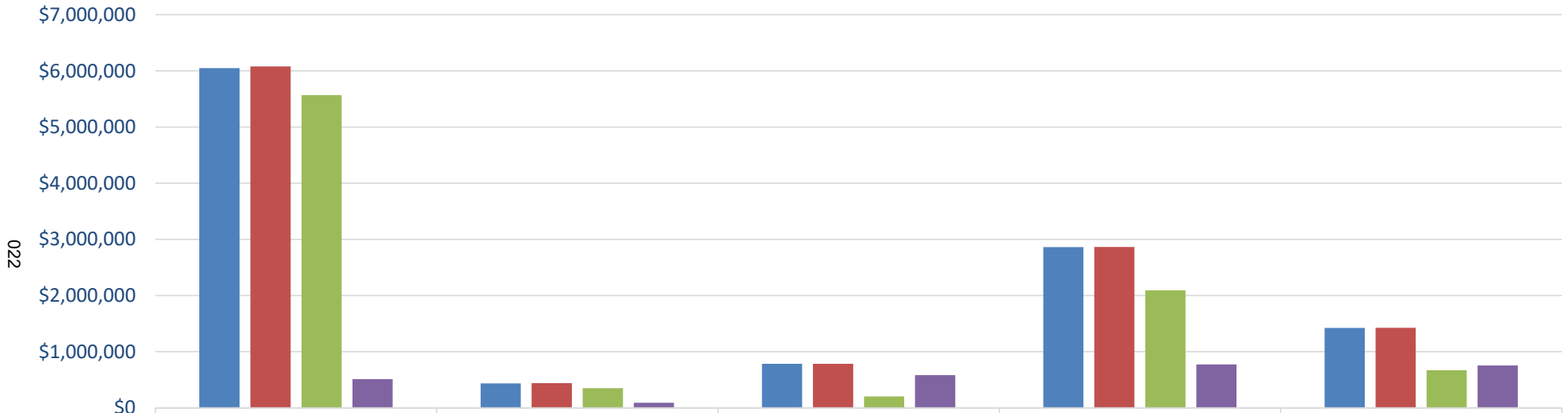
BUDGET
ANNUAL REPORT

021

Alexis Hildebrand
Administrative Officer II

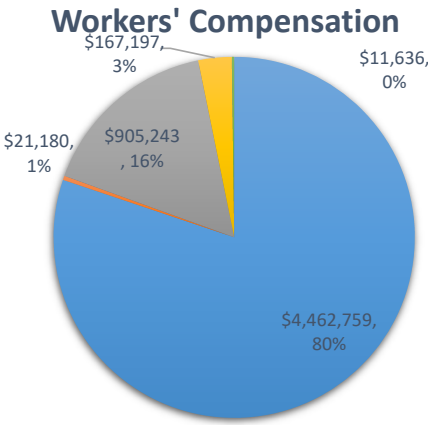
Workers' Compensation Division

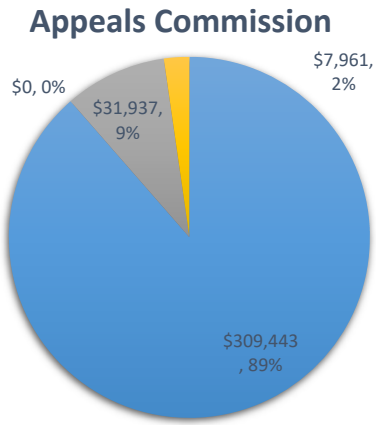
FY2022 Budget
Authority vs Actual Expenditures

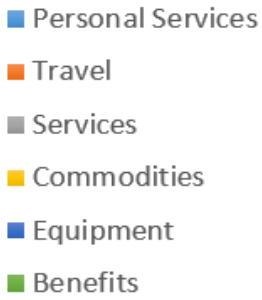


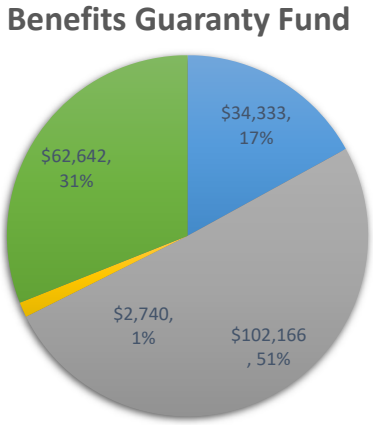
	Workers' Compensation	WC Appeals Commission	Benefits Guaranty Fund	Second Injury Fund	Fishermen's Fund
FY23 Budget	$6,048,600	$435,500	$784,700	$2,862,600	$1,423,100
FY22 Budget	$6,078,900	$440,500	$785,100	$2,864,900	$1,425,200
FY22 Actuals	$5,568,015	$349,341	$201,881	$2,091,991	$670,249
FY22 Balance	$510,885	$91,159	$583,219	$772,909	$754,951

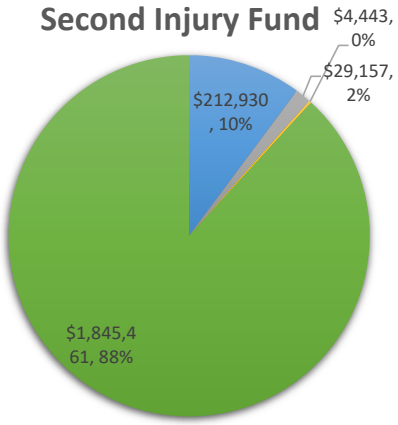
Workers' Compensation Division

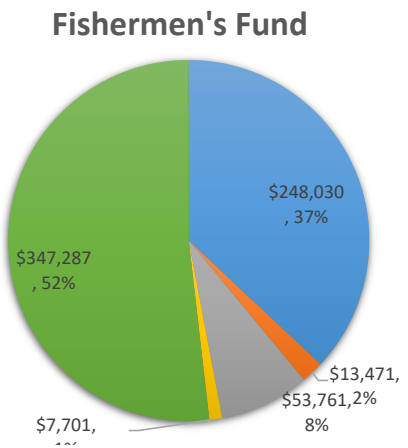












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FY2022 Division Summary Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of: 10/4/2022 | Q4 | FY2022

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2022

Summary:

Program	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/4/2022 Expend	10/4/2022 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Workers' Compensation	6,078,900	0	0	0	6,078,900	5,493,003	75,012	510,885	0	0	5,568,015	510,885	91.6%
WC Appeals Commission	440,500	0	0	0	440,500	349,341	0	91,159	0	0	349,341	91,159	79.3%
WC Benefits Guaranty Fund	785,100	0	0	0	785,100	201,881	0	583,219	0	0	201,881	583,219	25.7%
Second Injury Fund	2,864,900	0	0	0	2,864,900	2,091,991	0	772,909	0	0	2,091,991	772,909	73.0%
Fishermen's Fund	1,425,200	0	0	0	1,425,200	670,249	0	754,951	0	0	670,249	754,951	47.0%
Division Total	11,594,600	0	0	0	11,594,600	8,806,465	75,012	2,713,123	0	0	8,881,477	2,713,123	76.6%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
Revenue Type Workers' Safety	6,519,400	0	0	0	6,519,400
Revenue Type Benefits Guaranty Fund	785,100	0	0	0	785,100
Revenue Type Second Injury Fund	2,864,900	0	0	0	2,864,900
Revenue Type Fishermen's Fund	1,425,200	0	0	0	1,425,200
General Funds					
Total Program Funding	11,594,600	0	0	0	11,594,600

FY2022 Workers' Compensation Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of:

10/4/2022	Q4	FY2022

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2022

Workers' Compensation **AR Unit:073100060**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/4/2022 Expend	10/4/2022 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To Date
Personal Services	4,770,200.00	-96,401.86	0.00	0.00	4,673,798.14	4,462,758.64	0.00	211,039.50	0.00	0.00	4,462,758.64	211,039.50	95.5%
Travel	63,100.00	0.00	0.00	0.00	63,100.00	21,180.23	0.00	41,919.77	0.00	0.00	21,180.23	41,919.77	33.6%
Services	1,146,700.00	0.00	0.00	0.00	1,146,700.00	848,531.36	56,711.63	241,457.01	0.00	0.00	905,242.99	241,457.01	78.9%
Commodities	80,900.00	96,401.86	0.00	0.00	177,301.86	148,896.92	18,300.00	10,104.94	0.00	0.00	167,196.92	10,104.94	94.3%
Equipment	6,000.00	0.00	0.00	0.00	6,000.00	0.00	0.00	6,000.00	0.00	0.00	0.00	6,000.00	0.0%
NPS Subtotal	1,296,700.00	96,401.86	0.00	0.00	1,393,101.86	1,018,608.51	75,011.63	299,481.72	0.00	0.00	1,093,620.14	299,481.72	78.5%
Grants	12,000.00	0.00	0.00	0.00	12,000.00	11,635.73	0.00	364.27	0.00	0.00	11,635.73	364.27	97.0%
Total Program Expenditures	6,078,900.00	0.00	0.00	0.00	6,078,900.00	5,493,002.88	75,011.63	510,885.49	0.00	0.00	5,568,014.51	510,885.49	91.6%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
GF Program Receipts					
Revenue Type Workers' Safety	6,078,900.00				6,078,900.00
Interagency Receipts					
General Funds					0.00
Total Program Funding	6,078,900.00	0.00	0.00	0.00	6,078,900.00

FY2022 Appeals Commission Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of:

10/4/2022	Q4	FY2022

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2022

WC Appeals Commission **AR Unit:073200060**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/4/2022 Expend	10/4/2022 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	302,500.00	0.00	0.00	6,943.43	309,443.43	309,443.43	0.00	0.00	0.00	0.00	309,443.43	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	133,000.00	0.00	0.00	-9,904.02	123,095.98	31,936.74	0.00	91,159.24	0.00	0.00	31,936.74	91,159.24	25.9%
Commodities	5,000.00	0.00	0.00	2,960.59	7,960.59	7,960.59	0.00	0.00	0.00	0.00	7,960.59	0.00	100.0%
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%
026 NPS Subtotal	138,000.00	0.00	0.00	-6,943.43	131,056.57	39,897.33	0.00	91,159.24	0.00	0.00	39,897.33	91,159.24	30.4%
Grants	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00			0.0%
Total Program Expenditures	440,500.00	0.00	0.00	0.00	440,500.00	349,340.76	0.00	91,159.24	0.00	0.00	349,340.76	91,159.24	79.3%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
GF Program Receipts					
Revenue Type: Workers' Safety	440,500.00				440,500.00
Interagency Receipts					
General Funds					
Total Program Funding	440,500.00	0.00	0.00	0.00	440,500.00

FY2022 Benefits Guaranty Fund Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of: | **6/17/2021** | **Q4** | **FY2022** |

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2022

Benefits Guaranty Fund **AR Unit:073300061**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/4/2022 Expend	10/4/2022 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	95,100.00	0.00	0.00	0.00	95,100.00	34,333.36	0.00	60,766.64	0.00	0.00	34,333.36	60,766.64	36.1%
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	255,300.00	0.00	0.00	-740.16	254,559.84	102,165.72	0.00	152,394.12	0.00	0.00	102,165.72	152,394.12	40.1%
Commodities	2,000.00	0.00	0.00	740.16	2,740.16	2,740.16	0.00	0.00	0.00	0.00	2,740.16	0.00	100.0%
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	257,300.00	0.00	0.00	0.00	257,300.00	104,905.88	0.00	152,394.12	0.00	0.00	104,905.88	152,394.12	40.8%
Grants	432,700.00	0.00	0.00	0.00	432,700.00	62,641.65	0.00	370,058.35	0.00	0.00	62,641.65	370,058.35	14.5%
Total Program Expenditures	785,100.00	0.00	0.00	0.00	785,100.00	201,880.89	0.00	583,219.11	0.00	0.00	201,880.89	583,219.11	25.7%

027

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
GF Program Receipts					
Revenue Type: Benefits Guaranty Fund	785,100.00	0.00			785,100.00
Interagency Receipts					
General Funds					
Total Program Funding	785,100.00	0.00	0.00	0.00	785,100.00

FY2022 Second Injury Fund Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of:

6/17/2021	Q4	FY2022

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2022

Second Injury Fund **AR Unit:073400062**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/4/2022 Expend	10/4/2022 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	209,200.00	0.00	0.00	3,730.44	212,930.44	212,930.44	0.00	0.00	0.00	0.00	212,930.44	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	83,100.00	0.00	0.00	-3,873.50	79,226.50	29,157.01	0.00	50,069.49	0.00	0.00	29,157.01	50,069.49	36.8%
Commodities	4,300.00	0.00	0.00	143.06	4,443.06	4,443.06	0.00	0.00	0.00	0.00	4,443.06	0.00	100.0%
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	87,400.00	0.00	0.00	-3,730.44	83,669.56	33,600.07	0.00	50,069.49	0.00	0.00	33,600.07	50,069.49	40.2%
Grants	2,568,300.00	0.00	0.00	0.00	2,568,300.00	1,845,460.50	0.00	722,839.50	0.00	0.00	1,845,460.50	722,839.50	71.9%
Total Program Expenditures	2,864,900.00	0.00	0.00	0.00	2,864,900.00	2,091,991.01	0.00	772,908.99	0.00	0.00	2,091,991.01	772,908.99	73.0%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
GF Program Receipts					
Revenue Type Second Injury Fund	2,864,900.00				2,864,900.00
Interagency Receipts					
General Funds					
Total Program Funding	2,864,900.00	0.00	0.00	0.00	2,864,900.00

FY2022 Fishermen's Fund Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of: **6/17/2021** | **Q4** | **FY2022**

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2022

Fishermen's Fund **AR Unit:073500063**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/4/2022 Expend	10/4/2022 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	271,200.00	0.00	0.00	0.00	271,200.00	248,030.01	0.00	23,169.99	0.00	0.00	248,030.01	23,169.99	91.5%
Travel	46,000.00	0.00	0.00	0.00	46,000.00	13,470.81	0.00	32,529.19	0.00	0.00	13,470.81	32,529.19	29.3%
Services	182,200.00	0.00	0.00	0.00	182,200.00	53,761.14	0.00	128,438.86	0.00	0.00	53,761.14	128,438.86	29.5%
Commodities	9,700.00	0.00	0.00	0.00	9,700.00	7,700.74	0.00	1,999.26	0.00	0.00	7,700.74	1,999.26	79.4%
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	237,900.00	0.00	0.00	0.00	237,900.00	74,932.69	0.00	162,967.31	0.00	0.00	74,932.69	162,967.31	31.5%
Grants	916,100.00	0.00	0.00	0.00	916,100.00	347,286.78	0.00	568,813.22	0.00	0.00	347,286.78	568,813.22	37.9%
Total Program Expenditures	1,425,200.00	0.00	0.00	0.00	1,425,200.00	670,249.48	0.00	754,950.52	0.00	0.00	670,249.48	754,950.52	47.0%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
GF Program Receipts					
Revenue Type Fishermen's Fund	1,425,200.00				1,425,200.00
Interagency Receipts					
General Funds					
Total Program Funding	1,425,200.00	0.00	0.00	0.00	1,425,200.00

QUESTIONS?

030

TAB 6

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

DIVISION OF WORKERS' COMPENSATION

2021 ANNUAL REPORT

October 2022

Annual Reporting of Total Paid Compensation

In 2021, there were 16,470 reports of injury and occupational illness filed with the Workers' Compensation Division, a 9.9 % increase from 14,985 reports filed in 2020.

Of the case files established in 2021, claim type filings and distribution to total claims filed was:

- No-time-loss cases: 7,979 cases, 48%.
- Time-loss cases: 5,018 cases, 30%.
- Notification only cases: 3,436 cases, 21%.
- Fatalities: 37 cases, 0.22%.

The Alaska Workers' Compensation Board held 161 hearings in 2021, compared to 188 hearings in 2020, and 225, in 2019.

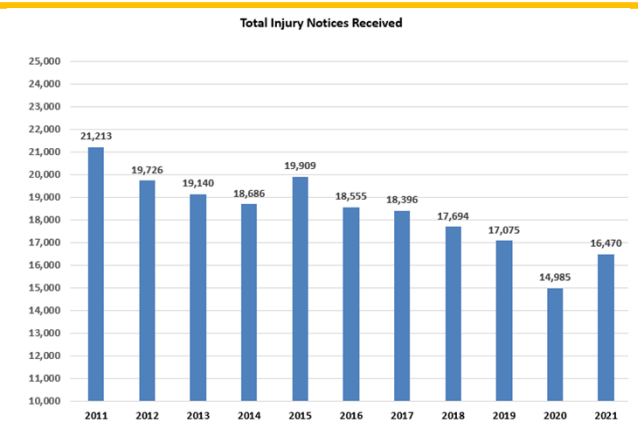
2021

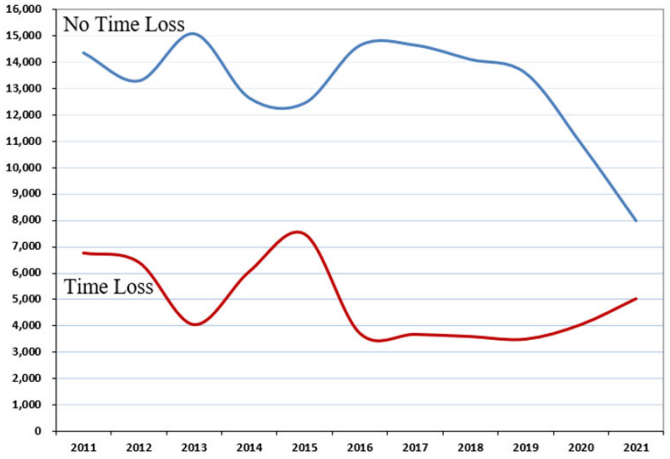
- 135 regular hearings
- 26 written record hearings

The Alaska Workers' Compensation Appeals Commission held 9 hearings and oral arguments in 2021, compared to 10 hearings in 2020 and 14 in 2019.

2021

- 7 merits of appeals
- 2 motions for stay





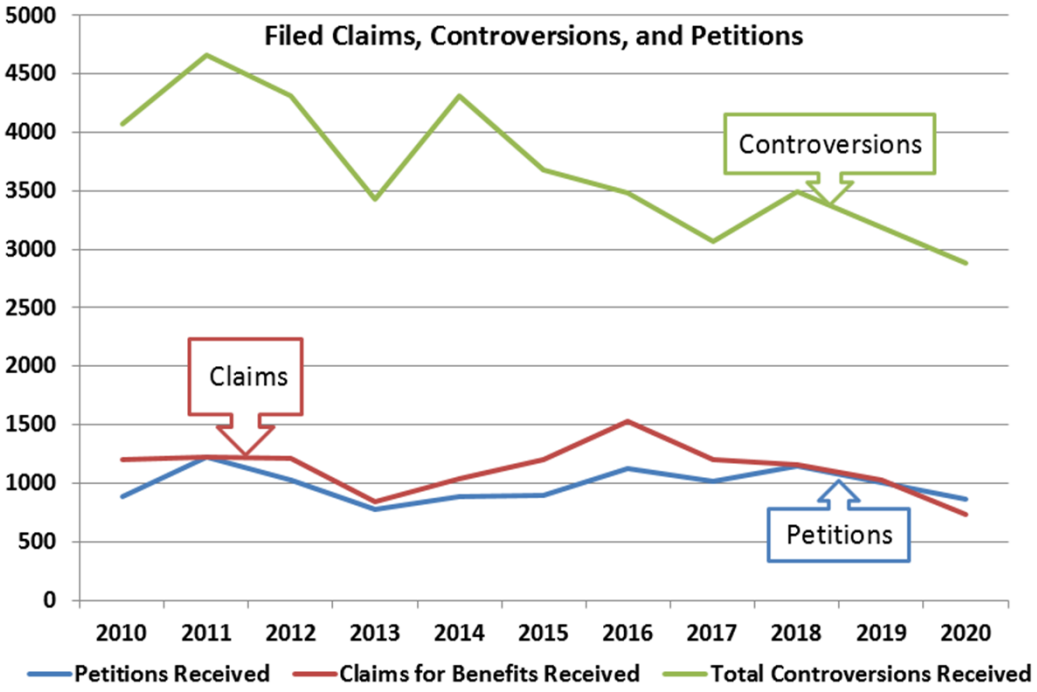
Analysis of Workers' Compensation Claims Data

In 2021, there were 678 claims for benefits filed for 551 cases, a 6.7% decrease from 727 claims filed in 2020.

There were 723 petitions filed for 461 cases in 2021, a 16.2% decrease from 863 petitions filed in 2020.

There were 3,605 total controversion received in 2021, a 24.9% increase from 2,886 in 2020.

The number of injury cases controverted in 2021 totaled 2,694, a 20.2% increase from 2,241 cases in 2020.



Annual Reporting of Total Paid Compensation

Financial Reports and Audits

MONITORING: This section of the report provides information from the prior calendar year.

Under Alaska Statute 23.30.155(m), each insurer, providing workers' compensation coverage in Alaska or their adjuster must file an annual report with the Alaska Workers' Compensation Board providing number of claims filed, the type of claims filed, total dollars spent on medical, lost wages compensation, death benefits, rehabilitation costs and claim litigation costs. The annual report requirement also applies to self-insured employers and uninsured employers.

Along with the annual report, each insurer, adjuster, self-insured employer, or uninsured employer must submit payment of their Second Injury Fund (SIF) contribution and their Workers' Safety and Compensation Administration Account fee (WSCAA). These fees fund reimbursements from the SIF and help support the Division's operations.

035

- This report covers activity from:
  - CY = Calendar Year Period from January 1, 2021 to December 31, 2021
  - FY = Fiscal Period from July 1, 2021 to June 30, 2022

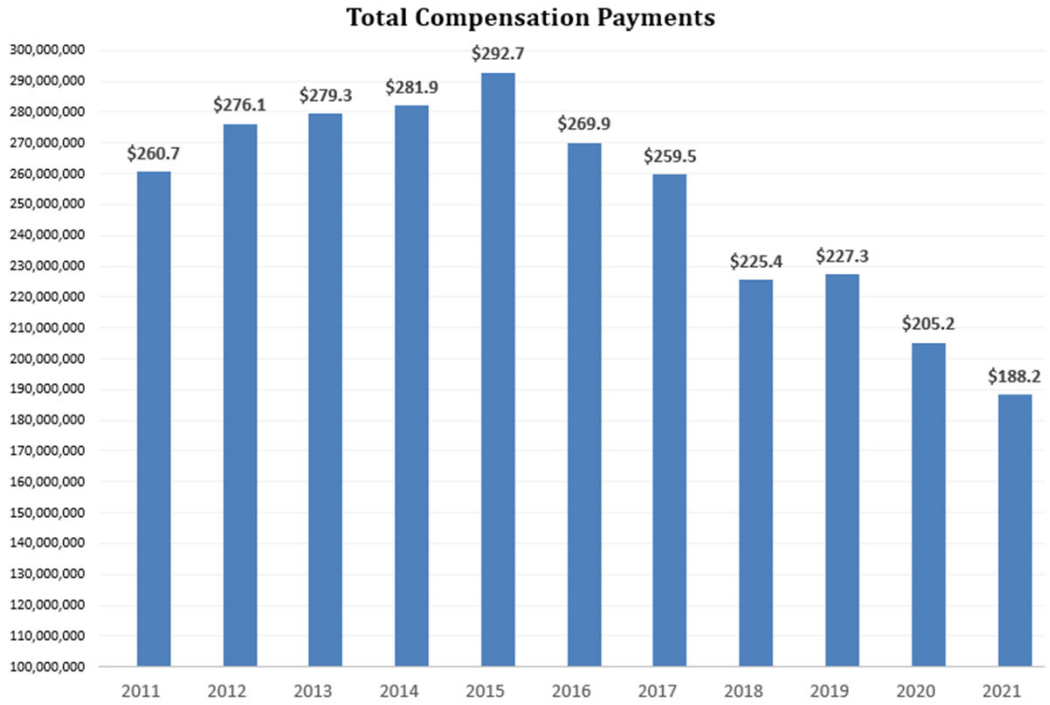
Notes:

Medical Costs Totals for CY 2021 include the following Medical Costs: Physical Therapy, Chiropractic Fees, Durable Medical expenses, Medical Travel, Employee Medical-Legal Costs. These costs were previously captured in the other category for CY2014, CY2015, CY2016, and CY2017.

Other Costs for CY 2021 include: Unspecified Lump Sum Payment/Settlement, interest, penalty and SIF Contribution Fee.

