



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

Alaska Workers' Compensation Board

Public Meeting Packet

October 23-24, 2025

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

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Director's Report

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TAB 1

ALASKA WORKERS' COMPENSATION BOARD MEETING AGENDA

OCT 23-24, 2025

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

Zoom Video Conference: <https://us02web.zoom.us/j/84407872140>

To participate telephonically: 833-548-0276, Webinar ID: 844 0787 2140

Thursday, Oct 23, 2025

- 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 15, 2025, Board meeting
- 9:30am** Director's Report
- Division 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** 2024 Annual Report
- Workers' Compensation – Velma Thomas, Program Coordinator
 - Special Programs - Velma Thomas, Program Coordinator
- 12:00pm** Lunch Break
- 1:30pm** 2024 Annual Report Continued
- Workers' Compensation – Velma Thomas, Program Coordinator
 - Special Programs - Velma Thomas, Program Coordinator
 - Reemployment Benefits Overview – Stacy Niwa, Reemployment Benefits Administrator
- 3:00pm** Break
- 3:15pm** 2024 Annual Report Continued
- Workers' Compensation SIU Overview – Michele Wall-Rood, Chief Investigator of the Special Investigations Unit
 - SIME Annual Report – Janel Wright, Chief of Adjudications
- 5:00pm** Adjournment

Friday, Oct 24, 2025

- 9:00am** Call to order
Roll call establishment of quorum
- 9:05am** Workers' Compensation Law Review
- Decisions and Summaries – Bill Soule Esq.
- 10:00am** Break
- 10:30am** Old Business
- Proposed Regulation Updates
 - 8 AAC 45.083 Fees for Medical
 - AO 360 review
- 12:00pm** Lunch Break
- 1:30pm** Old Business Continued
- Proposed Regulation Updates
 - 8 AAC 45.900 Definitions.
- 3:30pm** Break
- 3:45pm** New Business
- Proposed New Regulation Work
 - See List in Director's Report
- 5:00pm** Adjournment

TAB 2

Workers' Compensation Board
Meeting Minutes
May 15, 2025

Thursday, May 15, 2025

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:50 a.m. in Anchorage, Alaska. Participation was available in person and via video conference.

II. ROLL CALL

The following Board Members were present, constituting a quorum:

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

Members John Corbett and Mike Dennis were excused.

III. AGENDA APPROVAL

Member Lefebvre moved to approve the agenda, seconded by Member Zematis. Member Lefebvre noted that items requested in the January 9–10, 2025, minutes—specifically the draft resolution for an ombudsman program and WSCAA funding, as well as the history of the term *previously rehabilitated*—were not included in the agenda. Member Lefebvre amended the motion to add these items to Old Business; Member Zematis seconded. The amended agenda was approved unanimously.

IV. APPROVAL OF JANUARY 9-10, 2025 MEETING MINUTES

Member Beltz moved to approve the minutes, seconded by Member Austin. The minutes were adopted without objection.

V. DIRECTOR'S REPORT

Director Collins provided division updates and reviewed upcoming Board Member term expirations, as well as the list of Board Designees. Two errors were identified and corrected in the designee list. He also presented the 2026 Board Calendar. Additionally, Director Collins discussed the hiring and travel freeze and its anticipated impact on the Division. He reviewed the current organizational chart, noted existing vacancies, and emphasized the Division's priority in filling those positions.

A motion to approve the designees was made by Member Austin, seconded by Member White. The motion passed unanimously.

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

Jeffery Holloway – Babcock, Holloway, Caldwell & Stires

- Mr. Holloway expressed support for the proposed amendment to 8 AAC 45.092, which would allow for the digitization of SIME records. He noted that preparing paper records has been costly and inefficient, citing a personal case where six sets of binders cost nearly \$1,000. Holloway recommended modifying the regulation further to improve the

organization of records: he suggested delaying the final numbering and filing of records until after the SIME appointment is set, allowing all documents to be submitted in chronological order. This, he argued, would reduce confusion from misnumbered or out-of-order records and benefit both parties and physicians.

- Board members expressed appreciation for Mr. Holloway's valuable input and asked questions about how potential additional changes could help streamline the process.

Jonathon Faulkner – President of Land's End Acquisition Corporation

- Mr. Faulkner raised concerns about Workers' Compensation Division practices that allow claims to proceed without a preliminary determination of legal merit. He argued that this leads to settlements of potentially baseless claims, harming employers through increased insurance costs and discouraging benefits like employee housing. Citing a specific claim he believes was wrongly accepted, Mr. Faulkner urged the Division to assess whether claims meet statutory requirements before allowing them to proceed.
- Board members acknowledged Mr. Faulkner's concerns but explained that the system's presumption of compensability is a foundational part of Alaska's workers' compensation structure, intended to balance protections for both workers and employers. Director Collins agreed to follow up with Faulkner, and members expressed openness to discussing related issues such as the remote site doctrine and potential statutory reform.

VII. DIRECTOR'S REPORT, CONTINUED

A motion to approve the calendars was made by Member Lefebvre, seconded by Member Zematis. Member Frye noted that the proposed August meeting coincides with the AFL-CIO's convention. Member Lefebvre amended the motion to move the Joint Meeting to August 28, 2026; Member Zematis seconded. The motion passed unanimously. Member Lefebvre requested that calendar invites be sent for all scheduled meetings.

Break 11:28am-11:44am

VIII. REGULATIONS

Chief Janel Wright provided an overview of the recommended amendments to SIME regulation 8 AAC 45.092.

Member Lefebvre moved to approve the 8 AAC 45.092(b); Member Frye seconded. The Board discussed the current SIME physician selection process. The motion was tabled for further discussion.

Lunch Break 12:20pm – 1:48pm

8 AAC 45.900(j) – Definition of "Previously Rehabilitated"

Member Zematis moved to approve the amendment; Member Frye seconded. The Board discussed the effective date language in the current regulation and considered whether the regulation could be repealed in favor of relying on AS 23.30.041(f)(3). The motion failed with five in favor and four opposed. Members Beltz, Cline, Frye, Williams, and Zematis voted in favor; Members Austin, Faulkner, Lefebvre, and White voted against; and Member Ladd abstained.

8 AAC 45.176(d)(3) – Assessment of Civil Penalties

Chief Investigator Michele Wall-Rood presented the proposed amendment to add the word “consecutive” before “calendar days.” Motion to approve by Member Cline; seconded by Member Lefebvre. Motion passed unanimously.

8 AAC 45.180(b) – Attorney Fees

Motion to approve by Member Zematis; seconded by Member Frye. Motion passed unanimously.

8 AAC 45.092(b) – SIME Physician List (Un-tabled and Amended)

Member Lefebvre un-tabled the motion; seconded by Member Frye. She presented a revised version and amended the motion accordingly. The motion passed unanimously.

8 AAC 45.092(h) – SIME Procedures

Motion to approve by Member Lefebvre; seconded by Member Cline. Motion passed unanimously.

8 AAC 45.083 – Medical Treatment and Services Fees

Member Lefebvre moved to approve the repeal and readoption; seconded by Member Zematis. The Board discussed adding a new subsection (c) with language regarding conversion factors and coding based on CPT guidelines. Member Lefebvre amended the motion accordingly; Member Zematis seconded. The amended motion passed unanimously.

Member Zematis moved that the Board draft regulatory language in line with Mr. Holloway’s recommendations for presentation at the October Board Meeting; seconded by Member Lefebvre. Motion passed unanimously.

Member Lefebvre requested that the following topics be included under Old Business on the agenda for the October meeting: the Board’s ongoing financial challenges; a draft resolution addressing the establishment of an ombudsman program and the use of electronic service. Member Lefebvre also requested that the NCCI report be distributed with the August 22 Joint Meeting packet.

IX. ADJOURNMENT

Director Collins reminded the Board that the Joint Board-MSRC Meeting is scheduled for August 22, 2025, and the next regular Board Meeting is scheduled for October 2025.

Motion to adjourn by Member Frye, seconded by Member Zematis. Motion passed unanimously.

Meeting adjourned at 3:39 pm

TAB 3

ALASKA WORKERS' COMPENSATION BOARD

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

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

TAB 4



BOARD DESIGNEES – OCT 2025

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

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

TAB 5



WORKERS' COMPENSATION DIVISION

OCTOBER 2025 ALASKA WORKERS' COMPENSATION
DIRECTOR'S REPORT

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

ALASKA WORKERS COMPENSATION BOARD NEWS

The Board is still down several positions. A few applicants have been accepted but we still have openings, especially in District 3, that is the Anchorage, Mat Valley, and the Kenai Peninsula.

The members whose terms were up that reapplied have all been forwarded to the Legislature.

Name	Panel	Affiliation	Term Date
Brad Austin	Southern	Labor	2028
Debbie White	Southern	Industry	2027
Randy Beltz	Southcentral	Industry	2028
Mike Dennis	Southcentral	Industry	2028
Sara Faulkner	Southcentral	Industry	2028
Vacant	Southcentral	Industry	2028
Vacant	Southcentral	Industry	2026
Bronson Frye	Southcentral	Labor	2027
Pam Cline	Southcentral	Labor	2027
Anthony Ladd	Southcentral	Labor	2026
Vacant	Southcentral	Labor	2026
Vacant	Southcentral	Labor	2027
Sarah LeFebvre	Northern	Industry	2028
Vacant	Northern	Industry	2028
Lake Williams	Northern	Labor	2026
John Corbett	Northern	Labor	2026
Vacant	At Large	Industry	2027
Brian Zematis	At Large	Labor	2026

ALASKA WORKERS COMPENSATION RESOLUTIONS

The Board has active resolutions that have been shared with the Legislature and the Governor's office. A list of those can be found on the Boards web page, [Workers' Compensation Board](#). Resolution 24-01 is the only active Resolution and communicates our desire to use electronic mail for service delivery and reduce the costs to the Division by removing the requirement to send documents by certified mail. A new Resolution on the establishment of a workers' compensation ombudsman position is included in the Board packet for consideration in this meeting.

REGULATIONS

As an empowered Board with the task of providing regulations for procedures, benefits and other matters under the Alaska Workers Compensation Act, an ongoing task is the updating of our regulations. This process is ongoing and can be tedious, but very important.

LEGISLATION

Several pieces of legislation could be passed into law that affects workers' compensation. Additionally, we have been contacted by several parties about possible legislation action in process. The Department has asked the Governor to put forth a bill to increase the revenue flow into WSCAA, this would increase the fee on insurance premiums and will impact costs passed on to employers.

House Bill 44 – This bill would add a death benefit for the estate or parents of a worker who had no dependents. House Labor and Commerce committee heard this bill but there was no movement.

House Bill 88 – Tuition Waivers for peace officers, firefighters and armed forces members. This bill would allow for tuition to be waived for dependents if an injury occurred in the line of duty. House Education committee, no hearings.

House Bill 103 – A change in the language for the firefighter presumption in AS 23.30.121. Changes the exam schedule from annual to biannual. House Labor and Commerce, no hearings yet.

Senate Bill 35 – Delivery Network Companies, or what I call Uber Eats. This will exempt delivery network couriers from the workers' compensation benefits and identify those couriers as independent contractors. This closes a gap in the Transportation Network Company Act as drivers transporting passengers are deemed exempt in Alaska, but no mention is made of delivery network drivers, who may also work as delivery couriers. This bill sets equal status for both types of network company drivers to be treated as independent contractors. This bill was passed in Senate Affairs and is now in Senate Labor and Commerce. During the summer several meetings have been held on this legislation and amendments are pending. I expect this bill to pass.

Senate Bill 132 and House Bill 148 – an omnibus insurance bill that affects workers' compensation. This legislation passed and was signed into law by the Governor.

Senate Bill 134 and House Bill 149 – Pharmacy Benefit Managers. Adds the ability for the Director of Insurance to examine pharmacy benefit managers and third-party administrators to the list of insurance entities in statute. Requires pharmacy benefit managers and third-party administrators to be licensed in Alaska. This bill is in Senate Rules, it will come to the Senate floor for a vote in the next session.

House Bill 193 – Paid Parental leave Act, has nothing to do with Workers’ Compensation, however the Division has expertise in paying claims and has been suggested as a possible home for the claim tracking, adjudications, and paying of these benefits. This bill would allow for a weekly payment for new parents to collect a stipend mirroring the unemployed insurance process with funding coming from a fee on employers and employees and collected by the unemployment insurance team. This bill is in House Labor & Commerce and has been active between sessions.

Other bills are under construction in the Capitol that we are watching carefully, a proposal that would allow state actions and public hearings to be served by means prescribed by regulation, removing the certified mail requirement. Several versions of funding bills using fees levied on employers / employee’s paycheck, for example training funds, most of these bills lower the employment security tax sent to the Federal Unemployment Trust Fund and use those funds for job skill improvement training.

ISSUES ON THE HORIZON TO BE AWARE OF

For 2026 the Medical Services Review Committee will look different. Dr. Jeff Moore is stepping down, as he slows down his active practice and steps back from a leadership role in his clinic, he has made the decision to spend more time on grandkids who have recently moved to Alaska. Pam Scott, one of the original MSRC members, has also decided it is time to transition out of everyday work. Pam has moved out of Alaska, and we thank her for the time and effort over the years on the Medical Fee Schedule. Finally, Susan Kosinski has also decided to step down from the committee. Susan has recently taken on new duties, and we wish her great success in this endeavor.

Coming soon: AMA Guides Sixth 2025 available on AMA Guides Digital.
This will include a revision of Chapter 5 and minor updates to Chapter 11.

The board may recall that last August, (2024), our Medical Fee Schedule contractor Optum, transferred the portion of their business performing these fee schedule tasks to a new company named RefMed. Our author, Carla Gee, continued with us and was instrumental once again this year in keeping us on task and answering questions to produce the 2026 Official Workers’ Compensation Medical Fee Schedule. Carla has recently decided to retire, and the last note I received said she is bicycling in Europe and will no longer be our point person on medical billing questions. While devastating news to me personally, I was overjoyed when the replacement contacted us as I already knew her, Danean Tedford is RefMed’s new contact for us and Danean has a long background in workers compensation. Danean is a medical coding expert and performed claim work for Walmart for several years.

DIRECTOR THOUGHTS FOR 2025 - 2026

This year began with a little anxiety and a lot of hope, new programs, changes in reemployment benefits and several items the AWCB had worked on for years has now begun. The Division is operating with a few vacancies and will likely continue in this for the next fiscal cycle. I will note that we have continued to offer excellent service to the claimants and attorney representatives and will continue to concentrate on those

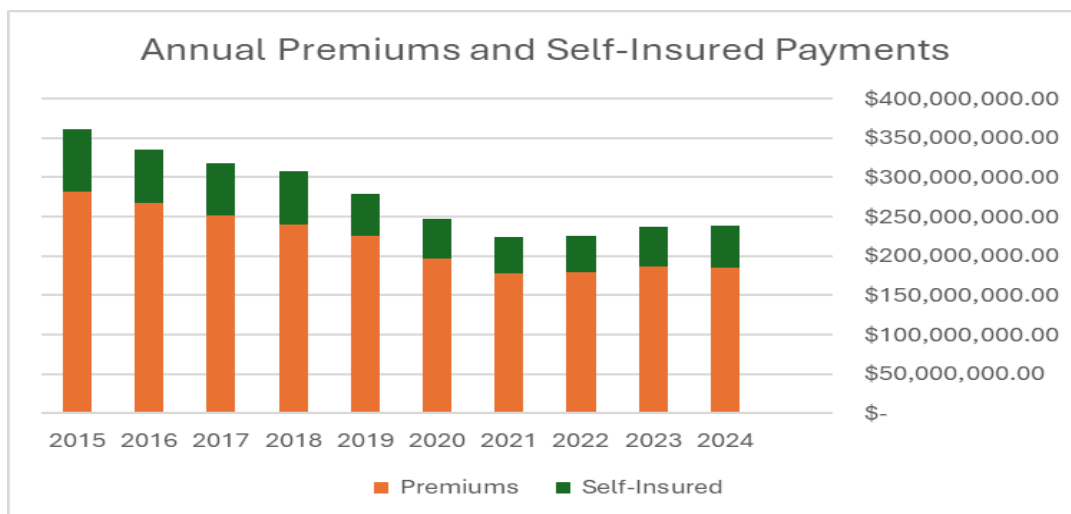
aspects of service. This may cause some issues of short notification to Board members when stipulations need answers, and we are unable to forward those documents as quickly as in the past.

We continue to struggle with the budgetary limit from our Workers Safety and Compensation Administrative Account, WSCAA, which is based on a service fee from market insurer premiums, AS 21.09.210, and self-insured annual expenditures, AS 23.05.067. Expenses have continued to rise, and the Workers' Compensation Division is not immune to the pressures of inflation.

Workers Safety and Compensation Administration Account (WSCAA)						
	FY23	FY24	FY25	FY26	FY27	FY28
Leg Allocation from WSCAA	\$ 7,266,100.00	\$ 7,418,900.00	\$ 7,907,700.00	\$ 8,032,600.00		
WSCAA Revenue	\$ 6,507,298.10	\$ 6,722,658.41	\$ 6,651,845.00	\$ 6,743,455.00	\$ 6,879,797.00	\$ 6,995,554.00
Empty Authority	\$ 758,801.90	\$ 696,241.59	\$ 1,255,855.00	\$ 1,289,145.00		
Workers' Comp	\$ 5,647,669.82	\$ 5,679,967.68	\$ 5,573,382.00	\$ 7,047,300.00	\$ 7,089,584.00	\$ 7,132,121.00
WC Appeals Commission	\$ 391,564.18	\$ 373,796.46	\$ 371,610.00	\$ 478,000.00	\$ 480,868.00	\$ 483,753.00
WC Capital Improvement Project	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Occupational Safety and Health	\$ 157,410.18	\$ 226,803.12	\$ 616,503.00	\$ 713,900.00	\$ 718,183.00	\$ 722,493.00
Labor Market Info	\$ 83,603.79	\$ 69,946.26	\$ 77,426.00	\$ 141,800.00	\$ 142,651.00	\$ 143,507.00
Expenditure Total	\$ 6,280,247.97	\$ 6,350,513.52	\$ 6,638,921.00	\$ 8,381,000.00	\$ 8,431,286.00	\$ 8,481,874.00
				Projection		
Revenue Shortfall	\$ 227,050.13	\$ 372,144.89	\$ 12,924.00	\$ (1,637,545.00)	\$ (1,551,489.00)	\$ (1,486,320.00)

The Division is in the unenviable position of competing for General Fund dollars, and some tough decisions have been made to continue operations. This has included holding several positions vacant, limiting travel, and closing the Fairbanks location for the current period.

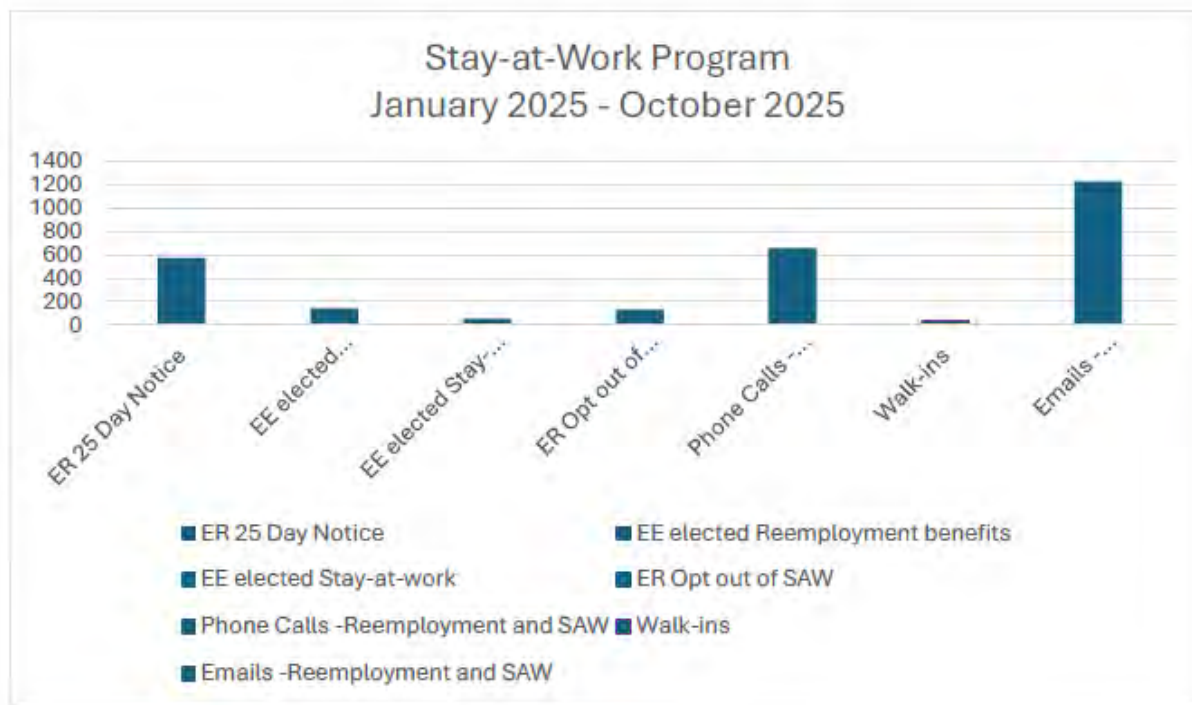
For context, Alaska's fee on insurance premiums is 2.7 percent up to \$100,000 and 0.08 percent on premiums exceeding the \$100,000 level. The WSCAA fund receives 2.5% of the premium fee and 2.9% of benefits paid from self-insured entities. This has resulted in approximately \$6.5 million in the past several years and has not kept pace with our expenses.



Alaska has held very steady on total costs for premiums and self-insurance reimbursement since 2019.

STAY-AT-WORK / RETURN-TO-WORK

The Stay-at-Work / Return-to-Work program continues to expand as employers and employees become aware of the program. Program Coordinator Grace has reached out to employer groups, educated insurance adjusters, and communicated with injured employees the benefits of this new program.



From January 1, 2025, through October of 2025, we have received a total of 574 employer notices that employees injured on or after January 1, 2025, have missed 25 consecutive days of employment due to their work injury. We received 325 responses from both employees and employers and of those 130 cases have opted out of the stay-at-work program, 54 have elected stay-at-work, and the rest will be participating in the reemployment benefits process. The Rehabilitation Benefits group has logged 1,917 entries via phone, email, or walk in for SAW/RTW questions.

Currently, fifty-four cases are in the process of a stay-at-work plan, twelve have returned to work. Another one hundred and forty-one cases have elected reemployment benefits instead of the SAW/RTW process.

TOTAL COSTS TO WORKERS COMPENSATION IN ALASKA

The Oregon Department of Consumer and Business Services, which ranks all the nation's workers' compensation costs on a biannual basis, and Alaska continues to shine by carefully controlling costs and partnering with providers and payers to improve outcomes for injured workers.

2024 rank	2022 rank	State	Index rate	Percent of study median	Effective date
1	2	Hawaii	2.52	231%	Jan. 1, 2023
2	1	New Jersey	2.16	198%	Jan. 1, 2024
3	4	New York	1.98	182%	Oct. 1, 2023
4	3	California	1.86	170%	Sept. 1, 2023
5	6	Vermont	1.60	147%	April 1, 2023
6	10	Connecticut	1.48	135%	Jan. 1, 2024
7	8	Wisconsin	1.42	130%	Oct. 1, 2023
8	7	Wyoming	1.41	130%	Jan. 1, 2024
9	5	Louisiana	1.41	129%	May 1, 2023
10	11	Rhode Island	1.38	127%	Aug. 1, 2023
11	9	Maine	1.37	125%	April 1, 2023
12	24	Washington	1.35	123%	Jan. 1, 2024
13	19	Illinois	1.34	123%	Jan. 1, 2024
14	15	Montana	1.34	122%	July 1, 2023
15	17	Oklahoma	1.33	122%	Jan. 1, 2023
16	13	Missouri	1.31	120%	Jan. 1, 2024
17	12	Minnesota	1.25	114%	Jan. 1, 2024
18	18	New Hampshire	1.22	112%	Jan. 1, 2023
19	14	Iowa	1.21	110%	Jan. 1, 2024
20	21	Alaska	1.16	106%	Jan. 1, 2024
21	26	Pennsylvania	1.14	105%	April 1, 2023
22	25	South Dakota	1.13	103%	July 1, 2023
23	29	Nebraska	1.12	103%	Feb. 1, 2023
24	20	Alabama	1.11	101%	March 1, 2023
25	16	Idaho	1.10	101%	Jan. 1, 2024

Alaska rose one position since the 2022 survey, but has moved 1% closer to the median for compensation premiums nationwide.

“PREVIOUSLY REHABILITATED” HISTORY

f an injured worker has been “previously rehabilitated” he or she is not eligible for reemployment benefits. The Alaska Workers’ Compensation Act provides a statutory definition of “previously rehabilitated” at AS 23.30.041(f).

AS 23.30.041. Rehabilitation of injured workers. . . .

Pre-2005 Amendments:

(f) An employee is not eligible for reemployment benefits if

. . . .

(2) the employee has been previously rehabilitated in a former workers’ compensation claim and returned to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury;

. . . .

2005 Amendments:

(f) An employee is not eligible for reemployment benefits if

. . . .

(2) the employee previously declined the development of a reemployment benefits plan under (g) of this section, received a job dislocation benefit under (g)(2) of this section, and returned to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury;

(3) the employee has been previously rehabilitated in a former workers’ compensation claim and returned to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury;

. . . .

On July 18, 2005, the Attorney General’s analysis of the 2005 amendments was provided to Gov. Murkowski, which noted AS 23.30.041(f) was changed to add an additional disqualification for reemployment benefits. The added disqualification is contained in subsection (2) above. An injured worker will be found ineligible for reemployment benefits under AS 23.30.042(f)(2) if the employee has been found eligible for reemployment benefits in an earlier case, declined those benefits, and selected a job dislocation benefit. If the employee returned to work in a job with the same or similar physical demands as the employee’s job of injury and was injured again, he or she would not be eligible for reemployment benefits.

AS 23.30.041(f)’s former subsection (2) became subsection (3), but neither the subsection’s language nor its effect changed. But the Attorney General’s letter to Gov. Murkowski also provided valuable insight into the legislative intent behind the original pre-2005 §.041(f)(2). The letter stated, “This subsection [the amended 2005 §.041(f)(2)] parallels the current disqualification of an employee *who receives reemployment benefits through a reemployment plan*, but who returns to work in the same or similarly demanding occupation as when previously injured and is injured

again.” (Italics added). This demonstrates that the legislative and executive branches both considered a person to be “previously rehabilitated” only after they had gone through a “reemployment plan.”

Believing injured workers regularly settled reemployment benefits and then returned to their jobs of injury or jobs with the same or similar physical demands, the Board desired to adopt a definition of “previously rehabilitated” to prevent this practice. The Board adopted 8 AAC 45.900(j) on December 22, 2011. This definition expanded the statute’s definition of “previously rehabilitated” to include waiving reemployment benefits under AS 23.30.041(q) or AS 23.30.012, or similar laws in other jurisdictions.

Effective December 22, 2011:

8 AAC 45.900(j). For an injury occurring after the effective date of this subsection, “previously rehabilitated” under AS 23.30.041(f)(3) means having

- (1) completed a reemployment benefits plan under AS 23.30.041 or a substantially similar law in another jurisdiction; or
- (2) waived reemployment benefits under AS 23.30.041(q), 23.30.012, or a substantially similar law in another jurisdiction.

The Board considered amendments to the regulation in 2017. The proposed amendment was to add to subsection (2) **stipulated to eligibility, or received or having been eligible to receive an eligibility evaluation under AS 23.30.041(c) and** waived reemployment benefits under AS 23.30.041(q), 23.30.012, or a substantially similar law in another jurisdiction. This amended version did not pass. The proposed amendment was revised during an October 6, 2017 Board meeting. The minutes say, “Member Murphy moved to amend the original amendment to substitute new language suggested by the Reemployment Benefits Administrator. . . . There was no objection. . . . The motion to adopt the amendment of 8 AAC 45.900(j) passed unanimously.”

The amendments to “previously rehabilitated” adopted on October 6, 2017, went into effect on July 27, 2017.

Effective July 27, 2017:

8 AAC 45.900(j). For an injury occurring after December 22, 2011, “previously rehabilitated” under AS 23.30.041(f)(3) means having

- (1) completed a reemployment benefits plan under AS 23.30.041 or a substantially similar law in another jurisdiction; or
- (2) done both of the following:
 - (A) having stipulated to eligibility, having an eligibility request approved, or having an eligibility evaluation ordered under AS 23.30.041(c);
 - (B) having waived reemployment benefits under AS 23.30.041(q), 23.30.012, or a substantially similar law in another jurisdiction.

Under the pre-2005 amendments to AS 23.30.041(f), an injured worker was not eligible for reemployment benefits if he or she completed a reemployment plan and returned to work in a job with the same or similar physical demands as the job of injury. That was consistent with the statute’s clear and plain language.

After the 2005 amendments, the previous subsection (f)(2) was renumbered and is now subsection (f)(3). Other than the number, nothing in that subsection changed. A new subsection was added, which provided an additional basis for an injured worker to be found not eligible for reemployment benefits, which is if the employee is found eligible and declines reemployment benefits and, instead, accepts a job dislocation benefit and then returns to work in a job with the same or similar physical demands as the job of injury.

Under both (f)(2) and (3), to be not eligible for reemployment benefits, an injured worker must return to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury.

The current regulation’s definition of “previously rehabilitated” under AS 23.30.041(f) renders an injured worker not eligible for reemployment benefits if an employee completed a reemployment plan; or either stipulated to eligibility, had an eligibility request approved, or an eligibility evaluation ordered under AS 23.30.041(c), and waived reemployment benefits in a settlement or otherwise.

REGULATIONS CONSIDERED “DISCRETIONARY”

8 AAC 45.032	REPEAL	8 AAC 45.110(a) & (b)	REPEAL
8 AAC 45.054		8 AAC 45.120(a) [a portion], (b), (c), (d), (e) NOTE: See fn 70 in <i>Rusch</i> 453 P3 784	
8 AAC 45.063(b)		8 AAC 45.130	REPEAL
8 AAC 45.071		8 AAC 45.132	REPEAL
8 AAC 45.072		8 AAC 45.134(b)	REPEAL
8 AAC 45.081(a) & (b)		8 AAC 45.142	REPEAL
8 AAC 45.082(a), (d), (e)		8 AAC 45.170	REPEAL
8 AAC 45.084(a), (b), (c), (d)		8 AAC 45.188	REPEAL
8 AAC 45.085	REPEAL	8 AAC 45.900(j)	REPEAL
8 AAC 45.090(a), (b), (c)			
8 AAC 45.095			

Although some of the regulations are discretionary, the board has authority to adopt them under AS 23.30.005 and are necessary and useful for administration of our work. For example, 8 AAC 45.071 identifies those matters a hearing officer can hear as the Commissioner’s designee. AS 23.30.005(h) says, “The department **may** by regulation provide for procedural, discovery, or stipulated matters to be heard and decided by the commissioner or a hearing officer designated to represent the commissioner rather than a panel.” The “may” signifies it is a discretionary regulation.



SCHEDULE

Proposed Stakeholder Regulation Reduction Workshops 2025

9/15/2025

All meetings to be held virtually with written comments accepted by mail or email.

Topics: Legal procedures and fees; medical procedures, forms, and fees; indemnity benefits and compensation; reemployment and rehabilitation, and Appeals.

October 20, 2025, 10am to 11am	Fishermen's Fund Alaska Administrative Code Chapter 55 https://us02web.zoom.us/j/85787362251	In Person at 3301 Eagle St, Suite 305 Anchorage, AK and Zoom
October 23, 2025, 9am to 4pm	Alaska Workers Compensation Board Alaska Administrative Code Chapter 45 Active Bulletins https://us02web.zoom.us/j/84407872140	In Person at 3301 Eagle St, Suite 208 Anchorage, AK and Zoom
November 6, 2025, 10am to 11am	Alaska Worker's Compensation Appeals Commission Alaska Administrative Code Chapter 57 https://us02web.zoom.us/j/84988868299	Zoom
November 18, 2025, 10am to 11am	Procedures before the Board Alaska Administrative Code Chapter 45 Active Bulletins https://us02web.zoom.us/j/81443354151	Zoom
December 16, 2025, 10am to 11am	Indemnity and Compensation Issues Alaska Administrative Code Chapter 45 Active Bulletins https://us02web.zoom.us/j/87026394377	Zoom

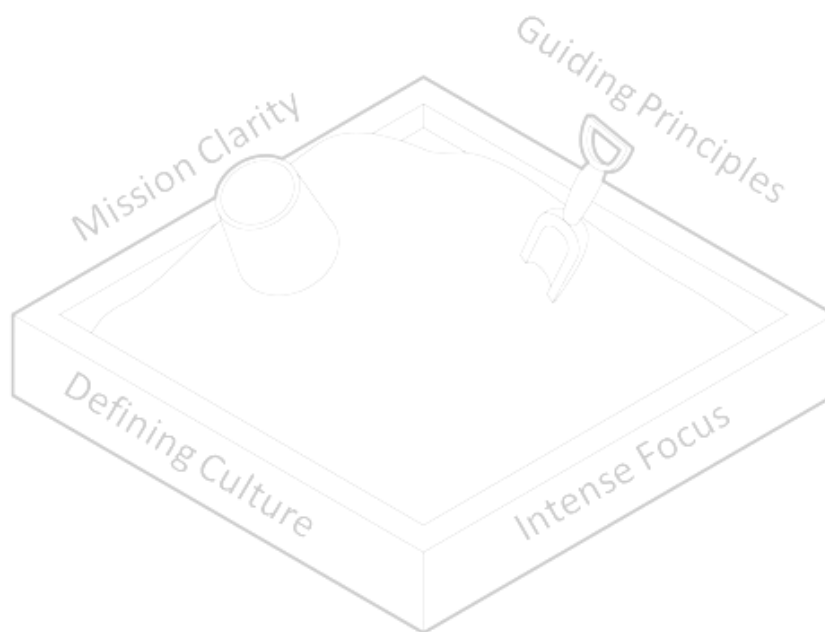


Additional Instruction:

To participate by Zoom, please use the appropriate link above.

To participate by phone, call 833-548-0276 and enter the Webinar ID in the appropriate link above.

Additional stakeholder meetings will be scheduled for 2026. Dates TBD.





SCHEDULE

Proposed Stakeholder Regulation Reduction Workshops

10/15/2025

All meetings to be held virtually with written comments accepted by mail or email.

Topics: Legal procedures and fees; medical procedures, forms, and fees; Indemnity benefits and compensation; reemployment and rehabilitation.

January 8, 2026, 9am to 4pm	Alaska Workers Compensation Board Alaska Administrative Code Chapter 45 Active Bulletins	In Person at 3301 Eagle ST, Suite 208 Anchorage, AK and Zoom
January 13, 2026, 10am to 11am	Medical Procedures and Forms Alaska Administrative Code Chapter 45 Alaska WC Medical Fee Schedule	Zoom
January 27, 2026, 10am to 11am	Reemployment and Rehabilitation Alaska Administrative Code Chapter 45 Active Bulletins	Zoom
February xx, 2026, 10am to 11am	Medical Procedures and Forms Alaska Administrative Code Chapter 45 Alaska WC Medical Fee Schedule	Zoom
February xx, 2026, 10am to 11am	Workers' Compensation and You Alaska Administrative Code Chapter 45 Workers' Compensation and you Handbook	Zoom
March xx, 2026, 10am to 11am	Workers' Compensation and You Alaska Administrative Code Chapter 45 Employers' Guide to the Workers' Compensation Act	Zoom



April 8, 2026,
10am to 11am

EDI Work Session

Zoom

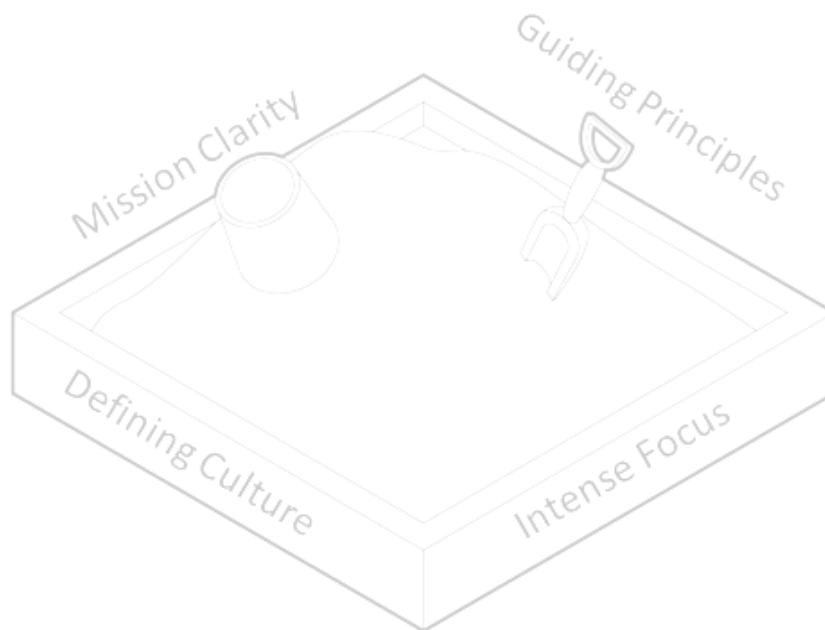
EDI resource Guide

Additional Instruction:

All meetings noticed by Online Public Notice.

Constituent groups to be noticed directly by electronic means. This includes the Alaska Bar, Alaska Medical Associations, Chamber of Commerce's, Registered Labor Union Offices and major employers.

An enhanced ask for written comments to capture the ideas directly from the source.





SEPTEMBER 2, 2025

AK-2025-01

LOSS COSTS OR RATE FILING**Alaska—Voluntary Loss Costs, Assigned Risk Rates, and Rating Values Proposed to Be Effective January 1, 2026****ACTION
NEEDED**

Please review this information before the voluntary loss costs, voluntary rating values, assigned risk rates, and assigned risk rating values cited in this circular are approved.

In accordance with AS 21.39.043(d), this loss cost filing is subject to an administrative hearing. Please visit the State of Alaska or Alaska Division of Insurance website for a public notice providing the details of the hearing.

Keep this filing circular because it will be **supplemented but not replaced** by an approval circular upon regulatory approval. This filing circular and the approval circular will provide the entire package of relevant information for this change.

Caution: When this filing circular was published, these values had been filed with the regulator but were **not yet approved**. This information is provided for your convenience and analysis. Please use the information “as is” and do not rely on the data until the filing has been approved by the regulator.

BACKGROUND

NCCI recently submitted a voluntary loss costs, assigned risk rates, and rating values filing to the Alaska Division of Insurance. The filing is proposed to be effective January 1, 2026, for new and renewal policies.