Total Compensation Payments

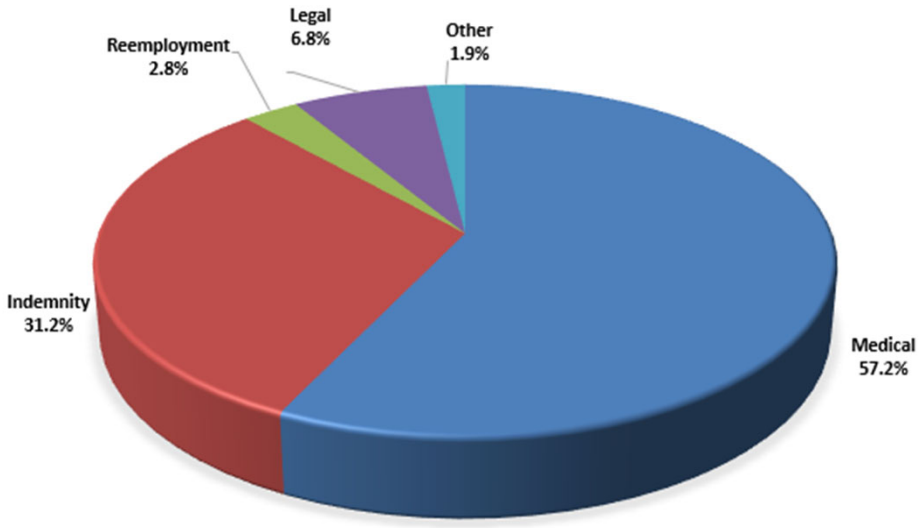
A total of $188.2 million was paid in workers' compensation benefits during calendar year 2021 by market-insured employers and self-insured employers. This is a decrease of 8.28% from $205.2 million in 2020.



036

Total Compensation Payments Distribution

Benefit Type	Amount Paid	% of Cost to Total Cost
Medical	$107,607,915	57.2%
Indemnity	$58,738,756	31.2%
Reemployment	$5,359,016	2.8%
Legal	$12,862,473	6.8%
Other*	$3,654,823	1.9%
Total	$188,222,984	



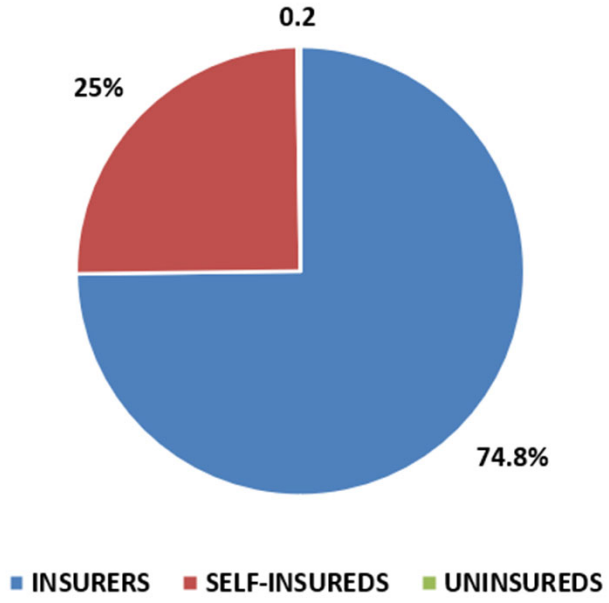
Total Benefits Paid by Top Twenty Insurers/Self-Insured Employers

Of total benefits paid, market-insured employers paid $140.7 million (74.8%), self-insured employers paid $46.9 million (25.0%).

Compared to 2020, market-insured employers paid $154.9 million (75.5%) and self-insured employers paid $49.9 million (24.3%).

INSURER TYPE	Total Benefits Paid	% of Total Costs
Market Insurers	$140,798,572	74.8%
Self-Insured Employers	$46,987,181	25.0%
Uninsured Fund	$437,231	0.2%
Total	$188,222,984	

038



Total Benefits Paid by Top Twenty Insurers/Self-Insured Employers

The top twenty insurers and self-insured employers paid $127.4 million, or 67.7% of total workers' compensation benefits paid in 2021. This compares to $138.4 million, or 67.5%, in 2020.

039

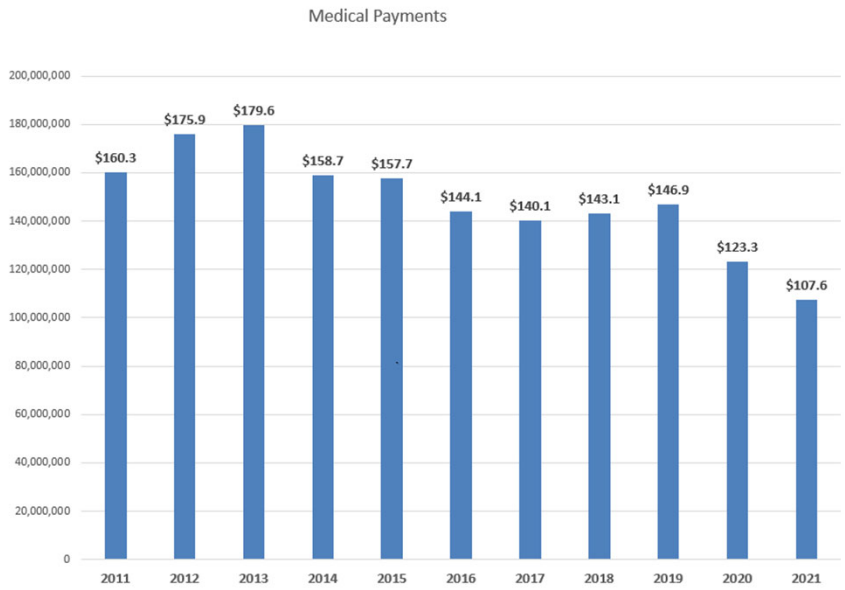
Rank	Insurer	Benefits Paid
1.	ALASKA NATIONAL INS CO	37,680,296
2.	ALASKA, STATE OF	13,854,760
3.	ANCHORAGE, MUNICIPALITY OF	7,260,204
4.	AMERICAN INTERSTATE INSURANCE CO	5,456,251
5.	INDEMNITY INS CO OF NORTH AMERICA	5,409,762
6.	LIBERTY INSURANCE CORP	5,222,965
7.	ACE AMERICAN INSURANCE COMPANY	4,804,459
8.	REPUBLIC INDEMNITY CO OF AMERICA	4,763,686
9.	EVEREST NATIONAL INS CO	4,492,441
10.	UMIALIK INSURANCE CO	4,397,944
11.	AMERICAN ZURICH INS CO	4,186,436
12.	ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOC	4,144,921
13.	BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY	3,779,563
14.	PROVIDENCE HEALTH SYSTEM - WASHINGTON	3,374,405
15.	TRAVELERS PROPERTY CASUALTY CO OF AMERICA	3,251,190
16.	ARCTIC SLOPE REGIONAL CORP	3,224,192
17.	EMPLOYERS INS CO OF WAUSAU	3,205,247
18.	NEW HAMPSHIRE INSURANCE CO	3,198,518
19.	ALASKA AIRLINES, INC.	2,866,895
20.	LIBERTY NORTHWEST INSURANCE CORP	2,859,290
	TOTAL	**$127,433,426**

Medical Benefits

In the calendar year 2021, medical benefits totaled $107.6 million, a 12.7 % decrease from $123.3 million in 2020.

Medical benefits were 57.2% of total benefits paid and 64.69% of loss costs in 2021, compared to 60.12% of total benefits paid and 68.34% of loss costs in 2020.

040

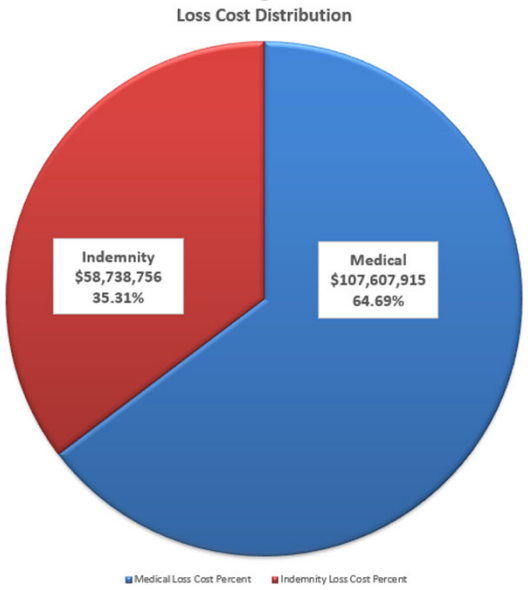


Loss Costs Distribution

Total loss costs were $166.3 million in 2021 compared to $180.5 million in 2020, a decrease of 7.86%.
Indemnity costs were $58.7 million in 2021, compared to $57.1 million in 2020.
Medical costs were $107.6 million in 2021, compared to $123.3 million in 2020.

Year	Total Loss Costs	% Change
2021	$166,346,671	-7.86%
2020	$180,527,315	-9.49%
2019	$199,464,202	1.05%
2018	$197,391,502	-2.56%
2017	$202,583,520	-4.28%
2016	$211,644,587	-5.79%
2015	$224,645,071	1.68%

041



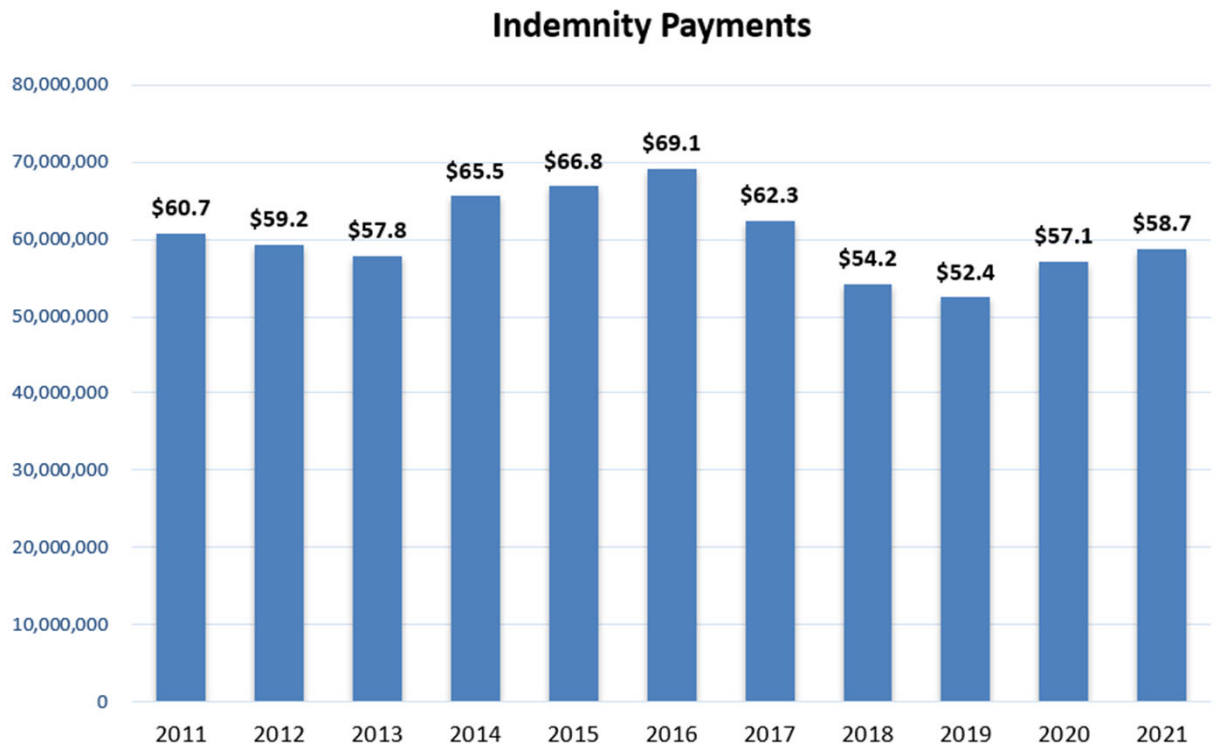
"Loss Costs" = medical and indemnity benefit costs only.

Indemnity Benefits

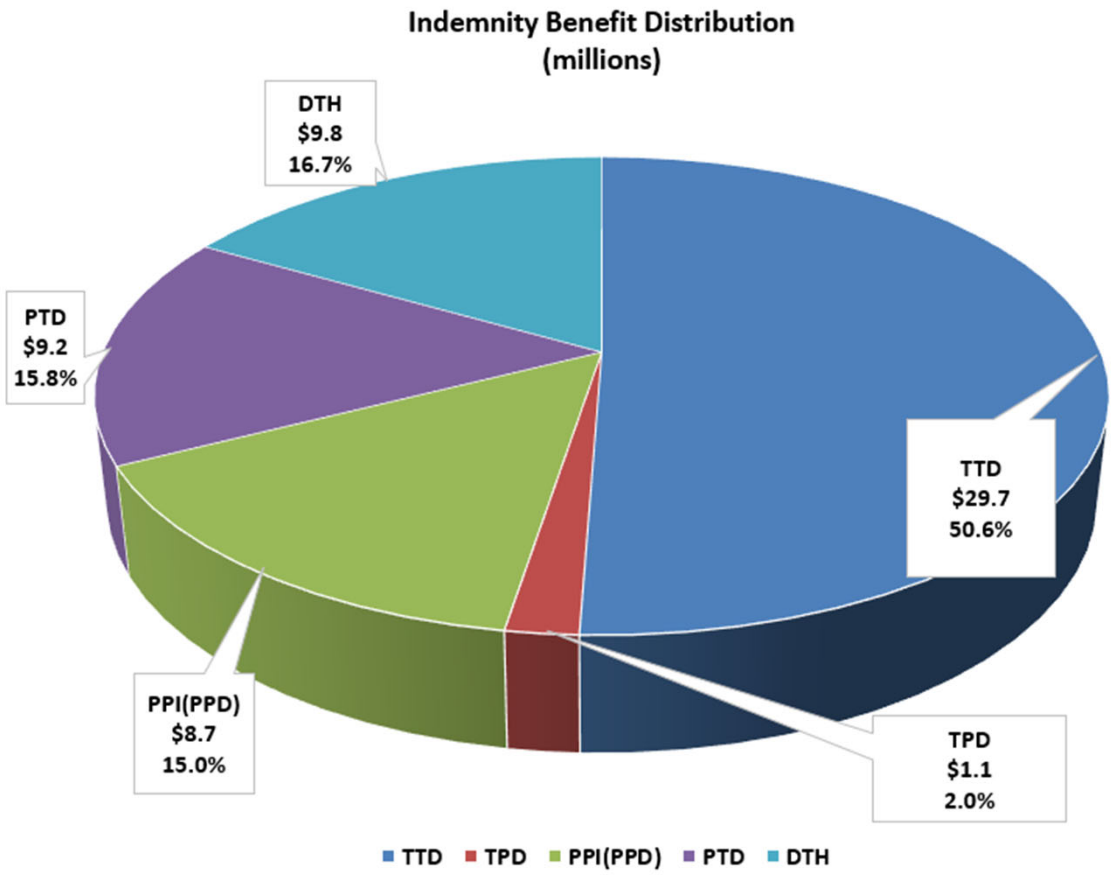
For calendar year 2021 indemnity benefits (TTD, TPD, PPI, PTD & Death Benefits) totaled $58.7 million, a 2.7% increase from $57.1 million in 2020.

- TTD benefits totaled $29.7 million in 2021, a 5.34% decrease from $31.3 million in 2020.
- TPD benefits totaled $1.1 million in 2021, a 13.4% decrease from $1.3 in 2020.
- PPI benefits totaled $8.7 million in 2021, a 20.2% decrease from $7.3 million in 2020.
- PTD benefits totaled $9.2 million in 2021, a 13.9% decrease from $10.7 million in 2020.
- Death benefits totaled $9.8 million in 2021, a 54.5% increase from $6.3 million in 2020.

042



Indemnity Benefits



043

Legal Costs

For calendar year 2021, legal expenses totaled $12.8 million, a 6.5% decrease from $13.7 million in 2020.

Employee attorney fees were $4.3 million in 2021, a 30.8% decrease from $6.3 million in 2020.

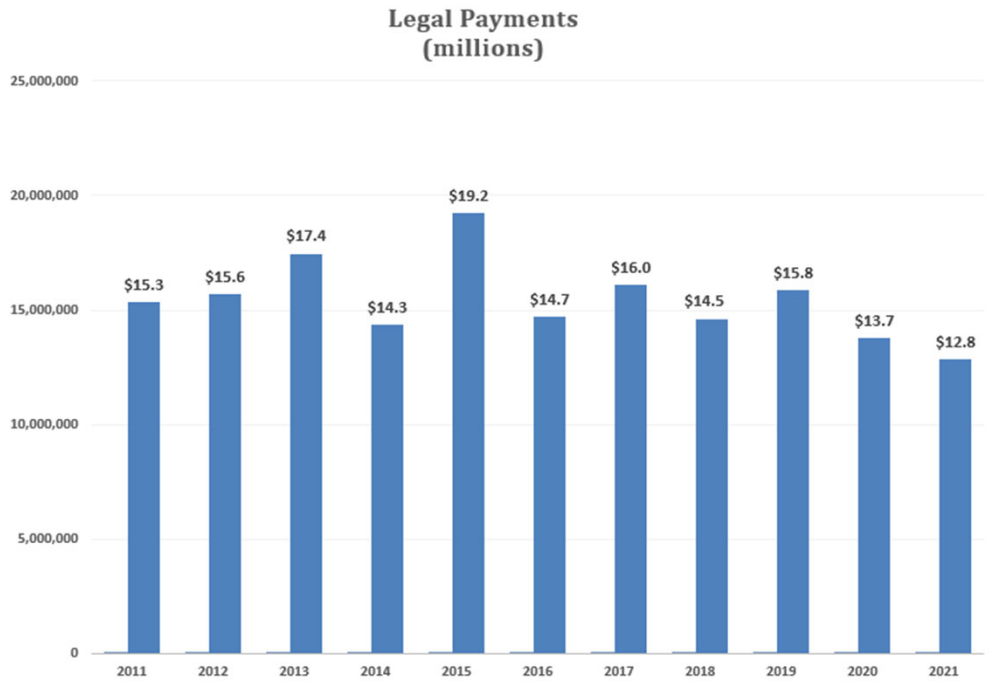
Employer attorney fees were $7.2 million in 2021, a 11.86% increase from $6.5 million in 2020.

Litigation costs totaled $1.2 million in 2021, a 29% increase from $946,180 in 2020.

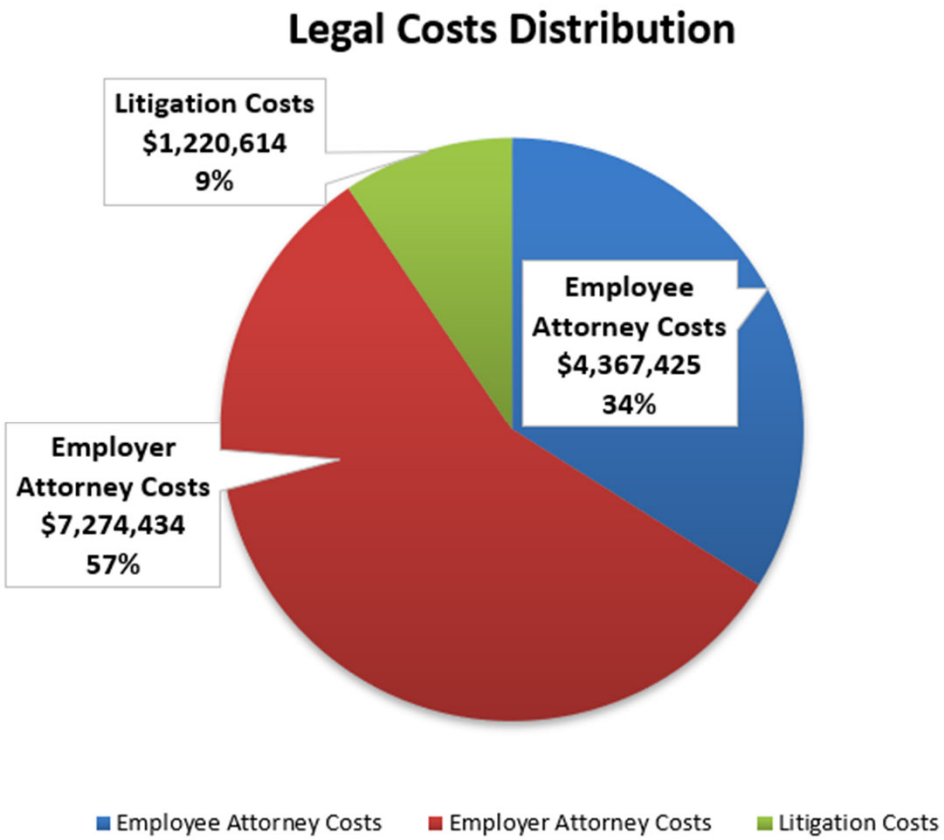
044

Litigation costs include:
Total Expert Witness Fees
Total Court Reporter Fees
Total Private Investigator Fees

*Some Legal costs may have been reported in lump sum settlements as a total benefit payment.



Legal Costs



045

Reemployment Benefits

Total reemployment benefit payments totaled $5.3 million in 2021, a 30.4% decrease from $7.6 million in 2020.

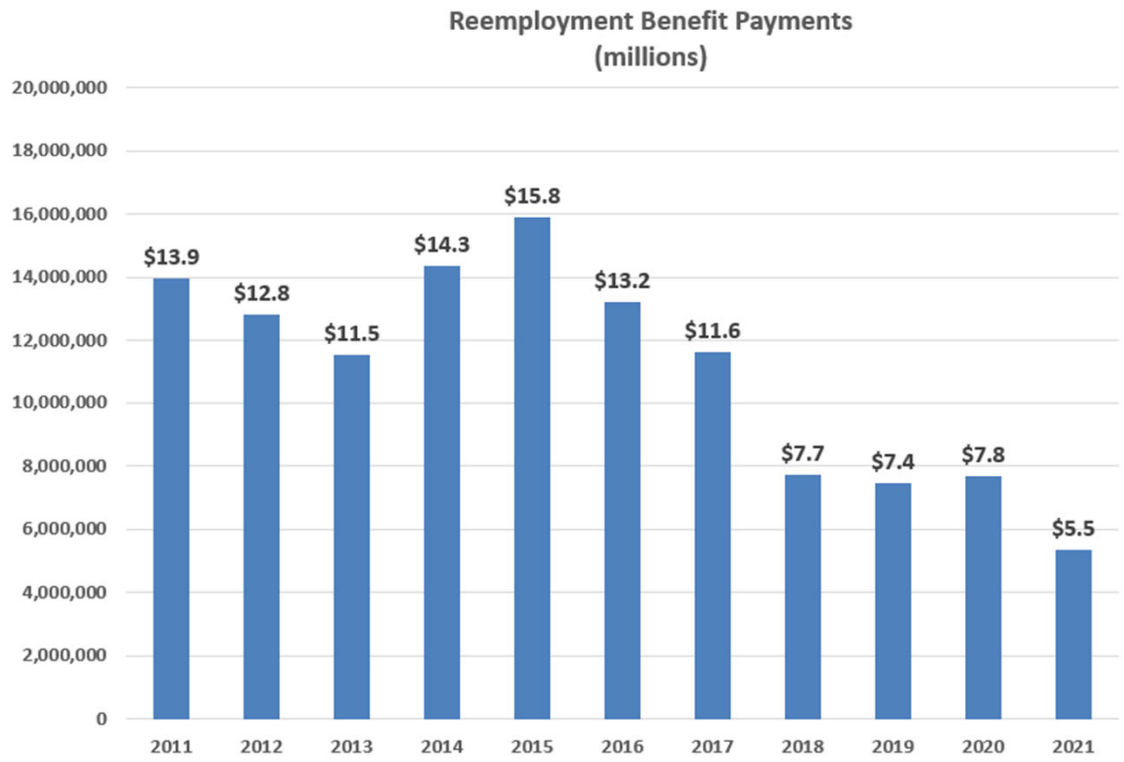
Rehabilitation benefit costs under AS 23.30.041(k) totaled $2.05 million in 2021, a 3.83% decrease from $2.1 million in 2020.

Rehabilitation benefit costs under AS 23.30.041(g) totaled $917,890 in 2021, a 69% decrease from $2.9 million in 2020.