Please note the following in connection with this filing:

- The proposed loss costs, rates, and expected loss rates (ELRs) are calculated to three decimal places
- As a result of Item R-1424, the Retrospective Rating Plan parameters have been updated

This circular contains the original filing and the detailed calculations and actuarial support. It is a confidential and proprietary document of NCCI intended for the use of its affiliates, and for their use only, as licensed by contract. NCCI, on behalf of its affiliates, reserves the right to limit its unauthorized use or distribution.

IMPACT

The filing proposes an average decrease of 3.7% in the voluntary loss cost level and a decrease of 4.8% in the assigned risk rate level for industrial classes.

NCCI ACTION

NCCI will announce in an approval circular that these or some alternative set of values have been approved by the regulator. We will post the filed voluntary loss costs, assigned risk rates, and rating values on **ncci.com**. In addition to this circular, the Individual Classification Experience Exhibit is available in both a downloadable PDF format and a Microsoft® Excel spreadsheet on **ncci.com**. For more information, please contact our Customer Service Center at 800-NCCI-123 (800-622-4123).

NCCI makes no representation or warranty, express or implied, as to any matter including, but not limited to, an assurance that the regulator will approve the values in this circular.

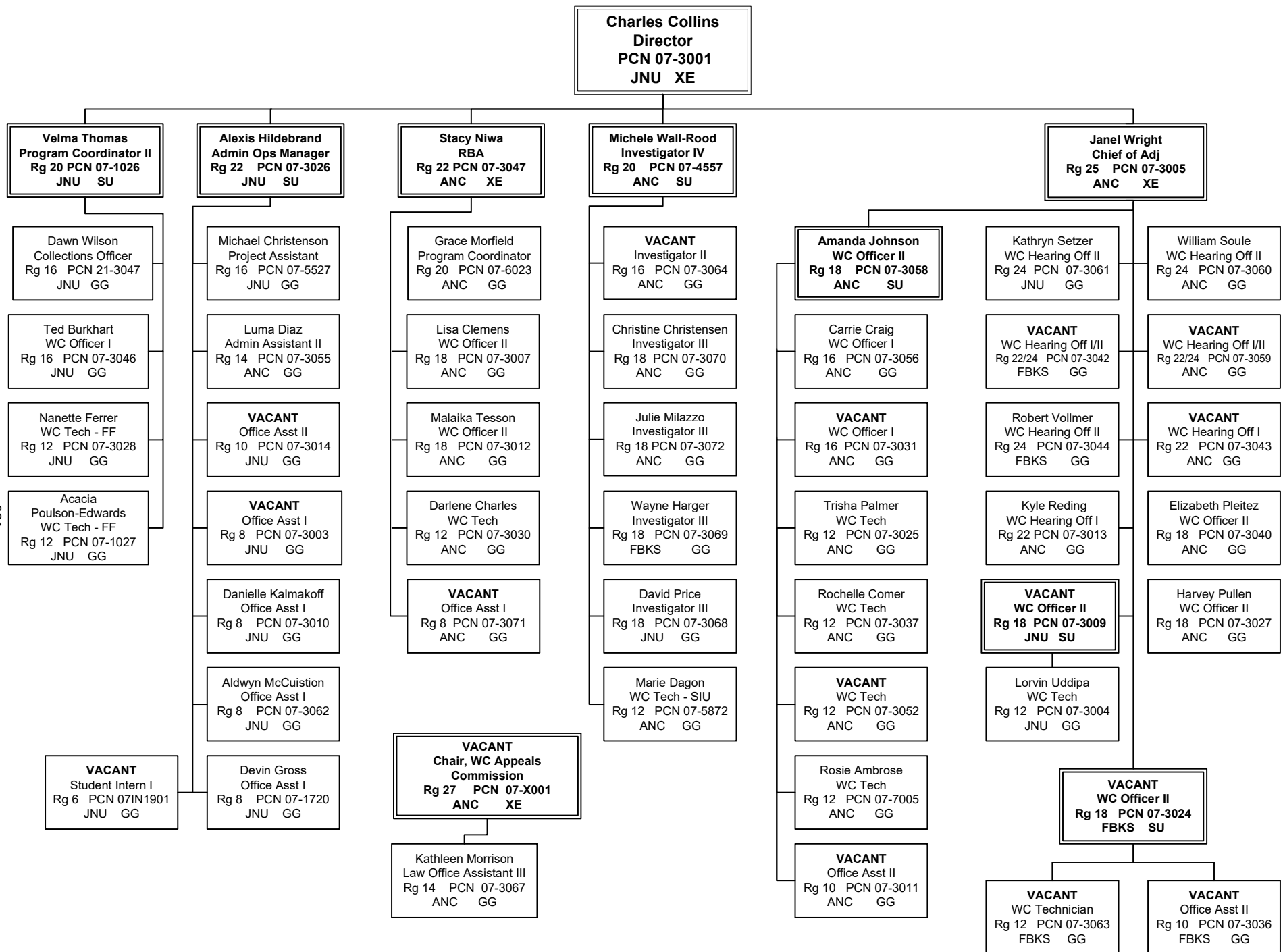
**PERSON TO
CONTACT**

If you have any questions, please contact:

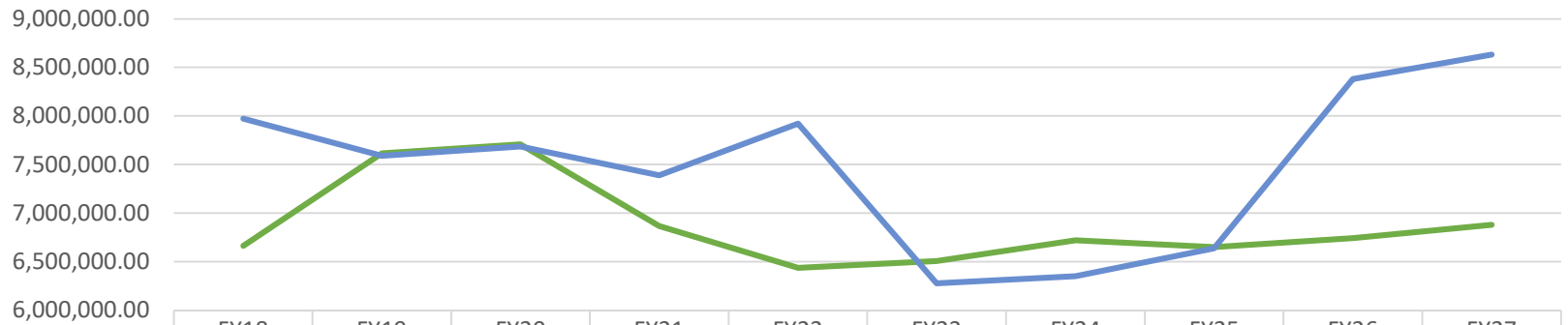
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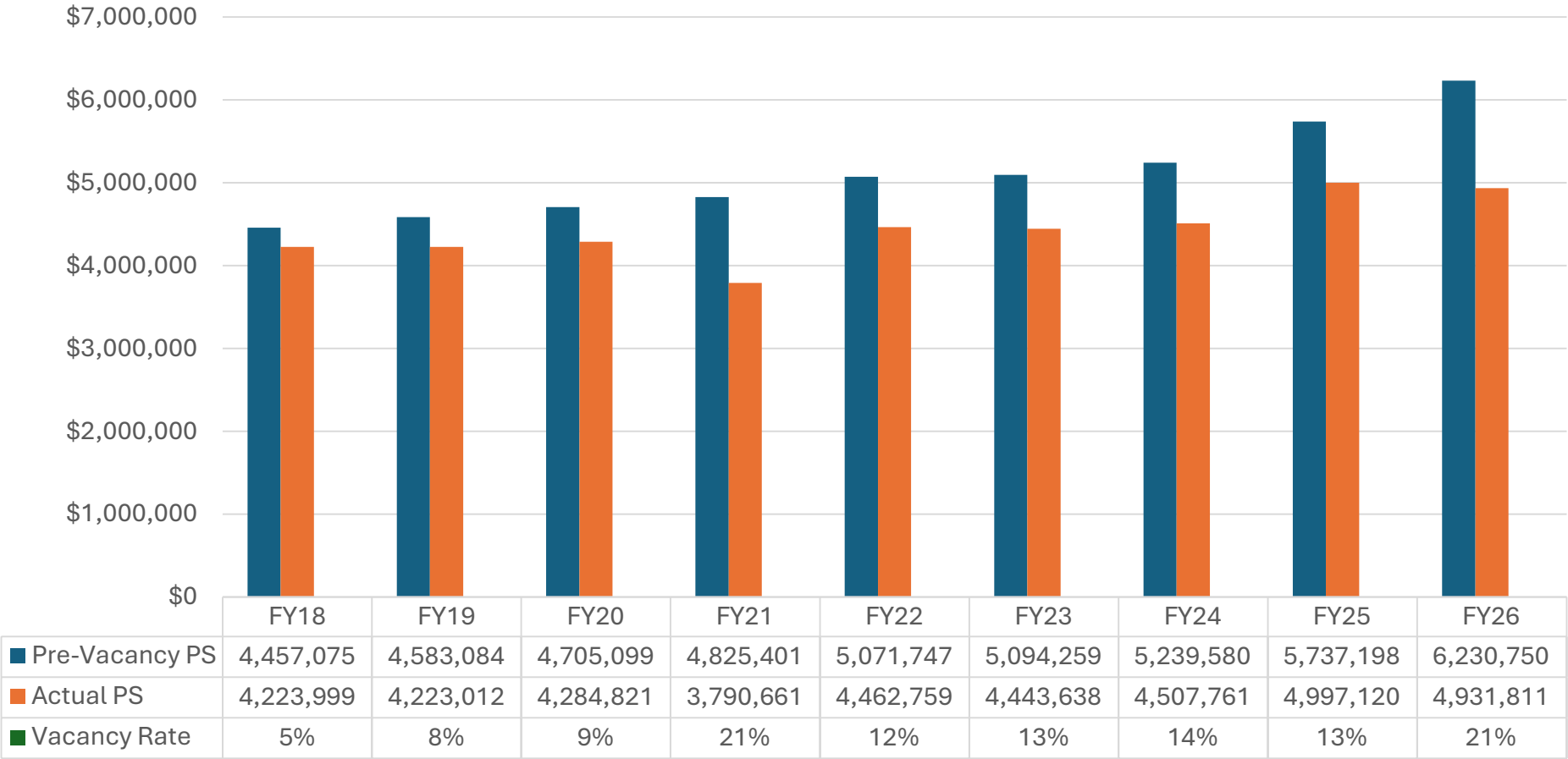
WSCAA FUND BALANCE



	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27
REVENUE										
Insurer Premium Tax	4,544,123	5,398,947	5,600,176	4,902,503	4,442,776	4,498,567	4,654,752	4,636,345	4,751,615	4,870,110
Self-Insurer Service Fee	2,109,489	2,063,408	1,667,542	1,411,007	1,684,670	1,486,445	1,600,136	1,664,868	1,648,220	1,672,940
WC Penalties	0	147,603	434,225	539,792	306,690	520,436	464,385	339,755	332,960	326,301
Misc	9,789	6,207	7,251	13,228	5,210	1,850	3,385	10,876	10,660	10,447
Revenue Total	6,663,401	7,616,164	7,709,194	6,866,529	6,439,346	6,507,298	6,722,658	6,651,845	6,743,455	6,879,797
EXPENDITURE										
Workers' Comp	5,511,057	5,368,923	5,330,051	4,849,491	5,568,015	5,647,670	5,679,968	5,573,382	7,047,300	7,290,100
WC Appeals Commission	301,739	323,041	344,934	330,968	349,341	391,564	373,796	371,610	478,000	480,868
Occupational Safety and Health	2,097,547	1,829,104	1,908,692	2,137,115	1,923,531	157,410	226,803	616,503	713,900	718,183
Labor Market Info	60,779	67,646	101,347	71,403	79,270	83,604	69,946	77,426	141,800	142,651
Expenditure Total	7,971,122	7,588,714	7,685,025	7,388,976	7,920,156	6,280,248	6,350,514	6,638,921	8,381,000	8,631,802
Fund Sweep					2,040,403.1	332,233.6	374,562.3			
FUND BALANCE (year end)	4,026,576	4,054,027	4,126,314	3,603,868	82,654	-22,530	-24,947	-12,024	-1,637,545	-1,752,005

Vacancy Factor

033



■ Pre-Vacancy PS ■ Actual PS ■ Vacancy Rate

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: 9/2/2025 Q4 FY2025

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2025

Summary:

Program	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/2/2025 Expend	Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Workers' Compensation	6,651,100	0	0	0	6,651,100	5,573,382	0	1,077,718	0	0	5,573,382	1,077,718	83.8%
WC Appeals Commission	482,400	0	0	0	482,400	371,610	0	110,790	0	0	371,610	110,790	77.0%
WC Benefits Guaranty Fund	794,300	0	0	0	794,300	335,916	0	458,384	0	0	335,916	458,384	42.3%
Second Injury Fund	2,887,700	0	0	0	2,887,700	2,405,477	0	482,223	0	0	2,405,477	482,223	83.3%
Fishermen's Fund	1,449,900	0	0	0	1,449,900	915,982	0	533,918	0	0	915,982	533,918	63.2%
Division Total	12,265,400	0	0	0	12,265,400	9,602,367	0	2,663,033	0	0	9,602,367	2,663,033	78.3%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
004					
Revenue Type Workers' Safety	7,088,400	0	0	0	7,088,400
Revenue Type General Funds	45,100	0	0	0	45,100
Revenue Type Benefits Guaranty Fund	794,300	0	0	0	794,300
Revenue Type Second Injury Fund	2,887,700	0	0	0	2,887,700
Revenue Type Fishermen's Fund	1,449,900	0	0	0	1,449,900
General Funds					
Total Program Funding	12,265,400	0	0	0	12,265,400

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: 9/2/2025 Q4 FY2025

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2025

Workers' Compensation

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/2/2025 Expend	9/2/2025 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To Date
Personal Services	5,409,900.00	-176,643.30	0.00	0.00	5,233,256.70	4,997,120.48	0.00	236,136.22	0.00	0.00	4,997,120.48	236,136.22	95.5%
Travel	75,000.00	-4,600.00	0.00	0.00	70,400.00	35,262.33	0.00	35,137.67	0.00	0.00	35,262.33	35,137.67	50.1%
Services	1,079,800.00	166,243.30	0.00	0.00	1,246,043.30	467,308.21	0.00	778,735.09	0.00	0.00	467,308.21	778,735.09	37.5%
Commodities	74,800.00	15,000.00	0.00	0.00	89,800.00	62,146.10	0.00	27,653.90	0.00	0.00	62,146.10	27,653.90	69.2%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	1,229,600.00	176,643.30	0.00	0.00	1,406,243.30	564,716.64	0.00	841,526.66	0.00	0.00	564,716.64	841,526.66	40.2%
Grants	11,600.00	0.00	0.00	0.00	11,600.00	11,545.08	0.00	54.92	0.00	0.00	11,545.08	54.92	99.5%
Total Program Expenditures	6,651,100.00	0.00	0.00	0.00	6,651,100.00	5,573,382.20	0.00	1,077,717.80	0.00	0.00	5,573,382.20	1,077,717.80	83.8%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
General Funds	19,800.0				19,800.00
Revenue Type Workers' Safety	6,631,300.00				6,631,300.00
					0.00
Total Program Funding	6,651,100.00	0.00	0.00	0.00	6,651,100.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/2/2025	Q4	FY2025
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Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2025

WC Appeals Commission

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/2/2025		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	366,300.00	-1,588.66	0.00	0.00	364,711.34	309,469.66	0.00	55,241.68	0.00	0.00	309,469.66	55,241.68	84.9%
Travel	0.00	700.00	0.00	0.00	700.00	624.55	0.00	75.45	0.00	0.00	624.55	75.45	89.2%
Services	111,100.00	-8,111.34	0.00	0.00	102,988.66	48,880.69	0.00	54,107.97	0.00	0.00	48,880.69	54,107.97	47.5%
Commodities	5,000.00	9,000.00	0.00	0.00	14,000.00	12,635.32	0.00	1,364.68	0.00	0.00	12,635.32	1,364.68	90.3%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	116,100.00	1,588.66	0.00	0.00	117,688.66	62,140.56	0.00	55,548.10	0.00	0.00	62,140.56	55,548.10	52.8%
Grants	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00			0.0%
Total Program Expenditures	482,400.00	0.00	0.00	0.00	482,400.00	371,610.22	0.00	110,789.78	0.00	0.00	371,610.22	110,789.78	77.0%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
General Funds	25,300.0				25,300.0
Revenue Type Workers' Safety	457,100.00				457,100.00
Total Program Funding	482,400.00	0.00	0.00	0.00	482,400.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/2/2025	Q4	FY2025
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Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2025

Benefits Guaranty Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/2/2025		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	123,900.00	4,100.00	0.00	0.00	128,000.00	128,576.89	0.00	-576.89	0.00	0.00	128,576.89	-576.89	100.5%
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	235,700.00	-4,100.00	0.00	0.00	231,600.00	73,915.91	0.00	157,684.09	0.00	0.00	73,915.91	157,684.09	31.9%
Commodities	2,000.00	0.00	0.00	0.00	2,000.00	146.00	0.00	1,854.00	0.00	0.00	146.00	1,854.00	7.3%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	237,700.00	-4,100.00	0.00	0.00	233,600.00	74,061.91	0.00	159,538.09	0.00	0.00	74,061.91	159,538.09	31.7%
Grants	432,700.00	0.00	0.00	0.00	432,700.00	133,277.23	0.00	299,422.77	0.00	0.00	133,277.23	299,422.77	30.8%
Total Program Expenditures	794,300.00	0.00	0.00	0.00	794,300.00	335,916.03	0.00	458,383.97	0.00	0.00	335,916.03	458,383.97	42.3%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
GF Program Receipts					
Revenue Type Benefits Guaranty Fund	794,300.00	0.00			794,300.00
Interagency Receipts					
General Funds					
Total Program Funding	794,300.00	0.00	0.00	0.00	794,300.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/2/2025	Q4	FY2025
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Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2025

Second Injury Fund

Program Expenditures

	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/2/2025		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	242,400.00	7,900.00	0.00	0.00	250,300.00	252,030.50	0.00	-1,730.50	0.00	0.00	252,030.50	-1,730.50	100.7%
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	72,700.00	-7,900.00	0.00	0.00	64,800.00	35,494.07	0.00	29,305.93	0.00	0.00	35,494.07	29,305.93	54.8%
Commodities	4,300.00	0.00	0.00	0.00	4,300.00	204.00	0.00	4,096.00	0.00	0.00	204.00	4,096.00	4.7%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	77,000.00	-7,900.00	0.00	0.00	69,100.00	35,698.07	0.00	33,401.93	0.00	0.00	35,698.07	33,401.93	51.7%
Grants	2,568,300.00	0.00	0.00	0.00	2,568,300.00	2,117,748.53	0.00	450,551.47	0.00	0.00	2,117,748.53	450,551.47	82.5%
Total Program Expenditures	2,887,700.00	0.00	0.00	0.00	2,887,700.00	2,405,477.10	0.00	482,222.90	0.00	0.00	2,405,477.10	482,222.90	83.3%

Program Revenue

	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
GF Program Receipts					
Revenue Type Second Injury Fund	2,887,700.00				2,887,700.00
Interagency Receipts					
General Funds					
Total Program Funding	2,887,700.00	0.00	0.00	0.00	2,887,700.00

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of:

9/2/2025	Q4	FY2025
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Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2025

Fishermen's Fund

Program Expenditures

	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	9/2/2025		Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
						Expend	Encumb						
Personal Services	300,600.00	13,200.00	0.00	0.00	313,800.00	287,733.15	0.00	26,066.85	0.00	0.00	287,733.15	26,066.85	91.7%
Travel	58,000.00	-30,500.00	0.00	0.00	27,500.00	13,216.18	0.00	14,283.82	0.00	0.00	13,216.18	14,283.82	48.1%
Services	322,500.00	0.00	0.00	0.00	322,500.00	236,192.09	0.00	86,307.91	0.00	0.00	236,192.09	86,307.91	73.2%
Commodities	24,100.00	17,300.00	0.00	0.00	41,400.00	7,747.96	0.00	33,652.04	0.00	0.00	7,747.96	33,652.04	18.7%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	404,600.00	-13,200.00	0.00	0.00	391,400.00	257,156.23	0.00	134,243.77	0.00	0.00	257,156.23	134,243.77	65.7%
Grants	744,700.00	0.00	0.00	0.00	744,700.00	371,092.15	0.00	373,607.85	0.00	0.00	371,092.15	373,607.85	49.8%
Total Program Expenditures	1,449,900.00	0.00	0.00	0.00	1,449,900.00	915,981.53	0.00	533,918.47	0.00	0.00	915,981.53	533,918.47	63.2%

Program Revenue

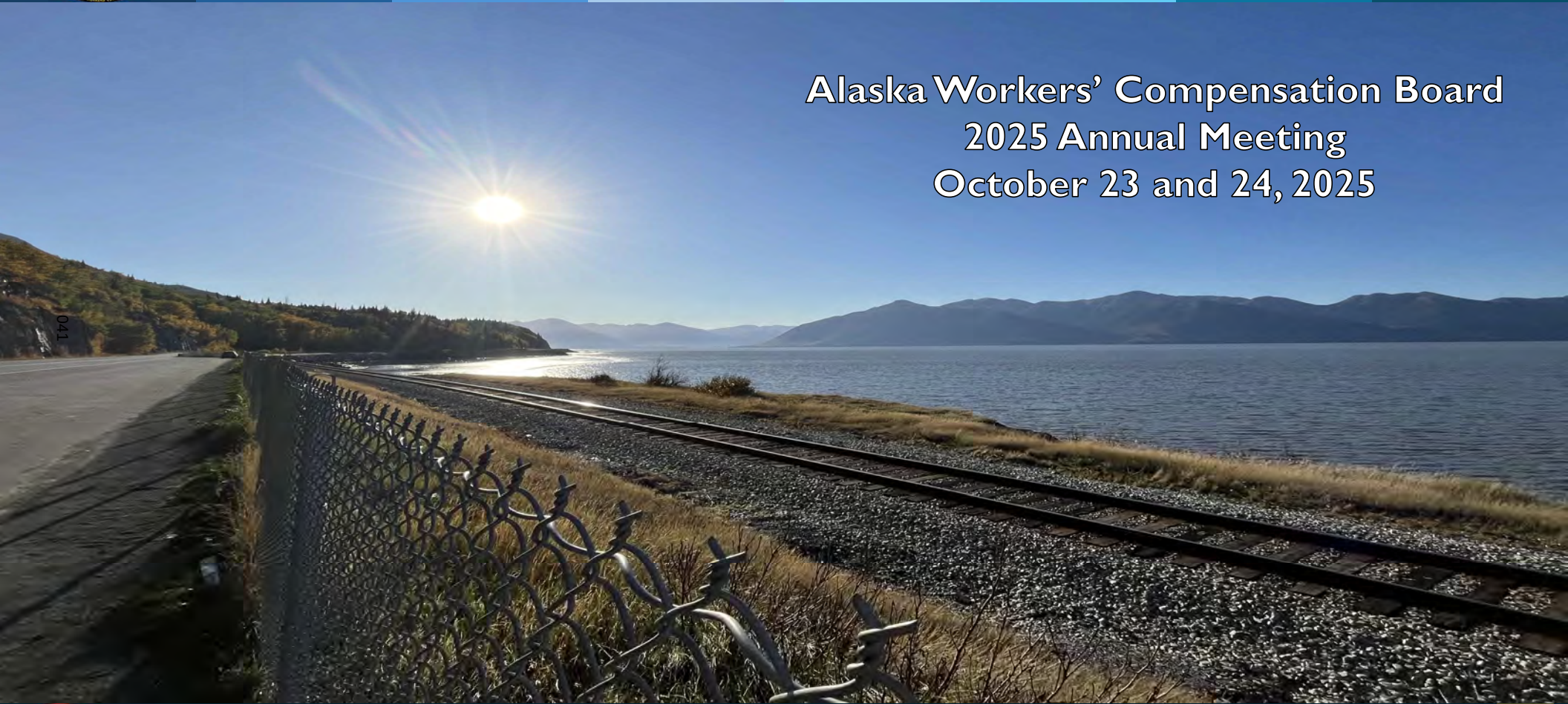
	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
GF Program Receipts					
Revenue Type Fishermen's Fund	1,449,900.00				1,449,900.00
Interagency Receipts					
General Funds					
Total Program Funding	1,449,900.00	0.00	0.00	0.00	1,449,900.00

TAB 6



Alaska Workers' Compensation Board

Alaska Workers' Compensation Board
2025 Annual Meeting
October 23 and 24, 2025



Catherine Muñoz Commissioner

October 16, 2025



Alaska Workers' Compensation Board

Alaska Department of Labor and Workforce Development
Workers' Compensation Division

2024 Annual Report

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Catherine Muñoz Commissioner

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October 16, 2025



Kids' Chance Alaska

- **Donate to something good.**

Kids' Chance of Alaska believes that we can make a significant difference in the lives of all children affected by a workplace injury by helping them pursue and achieve their educational goals.



kidschanceak.org



Alaska Workers' Compensation Board

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Alaska Workers' Compensation Board

Director's Report

In 2024, Alaska continued to experience lower workers' compensation premium costs (8th consecutive year), as a result of fewer claim filings and lower loss costs. This decline is expected to continue. According to the National Council on Compensation Insurance (NCCI), for CY 2024, the net written premium in the voluntary market decreased slightly, and the residual market premium in states serviced by NCCI remained approximately the same as 2023 (multistate overview). NCCI and the Alaska Division of Insurance project a decrease to the current loss costs for the voluntary market and a decrease to the assigned risk market rates, effective January 1, 2025.

The past year has given us many interesting issues to work on, the loss of some long-time workers' compensation contributors, interesting decisions by the Supreme Court, and funding woes. Through all of this, I am so proud of this team's accomplishments and the complete commitment that the Alaska Workers' Compensation Board and Division staff have exhibited.

With the continued partnership with our industry partners, medical providers, leadership from the Medical Services Review Committee, and support from the Commissioner, the Alaska Workers' Compensation Board has saved Alaskan employers over \$1 billion dollars in costs since 2015. During the same period, Alaska's employees enjoyed improved workplace safety and better outcomes from work injuries, with a 54% decrease in lost time incidents.

Challenges remain within Alaska Workers' Compensation, but our future has never looked brighter, and our people are prepared to meet the changes that inevitably will come our way.

Sincerely,

Charles Collins
Director, Workers' Compensation Division



Catherine Muñoz Commissioner



Alaska Workers' Compensation Board

Workers' Compensation is a system which requires an employer to pay an injured employee's work-related medical and disability benefits. Workers' Compensation also requires the payment of benefits to dependents in the case of work-related death.

The Workers' Compensation Division is the agency charged with the administration of the Alaska Workers' Compensation Act (Act). The Act provides for the payment by employers or their insurance carriers of medical, disability and reemployment benefits to injured workers.

The Division is required to administer the Act in a manner that is both fair and efficient in the delivery of benefits to injured workers at a reasonable cost to employers (AS 23.30.001).

In addition to its administrative function, the Division also houses the Alaska Workers' Compensation Board which hears disputes arising between employees and employers or their insurance carriers regarding the payment of benefits under the Act.

Thank you to the staff at the Workers' Compensation Division for their contributions collecting these important data.

For more information about the workers' compensation process, click the following links:

[Workers' Compensation \(state.ak.us\)](http://state.ak.us/workers-compensation)

Anchorage Office

3301 Eagle Street, Suite 304
Anchorage, AK 99503
Tel: (907) 269-4980
Fax: (907) 269-4975

Fairbanks Office

675 Seventh Ave., Station K
Fairbanks, AK 99701-4531
Tel: (907) 451-2889
Fax: (907) 451-2928

Juneau Office

1111 West 8th St., Room 305
Juneau, AK 99801
Tel: (907) 465-2790
Fax: (907) 465-2797



Catherine Muñoz Commissioner



Alaska Workers' Compensation Board

- **Established under AS 23.30.005**

Made up of 18 members

9 represent industry

9 represent Labor

Broke up into Panels, one from First Judicial District, two from the Second and Fourth Judicial District and Five from the Third Judicial District. One Panel is detailed at large and can represent any Judicial District.

Panels are normally three members, two Board members and a designated hearing officer.

The AWCB also is responsible for regulation under The Act.

The AWCB has two committees that annually meet:

Medical Services Review Committee

Second Independent Medical Evaluation Selection Committee



Alaska Workers' Compensation Board

Alaska Department of Labor and Workforce Development

Administrative Services:

- Department Budget
- Procurement
- Research and Analysis

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Alaska Workforce Investment Board:

- Apprenticeship Training
- Technical and Vocational Program
- State and Federal Grant Funding

AVTEC:

- Alaska's premier Training Facility
- Career Enhancement
- Employer Designed Training

Employment and Training Services:

- Alaska Job Centers
- Unemployment Insurance Benefits
- Connects job seekers and employers

Alaska Labor Relations Agency

- Conducts employee elections
- Administers Collective Bargaining for public employers
- Adjudicates unfair labor practice claims

Labor Standards and Safety

- Mechanical Inspections
- Alaska Occupational Safety and Health
- Wage and Hour enforcement

Vocational Rehabilitation

- Disability Determination Services
- Connects employers with employees and assists with workplace accommodations
- Provides training related to individual's disability

Workers' Compensation

- Tracks and adjudicates worksite injury claims
- Investigates uninsured employers
- Administers the Fisherman's Fund



Catherine Muñoz Commissioner



Alaska Workers' Compensation Board

Alaska Workers' Compensation Division

Administration:

- Log almost 20,000 reports of injury annually
- Track \$250m in benefits and services
- Compile and store data from over 60 years of claims

Adjudication:

- Publish decisions of formal hearings
- Mediate agreements between parties
- Hold thousands of informal meetings for expediency of claims

Reemployment:

- Orders eligibility evaluations
- Approves reemployment plans
- Monitors rehabilitation specialists
- 23.30.043 SAW/RTW

Investigation:

- Investigate and educate employers
- Follow up on fraud claims
- Collaborate with other investigative units to keep Alaska workers safe

Workers' Compensation Benefits Guaranty

- Provide for medical and indemnity benefits for injured uninsured workers
- Process payments on judgements from uninsured employers
- Actively manage the Benefits Guaranty Fund

Fisherman's Fund

- Manage and reimburse commercial fisherman's injury claims
- Actively manage the "Fisherman's Fund"
- Manage the claims database

Self-Insurance Program

- Ensure the self-insured entity meets statutory financial criteria
- Perform annual audits on each organization
- Collects proper collateral as prescribed by statute



Alaska Workers' Compensation Board

Legislation

SB 147 – Enacted, effective July 11, 2024

Relates to workers compensation reemployment rights and benefits; establishes a workers compensation stay-at-work program; relates to the workers compensation benefits guaranty fund; relates to the presumption of compensability for workers compensation claims related to post-traumatic stress disorder; relates to the Alaska senior benefits payment program.

HB 60 - Failed

Relates to repealing the Workers Compensation Appeals Commission; relating to decisions and orders of the Workers Compensation Appeals Commission; relating to superior court jurisdiction over appeals from Alaska Workers' Compensation Board decisions.

HB 63 – Failed

Relates to repealing the Workers Compensation Appeals Commission; relating to decisions and orders of the Workers Compensation Appeals Commission; relating to superior court jurisdiction over appeals from Alaska Workers' Compensation Board decisions.

HB 239 – Failed

Relates to the presumption of compensability for workers' compensation claims related to post-traumatic stress disorder.

HB 183 – Failed

Relates to the Workers' Compensation Benefits Guaranty fund.

HB 206 – Failed

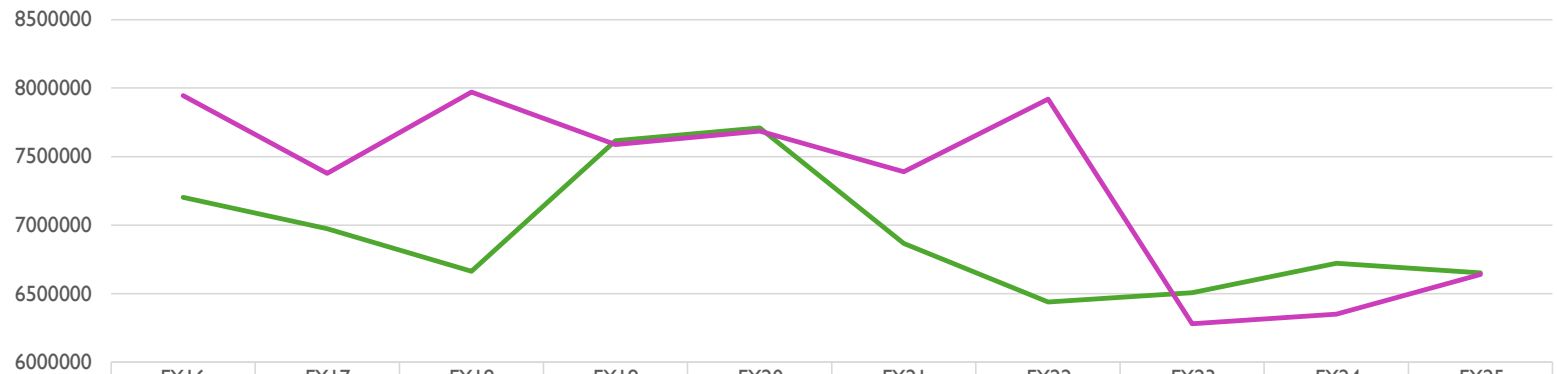
Relates to workers' compensation reemployment benefits; establishes a workers' compensation stay-at-work program.

HB 376 – Failed

Relates to transportation network and delivery network companies.



WSCAA FUND BALANCE



051

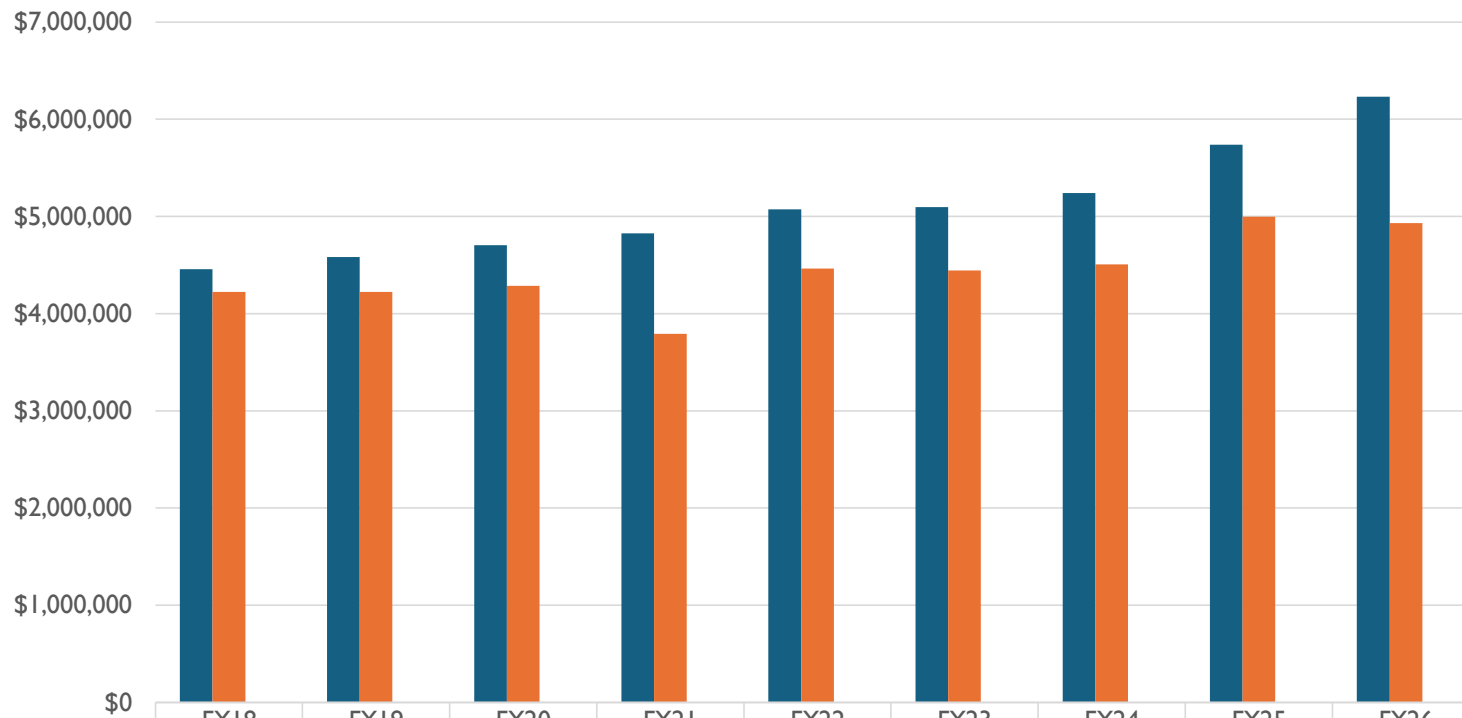
	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25
REVENUE										
Insurer Premium Tax	5,060,941	4,833,256	4,544,123	5,398,947	5,600,176	4,902,503	4,442,776	4,498,567	4,654,752	4,636,345
Self-Insurer Service Fee	2,134,135	2,130,704	2,109,489	2,063,408	1,667,542	1,411,007	1,684,670	1,486,445	1,600,136	1,664,868
WC Penalties	0	0	0	147,603	434,225	539,792	306,690	520,436	464,385	339,755
Misc	8,319	10,268	9,789	6,207	7,251	13,228	5,210	1,850	3,385	10,876
Revenue Total	7,203,395	6,974,228	6,663,401	7,616,164	7,709,194	6,866,529	6,439,346	6,507,298	6,722,658	6,651,845
EXPENDITURE										
Workers' Comp	5,522,901	5,360,429	5,511,057	5,368,923	5,330,051	4,849,491	5,568,015	5,647,670	5,679,968	5,573,382
WC Appeals Commission	377,405	251,146	301,739	323,041	344,934	330,968	349,341	391,564	373,796	371,610
Occupational Safety and Health	1,921,533	1,668,808	2,097,547	1,829,104	1,908,692	2,137,115	1,923,531	157,410	226,803	616,503
Labor Market Info	108,115	87,083	60,779	67,646	101,347	71,403	79,270	83,604	69,946	77,426
Expenditure Total	7,945,200	7,377,342	7,971,122	7,588,714	7,685,025	7,388,976	7,920,156	6,280,248	6,350,514	6,638,921
Fund Sweep							2,040,403.1	332,233.6	374,562.3	
FUND BALANCE (year end)	5,737,410	5,334,296	4,026,576	4,054,027	4,126,314	3,603,868	82,654	-22,530	-24,947	-12,024