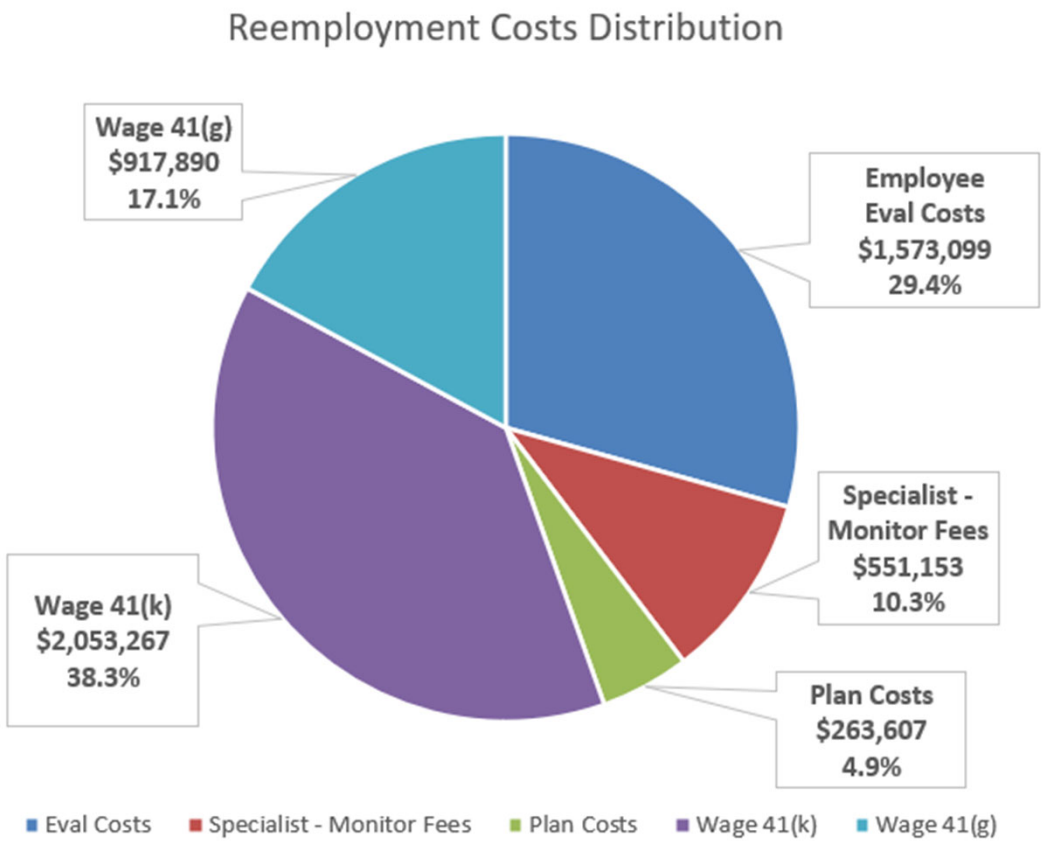
Employee evaluation costs totaled $1.5 million in 2021, a 6.8% increase from $1.4 million in 2020.

Rehabilitation specialist fees/plan monitoring fees totaled $551,153 in 2021, a 12% decrease from $626,545 in 2020.

Plan development costs totaled $263,607 in 2021, a 47.6% decrease from $503,629 in 2020.



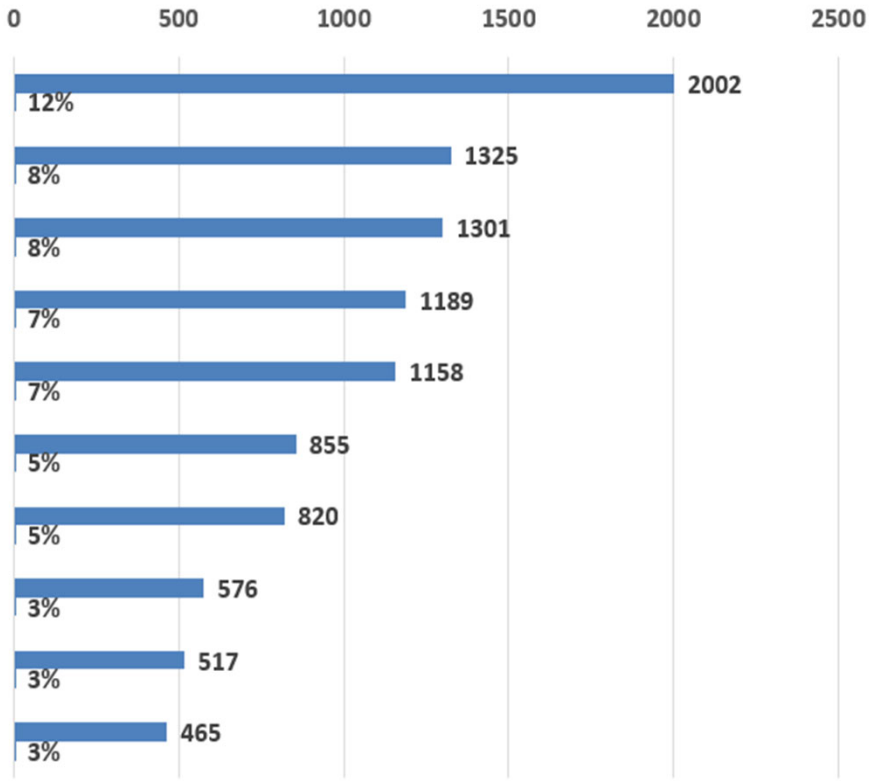
Reemployment Benefits



047

Top Ten Injuries by Body Part Injured

	Body Part Injured	Cases	%*
1.	Body Systems and Multiple Body Systems	2,002	12%
2.	Lower Back Area	1,325	8%
3.	Multiple Body Parts (Including Body Systems & Body Parts)	1,301	8%
4.	Fingers(s)	1,189	7%
5.	Knee	1,158	7%
6.	Shoulder(s)	855	5%
7.	Hand	820	5%
8.	Ankle	576	3%
9.	Eye(s)	517	3%
10.	Wrist	465	3%



*Percentage to total injury cases reported in 2020 of 14,985

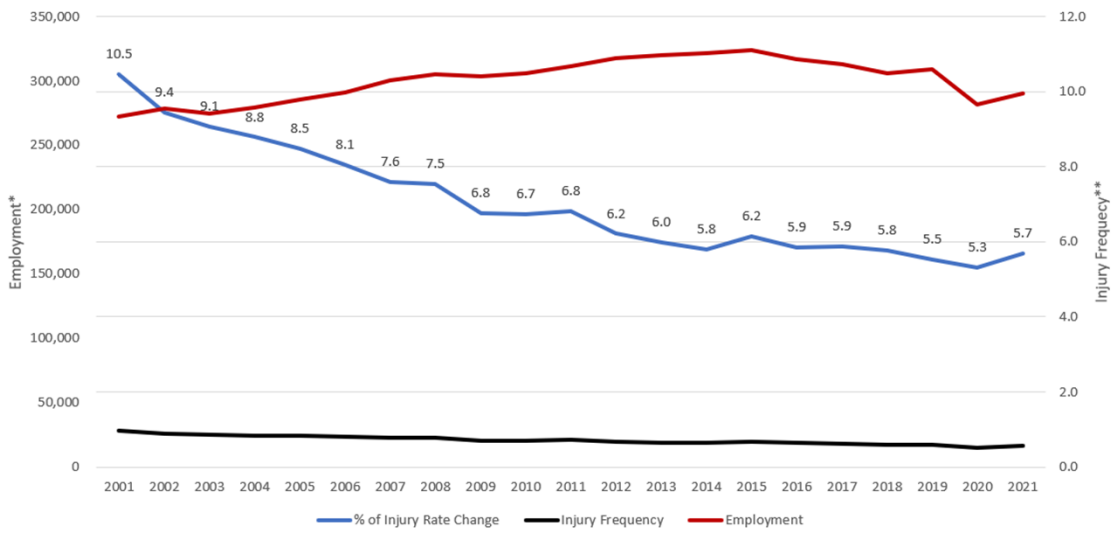
Alaska Injury Frequency

In 2021, 16,470 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.7%.
In 2020, 14,985 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.3%.

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment, Statewide totaled 305,004 in 2021, an increase from 297,389 in 2020. Excluding 15,058 federal employees, the number of workers covered under the Alaska Workers' Compensation Act in 2021 was approximately 289,946 an 2.83% increase from 281,976 in 2020.

Year	Injury Frequency	Employment
2021	16,470	289,946
2020	14,985	281,976
2019	17,075	308,796
2018	17,694	306,211
2017	18,396	312,886
2016	18,555	316,979
2015	19,909	323,619
2014	18,686	321,874
2013	19,140	319,893
2012	19,726	317,562
2011	21,213	311,529

Employment in Alaska ↑ Alaska Injury Frequency ↑

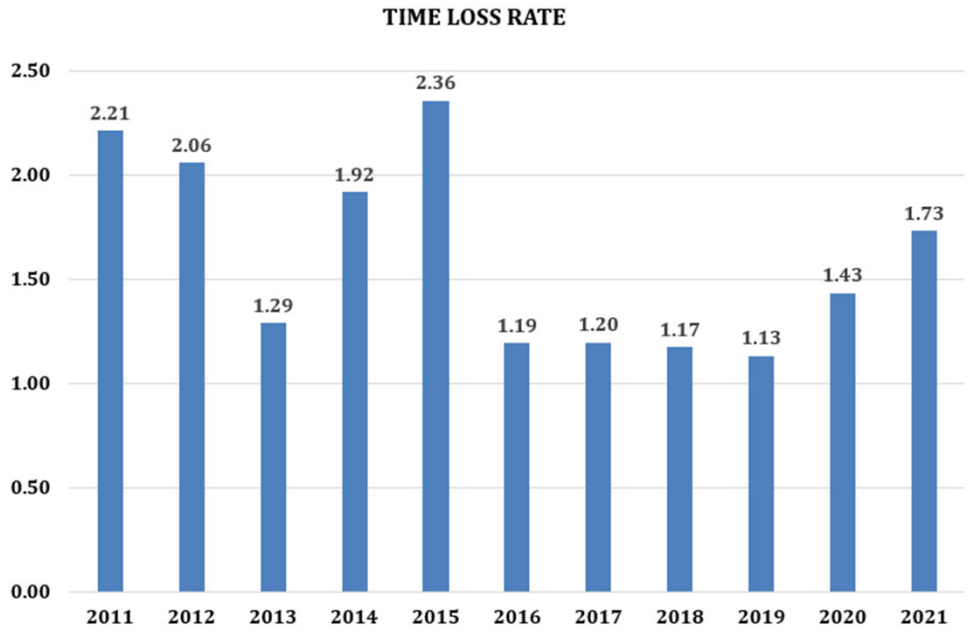


*Based on Department of Labor and Workforce Development, Research and Analysis Section Data, Average Alaska Monthly Employment.
**Alaska injury frequency rate equals annual reported claims divided by Average Alaska Monthly Employment.

Time Loss Rate

Using the number of time-loss claims (5,018) established by the Workers' Compensation Division divided by average monthly employment statewide (less Federal Government employment (305,004-15,058 = 289,946), the time loss rate per 100 employees in 2021 was 1.73, a 20.88% increase from a time loss rate of 1.43 in 2020.

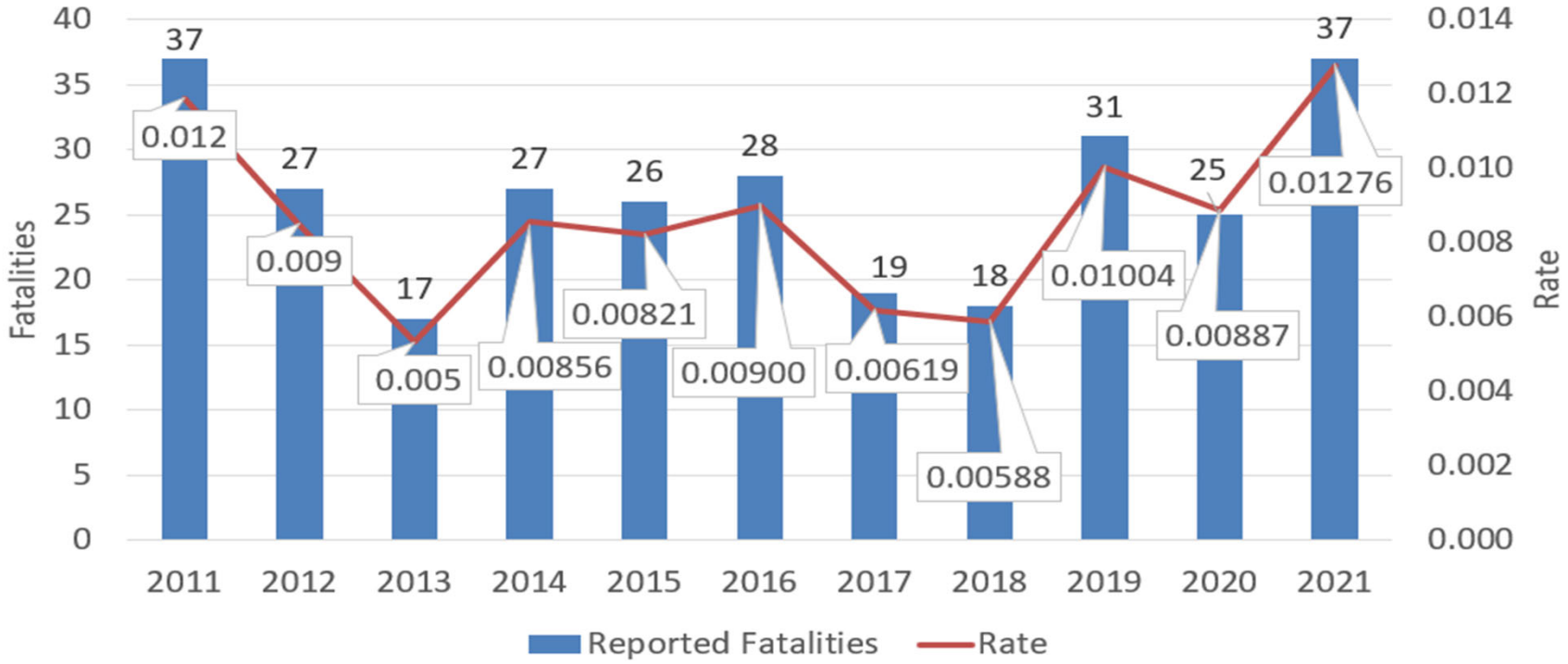
050



A lost time claim is the compensation (financial, leave, other benefits) that is paid to a worker who remains absent for 3 days or more because of a work-related injury.

Fatality Rate

There were 37 fatalities reported in 2021, a 20.88% increase from 25 fatalities reported in 2020. The fatality rate per 100 employees in 2020 was 0.00887, compared to 0.01004 in 2019.



Note: The agency received a total of 60 reports of injured workers that passed away in 2021.
Trading partners reported that 23 deaths were not work-place injuries.

051

Direct Written Premiums

Calendar Year	Direct Written Premiums (000s)
2021	$179,252*
2020	$196,813
2019	$225,779
2018	$240,150
2017	$251,110
2016	$268,052

*Estimate based on The Division of Insurance Calendar Year 2021 reconciliation report for Workers' Compensation Service Fee.

052

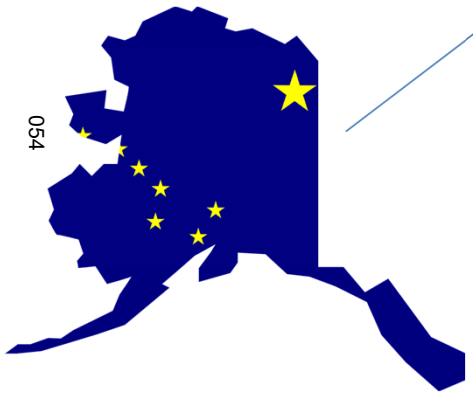
Active Self-Insured Employers

Active Alaska Self-Insured Employers	Start Date of Self-Insurance
Alaska Air Group, Inc.	5/1/1980
Alaska Railroad Corp.	7/1/1996
Alyeska Pipeline Service Co.	7/1/1983
Anchorage School District	6/1/2004
Arctic Slope Regional Corp.	6/1/2005
Bristol Bay Area Health Corporation	2/1/2005
Chevron Corporation	5/12/1999
Chugach Electric Assn. Inc.	1/1/2014
City & Borough of Juneau	4/1/2004
Costco Wholesale Corp.	9/3/1999
Fairbanks North Star Borough & School District	7/1/1977
Federal Express Corp.	10/10/1990

Active Alaska Self-Insured Employers	Start Date of Self-Insurance
Fred Meyer Stores, Inc.	10/1/1996
GCI Holdings, LLC	12/31/2017
Harnish Group Inc.	5/1/2005
Kenai Peninsula Borough & School District	2/16/1992
Matanuska-Susitna Borough	8/15/2008
Matanuska-Susitna School District	7/1/1994
Municipality of Anchorage	1/1/2004
PeaceHealth Networks	7/2/2020
Providence Health System – WA	4/1/1995
State of Alaska	11/24/2003
University of Alaska	2/1/2004

053

Workers' Compensation Premium Rate Ranking



2020 Ranking	2018 Ranking	State	Index Rate	Percent of study median	Effective Date	Percent of 2018 study median
1	3	New Jersey	2.52	175%	January 1, 2020	167%
2	1	New York	2.23	155%	October 1, 2019	181%
3	9	Vermont	2.21	153%	April 1, 2019	123%
4	2	California	2.16	150%	January 1, 2020	169%
5	13	Hawaii	2.08	144%	January 1, 2020	118%
6	8	Connecticut	1.99	138%	January 1, 2020	129%
7	4	Delaware	1.97	137%	December 1, 2019	148%
8	10	Louisiana	1.95	135%	January 1, 2019	121%
9	7	Rhode Island	1.93	134%	August 1, 2019	132%
10	5	Alaska	1.86	129%	January 1, 2020	148%
11	12	Wisconsin	1.74	121%	October 1, 2019	119%
12	11	Montana	1.69	117%	July 1, 2019	119%
13	23	Oklahoma	1.66	115%	January 1, 2020	103%
14	25	Missouri	1.65	115%	January 1, 2020	101%
15	6	Georgia	1.64	114%	July 1, 2019	134%
16	19	Maine	1.62	113%	January 1, 2020	108%
17	28	Minnesota	1.61	112%	January 1, 2020	98%
19	21	Idaho	1.56	108%	January 1, 2020	106%
19	14	South Carolina	1.56	108%	April 1, 2019	115%
20	17	Pennsylvania	1.55	108%	April 1, 2019	109%
21	30	Iowa	1.54	107%	January 1, 2020	96%
22	16	Washington	1.53	106%	January 1, 2020	110%
23	24	South Dakota	1.48	103%	July 1, 2019	102%
24	22	Illinois	1.46	101%	January 1, 2020	106%
26	16	Wyoming	1.44	100%	January 1, 2020	110%
26	27	Nebraska	1.44	100%	February 1, 2019	100%
27	21	Florida	1.41	98%	January 1, 2020	106%
28	27	New Hampshire	1.37	95%	January 1, 2020	100%
29	34	New Mexico	1.34	93%	January 1, 2020	88%
30	29	Alabama	1.33	92%	March 1, 2019	97%
31	19	North Carolina	1.31	91%	April 1, 2019	108%
32	41	Virginia	1.28	89%	April 1, 2019	76%
33	35	Colorado	1.25	87%	January 1, 2020	84%
34	31	Mississippi	1.20	83%	March 1, 2019	91%
35	38	Massachusetts	1.17	81%	July 1, 2018	81%
37	37	Michigan	1.14	79%	January 1, 2020	81%
37	39	Maryland	1.14	79%	January 1, 2020	78%
38	33	Kentucky	1.13	78%	October 1, 2019	89%
39	46	Kansas	1.12	78%	January 1, 2020	68%
40	36	Ohio	1.11	77%	July 1, 2019	82%
41	32	Tennessee	1.09	76%	March 1, 2019	89%
42	44	Nevada	1.07	74%	September 1, 2019	70%
43	40	Arizona	1.05	73%	January 1, 2020	78%
44	42	District of Columbia	1.04	72%	November 1, 2019	74%
45	**46**	**Oregon**	**1.00**	**69%**	**January 1, 2020**	**68%**
46	43	Texas	0.98	68%	July 1, 2019	71%
47	47	Utah	0.85	59%	January 1, 2020	62%
48	48	West Virginia	0.79	55%	November 1, 2019	59%
49	50	Indiana	0.77	53%	January 1, 2020	51%
50	49	Arkansas	0.72	50%	July 1, 2019	53%
51	51	North Dakota	0.67	47%	July 1, 2019	48%

Source: Oregon Department of Consumer and Business Services

Supplemental

REGULATIONS

CCS SB 131 passed effective January 1, 2023

- **Base rate for PPI benefit increases to $273,000.**
- **Funeral expenses increase to $12,000.**
- **Surviving widows and widowers benefit increases to $8,000.**
- **Aggregate benefit for all beneficiaries increased to $150,000.**

LOSS COSTS PROJECTIONS

No Regulatory Orders issued in 2021.

On August 24, 2020, the Division of Insurance approved the 2021 Alaska Workers' Compensation Filing for Voluntary Loss Costs and Assigned Risk Rates from the National Council on Compensation Insurance, Inc. (NCCI). Under regulatory order number R 20-09, in accordance with AS 21.39.043, the filing proposed an overall 17.5% decrease in voluntary loss costs and an overall 11.2% decrease in assigned risk rates. The order went into effect on October 27, 2020.

On August 20, 2019, the Division of Insurance approved the 2020 Alaska Workers' Compensation Filing for Voluntary Loss Costs and Assigned Risk Rates from the National Council on Compensation Insurance, Inc. (NCCI). Under regulatory order number R 19-04, in accordance with AS 21.39.043, the filing proposed an overall 14.4% decrease in voluntary loss costs and an overall 11.3% decrease in assigned risk rates. Regulatory Order R19-04 provides an estimated 13.8% reduction in voluntary loss costs and 10.7% decrease in assigned risk rates. The order went into effect on November 5, 2019.

QUESTIONS?

050

SPECIAL PROGRAMS ANNUAL REPORT

Velma Thomas
Program Coordinator I

057

Administrator for the following:

- Benefits Guaranty Fund
- Fishermen's Fund
- Second Injury Fund
- Self Insured Employers Program
- Assist with IT programs (ICERs, IRIS, Proof of Coverage)

Supervise direct report staff positions:

- Ted Burkhart, Workers' Compensation Officer I
- Dawn Wilson, Collections/Loan Officer I
- Nanette Ferrer, Fishermen's Fund WC Technician I
- Vacant, Fishermen's Fund WC Technician I

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.

- Fund revenues comes from civil penalties assessed against uninsured employers.

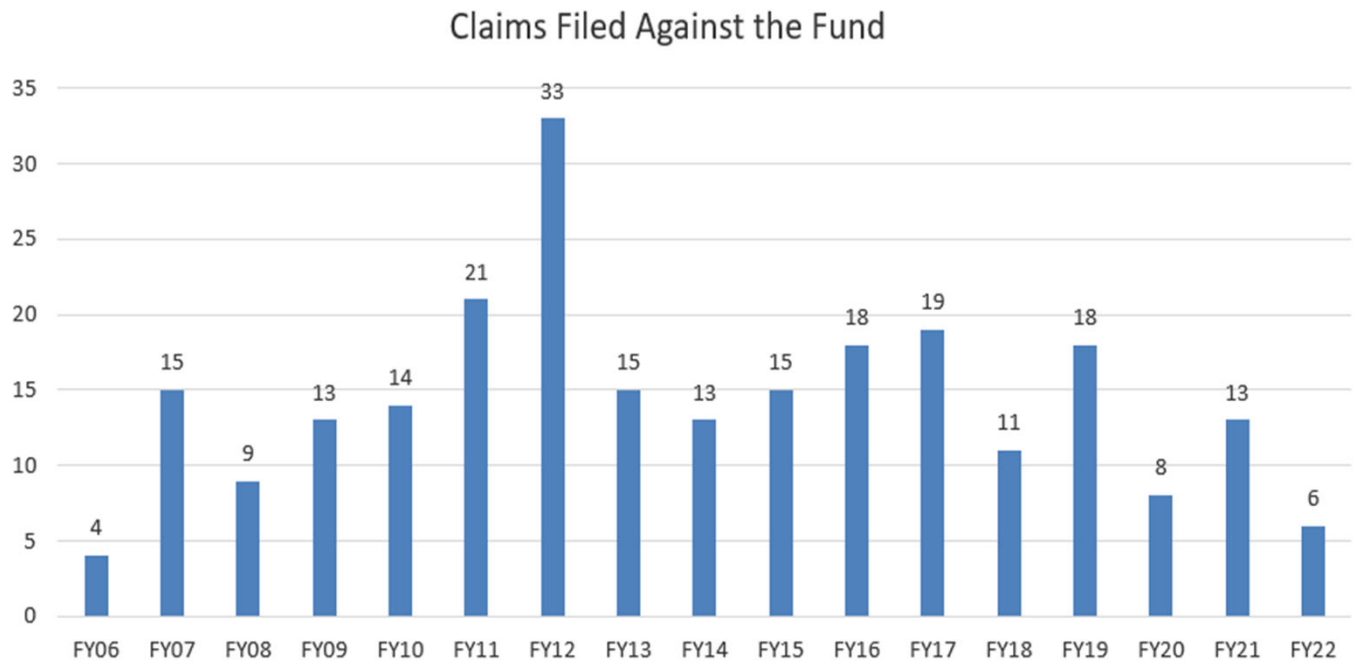
- Requirements:
  1. The injured worker must be an employee of the uninsured employer at the time of injury.
  2. The employee's work for the employer must be the substantial factor in the cause of the injury or illness.
  3. The injured worker must file a claim for benefits against the employer and a separate claim against the Fund. Must be in 2 years of injury or knowledge that the injury/illness was work related.
  4. Claim must result in an order by the Board to pay benefits.
  5. Employer must be in default of paying employee's compensable benefits.