Catherine Muñoz Commissioner

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October 16, 2025



Vacancy Rate



	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26
Pre-Vacancy PS	4,457,075	4,583,084	4,705,099	4,825,401	5,071,747	5,094,259	5,239,580	5,737,198	6,230,750
Actual PS	4,223,999	4,223,012	4,284,821	3,790,661	4,462,759	4,443,638	4,507,761	4,997,120	4,931,811
Vacancy Rate	5%	8%	9%	21%	12%	13%	14%	13%	21%

■ Pre-Vacancy PS ■ Actual PS ■ Vacancy Rate

Catherine Muñoz Commissioner

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October 16, 2025



Alaska Workers' Compensation Board

2024 Annual Report

Compensation Benefit Payments

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Catherine Muñoz Commissioner

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October 16, 2025



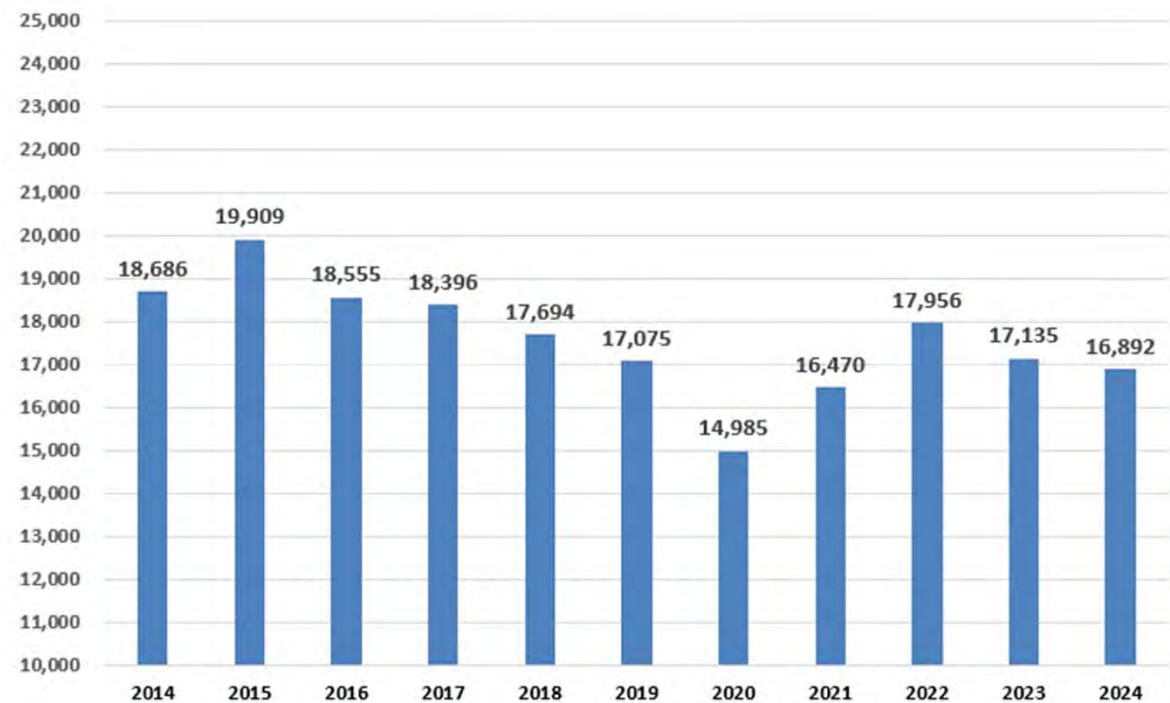
Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data

064

In 2024, there were 16,892 reports of injury and occupational illness filed with the Workers' Compensation Division, a 1.42% decrease from 17,135 reports filed in 2023.

Total Injury Notices Received





Alaska Workers' Compensation Board

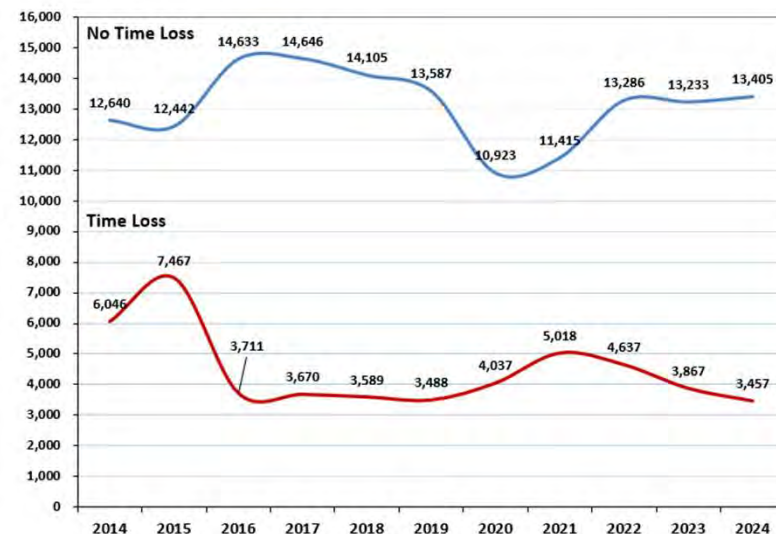
Analysis of Workers' Compensation Claims Data

Case Distribution by Type

Of the 16,892 case files established in 2024, claim type filings and distribution to total claims filed was:

- There were 13,405 "No Time Loss" cases. This was 79% of total claims compared to 13,233. It went down 2% from 2023, when "No Time Loss" cases were 77% of total claims. Of the 13,405 "No Time Loss" cases, 3,907 were notification only filings.
- There were 3,457 "Time Loss" cases. This was 20.5% of total claims compared to 3,867, 22.6% of total claims in 2023.
- There were 30 fatality cases, which was 0.18% of total claims filed in 2024. Fatalities were down .02% compared to 35, which was 0.20% of total claims in 2023.

Type of Claims Filed





Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data Adjudications

The Alaska Workers' Compensation Board

The board held or processed the following in 2024.

Held

- Prehearings: 1,846 compared to 1,204, in 2023 and 1,187 in 2022.
- Hearings: 172 compared to 123 in 2023 and 99 in 2022.
- Mediations: 55 compared to 68 in 2023 and 69 in 2022.

Compromise & Release Agreements – Totaled 408

- Board approved 375 compared to 417 in 2023 and 344 in 2022.
- Board denied 33 compared to 39 in 2023 and 43 in 2022.

Issued

- 79 Decision & Order Decisions, compared to 84 in 2023 and 76 in 2022.

The Alaska Workers' Compensation Appeals Commission

The Commission hearing data for 2024.

Hearings

- The Commission held 3 hearings, compared to 2 in 2023 and 8 in 2022.

Oral Arguments on the Merit of Appeals

- The Commission held three oral arguments, compared to 1 in 2023.

Motion For Stays of Board Orders

- The Commission held zero hearings on a motion for stay.

050

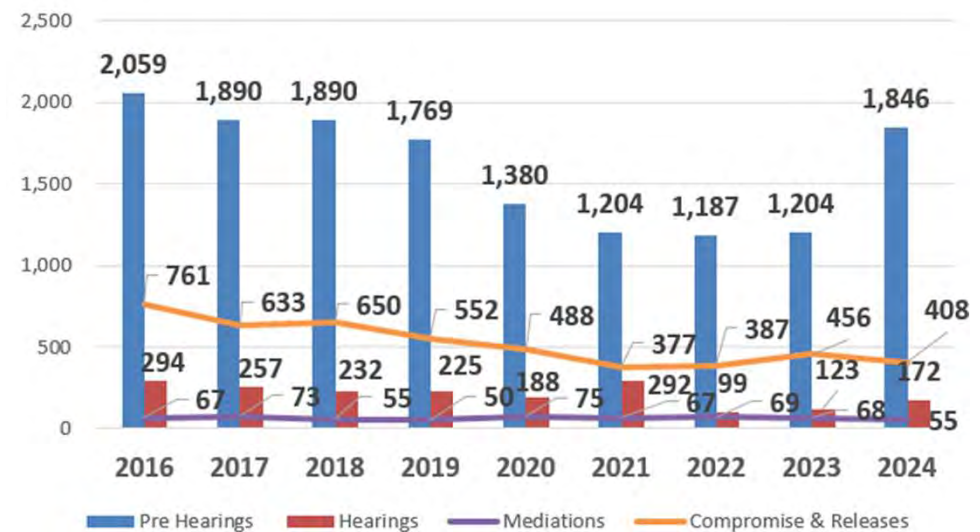


Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data

Adjudications: Hearings, Mediations & C&R's History

Calendar Year	2020	2021	2022	2023	2024
Pre Hearings	1,380	1,204	1,187	1,204	1,846
Hearings	188	292	99	123	172
Mediations	75	67	69	68	55
Compromise & Releases	488	377	387	456	408





Alaska Workers' Compensation Board

Analysis of Workers' Compensation Claims Data

Filed Claims, Controversions, and Petitions

In 2024, there were 625 claims for benefits filed, a 0.3% decrease from 627 claims filed in 2023.

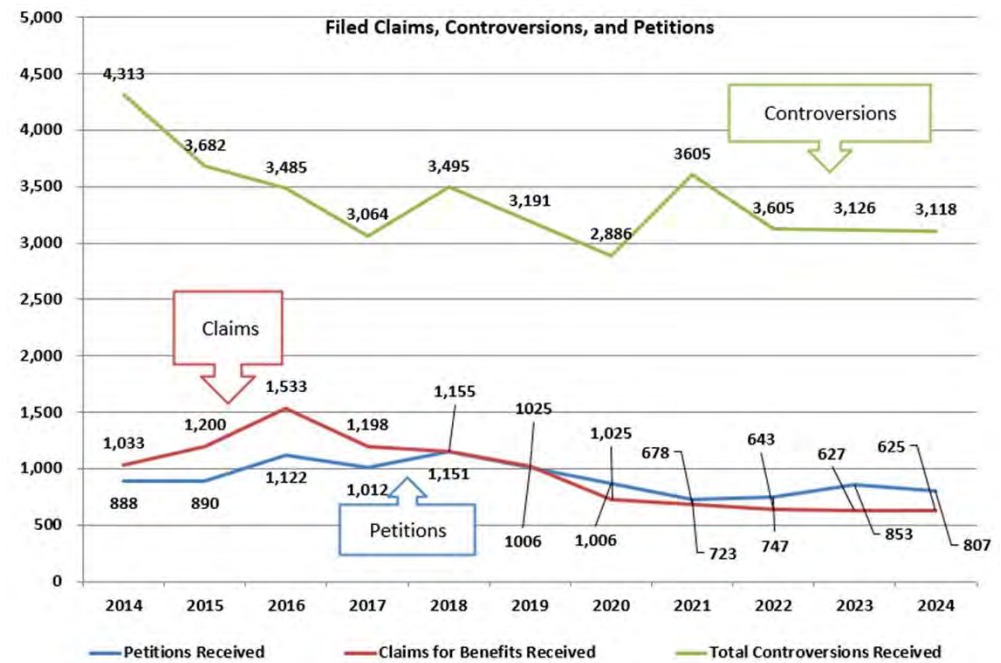
- 591 cases of which 136 cases had more than one filing.
- 34 cases were withdrawn.

There were 807 petitions filed in 2024, a 5.4% decrease from 853 petitions filed in 2023.

- 765 cases of which 323 cases had more than one filing.
- 42 cases reflected withdrawn petitions of which 4 cases had more than one filing.

There were 3,105 total controversions received in 2024, a 0.4% decrease from 3,118 in 2023.

- 2,860 cases of which 711 cases had more than one filing.
- 245 cases reflected withdrawn controversions of which 14 cases had more than one filing.





Alaska Workers' Compensation Board

Annual Reporting of Total Compensation Benefits

Financial Reports and Audits

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.

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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.

This report covers activity from:

CY = Calendar Year Period from January 1, 2024 to December 31, 2024.

Notes:

Medical Costs Totals 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 CY 2014 through CY2017.

PPI benefit type code transferred from 030/530 to 040/540 under EDI Claims R3.1.

Other Costs includes: Unspecified Lump Sum Payment/Settlement, interest, penalty and SIF Contribution Fee.



Alaska Workers' Compensation Board

Total Compensation Benefits Paid by Alaska Employers

A total of \$213.2 million was paid in workers' compensation benefits during calendar year 2024 by market-insured employers and self-insured employers. This is an increase of 6.9 million, up 3.37% from \$206.2 million paid in 2023.

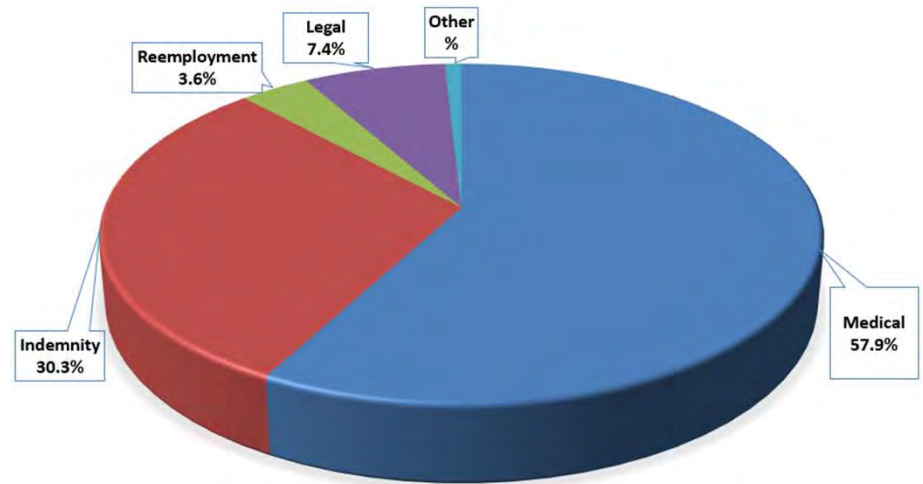




Alaska Workers' Compensation Board

Total Compensation Benefits Payment Distribution

Benefit Type	Amount Paid	% of Cost to Total Cost
Medical	\$123,359,430	57.9%
Indemnity	\$64,493,039	30.3%
Reemployment	\$7,752,817	3.6%
Legal	\$15,699,324	7.4%
Other*	\$1,865,899	0.9%
Total	\$213,170,510	



*Other costs include interest, penalty, and Second Injury Fund contribution.

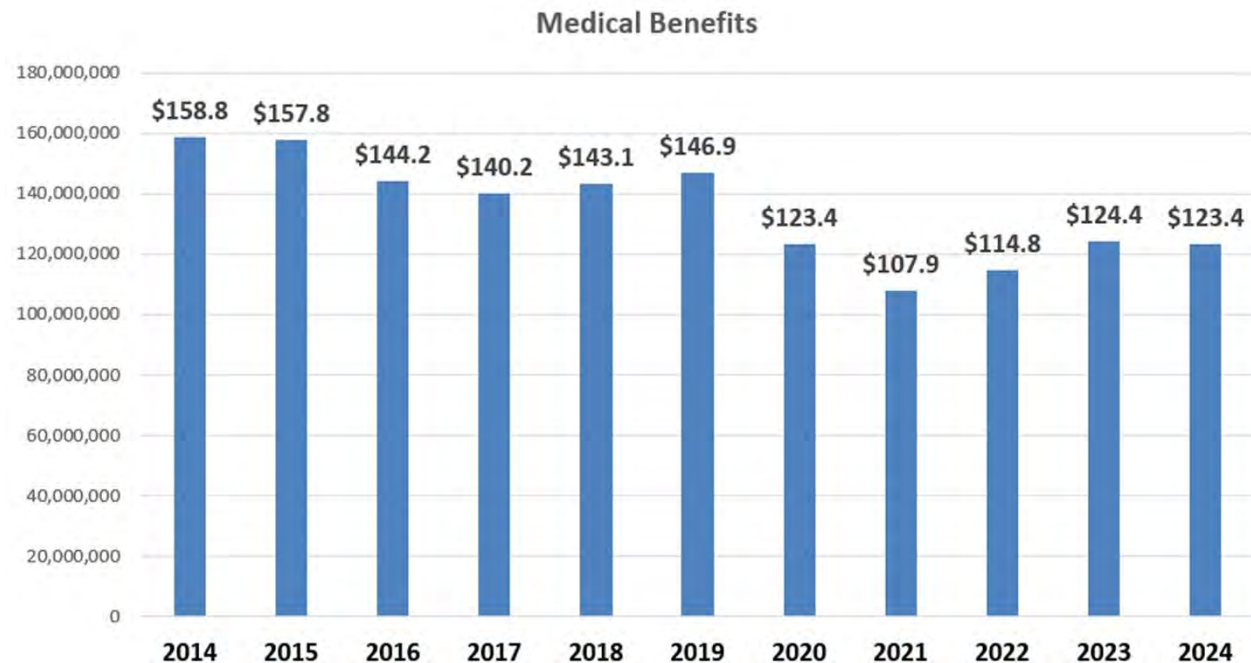


Alaska Workers' Compensation Board

Medical Benefit Payments

In the calendar year 2024, medical benefits totaled \$123.4 million, an 0.86% decrease from \$124.4 million in 2023.

Medical benefits were 57.9% of total benefits paid and 65.67% of total loss costs in 2024. This compares 57.9% of total benefits paid and 68.06% of loss costs in 2023.



062

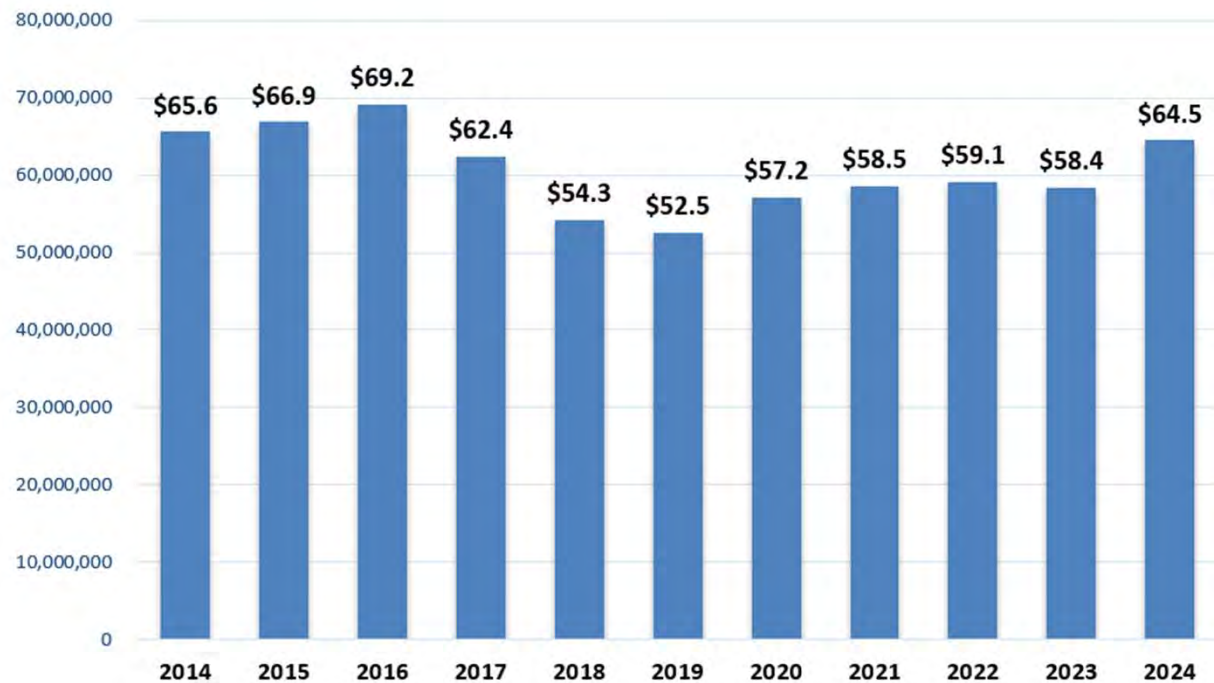


Alaska Workers' Compensation Board

Indemnity Benefit Payments

For calendar year 2024 indemnity benefits (TTD, TPD, PPI, PTD & Death Benefits) totaled \$64.5 million, a 10.42% increase from \$58.4 million in 2023.

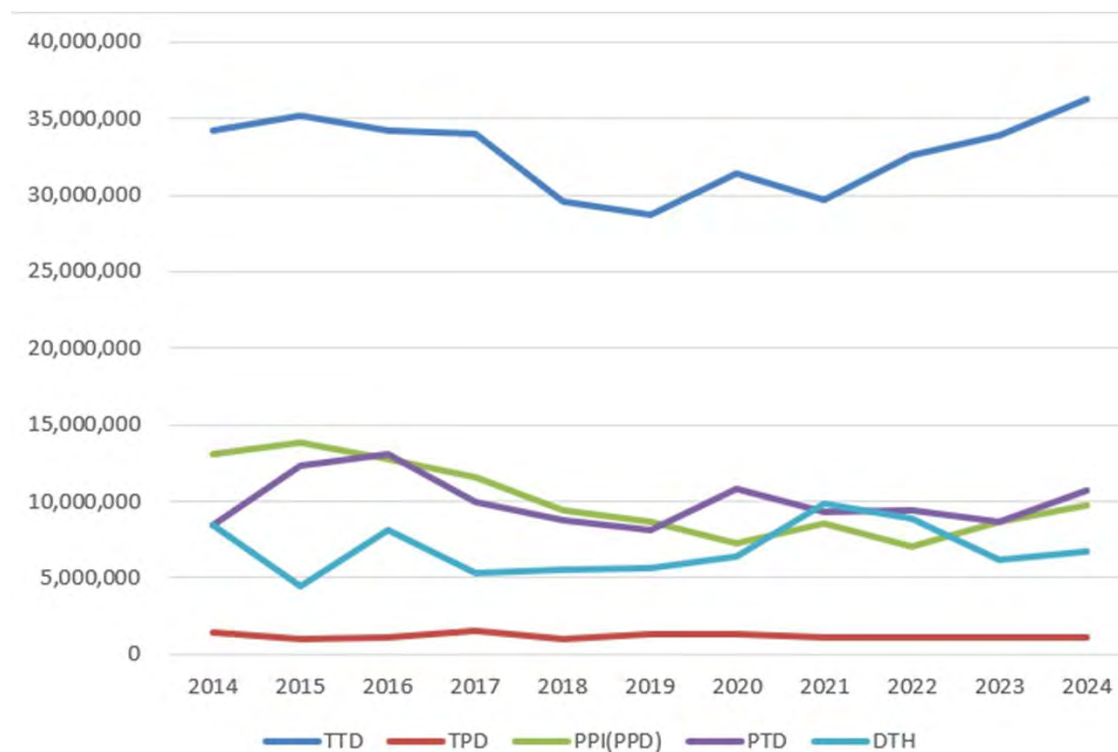
- TTD benefits totaled \$36.2 million in 2024, a 7% increase from \$33.8 million in 2023.
- TPD benefits totaled \$1.096 million in 2024, a 0.45% increase from \$1.091 in 2023.
- PPI benefits totaled \$9.8 million in 2024, a 12.65% increase from \$8.7 million in 2023.
- PTD benefits totaled \$10.7 million in 2024, a 23.5% increase from \$8.7 million in 2023.
- Death benefits totaled \$6.7 million in 2024, a 9.48% increase from \$6.1 million in 2023.





Alaska Workers' Compensation Board

Indemnity Benefit Payments Distribution – 10 Year Review



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Alaska Workers' Compensation Board

Legal Benefit Payments

Total legal costs were \$15.7 million in 2024 compared to \$13.6 million in 2023 and \$11.1 million in 2022. Legal costs increased by \$2.08 million.

For calendar year 2024, legal expenses totaled \$15.7 million, up 15.30% from \$13.6 million reported in 2023.

- Employee attorney fees were \$5.4 million, up 1.5 % from \$5.3 million in 2023.
- Employer attorney fees were 9.1 million, up 34.3% from \$6.7 million in 2023.
- Litigation costs were \$1.3 million, down 20% from 1.6 million in 2023. Litigation costs include:
 - Total Expert Witness Fees
 - Total Court Reporter Fees
 - Total Private Investigator Fees



*Some legal costs may have been previously reported under medical-legal claim expenses for employer/claim administrator



Alaska Workers' Compensation Board

Legal Benefit Payments

Total legal costs were \$15.7 million in 2024 compared to \$13.6 million in 2023, and \$11.1 million in 2022. Legal cost represented 7% of total compensation costs.

Legal Costs - 2024	Payment Amount	% of Total Legal
Employee Attorney	\$5,374,125	34.2%
Employer Attorney	\$9,069,477	57.8%
Litigation	\$1,255,722	8%
Total	\$15,699,324	





Alaska Workers' Compensation Board

Reemployment Benefit Payments

Total reemployment benefit payments totaled \$7.8 million in 2024, an 10% increase from \$7.1 million in 2023.

•Rehabilitation benefit costs under AS 23.30.041(k) totaled \$2.8 million in 2024, a 10.4% decrease from \$3.1 million in 2023.

•Rehabilitation benefit costs under AS 23.30.041(g) totaled \$2.0 million in 2024, an 62% increase from \$1.3 in 2023.

•Employee evaluation costs totaled \$1.7 million in 2024, a 6.0% increase from \$1.6 million in 2023.

•Rehabilitation specialist fees/plan monitoring fees totaled \$684,179 in 2024, a 11.1% increase from \$615,759 in 2023.

•Plan development costs totaled \$515,940 in 2024, a 18.3% increase from \$435,966 in 2023.

Total Reemployment Benefits



Note:

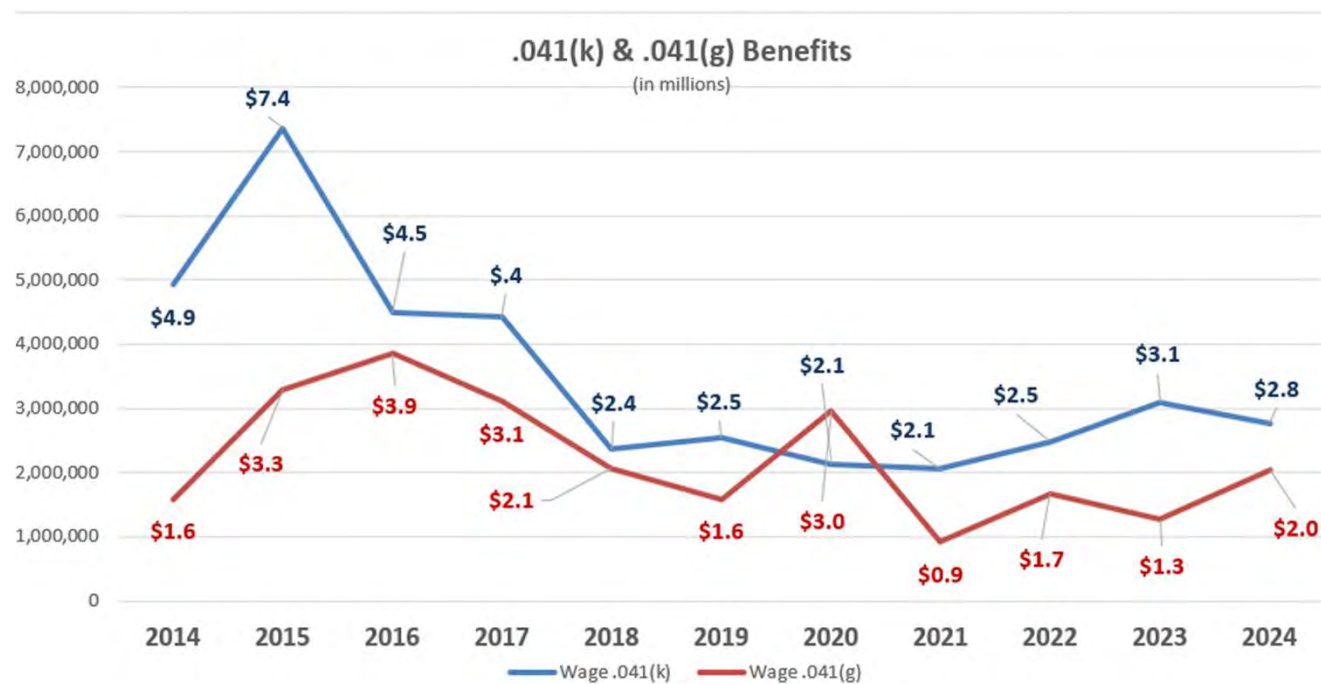
•.041(k) captures weekly scheduled payments only.

•.041(g) includes dislocation lump sum payments and .041(k) lump sum payments.



Alaska Workers' Compensation Board

Reemployment Benefit Cost Distribution - .041(k) & .041(g)





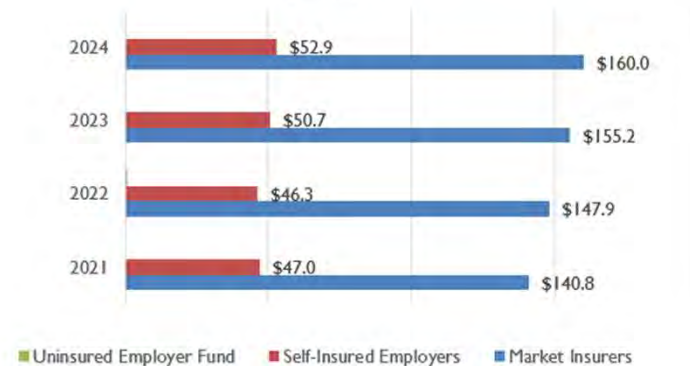
Alaska Workers' Compensation Board

Total Compensation Benefits Paid by Market Distribution

Of the \$213.2 million in total benefits paid, market-insured employers paid \$160.0 million and self-insured employers paid \$52.9 million. This compares to 2023, market-insured employers paid \$155.2 million (75.3%) and self-insured employers paid \$50.7 million (24.6%).

Insurer Type	Total Benefits Pd	% of Cost to Total Cost
Market Insurers	\$160,034,519	75.1%
Self-Insured Employers	\$52,933,307	24.8%
Uninsured Employer Fund	202,684	0.1%
Total	\$213,170,510	

Market Distribution - Total Benefits Paid
(millions)





Alaska Workers' Compensation Board

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

The top twenty insurers and self-insured employers paid \$137.4 million, or 64.5% of total workers' compensation benefits in 2024. This compares to \$133.2 million, or 64.6% in 2023 and \$130.8 million, or 67.0%, in 2022.

Rank	Insurer	Benefits Paid	Rank	Insurer	Benefits Paid
1.	ALASKA NATIONAL INS CO	\$ 29,530,800	11.	ARCTIC SLOPE REGIONAL CORP	\$4,078,569
2.	STATE OF ALASKA	\$ 16,582,211	12.	ALASKA AIRLINES GROUP	\$3,951,755
3.	AMERICAN ZURICH INSURANCE CO	\$ 9,276,645	13.	ALASKA MUNICIPAL LEAGUE JOINT INS ASSN	\$3,883,643
4.	INDEMNITY INS CO OF NORTH AMERICA	\$9,167,749	14.	EVEREST NATIONAL INSURANCE CO	\$3,549,620
5.	UMIALIK INSURANCE CO	\$8,551,751	15.	BERKSHIRE HATHAWAY HOMESTATE INS CO	\$3,480,827
6.	MUNICIPALITY OF ANCHORAGE	\$7,109,528	16.	REPUBLIC INDEMNITY CO OF AMERICA	\$3,352,897
7.	LM INSURANCE CORP	\$6,383,368	17.	AIU INSURANCE CO	\$3,202,348
8.	ACE AMERICAN INTERSTATE INS CO	\$6,326,993	18.	OHIO CASUALTY INS CO, The	\$ 3,142,320
9.	AMERICAN INTERSTATE INSURANCE CO	\$4,958,285	19.	OLD REPUBLIC INSURANCE CO	\$3,193,790
10.	LIBERTY INSURANCE CORP	\$4,207,775	20.	ZURICH AMERICAN INSURANCE CO	\$2,791,896
				TOTAL	\$137,388,847



Alaska Workers' Compensation Board

Active Alaska Self-Insured Employers

Active Alaska Self-Insured Employers	Start Date of Self-Insurance	Active Alaska Self-Insured Employers	Start Date of Self-Insurance
Alaska Air Group, Inc.	5/1/1980	Fred Meyer Stores, Inc.	10/1/1996
Alaska Railroad Corp.	7/1/1996	GCI Holdings, LLC	12/31/2017
Alyeska Pipeline Service Co.	7/1/1983	Harnish Group Inc.	5/1/2005
Anchorage School District	6/1/2004	Kenai Peninsula Borough & School District	2/16/1992
Arctic Slope Regional Corp.	6/1/2005	Matanuska-Susitna Borough	8/15/2008
Bristol Bay Area Health Corporation	2/1/2005	Matanuska-Susitna School District	7/1/1994
Chevron Corporation	5/12/1999	Municipality of Anchorage	1/1/2004
Chugach Electric Assn. Inc.	1/1/2014	PeaceHealth Networks	7/2/2020
City & Borough of Juneau	4/1/2004	Providence Health System – WA	4/1/1995
Costco Wholesale Corp.	9/3/1999	State of Alaska	11/24/2003
Fairbanks North Star Borough & School District	7/1/1977	University of Alaska	2/1/2004
Federal Express Corp.	10/10/1990		

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Alaska Workers' Compensation Board

Total Benefits Paid by Top Ten Self-Insured Employers

Self-Insured Employer	Medical	Indemnity (TTD,TPD, PPI, PTD)	Death	Reemployment	Legal	Other (EE Penalty, SIF, Interest)	Total	% To Total Benefits
STATE OF ALASKA	\$7,849,756	\$5,066,408	\$687,559	\$646,427	\$2,103,879	\$228,183	\$16,582,211	7.8%
MUNICIPALITY OF ANCHORAGE	\$4,401,945	\$2,202,651	\$174,419	\$72,052	\$198,263	\$60,196	\$7,109,528	3.3%
ARCTIC SLOPE REGIONAL CORP	2,056,144	1,552,490	\$35,549	\$159,918	\$230,469	\$43,998	\$4,078,569	1.9%
ALASKA AIRLINES GROUP	\$2,228,076	\$1,207,138	\$104,577	\$142,446	\$235,571	\$33,947	\$3,951,755	1.8%
PROVIDENCE HEALTH SERVICES	\$2,168,739	\$1,133,486	\$39,664	\$81,515	\$344,408	\$40,586	\$3,808,398	1.8%
ANCHORAGE SCHOOL DISTRICT	\$1,960,809	\$494,064	\$11,950	\$70,252	\$215,640	\$27,327	\$2,780,042	1.3%
UNIVERSITY OF ALASKA	\$1,145,174	\$395,901	\$ -	\$33,488	\$30,152	\$15,345	\$1,620,059	0.8%
FAIRBANKS NORTH STAR BORO & SD	\$1,284,582	\$128,035	\$ -	\$36,264	\$90,835	\$2,928	\$1,542,644	0.7%
CITY & BOROUGH OF JUNEAU	\$898,051	\$378,809	\$ -	\$20,287	\$55,688	\$10,277	\$1,363,111	0.6%
KENAI PENINSULA BORO & SD	\$821,289	\$474,102	\$ -	\$ -	\$42,555	\$16,759	\$1,354,706	0.6%
Total							\$44,191,023	



Alaska Workers' Compensation Board

Loss Cost Distribution

Total loss costs were \$187.9 million in 2024 compared to \$182.8 million in 2023 and \$173.9 million in 2022.

Year	Total Loss Costs	% Change
2024	\$187,852,469	2.74%
2023	\$182,842,584	5.14%
2022	\$173,897,723	4.51%
2021	\$166,396,179	-7.83%
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%
2014	\$220,938,561	-7.00%



"Loss Costs" = medical and indemnity benefit costs only. Indemnity includes TTD,TPD,PPI, PTD and Death benefits..

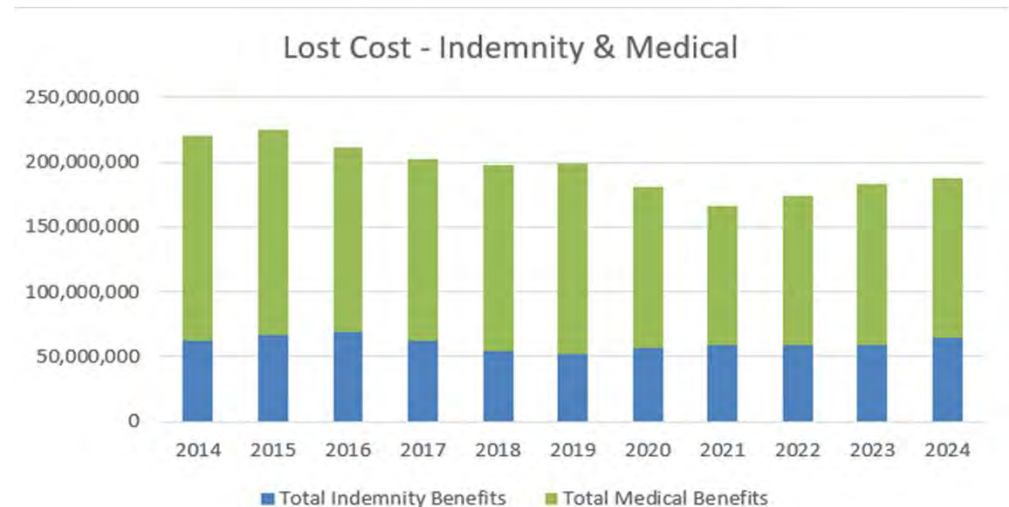
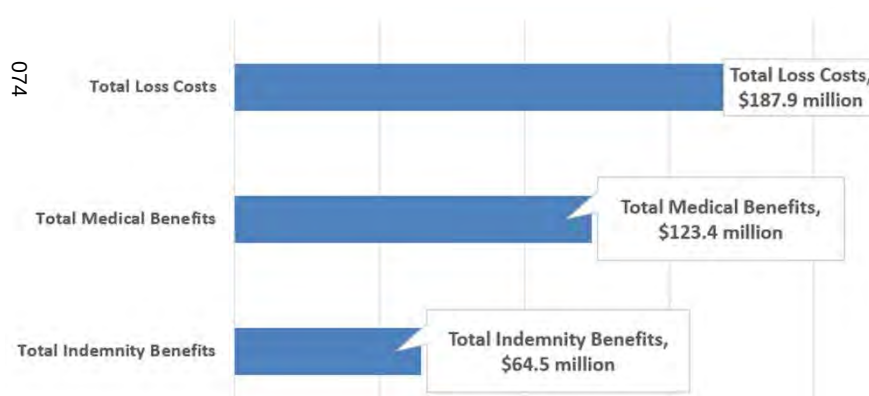


Alaska Workers' Compensation Board

Loss Cost Distribution

Indemnity loss costs were \$64.5 million in 2024 and 34.33% of total loss costs. This compares to \$58.4 million in 2023 and 31.94% of total loss costs.