058

Claim Data

Fiscal Year	Uninsured Injury Reports	Total New Claims Filed Against the Fund
2022	8	9
2021	21	13
2020	38	8
2019	38	24
2018	27	11

059

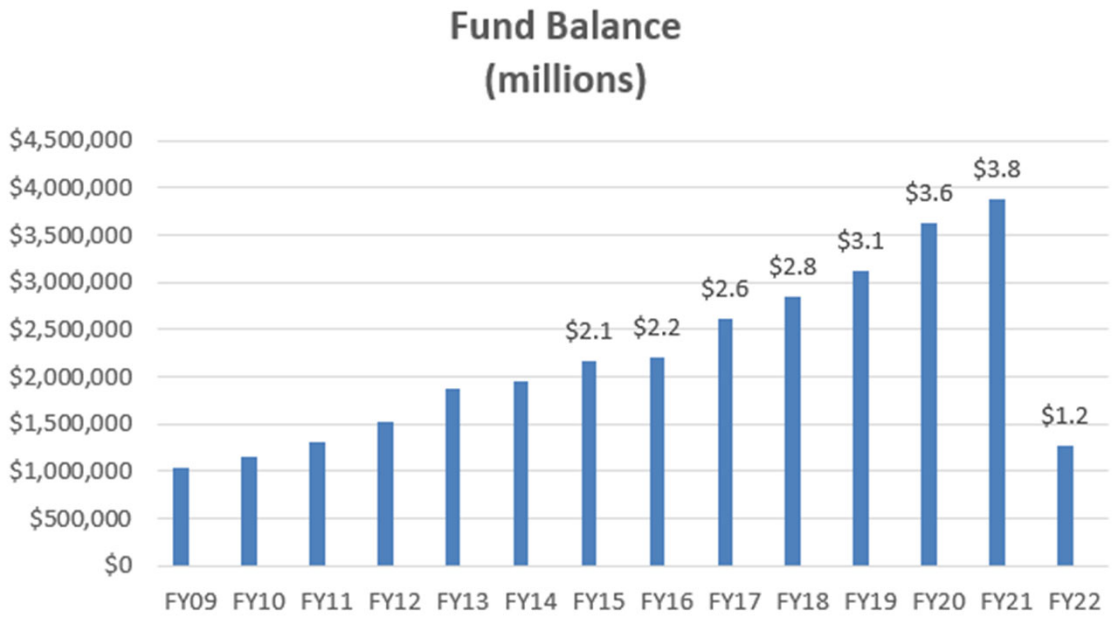


For FY2022, there were 9 reports of uninsured injuries. This compares to 21 reports of uninsured injuries in 2021.

In FY2022, 6 employees filed claims against the fund compared to 13 in FY2021.

Fund Balance

The fund balance was approximately $1.2 million in FY2022, a 67.1% decrease, down $2.6 million from FY2021 fund balance of $3.8 million. The decrease is attributed to sweep on 11/9/2021 of sub-funds into the unassigned repayment of the Constitutional Budget Reserve Fund (CBRF) in the amount of $3,100,950.10. There are no provisions to move funds back into designated accounts.



Fiscal Year	2022	2021	2020	2019	2018	2017	2016
Fund Balance	$1,277,363	$3,886,050	$3,626,699	$3,130,438	$2,852,200	$2,615,821	$2,208,700

Fund Balance

Most Notable Budget Accounts for Alaska
General Fund - The General Fund is the main financial operating component of the State and is contained in the Governments Funds group. Fund groups include Governmental Funds, Proprietary Funds, and Fiduciary Funds. The financial transactions of the State are recorded in many accounts and individual funds (sub-funds – created by law) that are accounted for and reported within the General Fund.

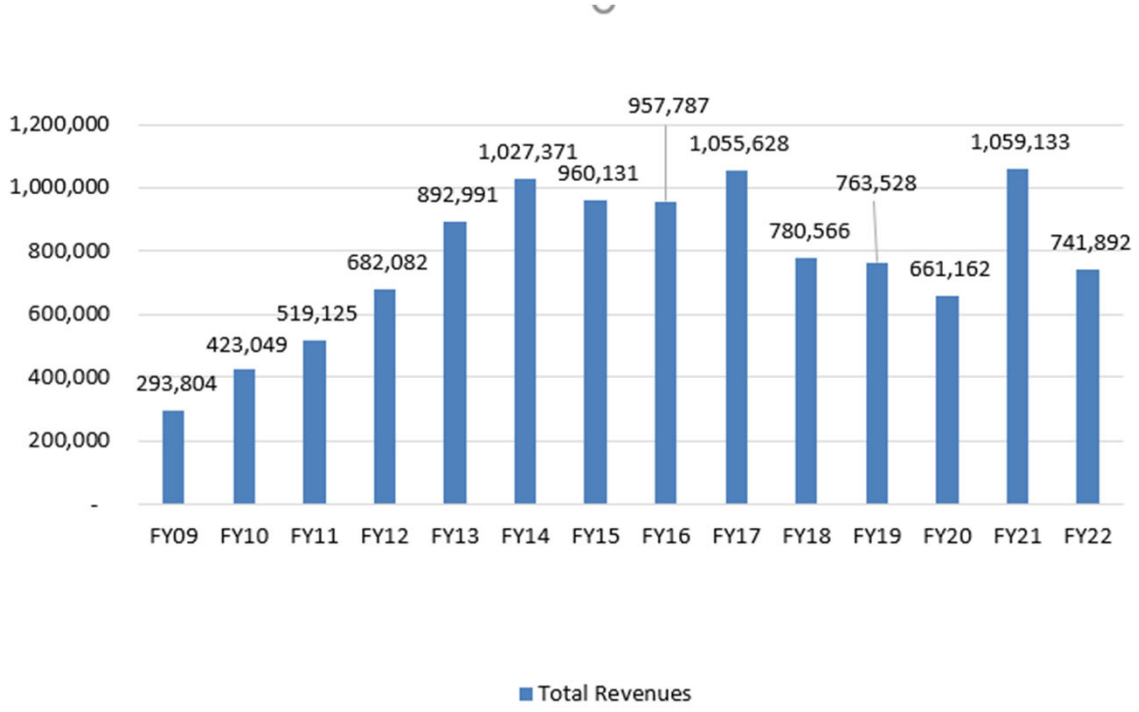
In 1990, The Statutory Budget Reserve Fund (SBRF) was created through Alaska Statute 37.05.540. The SBRF may transfer funds to the General Fund if unrestricted state revenue is insufficient to cover General Fund appropriations to prevent a cash deficiency in the General Fund. Appropriation transfers to the fund began in FY10.

In 1990, the voters of Alaska approved an amendment to the Alaska Constitution to establish a budget reserve fund (Constitutional Budget Reserve Fund - CBRF), under Article IX, section 17. The fund was established to enhance budget stability by depositing certain monies into the CBRF rather than into the General Fund. Oil tax settlement revenues are deposited into this fund. The constitution further provides that all money appropriated from the fund must be repaid to the fund. All borrowing from the CBRF was completely repaid in FY10 and no borrowing activity from the CBRF occurred during FY11 through FY14.

For FY2021, $1.79 billion must be repaid to the CBRF. The CBRF fund balance as of June 30, 2021, was $13,681 billion and on June 30, 2020, was $13,671 billion. For FY20, the amount owed to the CBRF was $1.44 billion.

Revenues

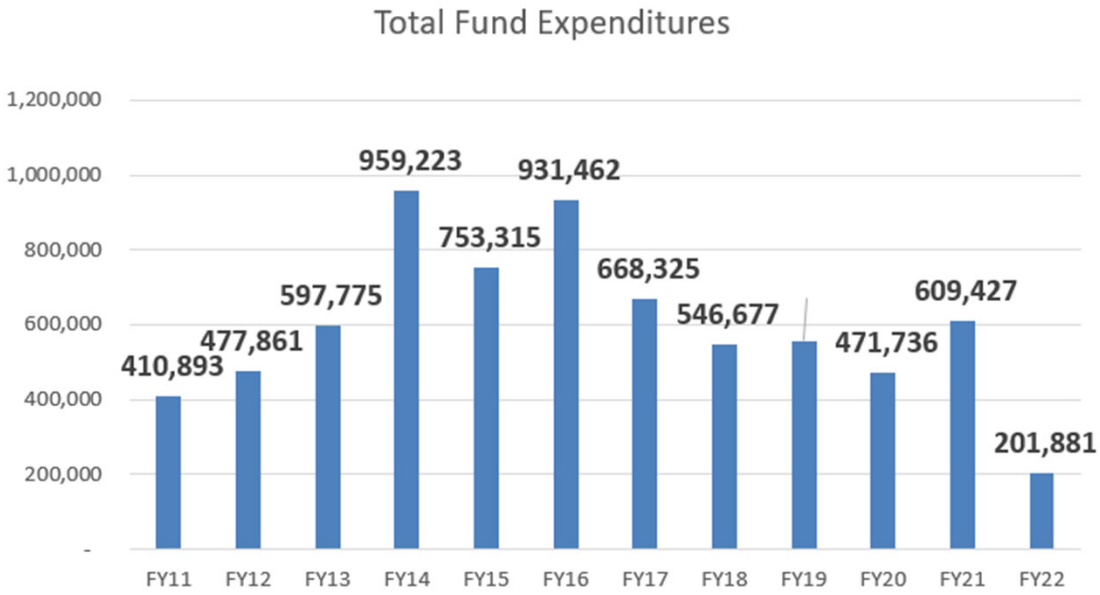
Fiscal Year	2022	2021	2020
Civil Penalty Stipulation	$209,129	$179,460	$209,129
Civil Penalty Settlement	$190,440	$464,936	$190,440
Civil Penalty D&O	$137,407	$177,231	$137,407
Uninsured Employer Reimbursement	$123,918	$70,317	$123,918
Judgments	$5,950	$176,564	$5,950
Less Adjustments (NSF Checks)	($5,682)	(9,442)	($5,682)
Total Revenues	**$661,162**	**$1,059,133**	**$661,162**
% from Civil Penalties	84%	61%	84%
% from Employer Reimbursement	16%	7%	16%
% from Judgments	1%	17%	1%



For FY2022, revenues decreased from $1.05 million in FY2021 to $741, 892. Decrease attributed to Loan/Collection Officer I vacancy.

Expenditures

Expenditure Details	FY2022	FY2021	FY2020
# of Employees Receiving Benefits	5	11	8
Benefit Payments by Type			
Indemnity Costs	$17,264	$97,111	$40,356
Medical Costs	$23,141	$169,215	$120,066
Reemployment Costs	$22,237	$4,542	$14,089
Employee Legal Costs	$0.	$82,343	$61,578
Total EE Benefits	$62,642	$362,257	$236,088
Administration Costs	$139,239	$247,944	$235,648
Total Expenses	**$201,881**	**$609,427**	**$471,736**
% of Benefit Payments to Total Costs	31%	59%	50%
%of Admin. Costs to Total Costs	69%	41%	50%



Potential Fund Liabilities On Open/Pending Claims

Fiscal Year	Total Claims Filed	No. of Claims (open and pending)	Closed Claims	Potential Liability	Paid Expenses	Balance Due (reserve)
FY2022	6	6	0	$ 169,000	$ -	$ 169,000
FY2021	13	9	4	$ 826,000.00	$ -	$ 826,000.00
FY2020	8	3	5	$ 848,000.00	$ 304,867.18	$ 213,132.82
FY2019	24	3	21	$ 1,617,212.41	$ 106,986.82	$ 1,510,225.59
FY2018	11	0	11	$ 325,082.88	$ 2,056.00	$ 323,026.88
FY2017	19	1	18	$ 1,735,970.26	$ 806,339.52	$ 929,630.74
FY2016	18	0	18	$ 1,532,960.83	$ 411,101.25	$ 1,121,859.58
FY2015	15	0	15	$ 426,056.00	$ 142,562.96	$ 283,493.04
FY2014	13	0	13	$ 1,266,238.09	$ 921,971.49	$ 344,266.60
FY2013	15	0	15	$ 507,515.82	$ 346,946.05	$ 160,569.77
FY2012	33	1	32	$ 2,123,300.36	$ 821,155.78	$ 1,302,144.58
FY2011	21	0	21	$ 592,946.38	$ 429,583.91	$ 163,362.47
Total	205	30	221	$4,847,260	$1,174,012	$3,6673,248

Report reflects liability on open & pending claims.
Open claim for 2010 – the fund is paying death benefits to two minors.
Open claim for 2012 – pending Supreme Court decision.

064

Second Injury Fund

- Second Injury Fund (Dedicated Fund) – is a fund to assist and reimburse compensation payments made by employers, or their insurers or adjusters who hire and/or retain certain injured employees.

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

- **Qualifications:**
  1. Employee has a pre-existing condition
  2. Employer had a written record establishing knowledge of pre-existing condition before the subsequent injury and the employee was retained.
  3. The subsequent injury has combined with the pre-existing condition such that the combined effect is greater than the subsequent injury alone.
  4. A notice was filed with the SIF within 100 weeks (within 2 years) of knowledge of a possible claim.
  5. 104 weeks of indemnity payments have been paid.
  6. **Claim for injury or death must have occurred before September 1, 2018.**
  7. **Claim and all required documentation must be submitted before October 1, 2020.**

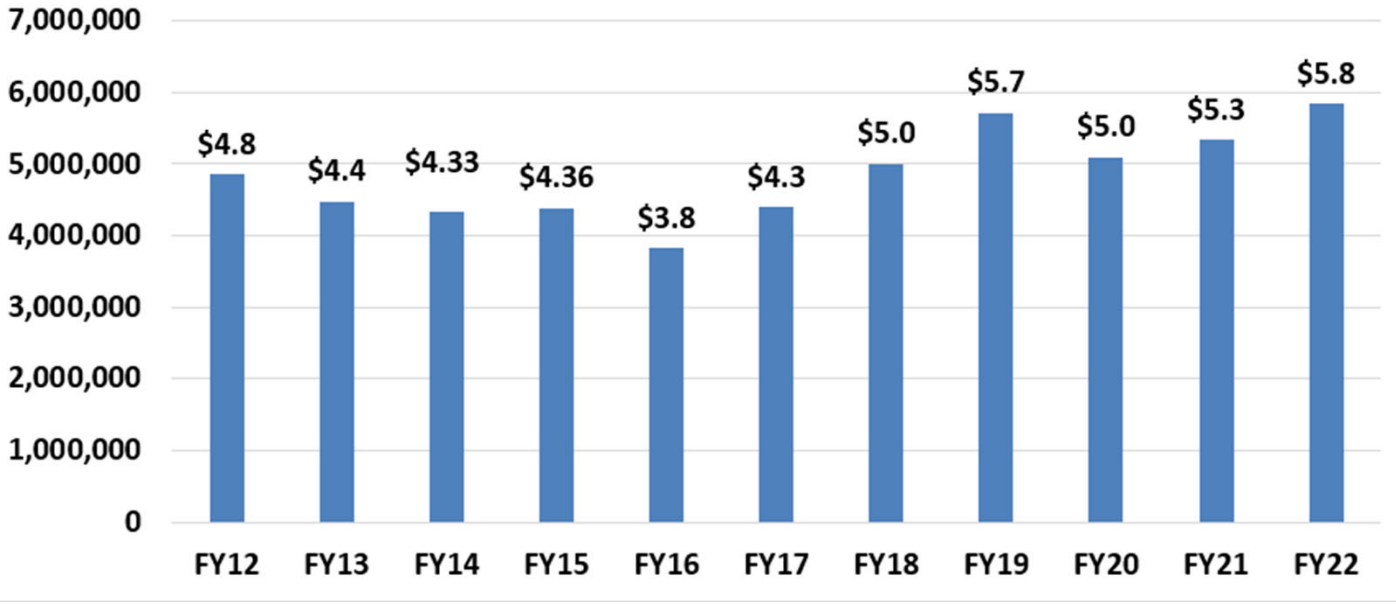
- **The workers' compensation reforms passed by the State of Alaska Legislature on May 11, 2018 (SCS CSHB 79(FIN)) provided for the closure of the Second Injury Fund. The Department of Labor and Workforce Development shall continue to administer the Second Injury Fund and payment of its remaining liabilities.**

065

Fiscal Year-End Balance (millions)

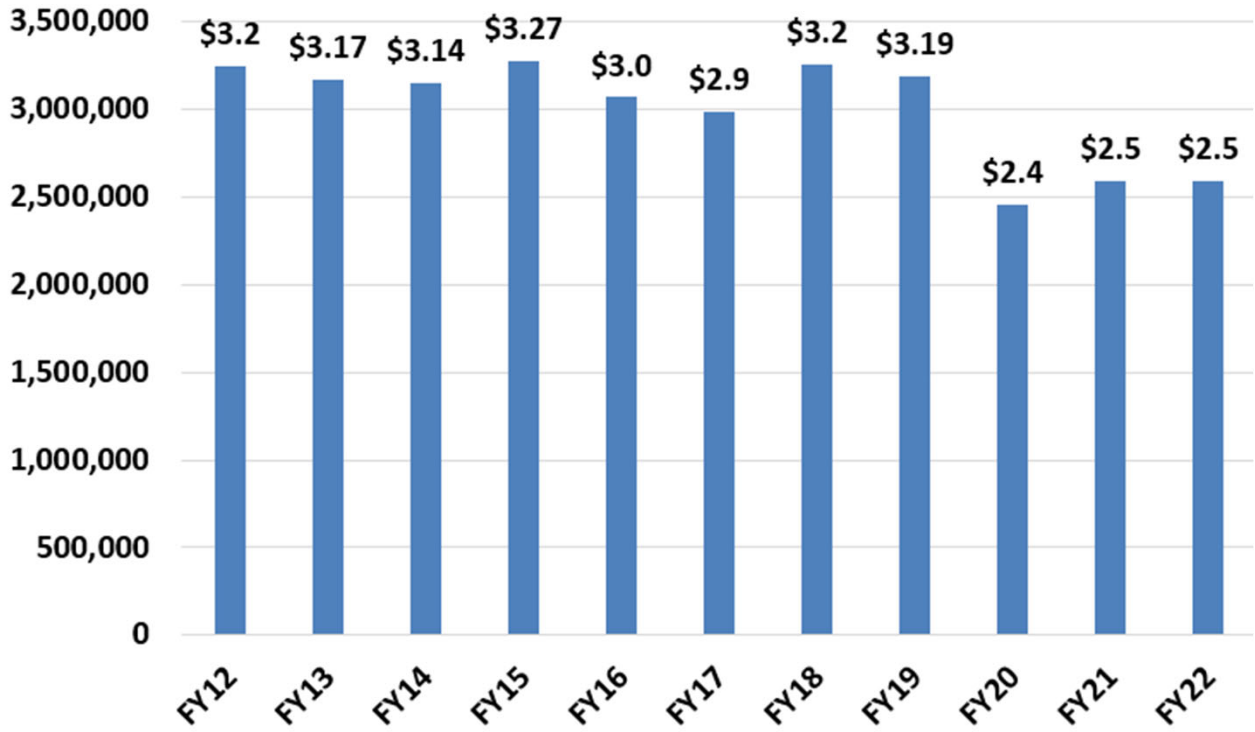
Fiscal Year	Balance
2022	$5,833,430
2021	$5,328,646
2020	$5,092,860
2019	$5,713,621
2018	$5,003,206
2017	$4,390,500
2016	$3,817,700
2015	$4,369,141
2014	$4,336,000
2013	$4,468,000
2012	$4,847,700

Second Injury Fund balance increased by $605,172 in FY2022, an 9% increase from $5.3 million to $5.8 million.