Medical loss costs were \$123.4 million in 2024 and 65.67% of total loss costs. This compares to \$124.4 million in 2023 and 68.06% of total loss costs.



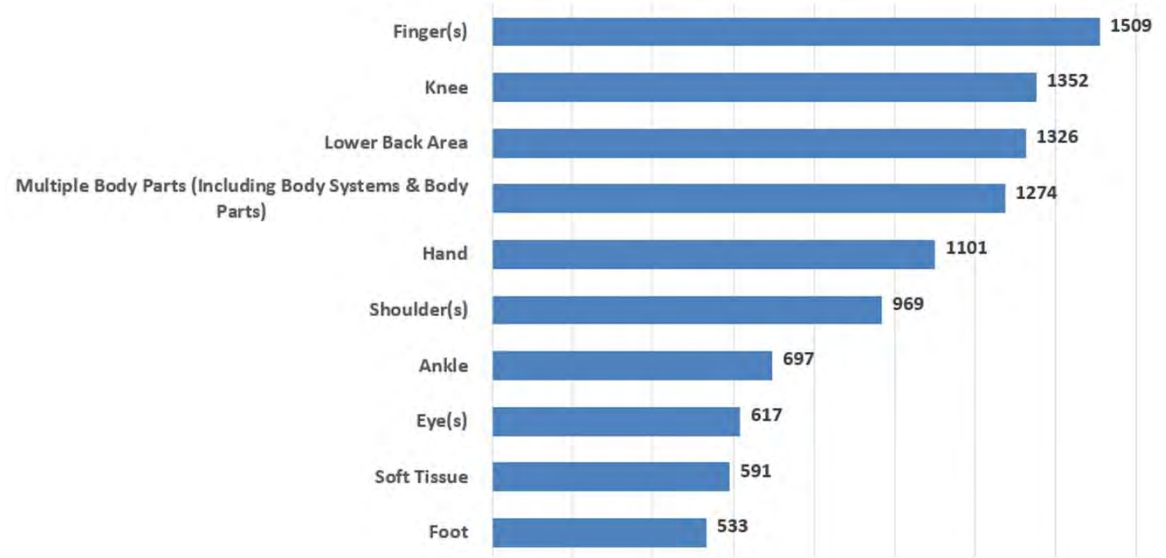
“Loss Costs” = medical and indemnity benefit costs only. Indemnity includes TTD,TPD,PPI,PTD and Death benefits..



Alaska Workers' Compensation Board

Top Ten Injuries by Body Part

	Body Part Injured	Cases	% *
1.	Finger(s)	1,509	8.9%
2.	Knee	1,352	8.0%
3.	Lower Back	1,326	0.08%
4.	Multiple Body Parts (including Body Systems & Body Parts)	1,274	0.08%
5.	Hand	1,101	0.07%
6.	Shoulder(s)	969	0.06%
7.	Ankle	697	0.04%
8.	Eye(s)	617	0.04%
9.	Soft Tissue	591	0.03%
10.	Foot	533	0.03%
	Total	9,969	59% *



*Percentage to total injury cases reported in 2024, 16,892



Alaska Workers' Compensation Board

Alaska Injury Frequency

9/20

Year	Reported Injuries	Average Monthly Employment	Injury Frequency Rate
2024	16,892	298,093	5.7
2023	17,135	307,926	5.6
2022	17,956	298,762	6.0
2021	16,470	289,946	5.7
2020	14,985	281,976	5.3
2019	17,075	308,796	5.5
2018	17,694	306,211	5.8
2017	18,396	312,886	6.0
2016	18,555	316,979	6.0
2015	19,909	323,619	6.3
2014	18,686	321,874	5.9

In 2024, 16,892 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees of 5.7%.

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment totaled 313,630 in 2024, compared to 323,129 in 2023, 313,765 in 2022, and 305,004 in 2021.

Excluding federal employees, the number of workers covered under the Alaska Workers' Compensation Act in 2024 was approximately 298,093 a decrease of 3.19% from 307,926 in 2023.

Reports of injuries and average employment less Federal wages decreased in 2024.

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



Alaska Workers' Compensation Board

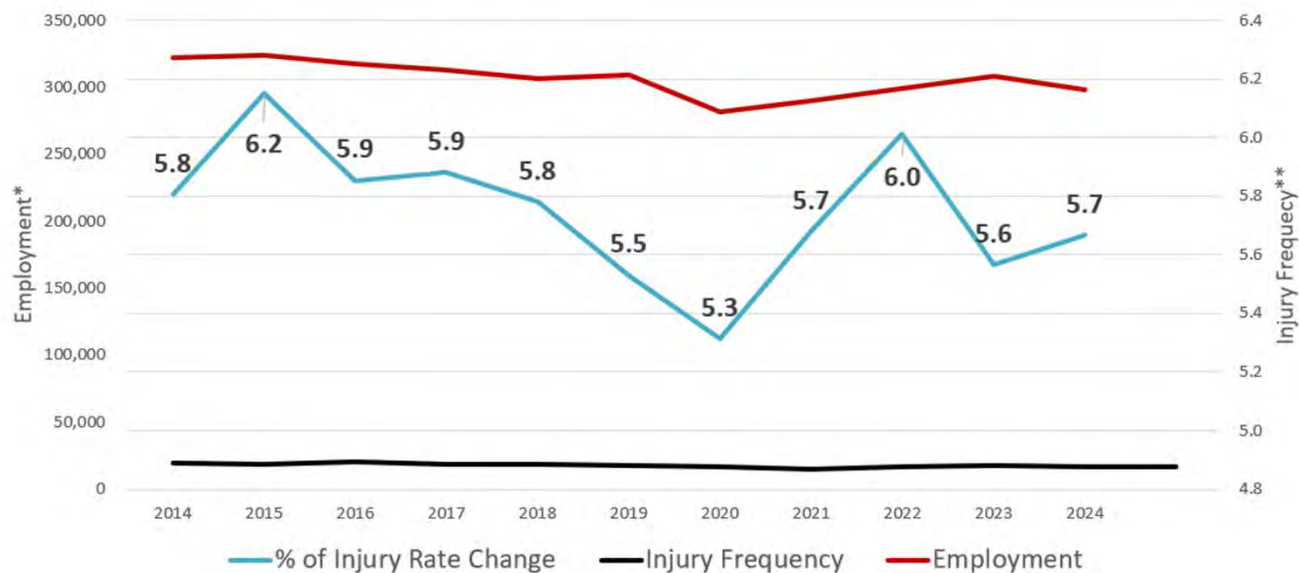
Alaska Injury Frequency



Employment in Alaska



Alaska Injury Frequency



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Catherine Muñoz Commissioner

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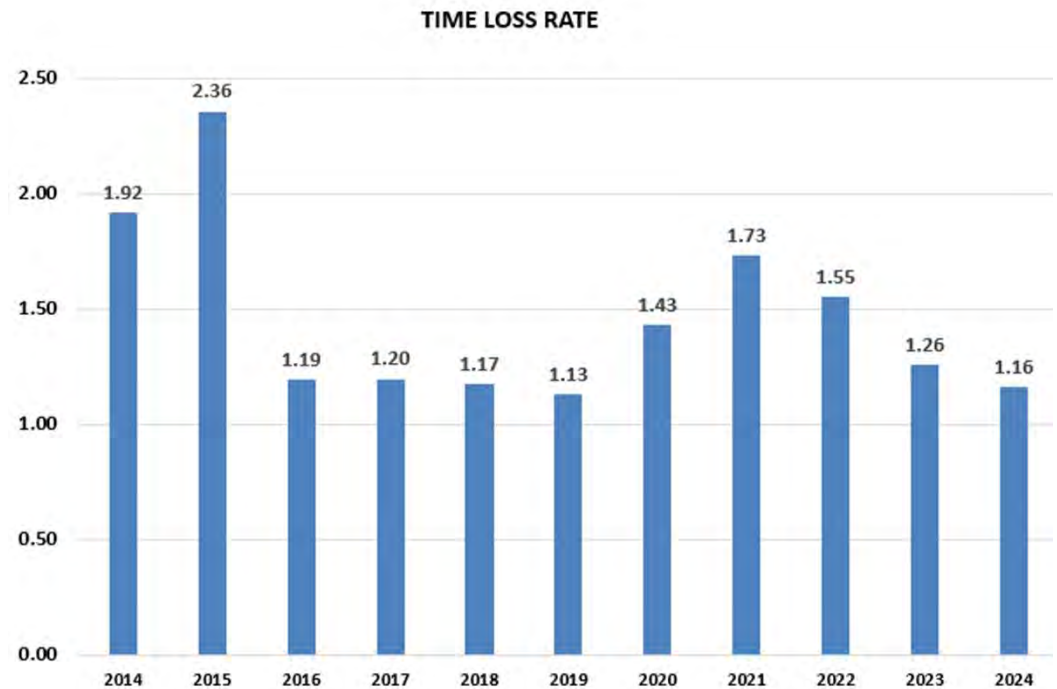
October 16, 2025



Alaska Workers' Compensation Board

Time Loss Rate

Year	Alaska Average Employment	Time Loss Cases	Rate
2024	298,093	3,457	1.16
2023	307,926	3,867	1.26
2022	298,762	4,637	1.55
2021	289,946	5,018	1.73
2020	281,976	4,037	1.43
2019	308,796	3,488	1.13
2018	306,211	3,589	1.17
2017	312,886	3,670	1.20
2016	316,979	3,711	1.19
2015	323,619	7,467	2.36
2014	321,893	6,046	1.92



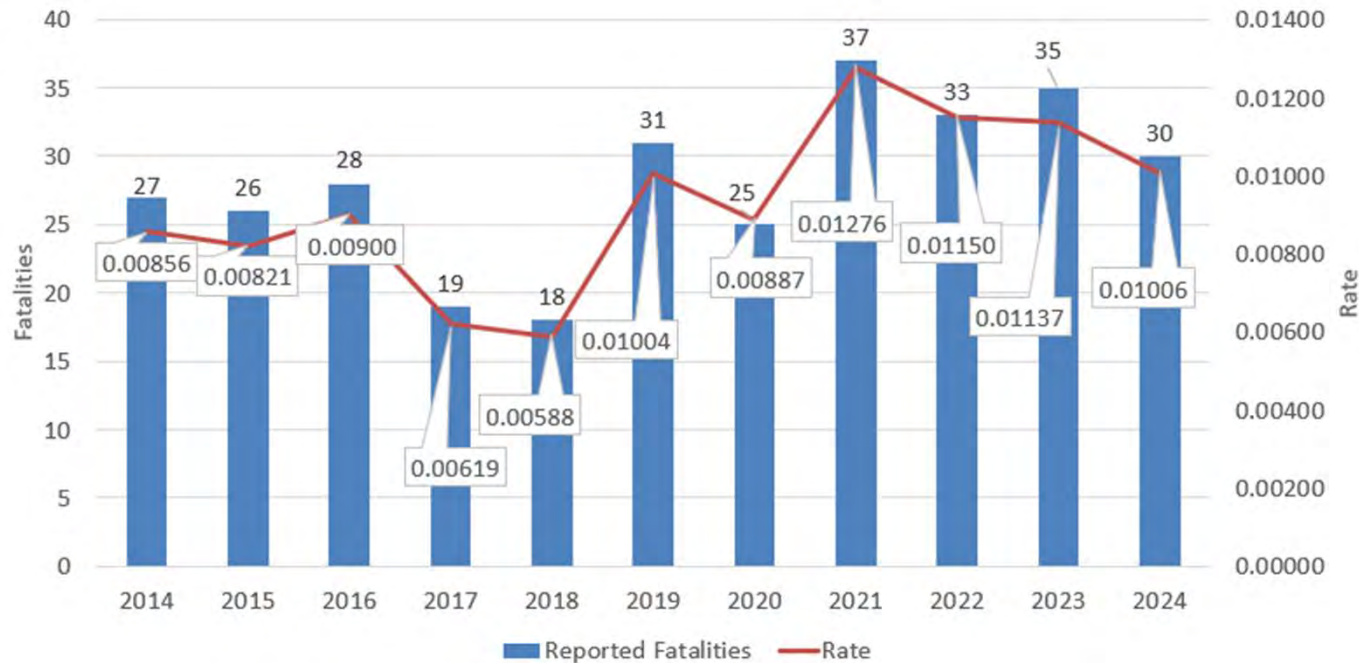
Time Loss Rate Formula: Reported time loss claims divided by the average Alaska wage times 100.



Alaska Workers' Compensation Board

Fatality Rate

Fatality Rate = Fatalities / (average Alaska employment wage less Federal wages) * 100



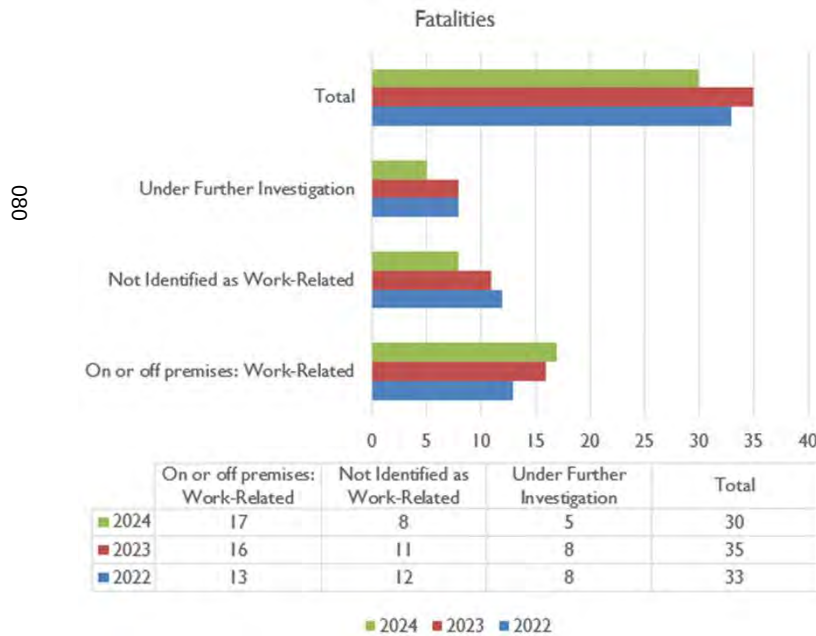
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Alaska Workers' Compensation Board

Workplace Fatalities & Workplace Fatalities as a Result of Injury

Each year, a small number of workplace accidents result in the tragic death of workers. The number of workplace fatalities was computed using data submitted by trading partners through initial electronic data submissions to the agency.



Incident Description	Count
Fall	8
Cardiac arrest	5
Passed, not caused by injury	4
Found passed away	3
Plane Crash	2
Struck by Equipment/Vehicle	2



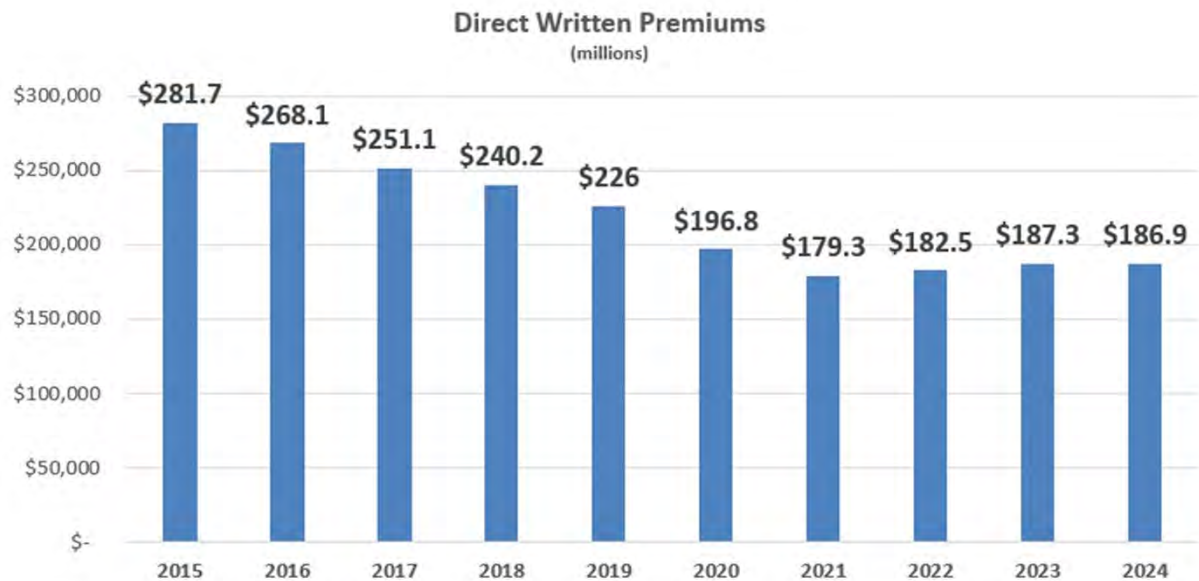
Alaska Workers' Compensation Board

Alaska Direct Written Premiums

Calendar Year	Direct Written Premiums * (000s)
---------------	-------------------------------------

2024	\$186,914
2023	\$187,269
2022	\$182,521
2021	\$179,252
2020	\$196,813
2019	\$225,954
2018	\$240,150
2017	\$251,110
2016	\$268,052
2015	\$281,738

As mentioned earlier in this report, a decrease in projected premium costs is expected for 2025.



*Based on The Division of Insurance calendar year reconciliation reports for Workers' Compensation Service Fee collection.



Alaska Workers' Compensation Board

Alaska Direct Written Premiums

Under regulatory order no R24-03, on August 15, 2024, the Division of Insurance received and approved the 2025 Alaska Workers' Compensation filing for Voluntary Loss Costs and Assigned Risk Rates from the National Council on Compensation Insurance, Inc. (NCCI), effective November 21, 2024. The filing proposed an overall 5.5% decrease in voluntary loss costs and an overall 17.6% decrease in assigned risk rates from current approved levels.

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Alaska Workers' Compensation Board

Oregon Workers' Compensation Premium Rate Ranking By State

2024 Rank	2022 Rank	State	Index Rate	% of Study Median	2024 Rank	2022 Rank	State	Index Rate	% of Study Median
1	2	Hawaii	2.52	231%	15	17	Oklahoma	1.33	122%
2	1	New Jersey	2.16	198%	16	13	Missouri	1.31	120%
3	4	New York	1.98	182%	17	12	Minnesota	1.25	114%
4	3	California	1.86	170%	18	18	New Hampshire	1.22	112%
5	6	Vermont	1.60	147%	19	14	Iowa	1.21	110%
6	10	Connecticut	1.48	135%	20	21	Alaska	1.16	106%
7	8	Wisconsin	1.42	130%	21	26	Pennsylvania	1.14	105%
8	7	Wyoming	1.41	130%	22	25	South Dakota	1.13	103%
9	5	Louisiana	1.41	129%	23	29	Nebraska	1.12	103%
10	11	Rhode Island	1.38	125%	24	20	Alabama	1.11	101%
11	9	Maine	1.37	123%	25	16	Idaho	1.10	101%
12	24	Washington	1.34	123%	26	31	Georgia	1.09	101%
13	19	Illinois	1.34	123%	27	27	New Mexico	1.05	96%
14	15	Montana	1.34	122%	28	41	Colorado	1.05	96%

Courtesy of Oregon State, DCBS, Consumer & Business Services



Alaska Workers' Compensation Board

QUESTIONS?