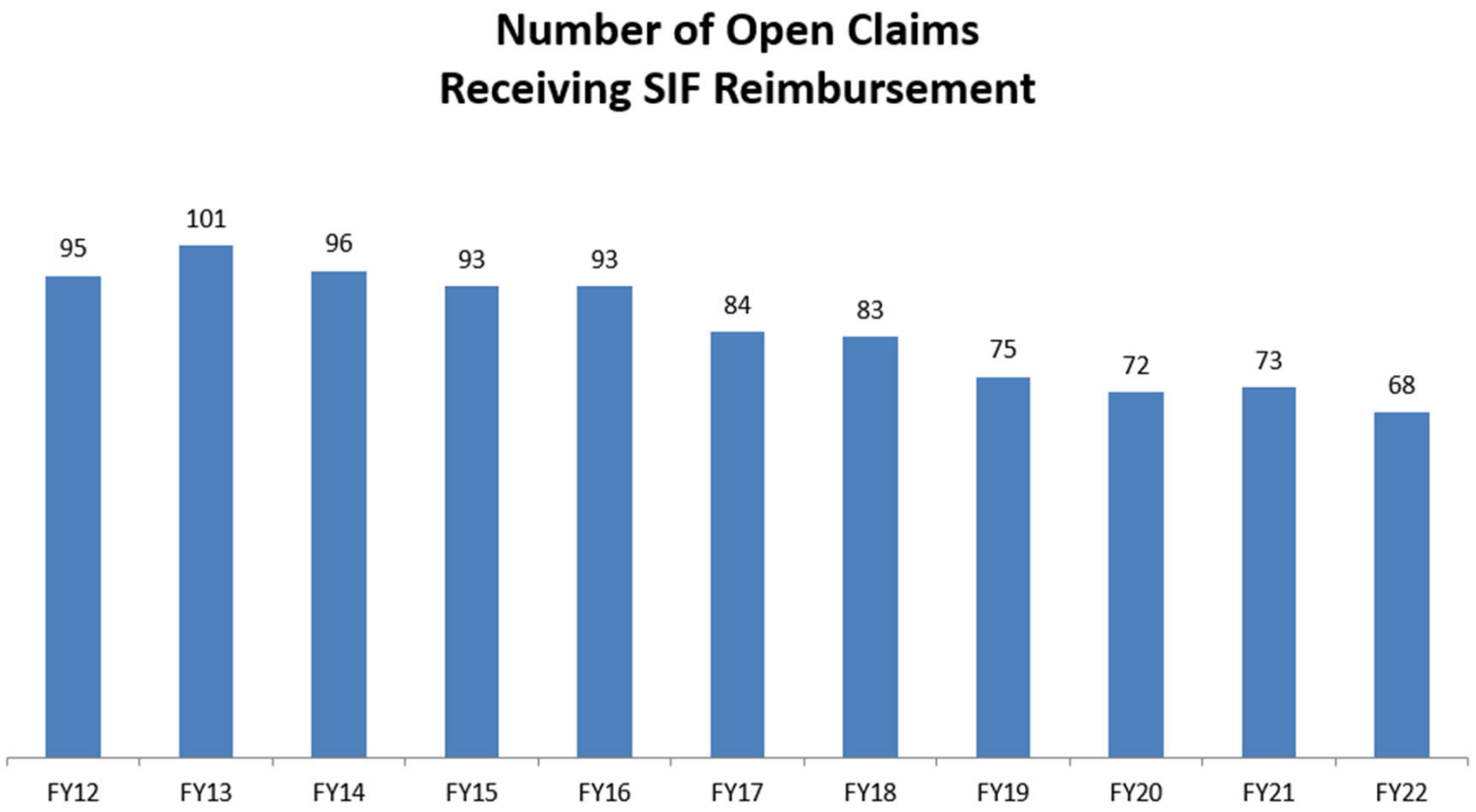


Revenues (millions)

Fiscal Year	Revenue
2022	$2,591,282
2021	$2,593,298
2020	$2,452,494
2019	$3,190,588
2018	$3,257,228
2017	$2,984,507
2016	$3,067,905
2015	$3,274,682
2014	$3,146,551

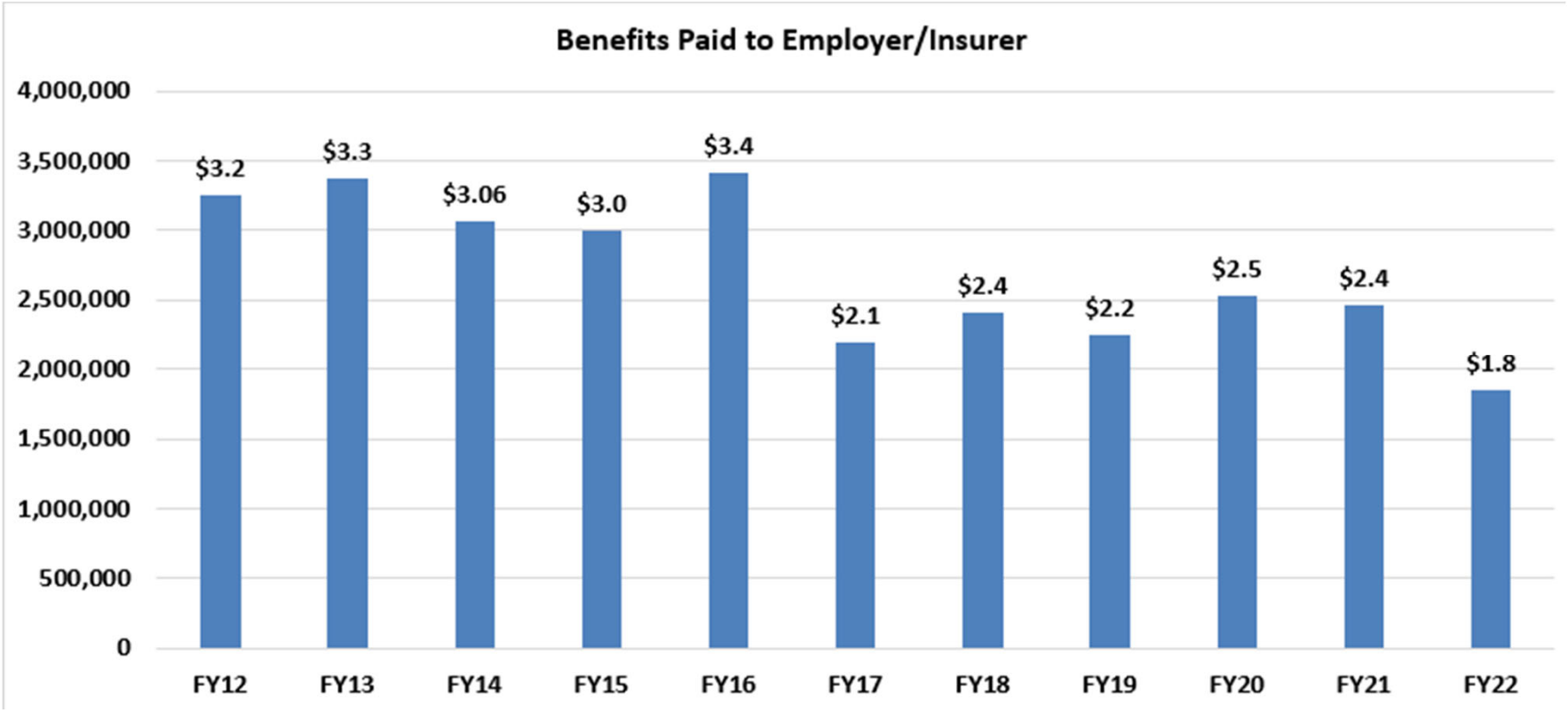


Open Claims



In FY2022, Trading Partners reported on 11 claims in which injured employees passed away.

Grant Payments (millions)



690

Projected liquidation of all claims is approximately 10 to 15 years.

Grant Payments by Employer/Type

Top Ten Reimbursement Recipients		
Rank	**Insurer/Self-Insurer**	**Amount**
1.	State of Alaska	**$271,431**
2.	Municipality of Anchorage	**$170,247**
3.	Alaska National	**$148,479**
4.	Alaska Timber Insurance Exchange	**$123,466**
5.	National Union Fire Ins	**$105,525**
6.	Arctic Slope Regional Corporation	**$104,950**
7.	Ace American	**$101,291**
8.	Ace Indemnity	**$95,371**
9.	ANCHORAGE SCHOOL DISTRICT	**$74,738**
10.	Commerce & Industry	**$71,382**
	Total	**$1,266,879**

070

For FY2022, Second Injury Fund reimbursements totaled $1.8 million compared to $2.8 million in FY2021.

For FY2022, top ten employer reimbursement payments totaled $1.2 million compared to $1.7 million in FY2021.

Reimbursement Recipients by Type			
#	**Type**	**Amount**	**%**
15	Market Insurer	$980,842	53%
12	Self-Insureds	$860,954	47%
27	**Total**	**$1,841,796**	

Contribution Rate History

The 2018 reform amendment, effective November 22, 2018, changed revenue stream of SIF penalties for late compensation report filing, under AS 23.30.155(c) from Second Injury Fund to the Workers' Safety and Compensation Administrative Account.

SECOND INJURY FUND RATE		
Year	Rate	Calculated On
1959 - 1966	2%	PPD
1966 - 1970	5%	PPD
1971 - 1981	8%	PPD
1982 - 1985	6%	TTD,TPD,PPI & PTD
1986	5%	TTD,TPD,PPI & PTD
1987-1989	0%	TTD,TPD,PPI & PTD
1990	3%	TTD,TPD,PPI & PTD
1991	5%	TTD,TPD,PPI & PTD
1992 -1994	6%	TTD,TPD,PPI & PTD
1995	5%	TTD,TPD,PPI & PTD
1996	6%	TTD,TPD,PPI & PTD
1997 - 1998	5%	TTD,TPD,PPI & PTD
1999	6%	TTD,TPD,PPI & PTD
2000	5%	TTD,TPD,PPI & PTD
2001 - 2008	6%	TTD,TPD,PPI & PTD
2009	5%	TTD,TPD,PPI & PTD
2010	4%	TTD,TPD,PPI & PTD
2011	5%	TTD,TPD,PPI & PTD
2012 - 2018	6%	TTD,TPD,PPI & PTD
2019 - 2021	5%	TTD,TPD,PPI & PTD

071

QUESTIONS?

072

REEMPLOYMENT BENEFITS ANNUAL REPORT
Calendar Year 2021

073

Stacy Niwa
Reemployment Benefits Administrator

Reemployment Benefits Section

- Provides information about reemployment benefits
- Notifies employees of their reemployment 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 benefits plans upon request

074

2021 By the Numbers

- 438 injured workers were referred for evaluations for eligibility for reemployment benefits.
- 952 eligibility evaluation reports were reviewed.
- 146 suspension letters were issued.
- 341 eligibility determinations were made.
- 73 injured workers were found eligible for reemployment benefits.
- 30 injured workers elected to receive a job dislocation benefit.

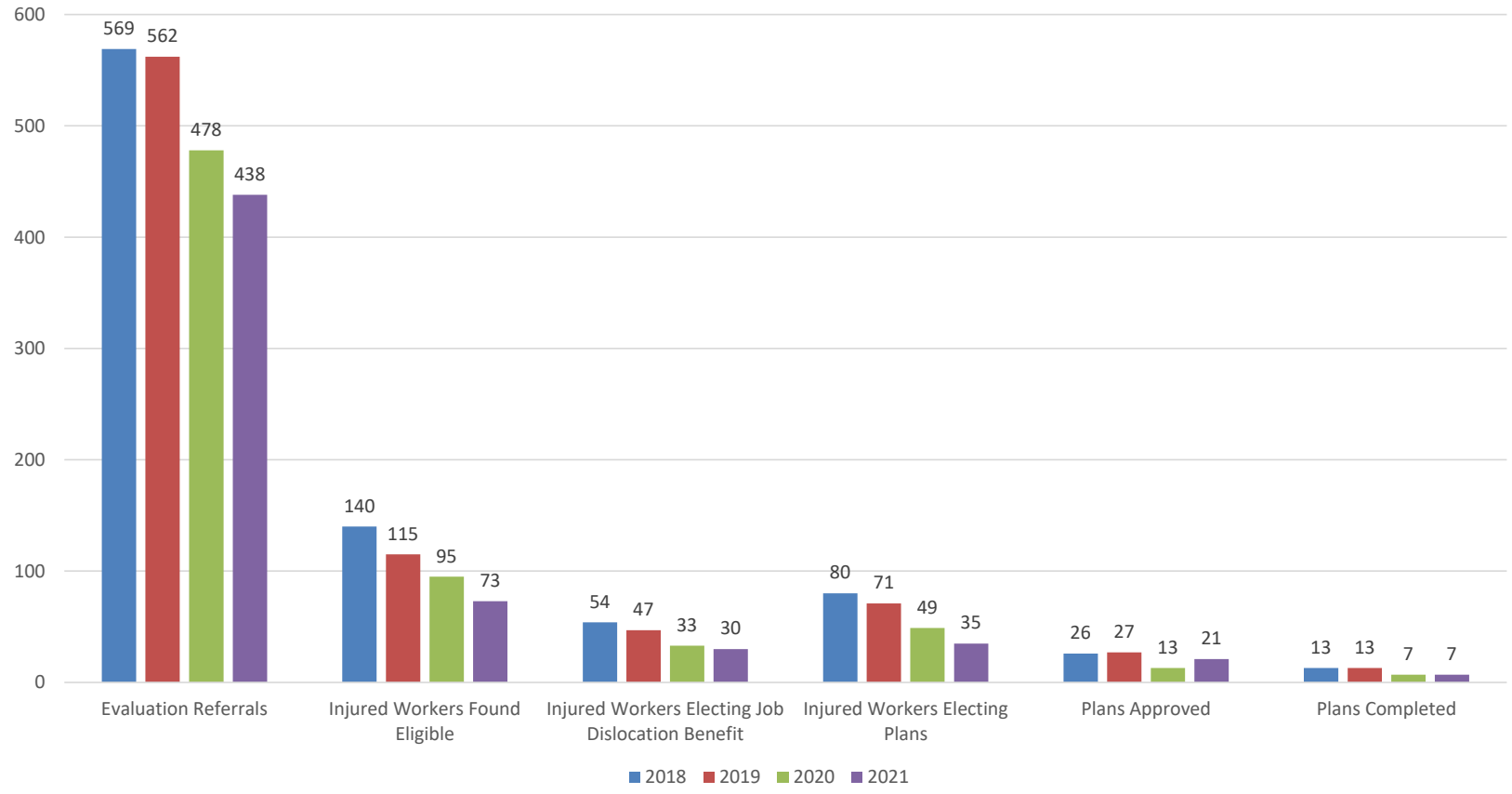
075

2021 By the Numbers, Cont.

- 35 elected to pursue reemployment benefits.
- 39 reemployment plans were submitted.
- 21 plans were signed by all parties and moved forward as agreed upon plans.
- 4 plan reviews were completed.
- 4 informal rehabilitation conferences were held to assist the parties in moving forward with reemployment benefits.
- 7 injured workers completed reemployment plans.

076

Reemployment Trends



077

Reemployment Benefit Plans

- 95 injured workers were in the plan process at some point during 2021.
- 29 injured workers were referred for plan development in 2021.
- 34 injured workers exited the process through a Compromise and Release after plan referral and before plan completion.
- 21 injured workers were in an approved plan at year end.
- 26 injured workers were in plan development and 15 plans were pending approval at year end.
- 7 injured workers successfully completed plans with an average plan length of 21 months from plan approval to plan completion.

078

Reemployment Benefit Plans, Cont.

- 55 plans were stalled or exited for various reasons.
  - 8 injured workers' plan process was medically suspended.
  - 30 injured workers exited through a Compromise and Release agreement.
  - 10 plans were controverted or a petition to terminate reemployment benefits was filed.
  - 1 plan was unable to be developed to meet statutory requirements.
  - 3 plan processes were halted because the injured worker was non-participatory.
  - 1 plan was unsuccessful because the time had expired.
  - 1 employee was deceased.
  - 1 employee returned to work in their job of injury.

Outcomes for Workers Completing Plans

- The Reemployment Benefits Section attempted to contact 28 injured workers that had completed plans between 2019 and 2021.
- 14 injured workers responded.
- 7 injured workers had returned to the workforce.
- 4 reported they were working in the plan goal or related.
- 7 injured workers reported they had not returned to work.
  - 2 reported they are undergoing medical treatment
  - 2 reported they are unemployed but did not provide a reason
  - 1 reported they are caring for family rather than working
  - 1 reported they are continuing their education
  - 1 injured worker is deceased

080

Reemployment Benefit Costs

	2019	2020	2021
Evaluation Costs	$2,063,164	$1,472,596	$1,573,099
Reemployment Specialist Plan Fees	$641,112	$626,545	$551,153
Plan Costs	$640,734	$503,629	$263,607
Wage Benefits (AS 23.30.041(k))	$2,536,056	$2,135,149	$2,053,267
Job Dislocation Benefits (AS 23.30.041(g))	$1,587, 030	$2,961,687	$917,890
TOTALS	$7,468,096	$7,699,606	$5,359,016
% Change	-3.59%	-3.10%	-30.40%

081

Reemployment Benefits in Settlements

Impact of settlements on reemployment benefits in 2021

- 45 injured workers exited the reemployment benefits process through Compromise and Release agreements during the reemployment benefits process.
- 48 injured workers had funds designated for reemployment benefits included in settlements approved in 2021, increasing reemployment benefit costs.
    - 23 of these injured workers had never been determined eligible for reemployment benefits, many had never entered the reemployment process or had been found not eligible for reemployment benefits.
- 88 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.

082

Rehabilitation Specialists

- 17 Alaska Rehabilitation Specialists accepted 357 referrals for eligibility evaluations; 81 evaluations were referred to 35 specialists out of state.
- 1 Alaska specialist retired, and 1 Alaska specialist passed away in 2021.
- For Alaska Based Specialists:
  - 263 or 74% of the first reports were submitted within 60 days of the referral.
  - 137 or 38% of the evaluations were completed on the first report submission.
  - 194 or 54% of the evaluations were completed prior to a suspension letter from a Reemployment Benefits Administrator Designee.
  - 173 reports did not meet statutory/regulatory requirements.
- Continued improvements in our process are being made to ensure all 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.

083

2021 Reemployment Benefit Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1st report	Complete on 1st report or w/o suspension letter	# of late 1st reports	# 60 day gaps in reporting	# reports not meeting stat/reg	Median # days to determ
L. Cortis	17	62	47%	17%	2	6	71
J. Cranston	31	31	61%	0.3%	3	57	57
K. Davis	21	41	29%	14%	2	9	74
J. Doerner	36	30	97%	0.5%	0	2	33
P. Harmon	8	33	50%	38%	1	7	44
R. Hoover	38	30	63%	11%	1	5	44
T. Hutto	11	34	45%	18%	0	14	52
S. Krier	12	30	83%	17%	0	4	41

084

2021 Reemployment Benefit Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1st report	Complete on 1st report or w/o suspension letter	# of late 1st reports	# 60 day gaps in reporting	# reports not meeting stat/reg	Median # days to determ
D. LaBrosse	10	32	30%	30%	3	17	54
C. Robbins	36	35	94%	17%	0	9	34
B. Roberts	6	35	50%	33%	0	6	76
F. Sakata	15	45	40%	20%	1	23	47
J. Shipman	19	20	95%	0%	0	0	24
N. Silta	24	26	83%	0.4%	0	2	29
T. Torvie	2	28	50%	0%	0	0	28
P. Vargas	35	42	86%	0.9%	0	5	43
A. White	34	28	38%	18%	0	7	84

085

QUESTIONS?

080

SPECIAL INVESTIGATION UNIT
ANNUAL REPORT

087

Rhonda Gerharz
Chief Investigator

Special Investigation Unit

- Established by Alaska Legislature in 2005 – AS 23.30.280
- Part of Overall Division Budget
- Staffing:
  - Rhonda Gerharz, Chief Inv. – Anchorage (1/2009)
  - Christine Christensen, Inv. 3 – Anchorage (10/2007)
  - Wayne Harger, Inv. 3 – Fairbanks (4/2011)
  - Dave Price, Inv. 3 – Juneau (3/2014)
  - Michele Wall-Rood, Inv. 3 – Anchorage (10/2021)
  - Julie Milazzo, Inv. 2 – Anchorage (02/2022)

088

Mission and Core Values

- SIU In-Person Staff Meeting July 2022 – Dedicated, Responsible, Diligent and Resilient

- **Mission Statement**: SIU 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.

- **Core Values**:
  - **Integrity** – We do the right thing, for the right reason, even when no one is looking. We act with honesty, honor, impartiality, fairness, and transparency. We never compromise the truth.
  - **Respect** – We treat others how we expect to be treated, 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 as much as possible, 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 care for each other. We support each other in creating an exceptional work environment, and encourage a healthy work-life balance

Challenges

- Criminal Fraud Prosecution
- Employers Without Records
- Staffing (Quantity, Not Quality)
  - Recruited Inv. 2 and 3 PCNs
  - New Performance Evaluation System
  - Tech Support
  - Proactive Outreach
  - Caseloads

090

Achievements

- 70 Settlements Despite Reduced Staff
- Continued Multi-Agency Collaboration
  - FBI Healthcare Fraud Task Force
  - FBI Financial Crimes Task Force
  - Local and State Law Enforcement Agencies
  - Labor Standards & Safety (AKOSH, W&H)
- 363 FTI Investigations – 254 Opened/257 Closed
- Increased Percentage of Cases Closed in 6 Months
- Website Update Revised Employer Guide and Podcast

091

Fraud Hotline and Email Tips

	FY2020	FY2021	FY2022	Year-to-Date First Quarter FY2023 (7/1/2022-9/30/2022)
Total Fraud Tip Calls and Emails	205	143	116	52
Claimant/Injured Worker Tips	21	13	18	3
Employer Tips	82	66	41	20
Care Providers	6	2	2	0
Attorneys/Non-Attorney Reps	0	0	1	1
Insurance Companies/Agents	6	0	2	0
Fish Fund Claimants	1	0	0	0
Law Enforcement Agency Assist Requests	86	60	51	27
Other/Non-Related	3	2	1	1

092

Failure to Insure Fraud Investigations

ACTIVITY	FY2020	FY2021	FY2022	Year-to-Date First Quarter FY2023 (7/1/2022-9/30/2022)
Pending Cases Carried Forward	91	116	87	106
New Cases Opened	253	235	254	130
Cases Closed	229	240	257	93
Total Cases Worked	347	323	363	236
Petitions	71	93	101	32
Pre-Hearings Attended	97	126	116	44
Compliance Checks	412	368	350	115
Public Inquiries	288	255	254	61
Formal Hearings	3	7	5	2
Warning Letters	63	19	43	5
Investigation Only	97	115	125	49
Settlements Paid in Full	48	66	59	38
Settlements with Payment Plans	11	15	11	1
Percentage Closed in 6 Months	74.24% (170 of 229)	67.23% (158 of 235)	76.65% (197 of 257)	83.87% (78 of 93)
Total Penalties	$684,008	$1,728,592	$4,535,255	$470,503
Total Discounts	$115,575	$260,930	$164,586	$72,004
Total Suspensions	$193,082	$598,928	$3,757,865	$126,184
Total Payable	$375,351	$868,734	$612,804	$272,314
Uninsured Injuries	20	21	9	4
Interagency Referrals	28	27	18	12

093

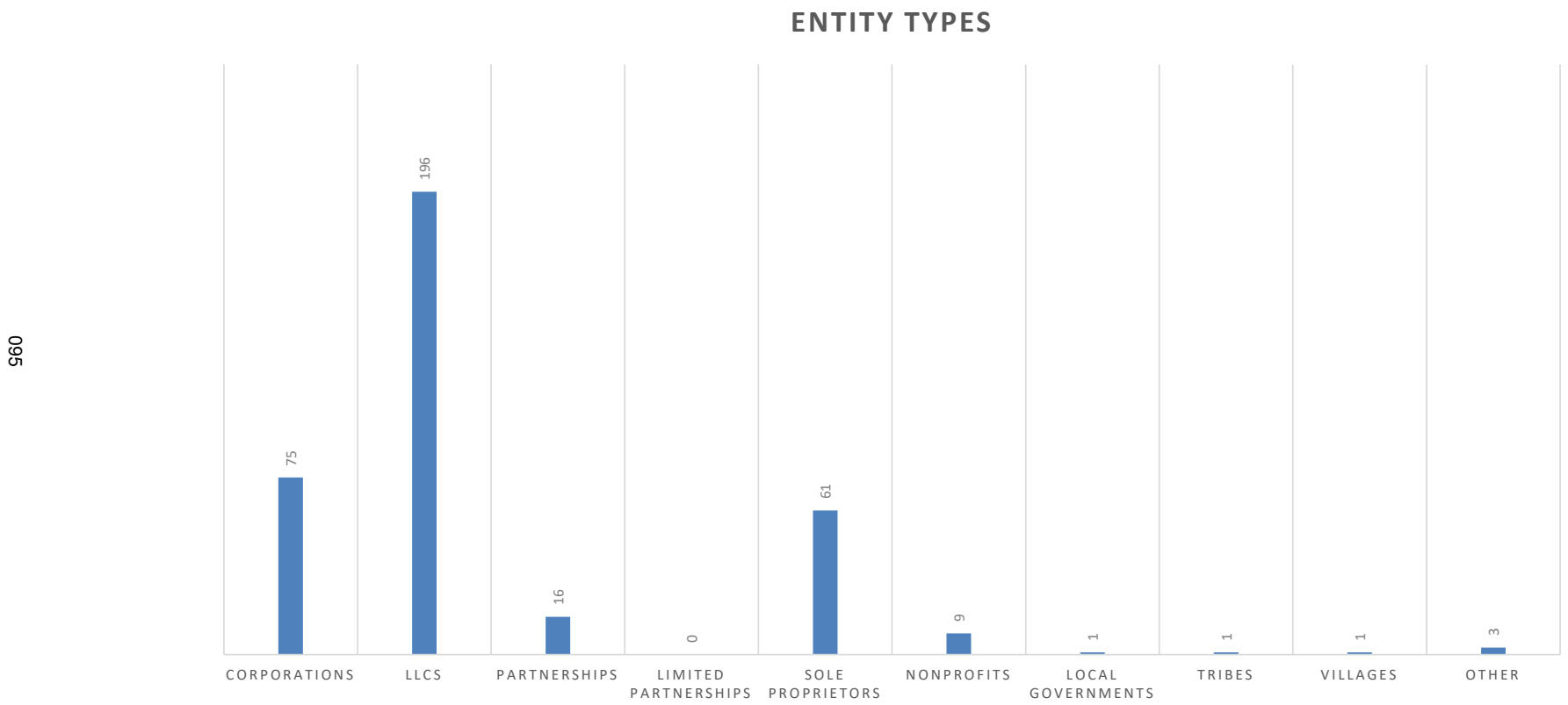
Failure to Insure FY2022

Investigations Opened/Re-Opened	Investigations Closed	Uninsured Injury Referrals Received	Uninsured Injuries Confirmed	Employers With Uninsured Injuries Petitioned
254	257	9	9	8

	Assessed By	Total Assessed	Discounted	Suspended	Ordered to Pay
FY2022	70 Settlements (11 with payment plans)	$1,056,891	$164,586	$361,707	$530,598
	5 Decisions (All Final)	$3,478,364	N/A	$3,396,158	$82,206
	TOTALS	**$4,535,255**	**$164,586**	**$3,757,865**	**$612,804**

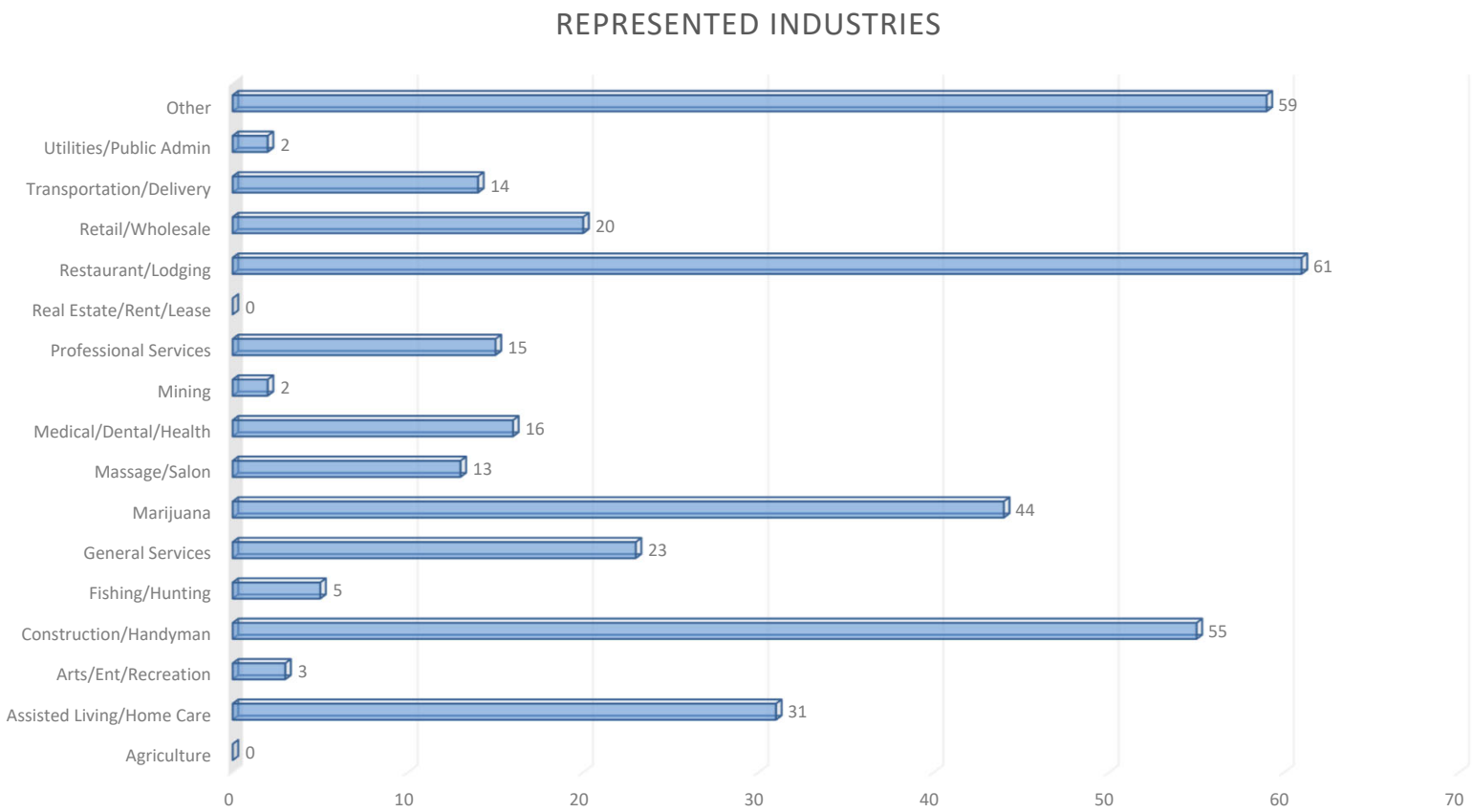
094

Industry Data for FTI Investigations



Industry Data for FTI Investigations

960



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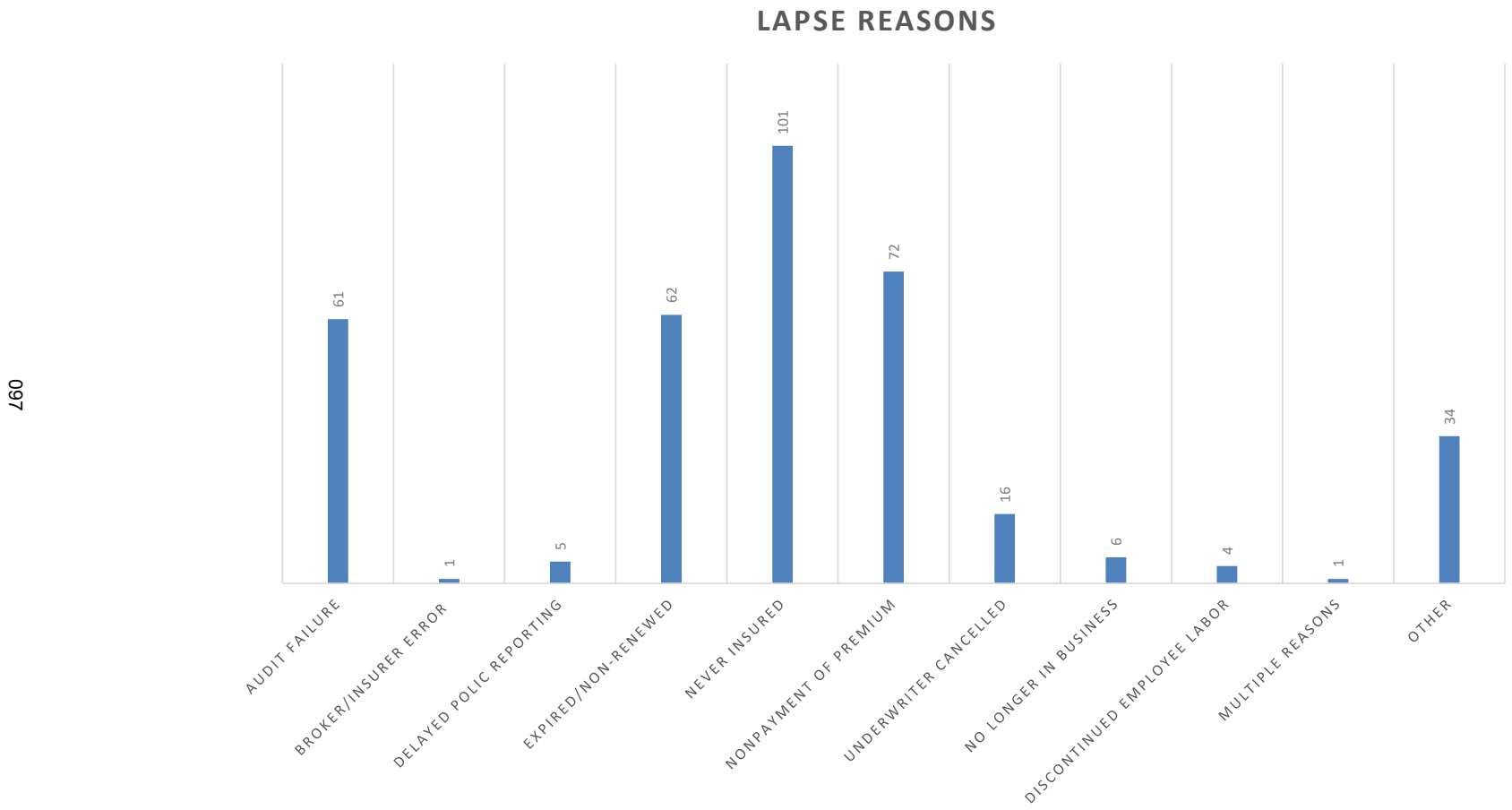

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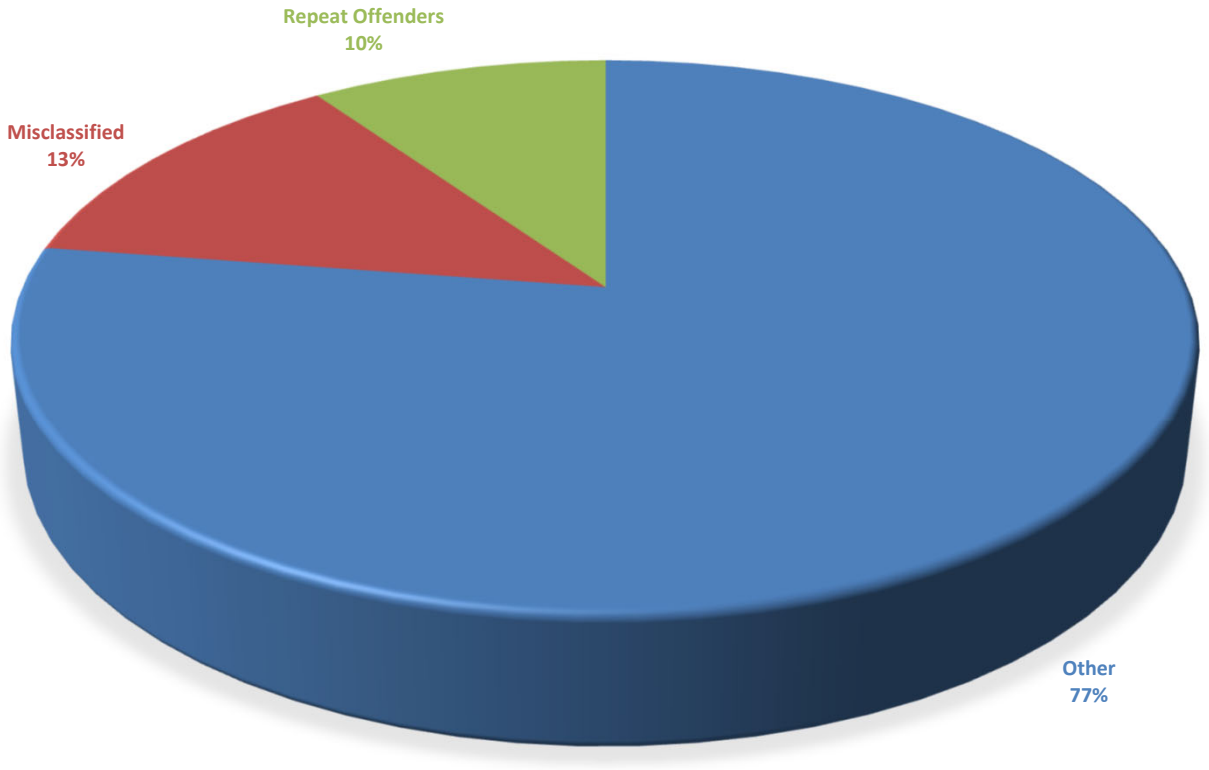

098

Current Goals/Priorities

- Stronger Criminal Fraud Laws
- SIU Separate Budget/Increased Staffing
- Continued Six Month Case Resolution
- Continued Multiple Agency Joint Investigations
- Resume Targeted Proactive Education

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QUESTIONS?

100

Second Independent Medical Evaluations (SIME)
Annual Report for October 2022 Board Meeting

AS 23.30.095
8 AAC 45.092

Dani Byers
Workers' Compensation Officer II, SIME Coordinator

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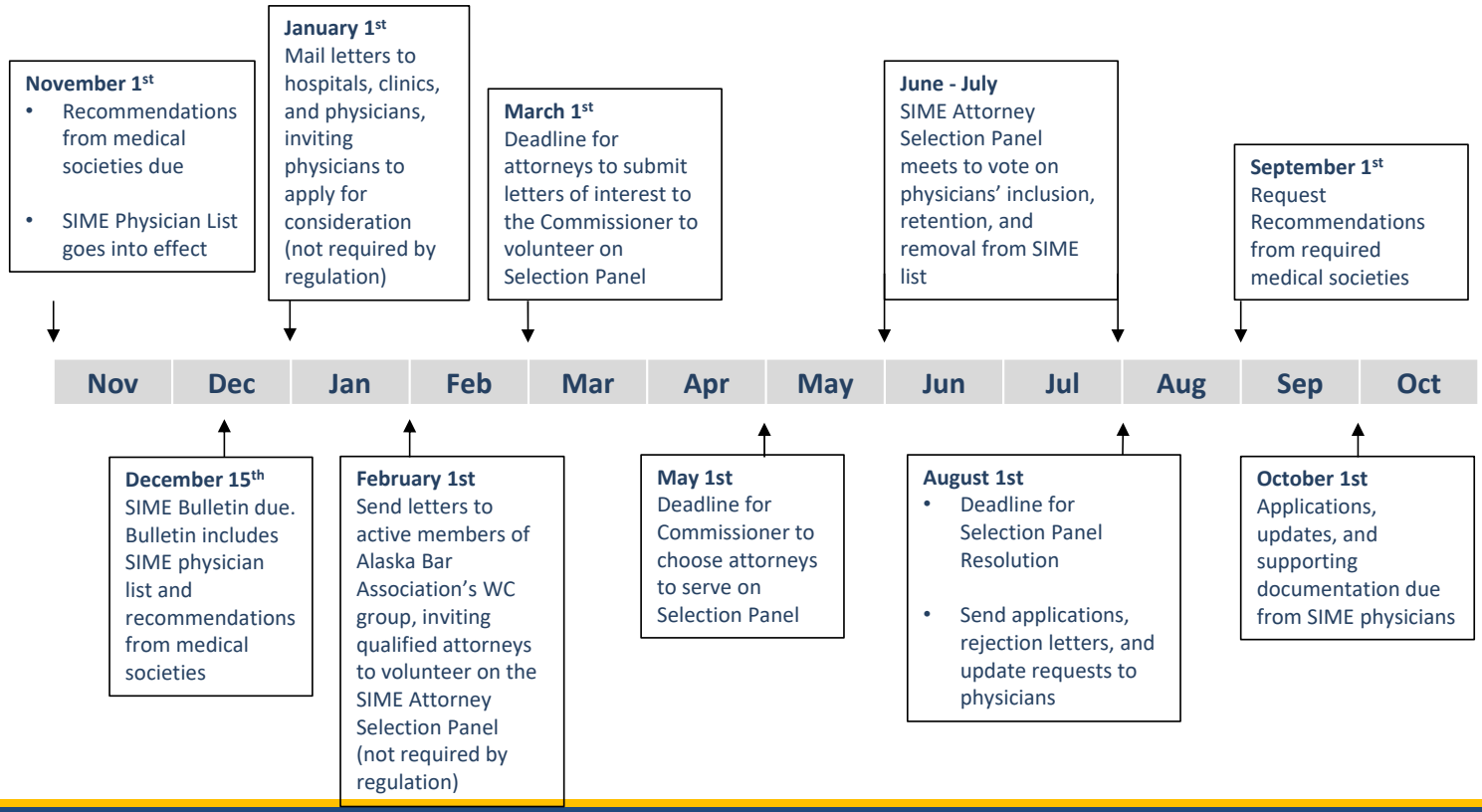
Second Independent Medical Evaluations

SIME ANNUAL PROCESS

November 1st – October 31st



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2022 SIME Selection Panel

2022 Panel Meetings:

- June 8, 2022
- June 22, 2022
- July 6, 2022
- July 27, 2022

Panel Members:

- J. John Franich, Employee Attorney
- Andrew Wilson, Employee Attorney
- Rebecca Holdiman Miller, Employer Attorney
- Aaron Sandone, Employer Attorney

Panel Staff:

- Charles Collins, Division Director
- Dani Byers, Workers' Compensation Officer II, SIME Coordinator
- Alexis Hildebrand, Administrative Officer II
- Rachel Michaud, Administrative Assistant II

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2022 SIME Selection Panel

New 2022/2023 SIME Physicians Selected:

- Raj Ahluwalia, MD -Orthopedic Surgery
- Vincente Bernabe, DO -Orthopedic Surgery
- Adam Brooks, MD -Orthopedic Surgery
- Rina Jain, MD -Orthopedic Surgery
- Ardalan Alen Nourian, MD-Orthopedic Surgery
- Purab Viswanath, MD -Orthopedic Surgery
- Lucas Campos, MD, PhD -Anesthesiology & Pain Medicine
- Benjamin Simon, MD -Cardiology & Internal Medicine
- Hirsh Kaveeshvar, DO -Neurology & Pain Medicine
- Paul Kaloostian, MD - Neurosurgery
- Todd Lefkowitz, MD -Ophthalmology
- Andrew Berman, MD -Otolaryngology
- Rachyll Dempsey, PsyD –Psychology
- Jeffrey Brent, MD, PhD-Toxicology

2022 SIME Selection Panel

2019 SIME Physicians Re-Selected:

- Roy L. Curry, MD - Psychiatry (declined to renew)
- Paul C. Murphy, MD - Orthopedic Surgery

2019 SIME Physicians Not Re-Selected:

- Robert L. Tatsumi, MD – Orthopedic Surgery

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SIME Physicians Removed:

- None

2022 SIME Physician Retirements and Non-Renewals

SIME physicians retiring this year, after many years assisting the board:

Ronald G. Early, MD, PhD – Psychiatry (SIME since 1999)
29 SIMEs assigned

Ronald N. Turco, MD – Psychiatry (SIME since 1998)
22 SIMEs assigned

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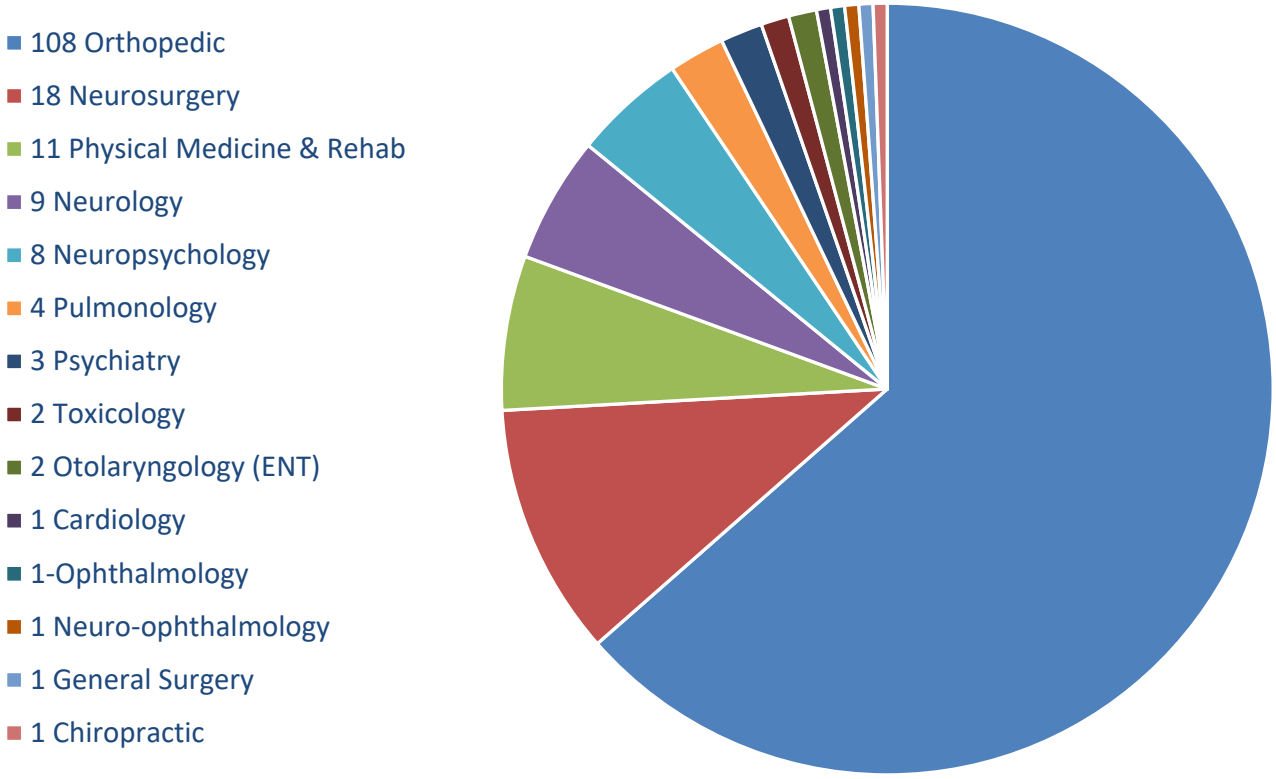
SIME physicians not renewing this year for other reasons:

- Roy Curry, MD – Psychiatry (since 2019)
- Mark Silver, MD – Endocrinology (since 2017)

SIMEs by Specialty 11/1/2021 – 10/31/2022



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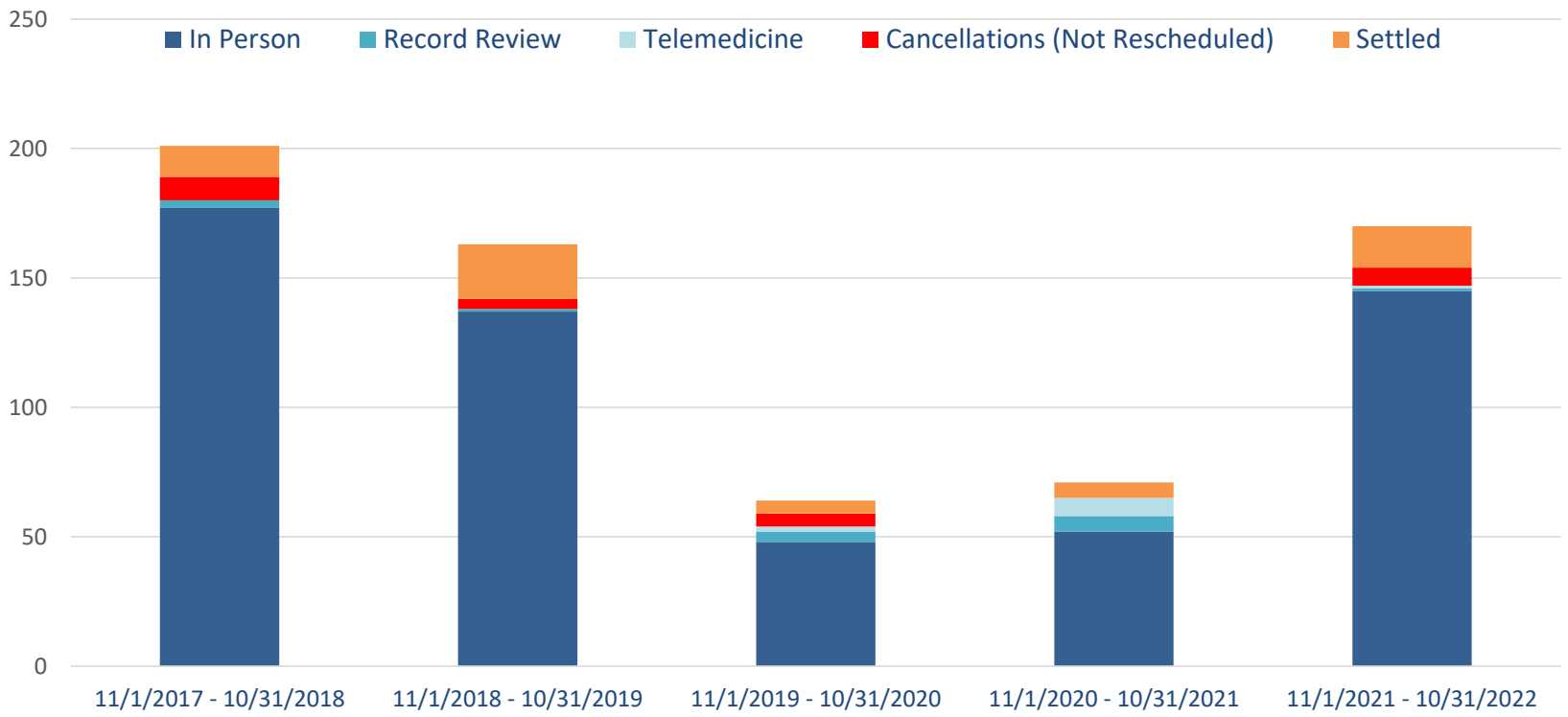
Number of SIMEs and Methods - 5 Year Comparison



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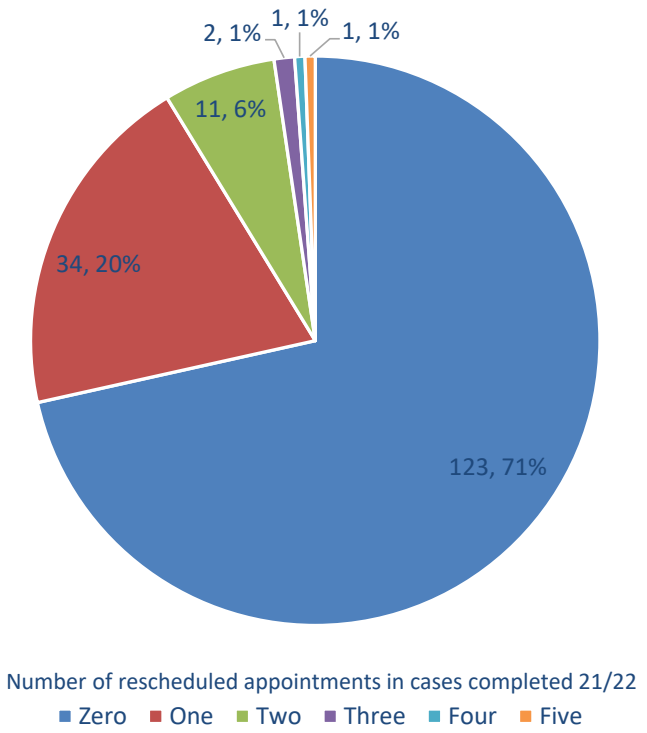
Rescheduling SIMEs 11/1/2021 – 10/31/2022

Many SIMEs have been canceled and rescheduled over the last two years due to the Covid pandemic.

Of the 170 SIMEs completed, canceled, or settled 11/1/21 – 10/31/22, many have been rescheduled multiple times, some throughout multiple years. This has affected the accuracy of cancelation statistics. This chart is included to provide a more accurate impression of the number of rescheduled appointments that have occurred historically in this year's cases.



QUESTIONS?

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TAB 7

8 AAC 45.083(a) is amended to read:

(a) A fee or other charge for medical treatment or service may not exceed the maximums in AS 23.30.097. The fee or other charge for medical treatment or service

(1) provided on or after December 1, 2015, but before April 1, 2017, may not exceed the fee schedules set out in (b) – (*l*) of this section;

(2) provided on or after April 1, 2017, but before January 1, 2018, may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective April 1, 2017, and adopted by reference;

(3) provided on or after January 1, 2018, but before January 1, 2019, may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective January 1, 2018, and adopted by reference;

(4) provided on or after January 1, 2019, but before January 1, 2020, may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective January 1, 2019, and adopted by reference.

(5) provided on or after January 1, 2020, but before January 1, 2021, may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective January 1, 2020, and adopted by reference.

(6) provided on or after January 1, 2021, but before February 24, 2022, may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective January 1, 2021, and adopted by reference.

(7) provided on or after February 24, 2022, may not exceed the maximum allowable reimbursement established in the Official Alaska Workers' Compensation Medical Fee Schedule, January 1, 2022 edition, and adopted by reference.

(8) provided on or after January 1, 2023, may not exceed the maximum allowable reimbursement established in the Official Alaska Workers' Compensation Medical Fee Schedule, January 1, 2023 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 ___/___/____, Register _____)

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

8 AAC 45.083(m)(10) is amended to read:

(10) *Hospital Outpatient Prospective Payment System*, dated January 1, **2023** [2022], produced by the federal Centers for Medicare and Medicaid Services;

(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 ___/___/____, Register _____)

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

8 AAC 45.025. Forms is amended to read:

(a) The **division** [*board*] will, in its discretion and from time to time, prescribe and require the use of forms for the reporting of any information required by this chapter or by the Act.

(b) A person may obtain a list of prescribed and required forms by contacting the division at its offices in Juneau, Anchorage, or Fairbanks.

(c) A list or form referred to in this chapter may be obtained by writing to the State of Alaska, Workers' Compensation Division, P.O. Box 115512, Juneau, Alaska 99811-5512 or on the division's Internet website at http://www.labor.alaska.gov/wc/pdf=hrzlist.htm.

Authority: AS 23.30.005

8 AAC 45.040. Parties is amended to read:

(a) Except for a deceased employee's dependent or a rehabilitation specialist appointed by the administrator or chosen by an employee in accordance with AS 23.30.041, a person other than the employee filing a claim shall join the injured employee as a party.

(b) Except for a rehabilitation specialist appointed by the administrator or chosen by the employee in accordance with AS 23.30.041, a person who files a claim must first prove a compensable injury to be eligible for benefits, or the opposing party must stipulate to or admit facts from which the board can find the employee's injury is compensable.

(c) Any person who may have a right to relief in respect to or arising out of the same transaction or series of transactions should be joined as a party.

(d) Any person against whom a right to relief may exist should be joined as a party.

(e) In a death case, all persons, except minor children, who may be dependents or beneficiaries of the deceased employee, should either join or be joined as parties so the entire liability of the employer or carrier to the dependents or beneficiaries is determined in one proceeding. A minor child's claim must be filed by the surviving parent or other authorized representative.

(f) Proceedings to join a person are begun by

(1) a party filing with the board a petition to join the person and serving a copy of the petition, in accordance with 8 AAC 45.060, on the person to be joined and the other parties; or

(2) the board or designee serving a notice to join on all parties and the person to be joined.

(g) A petition or a notice to join must state the person will be joined as a party unless, within 20 days after service of the petition or notice, the person or a party files an objection with the board and serves the objection on all parties. If the petition or notice to join does not conform to this section, the person will not be joined.

(h) If the person to be joined or a party

(1) objects to the joinder, an objection must be filed with the board and served on the parties and the person to be joined within 20 days after service of the petition or notice to join; or

(2) fails to timely object in accordance with this subsection, the right to object to the joinder is waived, and the person is joined without further board action.

(i) If a claim has not been filed against the person served with a petition or notice to join, the person may object to being joined based on a defense that would bar the employee's claim, if filed.

(j) In determining whether to join a person, the board or designee will consider

(1) whether a timely objection was filed in accordance with (h) of this section;

(2) whether the person's presence is necessary for complete relief and due process among the parties;

(3) whether the person's absence may affect the person's ability to protect an interest, or subject a party to a substantial risk of incurring inconsistent obligations;

(4) whether a claim **or petition** was filed against the person by the employee; and

(5) if a claim was not filed as described in (4) of this subsection, whether a defense to a claim, if filed by the employee, would bar the claim.

(k) If claims are joined together, the board or designee will notify the parties which case number is the master case number. After claims have been joined together,

(1) a pleading or documentary evidence filed by a party must list the master case number first and then all the other case numbers;

(2) a compensation report, controversion notice, or a notice under AS 23.30.205(f) must list only the case number assigned to the particular injury with the employer filing the report or notice;

(3) documentary evidence filed for one of the joined cases will be filed in the master case and the evidence will be considered as part of the record in each of the joined cases; and

(4) the original of the board's decision and order will be filed in the master case file, and a copy of the decision and order will be filed in each of the joined case files.

(l) After the board hears the joined cases and, if appropriate, the division will separate the case files and will notify the parties. If the joined case files are separated, a pleading or documentary evidence filed thereafter by a party must list only the case number assigned to the particular injury with the employer filing the pleading or documentary evidence.

Authority: AS 23.30.005 AS 23.30.110 AS 23.30.140
AS 23.30.010 AS 23.30.135 AS 23.30.225

8 AAC 45.050. Pleadings is amended to read:

(a) A person may start a proceeding before the board by filing a written claim or petition.

(b) Claims and petitions.

(1) A claim is a written request for benefits, including compensation, attorney's fees, costs, interest, reemployment or rehabilitation benefits, rehabilitation specialist or provider fees, or medical benefits under the Act, that meets the requirements of (4) of this subsection. The board has a form that may be used to file a claim. In this chapter, an application is a written claim.

(2) A request for action by the board other than by a claim must be by a petition that meets the requirements of (8) of this subsection. The board has a form that may be used to file a petition.

(3) Parties must be designated in accordance with 8 AAC 45.170.

(4) Within 10 days after receiving a claim that is complete in accordance with this paragraph, the board or its designee will notify the employer or other person who may be an

interested party that a claim has been filed. The board will give notice by serving a copy of the claim by certified mail, return receipt requested, upon the employer or other person. **If the employer was not insured at the time of the injury, the board or its designee will in addition to the above, serve a copy of the claim on the Alaska Workers' Compensation Benefits Guaranty Fund.** The board or its designee will return to the claimant, and will not serve, an incomplete claim. A claim must

(A) state the names and addresses of all parties, the date of injury, and the general nature of the dispute between the parties; and

(B) be signed by the claimant or a representative.

(5) A separate claim must be filed for each injury for which benefits are claimed, regardless of whether the employer is the same in each case. 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 for consolidation and asking in writing for a prehearing, or a designee may raise the issue at a prehearing. To consolidate cases, at the prehearing the designee must

(A) determine the injuries or issues in the cases are similar or closely related;

(B) determine that hearing both cases together would provide a speedier remedy; and

(C) state on the prehearing summary that the cases are consolidated, and state which case number is the master case number.

(6) After cases have been consolidated under (5) of this subsection,

(A) a pleading or documentary evidence filed by a party must list the master case number first and then all the other consolidated case numbers;

(B) a compensation report, controversion notice, or a notice under AS 23.30.205(f) must list only the case number assigned to the particular injury with the employer filing the report or notice;

(C) documentary evidence filed for one of the consolidated cases will be filed in the master case file; the evidence is part of the record in each of the consolidated cases; and

(D) the original of the board's decision and order will be filed in the master case file, and a copy of the decision and order will be filed in each of the consolidated case files.

(7) After the board hears the consolidated cases and, if appropriate, the division will separate the case files and will notify the parties. If the consolidated case files are separated, a pleading or documentary evidence filed thereafter by a party must list only the case number assigned to the particular injury with the employer filing the pleading or documentary evidence.

(8) Except for a petition for a self-insurance certificate or an executive officer waiver, a petition must be signed by the petitioner or representative and state the names and addresses of all parties, the date of injury, and the general nature of the dispute between the parties. The petitioner must provide proof of service of the petition upon all parties. The board or its designee will return to the petitioner a petition which is not in accordance with this paragraph, and the board will not act on the petition. A petition alleging that disability has ended or an impairment became permanent must

(A) state the dates for which compensation was paid;

(B) state the amount of compensation paid to the employee;

(C) state the date on which the petitioner claims the disability ended or the impairment became permanent; and

(D) be accompanied by a completed medical summary on form 07-6103.

(c) Answers.

(1) An answer to a claim for benefits must be filed within 20 days after the date of service of the claim and must be served upon all parties. A default will not be entered for failure to answer, but, unless an answer is timely filed, statements made in the claim will be deemed admitted. The failure of a party to deny a fact alleged in a claim does not preclude the board from requiring proof of the fact.

(2) An answer to a petition must be filed within 20 days after the date of service of the petition and must be served upon all parties.

(3) An answer must be simple in form and language. An answer must state briefly and clearly the admitted claims and the disputed claims so that a lay person knows what proof will be required at the hearing and, when applicable, 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, 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 being under the influence of a drug or combination of drugs;

(E) whether the last injurious exposure rule applies;

(F) whether the employee has failed to minimize the disability, giving specifics of the allegation;

(G) whether the employee has been overpaid or paid at a different rate than that which is due; and

(H) whether the employee's compensation rate should be adjusted under AS 23.30.175(b).

(4) A general denial is not an answer.

(5) The evidence presented at the hearing will be limited to those matters contained in the claim, petition, and answer, except as otherwise provided in this chapter.

(6) Upon a verified petition of a party or upon its own motion, the board will, in its discretion, extend or postpone the time for filing an answer or otherwise continue the proceedings under such terms as may be reasonable.

(d) Replies. A reply is a response to an answer. No party is required to file a reply. However, a reply, if filed, must be filed within seven days of service of the answer upon the parties.

(e) Amendments. A pleading may be amended at any time before award upon such terms as the board or its designee directs. 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. An amendment changing the party against whom a claim is asserted relates back if, additionally,

(1) within the period provided by AS 23.30.105 for filing a claim, the party to be brought in by amendment has received, under AS 23.30.100, such notice of the injury that the party will not be prejudiced in defending the claim; and

(2) the party to be joined by the amendment knew or should have known that, but for a mistake concerning the identity of the proper party, the action would have been brought against the party.

(f) Stipulations.

(1) If a claim or petition has been filed and the parties agree that there is no dispute as to any material fact and agree to the dismissal of the claim or petition, or to the dismissal of a party, a stipulation of facts signed by all parties may be filed, consenting to the immediate filing of an order based upon the stipulation of facts.

(2) Stipulations between the parties may be made at any time in writing before the close of the record, or may be made orally in the course of a hearing or a prehearing.

(3) Stipulations of fact or to procedures are binding upon the parties to the stipulation and have the effect of an order unless the board, for good cause, relieves a party from the terms of the stipulation. A stipulation waiving an employee's right to benefits under the Act is not binding unless the stipulation is submitted in the form of an agreed settlement, conforms to AS 23.30.012 and 8 AAC 45.160, and is approved by the board.

(4) The board will, in its discretion, base its findings upon the facts as they appear from the evidence, or cause further evidence or testimony to be taken, or order an investigation into the matter as prescribed by the Act, any stipulation to the contrary notwithstanding.

Authority:

AS 23.30.005	AS 23.30.105	AS 23.30.190
AS 23.30.012	AS 23.30.110	AS 23.30.235
AS 23.30.022	AS 23.30.135	
AS 23.30.100	AS 23.30.175	

8 AAC 45.072. Venue is amended to read:

The venue for injuries occurring in the 1st Judicial District is Juneau; for injuries occurring in the 2nd and 4th Judicial Districts the venue is Fairbanks; for injuries occurring in the 3rd Judicial District the venue is Anchorage. A hearing will be held only in a city in which a division office is located. [*Except as provided in this section, a hearing will be held in the city nearest the place where the injury occurred and in which a division office is located.*] The **venue** [*hearing location*] may be changed to a different city in which a division office is located if

(1) the parties stipulate to the change;

(2) after receiving a party's request in accordance with 8 AAC 45.070(b)(1)(D) and based on the documents filed with the board and the parties' written arguments, the board orders the **venue** [*hearing location*] changed for the convenience of the parties and the witnesses; the board's panel in the city **with initial venue** [*nearest the place where the injury occurred*] will decide the request filed under 8 AAC 45.070(b)(1)(D) to change the **venue** [*hearing's location*]; or

(3) the board or designee, in its discretion and without a party's request, changes the **venue** [*hearing's location*] for the board's convenience or to assure a speedy remedy.

Authority: AS 23.30.005 AS 23.30.110 AS 23.30.135

8 AAC 45.092. Second independent medical evaluation is amended to read:

(a) The board will maintain a list of physicians' names for second independent medical evaluations. The names will be listed in categories based on the physician's designation of specialty or particular type of practice and the geographic location of the physician's practice.

(b) The list of physicians will be created as follows:

(1) The board or its designee will ask the Alaska Chiropractic Society, Alaska Dental Society, Alaska Optometric Society, and Alaska State Medical Association to make recommendations from within their respective specialty. The recommendations must be received by the board on or before November 1, 1989 and on or before November 1 of each year after that.

(2) Not later than December 15 of each year, the board will publish a bulletin listing the names of the physicians recommended by the Alaska Chiropractic Society, the Alaska Dental Society, the Alaska Optometric Society, and the Alaska State Medical Association as well as the names of second independent medical examiners.

(3) An attorney who meets the following criteria may, not later than 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 list 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 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) 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 panel shall meet and select physicians by August 1 of each year. 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.

(5) The panel members shall vote, or abstain from voting, upon the physicians 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 did not appear in the bulletin. A physician who receives three affirmative votes will be sent by the board or its designee an application and a letter asking if the physician is interested in performing second independent medical examinations. Unless the board determines that good cause exists to extend the time, not later than 60 days after the date of the board's letter the physician 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.

(6) If the physician complies with (5) of this subsection, the physician's name will be added to the board's list of second independent medical examiners, effective November 1 of that year. Except as provided in (7) of this subsection and (c) of this section, the physician's name will remain on the list for three years. After three years, the physician must be reselected in accordance with (5) of this subsection. If reselected, the physician will remain on the list unless

(A) three members of the panel described in (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 (7) of this subsection or (c) of this section.

(7) Notwithstanding (d) of this section, the board may remove a physician's name from the list compiled in accordance with (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.

(c) The board will, in its discretion, remove a physician's name from the list for

(1) the physician's repeated failure to

(A) timely file medical reports for treatment of injured workers;

(B) timely file written treatment plans when required by AS 23.30.095(c); or

(C) provide medical services and examinations to injured workers;

(2) the physician's failure to comply with an order of the board;

(3) revocation by the appropriate licensing agency of the physician's license to provide services;

(4) decertification of or disciplinary action against the physician by an applicable certifying agency or professional organization;

(5) disciplinary action taken against the physician by the State Medical Board, a representative of Medicare or Medicaid, or a hospital, for fraud, abuse, or the quality of care provided;

(6) fraudulent billing or reporting by the physician;

(7) knowingly falsifying information on the physician's application;

(8) conviction of the physician in a state or federal court of any offense involving moral turpitude or drug abuse, including excessive prescription of drugs;

(9) unprofessional conduct or discriminatory treatment by the physician in the care and examination of patients;

(10) use of treatment by the physician which is not sanctioned by the physician's peers or national provider associations as beneficial for the injury or disease under treatment;

(11) declaration of the physician's mental incompetency by a court of competent jurisdiction;

(12) failure by the physician to maintain professional liability insurance or, if required, workers' compensation insurance; or

(13) failure by the physician to annually submit a certificate of insurance for professional liability insurance and, if required, workers' compensation insurance.

(d) Before removing a physician's name from the list,

(1) the board will notify the physician, in writing, either by personal service or by certified mail of the proposed removal and the reason for it;

(2) a physician who receives a notification under (1) of this subsection may, within 30 days after the receipt of the notice, file a written request with the board for a hearing in accordance with AS 23.30.110;

(3) the board will issue a written decision within 30 days after the hearing, or, if no hearing is requested, the board will issue a written decision within 45 days after the written notice of proposed removal; the board's decision will be served on the physician personally or by certified mail, and will state whether the physician's name was removed from the list and the reason for the removal.

(e) If the parties stipulate that a physician not on the board's list may perform an evaluation under AS 23.30.095(k), the board or its designee may select a physician in accordance with the parties' agreement. If the parties do not stipulate to a physician not on the board's list to

perform the evaluation, the board or its designee will select a physician to serve as a second independent medical examiner to perform the evaluation. The board or its designee will consider these factors in the following order in selecting the physician:

(1) the nature and extent of the employee's injuries;

(2) the physician's specialty and qualifications;

(3) whether the physician or an associate has previously examined or treated the employee;

(4) the physician's experience in treating injured workers in this state or another state;

(5) the physician's impartiality; and

(6) the proximity of the physician to the employee's geographic location.

(f) If the board or its designee determines that the list of second independent medical examiners does not include an impartial physician with the specialty, qualifications, and experience to examine the employee, the board or its designee will notify the employee and employer that a physician not named on the list will be selected to perform the examination. The notice will state the board's preferred physician's specialty to examine the employee. Not later than 10 days after notice by the board or its designee, the employer and employee may each submit the names, addresses, and curriculum vitae of no more than three physicians. If both the employee and the employer recommend the same physician, that physician will be selected to perform the examination. If no names are recommended by the employer or employee or if the employee and employer do not recommend the same physician, the board or its designee will select a physician, but the selection need not be from the recommendations by the employee or employer.

(g) If there exists a medical dispute under AS 23.30.095(k),

(1) the parties may file a

(A) completed second independent medical form, available from the division, listing the dispute together with copies of the medical records reflecting the dispute, and

(B) stipulation signed by all parties agreeing

(i) upon the type of specialty to perform the evaluation or the physician to perform the evaluation; and

(ii) that either the board or the board's designee determine whether a dispute under AS 23.30.095(k) exists, and requesting the board or the board's designee to exercise discretion under AS 23.30.095(k) and require an evaluation;

(2) a party may petition the board to order an evaluation; the petition must be filed within 60 days after the party received the medical reports reflecting a dispute, or the party's right to request an evaluation under AS 23.30.095(k) is waived;

(A) the completed petition must be filed timely together with a completed second independent medical form, available from the division, listing the dispute; and

(B) copies of the medical records reflecting the dispute; or

(3) the board will, in its discretion, order an evaluation under AS 23.30.095(k) even if no party timely requested an evaluation under (2) of this subsection if

(A) the parties stipulate, in accordance with (1) of this subsection, to the contrary and the board determines the evaluation is necessary; or

(B) the board on its own motion determines an evaluation is necessary.

(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 may direct

(1) a party to make a copy of all medical records, including medical providers' depositions, regarding the employee in the party's possession, put the copy in chronological order by date of treatment with the initial report on top, number the records consecutively, and put the records in a binder;

(2) the party making the copy to serve the 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;

(3) the party served with the binder to review 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; the party served with the binder must file the binder with the board not later than 10 days after receipt and, if the binder is

(A) complete, the party served with the binder must file the binder upon the board together with an affidavit verifying that the binder contains copies of all the employee's medical records in the party's possession; or

(B) incomplete, the party served with the binder must file the binder upon the board together with a supplemental binder with copies of the medical records in that party's possession that were missing from the binder and an affidavit verifying that the binders contain copies of all medical records in the party's possession; the copies of the medical records in the supplemental binder must be placed in chronological order by date of treatment, with the initial report on top,

and numbered consecutively; the party must also serve the party who prepared the first binder with a copy of the supplemental binder together with an affidavit verifying that the binder is identical to the supplemental binder filed with the board;

(4) the party, who receives additional medical records after the binder has been prepared and filed with the board, to make two copies of the additional medical records, put the copies in two separate binders in chronological order by date of treatment, with the initial report on top, and number the copies consecutively; the party must file 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 binder is identical to the binder filed with the board, not later than seven days after receiving the medical records;

(5) Repealed 5/12/2019.

(i) The report of the physician who is serving as a second independent medical examiner must be done not later than 14 days after the evaluation ends. The evaluation ends when the physician reviews the medical records provided by the board, receives the results of all consultations and tests, and examines the injured worker, if that is necessary. The board will presume the evaluation ended after the injured worker was examined. If the evaluation ended at a later date, the physician must state in the report the date the evaluation was done. An examiner's report must be received by the board not later than 21 days after the evaluation ended. If an examiner's report is not timely received by the board, a party may file a petition asking that another physician be selected to serve as a second independent medical examiner. The board or its designee may, select another physician to serve as a second independent medical examiner, and will make the selection in accordance with this section. Until the parties receive the second

independent medical examiner's written report, communications by and with the second independent medical examiner are limited, as follows:

(1) a party or a party's representative and the examiner may communicate as needed to schedule or change the scheduling of the examination;

(2) the employee and the examiner may communicate as necessary to complete the examination;

(3) the examiner's communications with a physician who has examined, treated, or evaluated the employee must be in writing, and a copy of the written communication must be sent to the board and the parties; the examiner must request the physician report in writing and request that the physician not communicate in any other manner with the examiner about the employee's condition, treatment, or claim.

(j) After a party receives an examiner's report, communication with the examiner is limited as follows and must be in accord with this subsection. If a party wants the opportunity to

(1) submit written questions or depose the examiner, the party must

(A) file with the board and serve upon the examiner and all parties, not later than 30 days after receiving the examiner's report, a notice of scheduling a deposition or copies of the written questions; if notice or the written questions are not served in accordance with this paragraph, the party waives the right to question the examiner unless the opposing party gives timely notice of scheduling a deposition or serves written questions; and

(B) initially pay the examiner's charges to respond to the written questions or for being deposed; after a hearing and in accordance with AS 23.30.145 or 23.30.155(d), the charges may be awarded as costs to the prevailing party;

(2) communicate with the examiner regarding the evaluation or report, the party must communicate in writing, serve the other parties with a copy of the written communication at the same time the communication is sent or personally delivered to the examiner, and file a copy of the written communication with the board; or

(3) question the examiner at a hearing, the party must initially pay the examiner's fee for testifying; after a hearing and in accordance with AS 23.30.145 or AS 23.30.155(d), the board will, in its discretion, award the examiner's fee as costs to the prevailing party.

(k) If a party's communication with an examiner is not in accordance with (j) of this section, the board may not admit the evidence obtained by the communication at a hearing and may not consider it in connection with an agreed settlement.

Authority: AS 23.30.005 AS 23.30.095 AS 23.30.110

Official

ALASKA

WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2023

STATE OF ALASKA DISCLAIMER

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

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

NOTICE

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

QUESTIONS ABOUT THE OFFICIAL WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

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

GENERAL QUESTIONS ABOUT WORKERS' COMPENSATION

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

AMERICAN MEDICAL ASSOCIATION NOTICE

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

AMERICAN SOCIETY OF ANESTHESIOLOGISTS NOTICE

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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.

An employee shall not be required to pay a fee or charge for medical treatment or service provided under this chapter including prepayment, deposit, or balance billing for services (Alaska Statute 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

SCOPE OF PRACTICE LIMITS

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

ORGANIZATION OF THE FEE SCHEDULE

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

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

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

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

Changes to the Evaluation and Management (E/M) section of codes effective January 1, 2021 are discussed in more detail in the Evaluation and Management section of this fee schedule. Additional changes that are similar to codes 99202-99215 were made to the E/M codes for 2023.

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

PROVIDER SCHEDULE

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

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

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

The provider schedule contains facility and non-facility designations dependent upon the place where the service was rendered. Many services can be provided in either a non-facility or facility setting, and different values will be listed in the respective columns. The facility total fees are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total fees 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 fee 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 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;

3. Compounded and/or mixed drugs shall be limited to medical necessity and must be U.S. Food and Drug Administration (FDA)-approved combinations. Reimbursement for compounded or mixed drugs will be at the lowest generic National Drug Code (NDC) for each specific or over the counter drug.

HCPCS LEVEL II

Durable Medical Equipment

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

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

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

Ambulance Services

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

OUTPATIENT FACILITY

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

INPATIENT HOSPITAL

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

DEFINITIONS

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

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

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

Board — the Alaska Workers' Compensation Board.

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

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

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

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

Day — a continuous 24-hour period.

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

Drugs — a controlled substance as defined by law.

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

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

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

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

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

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

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

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

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

Medical record — an electronic or paper record in which the medical service provider records the subjective and objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and improvement rating as applicable.

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

Modifier — a two-digit number 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.

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 — a request by a provider for payment of health care services submitted to an insurer on the appropriate forms, with appropriate documentation, and within the time frame established in Alaska Statute 23.30.097.

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.

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.

General Information and Guidelines

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

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

BILLING AND PAYMENT GUIDELINES

Fees for Medical Treatment

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

(Work RVUs x Work GPCI) + (Practice Expense RVUs x Practice Expense GPCI) + (Malpractice RVUs x Malpractice GPCI) = Total RVU

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.03	1.500	1.545
Practice Expense RVU x Practice Expense GPCI	1.87	1.118	2.09066
Malpractice RVU x Malpractice GPCI	0.12	0.614	0.07368
Total RVU			3.70934

Data for the purpose of example only

Calculation using example data:

1.03 x 1.500 = 1.545

+ 1.87 x 1.118 = 2.09066

+ 0.12 x 0.614 = 0.07368

= 3.70934

3.70934 x $119.00 (CF) = 441.4115

Payment is rounded to $441.41

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 fees are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total fees 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 fee 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)	90281–99082 and 99151–99199 and 99500–99607	$80.00
Evaluation and Management	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 for codes 97014 and 97810–97814.

An employee may not be required to pay a fee or charge for medical treatment or service. For more information, refer to AS 23.30.097(f).

RBRVS Status Codes

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

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
A	Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status.	The maximum fee for this service is calculated as described in Fees for Medical Treatment.
B	Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.	No separate payment is made for these services even if an RVU is listed.
C	Carriers price the code. Contractors will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
D	Deleted Codes. These codes are deleted effective with the beginning of the applicable year.	Not in current RBRVS. Not payable under the ***Official Alaska Workers' Compensation Medical Fee Schedule***.
E	Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes.	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
F	Deleted/Discontinued Codes. (Code not subject to a 90 day grace period).	Not in current RBRVS. Not payable under the ***Official Alaska Workers' Compensation Medical Fee Schedule***.
G	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.)	Not in current RBRVS. Not payable under the ***Official Alaska Workers' Compensation Medical Fee Schedule.***
H	Deleted Modifier. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H."	Not in current RBRVS. Not payable with modifiers TC and/or 26 under the ***Official Alaska Workers' Compensation Medical Fee Schedule***.
I	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.

STATUS CODE	THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DEFINITION	OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE GUIDELINE
J	Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.	Alaska recognizes the anesthesia base units in the ***Relative Value Guide*** published by the American Society of Anesthesiologists. See the ***Relative Value Guide*** or Anesthesia Section.
M	Measurement Codes. Used for reporting purposes only.	These codes are supplemental to other covered services and for informational purposes only.
N	Non-covered Services. These services are not covered by Medicare.	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
P	Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. • If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) • If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
R	Restricted Coverage. Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D." We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider.
T	T = Injections. These codes are paid only if there are no other services payable under the PFS billed on the same date by the same practitioner. If any other services payable under the PFS are billed on the same date by the same practitioner, these services are bundled into the service(s) for which payment is made.	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***.
X	Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)	The service may be a covered service of the ***Official Alaska Workers' Compensation Medical Fee Schedule***. The maximum fee for this service is calculated as described in Fees for Medical Treatment or negotiated between the payer and provider. For ambulance services see HCPCS Level II section of this guideline.

Add-on Procedures

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

The same physician or other health service worker that performed the primary service/procedure must perform the add-on service/procedure. Add-on codes describe additional intra-service work associated with the primary service/procedure (e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)).

Add-on codes are not subject to reduction and should be reimbursed at the lower of the billed charges or 100 percent of MAR. Do not append modifier 51 to a code identified as an add-on procedure. Designated add-on codes are identified in Appendix D of the CPT book. Please reference the CPT book for the most current list of add-on codes.

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

Exempt from Modifier 51 Codes

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

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

Professional and Technical Components

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

Global Days

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

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

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

XXX Designates services where the global concept does not apply.

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

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

Telehealth Services

Telehealth services are covered and reimbursed at the lower of the billed amount or non-facility MAR. Telehealth services are identified in CPT with a star ★ icon for audiovisual services and with the ◂ icon for audio only services. CPT Appendix P identifies the audiovisual codes appropriate to report with modifier 95, and Appendix T identifies the audio only codes appropriate to report with modifier 93. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

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 required by the Workers' Compensation Division. A medical provider may not charge a separate fee for medical reports that are required to substantiate the medical necessity of a 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 is not liable for payment for any services for the injury or illness.

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 the medical provider's bill, or a completed medical report, as prescribed by the Board under Alaska Statute 23.30.097. 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.

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.

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.

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.

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

Data for the purpose of example only

Modifier TC—Technical Component

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

Modifier QZ—CRNA without medical direction by a physician

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

State-Specific Modifiers

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

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

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

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

Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

This brief overview of the current guidelines should not be the provider's or payer's only experience with this section of the CPT book. Carefully read the complete guidelines in the CPT book; much information is presented regarding aspects of a family history, the body areas and organ systems associated with examinations, and so forth.

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.

Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.

When exact text of the AMA 2022 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. Note that many of the services identified by CMS for telehealth have temporary approval during the calendar year of the public health emergency (PHE) and may not be approved services in the next calendar year. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

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/qualified health care professional or another physician/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/qualified health care professional, or another physician/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 new CPT code 99417 or HCPCS code G2212.

The MDM for codes 99202-99215 is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2023 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 new MDM guidelines table includes new 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 re-viewed 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 range of time for each code. Documentation should include notation of the times 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.

Presenting Problem

According to the CPT book, "a presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason" for the patient encounter.

The CPT book defines five types of presenting problems. These definitions should be reviewed frequently, but remember, this information merely contributes to code selection—the presenting problem is not a key factor. 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.

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 and 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 not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. 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 any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital and Observation Care code.

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 except when documentation describes the medical necessity of more than one visit by a particular provider. Hospital visit codes shall be combined into the single code that best describes the service rendered where appropriate.

Consultations (99242-99245 and 99252–99255)
Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations. For Follow-up Inpatient Consultations, see Subsequent Hospital 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 office visit codes (99202–99215). 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 appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of 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. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (99202–99215). 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 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 subsequent to the consultation encounter, consultation codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

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 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 three subcategories: Comprehensive Nursing Facility Assessments, Subsequent Nursing Facility Care, and Nursing Facility Discharge Services. Included in these codes are E/M services provided to patients in psychiatric residential treatment centers. These facilities must provide a "24-hour therapeutically planned and professionally staffed group living and learning environment." 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, 99415-99417)
This section of E/M codes includes the three service categories:

Prolonged Physician Service with Direct (Face-to-Face) Patient Contact

These codes report services involving direct (face-to-face) patient contact beyond the usual service. Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

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. For codes 99205 and 99215 prolonged services are reported with CPT code 99417 or HCPCS code G2212.

Prolonged Physician Service without Direct (Face-to-Face) Patient Contact

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, including any level of E/M service. Use 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

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 more than 30 minutes is 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 (99441–99443, 99446–99449, 99451–99452)
Telephone services are reported for telehealth services where only audio communication is available. Usually initiated by the patient or guardian, these codes are not

reported if the telephone call results in a face-to-face encounter within 24 hours or the next available visit. Telephone services are not reported if provided within seven days of a face-to-face encounter or during the follow-up time associated with a surgical procedure.

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 arthroscopic procedure of knee joint

Dollar Conversion Unit = $100.00

Base Unit Value = 3

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

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

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

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

Anesthesia Supervision

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

Anesthesia Monitoring

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

Other Anesthesia

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

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

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

ANESTHESIA MODIFIERS

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

Physical Status Modifiers

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

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

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

Qualifying Circumstances

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

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

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

Modifiers

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

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

Applicable HCPCS Modifiers

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

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

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

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

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

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

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

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

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

Surgery

GENERAL INFORMATION AND GUIDELINES

Definitions of Surgical Repair

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

BILLING AND PAYMENT GUIDELINES

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

Data for the purpose of example only

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

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

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

Data for the purpose of example only

Anesthesia by Surgeon

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

Multiple or Bilateral Procedures

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

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

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

Data for the purpose of example only

Endoscopic Procedures

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

Example:

Code	MAR	Adjusted amount
29827	$5,167.92	$5,167.92 (100%)
29824	$3,222.09	$988.35 (the value of 29824 minus the value of 29805)
29805	$2,233.74	
	Total	$6,156.27

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.

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.

When a PA or advanced practice registered nurse (APRN) provides care to a patient, modifier PE is appended.

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 AS)	$1,350.00
Procedure 2 (Modifier 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

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.

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.

Alaska MAR:

72142	$1,448.61
72142-TC	$998.14
72142-26	$490.48
72147	$1,479.15
72147-TC	$990.25
72147-26	$488.90

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	$998.14	100% of the TC
72147-TC	$495.13	(50% of the TC for the second procedure)
Total	$1,493.27	

Professional Component:

72142-26	$490.48	100% of the 26
72147-26	$464.46	(95% of the 26 for the second procedure)
Total	$954.94	

Global Reimbursement:

72142	$1,488.61	100% of the global
72147-51	$959.59	($495.13 + $464.46 TC and 26 above)
Total	$2,448.20	

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	0.32	1.118	0.35776
Malpractice RVU x Malpractice GPCI	0.02	0.614	0.01228
Total RVU			1.01504

Data for the purpose of example only

Calculation using example data:

0.43 x 1.500 = 0.645

+ 0.32 x 1.118 = 0.35776

+ 0.02 x 0.614 =0.01228

= 1.01504

1.01504 x $122.00 (CF) = 123.8349

Payment is rounded to $123.83

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 tests performed. These codes are valued in the CLAB schedule and the multiplier is 4.43.

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

Medicine

GENERAL INFORMATION AND GUIDELINES

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

BILLING AND PAYMENT GUIDELINES

All providers may report and be reimbursed for codes 97014 and 97810–97814.

Multiple Procedures

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

See modifier section below for examples of the reduction calculations.

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 1.75.

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 utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

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).

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 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

Publications, Books, and Videos

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

Functional Capacity Evaluation

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

Work Hardening

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

97545	3.41
97546	1.36

Osteopathic Manipulative Treatment

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

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

Chiropractic Manipulative Treatment

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

- Chiropractic manipulative treatment (CMT) is a form of manual treatment using a variety of techniques for treatment of joint and neurophysiological function. The chiropractic manipulative treatment codes include a pre-manipulation patient assessment.
- Evaluation and management services may be reported separately if, the patient's condition requires a separately identifiable E/M service with significant work that exceeds the usual preservice and postservice work associated with the CMT. Different diagnoses are not required for the reporting of the CMT and E/M service on the same date. Modifier 25 should be appended to the E/M service.

- There are five spinal regions recognized in the CPT book for CMT: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacroiliac joint) region. There are also five recognized extraspinal regions: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.
- Chiropractors may report codes 97014, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943.

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 and ophthalmology procedures apply when multiple services are furnished to the same patient on the same day. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services and to the TC of global services. The MPPRs are as follows:

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	$634.77
93303-TC	$434.77
93303-26	$200.00
93351	$673.34
93351-TC	$404.44
93351-26	$268.89

Data for the purpose of example only

Technical Component:

93303-TC	$434.77	100% of the TC
93351-TC	$303.33	(75% of the TC for the second procedure)
Total	$738.10	

Global Reimbursement:

93303	$634.77	100%
93351	$572.22	(75% of the TC for the second procedure + 100% of the 26) ($303.33 + $268.89 = $572.22)
Total	$1,206.99	

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	$184.85
92060-TC	$68.47
92060-26	$116.38
92132	$90.65
92132-TC	$39.84
92132-26	$50.80

Data for the purpose of example only

Technical Component:

92060-TC	$68.47	100% of the TC
92132-TC	$31.87	(80% of the TC for the second procedure)
Total	$100.34	

Global Reimbursement:

92060	$184.85	100% of the global
92132	$82.67	(80% of the TC for the second procedure + 100% of the 26) ($31.87 + $50.80 = $82.67)
Total	$267.52	

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	$36.40
[(.18 x 1.5) + (.16 x 1.118) + (0.01 x .0.614)] x 80	
97024	$20.21
[(.06 x 1.5) + (.14 x 1.118) + (0.01 x .0.614)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	$29.25
[(.18 x 1.5) + ((.16 x 1.118) x .5) + (0.01 x .0.614)] x 80	
97024	$13.95
[(.06 x 1.5) + ((.14 x 1.118) x .5) + (0.01 x .614)] x 80	

Example:

97016	$36.40
97016 (2nd unit same date)	$29.25
97024 (additional therapy same date)	$13.95

Applicable HCPCS Modifiers

TC Technical Component

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

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

Category II

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

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

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

Category III

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

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

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

CATEGORY III MODIFIERS

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

HCPCS Level II

GENERAL INFORMATION AND GUIDELINES

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

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

MEDICARE PART B DRUGS

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

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

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value for Alaska in effect at the time of treatment or service multiplied by 1.75 or billed charges. If no code identifies the supply, bill using the appropriate unlisted HCPCS code or CPT code 99070. An invoice is required and reimbursement shall be the lower of the manufacturer/supplier's invoice plus 20 percent or billed charges.

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 1.75. 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 patient must be referred by a physician for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes one year of follow-up care including all evaluations, tests, adjustments, repairs, or reprogramming of the hearing aids. New hearing aids may be dispensed 1) once every four years or 2) when new medical evaluation by a 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. 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 the 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 testing, dispensing and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V5110, V5160, V5240, and V5241 are not separately reimbursed services.

Hearing Aid Services

The codes below are reimbursed according to the listed maximum allowable reimbursement (MAR) or the actual fee, whichever is less.

CODE	MAR
92591	$193.62
92593	$99.64
92594	$57.89
92595	$124.11
V5014	$249.31
V5020	$116.17

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

NU New equipment

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

UE Used durable medical equipment

AMBULANCE SERVICES

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

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

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

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

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

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

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

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

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

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

(2) status 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;

(5) procedures without a relative weight in Addendum B shall use a payment rate where available with the multiplier of 2.08 for ASCs and 2.75 for outpatient facilities.

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	Not paid under OPPS. See the appropriate section under the provider fee schedule.
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. 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. *Alaska Specific Guideline: May be performed in the outpatient or ASC setting if beneficial to the patient and as negotiated by the payer and providers. Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
D	Discontinued codes	Not paid under OPPS.
E1	Items, codes and services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary	Not paid under OPPS. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.* *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
E2	Items and services for which pricing information and claims data are not available	Not paid under OPPS. Status may change as data is received by CMS. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
F	Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	Pass-through device categories	Separate cost-based pass-through payment. *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
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, 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) that are authorized or approved to treat or prevent COVID-19.

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, 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) that are authorized or approved to treat or prevent COVID-19. (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.
L	Influenza vaccine; pneumococcal pneumonia vaccine; Covid-19 Vaccine, Monoclonal Antibody Therapy Product	Not paid under OPPS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS.
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
P	Partial hospitalization	Paid under OPPS; per diem APC payment. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
Q1	STV packaged codes	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service 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 date of service as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment.
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.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
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.
T	Procedure or service, multiple reduction applies	Paid under OPPS; separate APC payment. *Alaska Specific Guideline: Two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classification's calculated amount and all other status indicator code T items paid at 50 percent.*
U	Brachytherapy sources	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPPS; separate APC payment.
Y	Non-implantable durable medical equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC.

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.

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

USE OF OUTPATIENT FACILITY AND ANCILLARY SERVICES

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

NURSING AND RELATED TECHNICAL PERSONNEL SERVICES

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

SURGICAL DRESSINGS, SPLINTING, AND CASTING MATERIALS

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

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

Example of Implant Outlier:

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

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

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

Any additional payments for high-cost acute care inpatient admissions are to be made following the methodology described in the Centers for Medicare and Medicaid Services (CMS) final rule CMS-1243-F published in the *Federal Register* Vol. 68, No. 110 and updated with federal fiscal year values current at the time of the patient discharge.

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, 2023 remains in effect, unless the Alaska Workers' Compensation Division publishes a notice that a new version is in effect. Besides the IPPS Web Pricer, two additional elements are required to determine a payment:

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

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

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

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

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

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

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

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

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

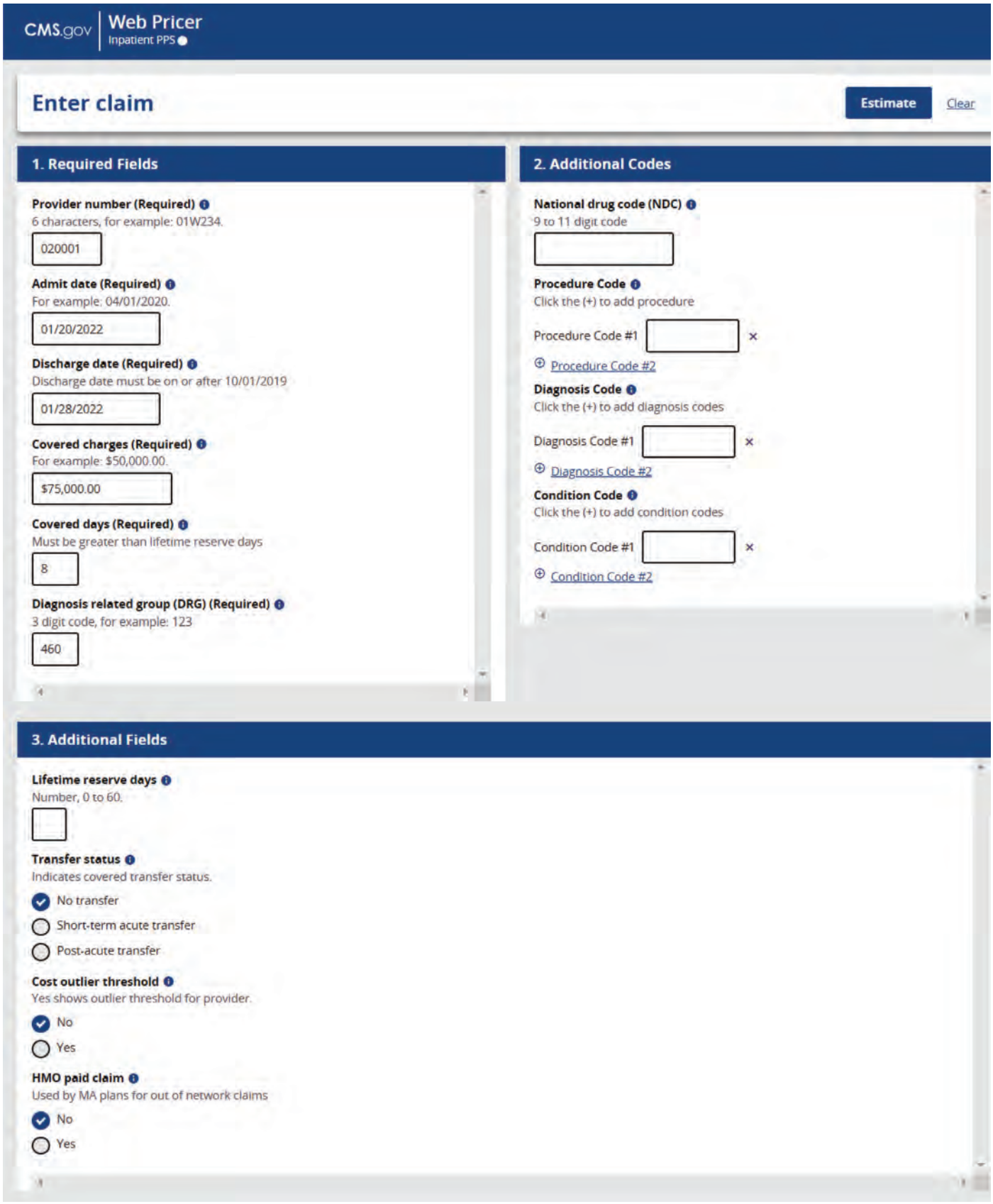
DATE OF SERVICE RECOMMENDATION

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

EXAMPLE

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

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


CMS.gov
Web Pricer
Inpatient PPS
Enter claim
Estimate
Clear
1. Required Fields
Provider number (Required)
6 characters, for example: 01W234.
020001
Admit date (Required)
For example: 04/01/2020.
01/20/2022
Discharge date (Required)
Discharge date must be on or after 10/01/2019
01/28/2022
Covered charges (Required)
For example: $50,000.00.
$75,000.00
Covered days (Required)
Must be greater than lifetime reserve days
8
Diagnosis related group (DRG) (Required)
3 digit code, for example: 123
460
2. Additional Codes
National drug code (NDC)
9 to 11 digit code
Procedure Code
Click the (+) to add procedure
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.

REQUIRED 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

Return code	**14**
Key claim information	
Provider number	020001
Effective date	12/17/2021
Diagnosis related group (DRG)	460
Claim estimate	
Claim estimate with provider adjustments	$35,218.14
Outlier calculation	$0.00
Grand total amount	**$35,218.14**

The estimate is based on submitted claim info

↓Download CSV

Provider details

Provider type	00
Geographic CBSA	11260
Reclassification CBSA	
Pass through amount allogeneic stem cell	
Total pass through & miscellaneous	$17.80
Pass through amount capital	$0.00
Pass through amount direct	$17.80
Pass through amount organ	$0.00

Capital amounts

Capital federal specific portion	$2,263.41
Capital outlier	$0.00
Capital disproportionate share hospital	$224.08
Capital indirect medical education	$54.43

Operating amounts

Operating federal specific portion	$29,203.19
Operating hospital specific payment	$0.00
Operating outlier	$0.00
Operating disproportionate share hospital	$2,020.86
Operating indirect medical education	$827.07
Uncompensated care	$874.96
Readmission adjustment	$-37.96
Value based purchasing adjustment	$0.00
New technology	$0.00

Other PPS amounts

Hospital acquired condition adjustment	$-354.30
Low volume	$0.00
Islet add on	$0.00
Electronic health record adjustment	$0.00
Bundle adjustment	$0.00

Review results

Edit Claim Clear

Operating amounts	
Operating federal specific portion	$29,203.19
Operating hospital specific payment	$0.00
Operating outlier	$0.00
Operating disproportionate share hospital	$2,020.86
Operating indirect medical education	$827.07
Uncompensated care	$874.96
Readmission adjustment	$-37.96
Value based purchasing adjustment	$0.00
New technology	$0.00

Other PPS amounts	
Hospital acquired condition adjustment	$-354.30
Low volume	$0.00
Islet add on	$0.00
Electronic health record adjustment	$0.00
Bundle adjustment	$0.00

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	$35,218.14
Total Pass through and miscellaneous x days ($17.80 x 8)	+ $142.40
Total	35,360.54
Multiplied by Providence Alaska Medical Center multiplier	x 2.38
Alaska Workers' Compensation Payment	$84,158.09

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 and Social Services, Division of Health Care Services.