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Catherine Muñoz Commissioner

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Alaska Workers' Compensation Board

2024 Annual Report Benefits Guaranty Fund

Velma Thomas, Administrator

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Catherine Muñoz Commissioner

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Alaska Workers' Compensation Board

Alaska Workers' Compensation Benefits Guaranty Fund

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

Fund revenues come from civil penalties assessed against uninsured employers.

Staffing:

Velma Thomas, Fund Administrator

Dawn Wilson, Collections Officer I

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Catherine Muñoz Commissioner

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October 16, 2025

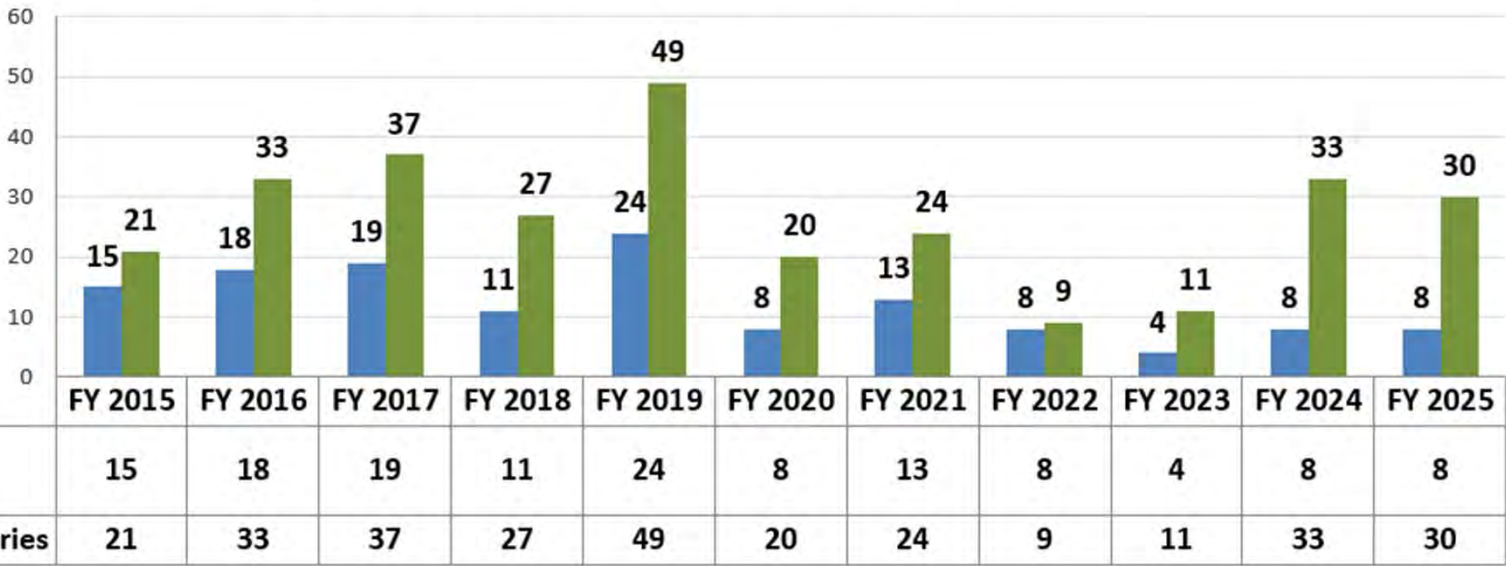


Alaska Workers' Compensation Board

Alaska Workers' Compensation Benefits Guaranty Fund Claim Data

In FY 2025, there were 8 claims for benefits filed against the fund compared to 8 claim filings in FY 2024. In FY 2025, there were 30 reports of uninsured injuries this compares to 33 reports of uninsured injuries in FY2024.

Claims Filed Against the Fund & Reported Uninsured Injuries



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Alaska Workers' Compensation Board

Alaska Workers' Compensation Benefits Guaranty Fund Potential Fund Liabilities for Open and Pending Claims

This report reflects potential liability for open & pending claims.

- 880 1. Fund paying death benefits.
2. Fund paying award for PTD benefits.
3. Pending litigation, possible award for one claim for PTD.

Fiscal Year	Total Claims Filed	Open/ Pending	Liability (Incurred)	Paid by Fund	Potential Liability (reserve)	Closed/ Inactive
2010 ₁	14	1	\$482,000	\$262,390	\$219,610	13
2012 ₂	33	1	\$1,407,690	\$887,164	\$520,526	32
2020	8	2	\$530,000	\$387,852	\$7,862	6
2021	13	1	\$300,000	\$115,037	\$184,963	14
2022	8	5	\$111,000	\$10,894	\$100,106	3
2023 ₃	4	4	\$1,092,500	\$0.00	\$1,092,500	0
2024	8	6	\$1,036,000	\$115,327	\$920,673	2
2025	8	8	\$505,000	\$4,976	\$500,024	0
Total			\$5,464,190	\$1,783,640	\$3,546,264	70



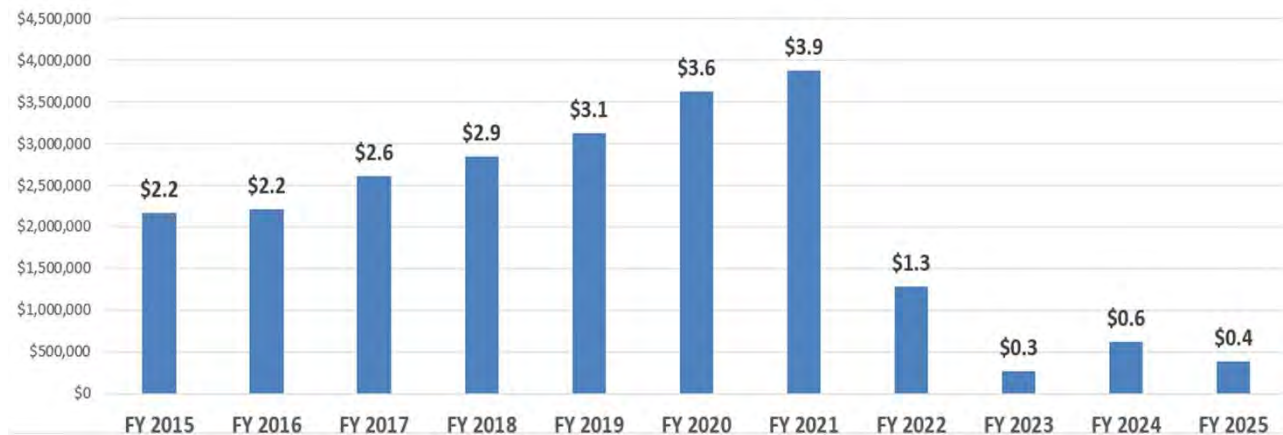
Alaska Workers' Compensation Board

Benefits Guaranty Fund Fund Balance

Fiscal Year	Balance	% of Change
2025	\$378,377	-39.0%
2024	\$621,177	131.7%
2023	\$268,091	-79.0%
2022	\$1,277,363	-67.1%
2021	\$3,886,050	7.2%
2020	\$3,626,699	15.9%
2019	\$3,130,438	9.8%
2018	\$2,852,200	8.9%

For FYE 2025, fund balance was \$378,377.

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



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Alaska Workers' Compensation Board

Benefits Guaranty Fund Revenues

Fiscal Year	2023	2024	2025
Civil Penalty - Settlement	\$593,388	\$280,211	\$338,395
Civil Penalty - Stipulation	\$104,451	\$56,787	\$143,500
Civil Penalty – D&O	\$27,157	\$134,724	\$24,861
BGF – Uninsured Employer Reimbursement	\$58,105	\$40,200	\$30,525
Judgments	\$77,886	\$55,813	\$50,313
Sub Total	\$860,987	\$567,735	\$587,645
Total Revenues after line adjustments (NSF Checks, GeFonsi, Other)	\$1,098,130	\$582,782	\$617,739
% from Civil Penalties – Before adjustments	84%	83%	87%
% from Employer Reimbursement – Before adjustments	7%	7%	5%
% from Judgments – Before adjustments	9%	10%	8%

FY 2023 Adjustments

- Add supplemental line increase of \$221,400
- Add GeFonsi \$29,450
- Minus NSF Fees \$10,807
- Minus Refund \$2,674
- Minus Admin Fee \$225

FY 2024 Adjustments

- Add GeFonsi \$21,617
- Minus Admin Fee \$221
- Minus NSF Fees \$5,050
- Minus Refund \$1,299

FY 2025 Adjustments

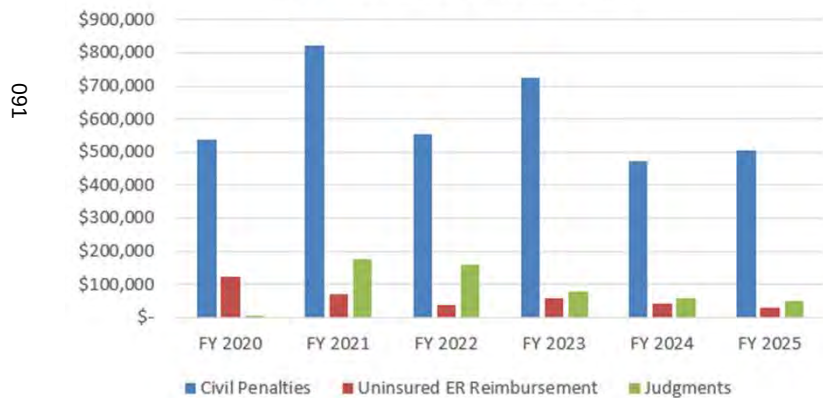
- Add GeFonsi \$33,467
- Minus NSF Fees \$1,150
- Minus Refund \$2,223



Alaska Workers' Compensation Board

Benefits Guaranty Fund Revenues

Revenue Before Adjustments



Revenues After Adjustments





Alaska Workers' Compensation Board

Benefits Guaranty Fund Expenditures

For FY 2023, 2024, and 2025 total expenditures include line adjustment for approved line increase and encumbered monies.

FY 2023 – Line adjustment of \$83,442.

FY 2024 – Encumbered monies to pay benefits in FY 2025.

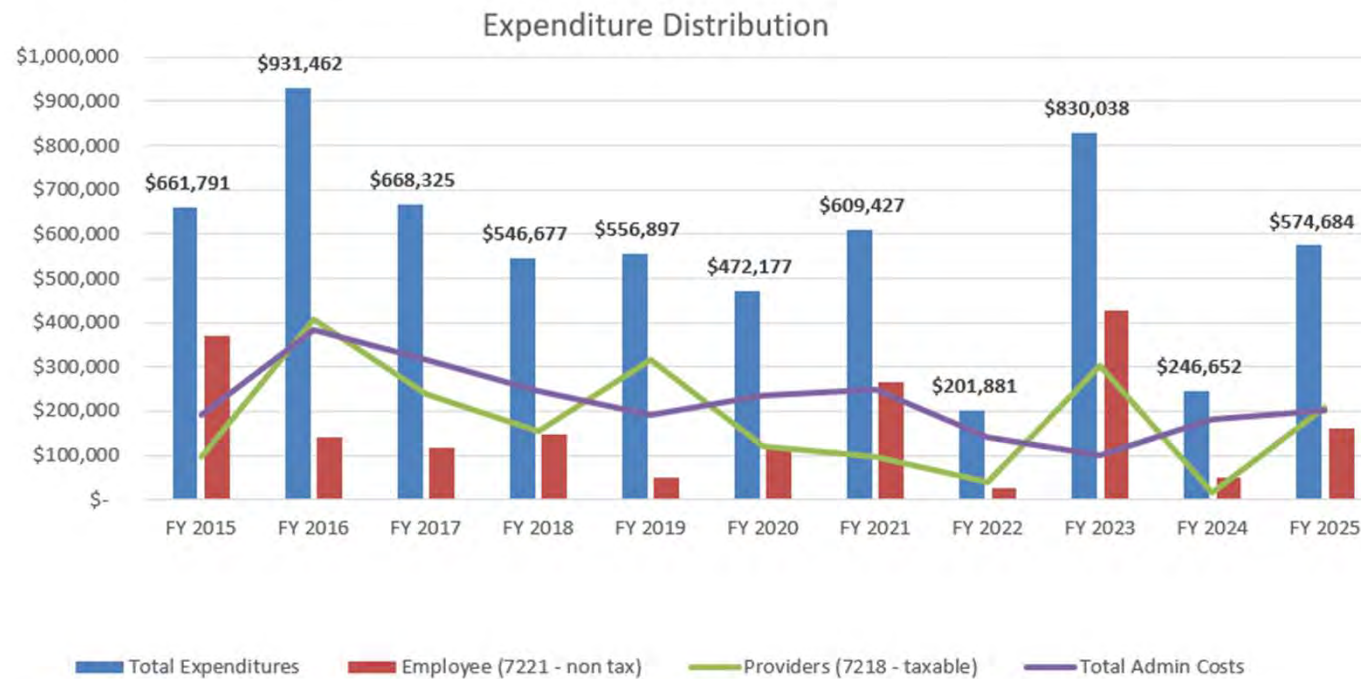
FY 2025 – Paid \$239,179 from FY 2024 encumbered funds.

Expenditure Detail	FY 2022	FY 2023	FY 2024	FY 2025
# of Employees Receiving Benefits	5	8	5	12
Benefit Payment by Type				
Indemnity Costs	\$17,264	\$293,616	\$34,168	\$122,377
Medical Costs	\$22,658	\$163,728	\$28,926	\$126,417
Reemployment Costs	\$22,237	\$14,778	\$1,875	\$2,250
Employee Legal Costs	\$0	\$169,456	\$0	\$80,731
Total Employee Benefit Costs	\$62,642	\$728,742	\$64,969	\$372,045
Administration Costs	\$139,239	\$184,739	\$181,682	\$202,639
Total Expenditures	\$201,881	\$830,039	\$246,651	\$574,684
% of EE Benefit Payments to Total Costs	31%	88%	26%	65%
% of Admin. Costs to Total Costs	69%	22%	74%	35%



Alaska Workers' Compensation Board

Benefits Guaranty Fund Expenditures



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Alaska Workers' Compensation Board

QUESTIONS?

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Catherine Muñoz Commissioner

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Alaska Workers' Compensation Board

2024 Annual Report Second Injury Fund

Velma Thomas, Administrator

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Catherine Muñoz Commissioner

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October 16, 2025



Alaska Workers' Compensation Board

Second Injury Fund

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

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

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

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

Staffing:

Velma Thomas, Fund Administrator

Ted Burkhardt, Workers' Compensation Officer I



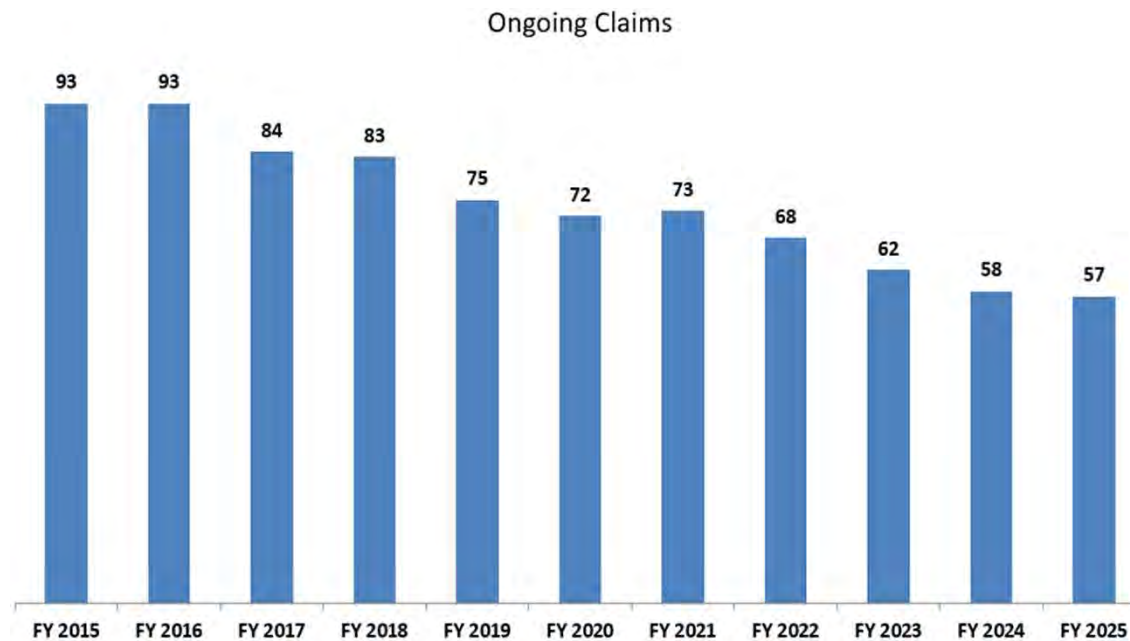
Alaska Workers' Compensation Board

Second Injury Fund Claim Data – Open Claims

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At the end of FY 2025, there were 57 on going claims. Benefits were paid on 55 claims.

Settlement Liquidations: 1



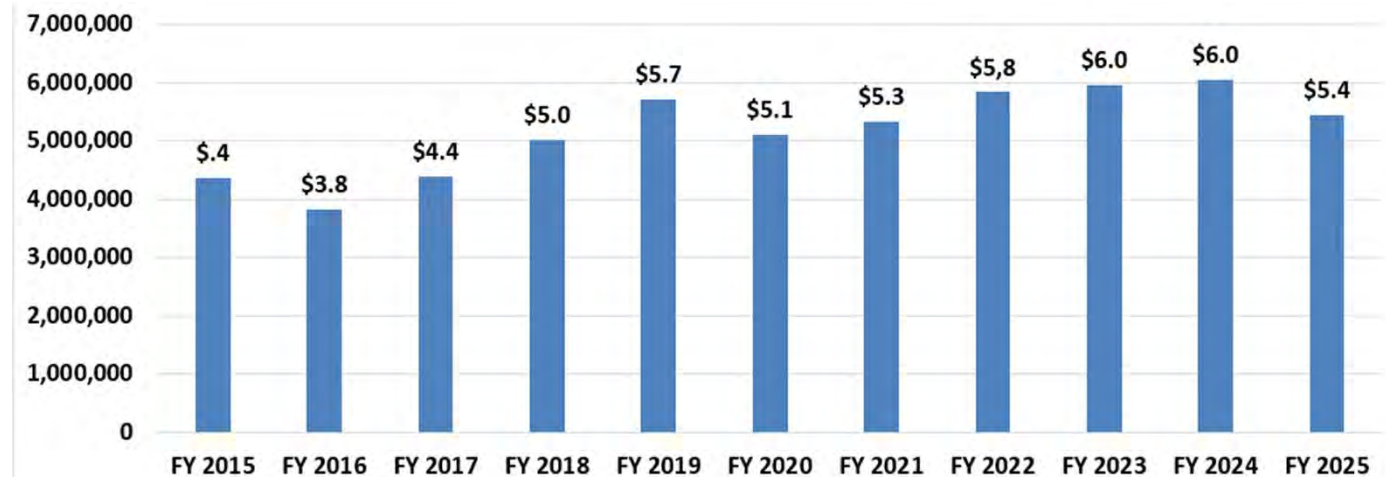


Alaska Workers' Compensation Board

Second Injury Fund Fund Balance

Fiscal Year	Balance	% of Change
2025	\$5,449,573	-9.9%
2024	\$6,048,876	1.6%
2023	\$5,951,037	2.0%
2022	\$5,833,430	9%
2021	\$5,328,646	5%
2020	\$5,092,860	-11%

For FY 2025, fund balance decreased by \$599,303, a 9.9% decrease from prior year.





Alaska Workers' Compensation Board

Second Injury Fund Revenues & Expenditures

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



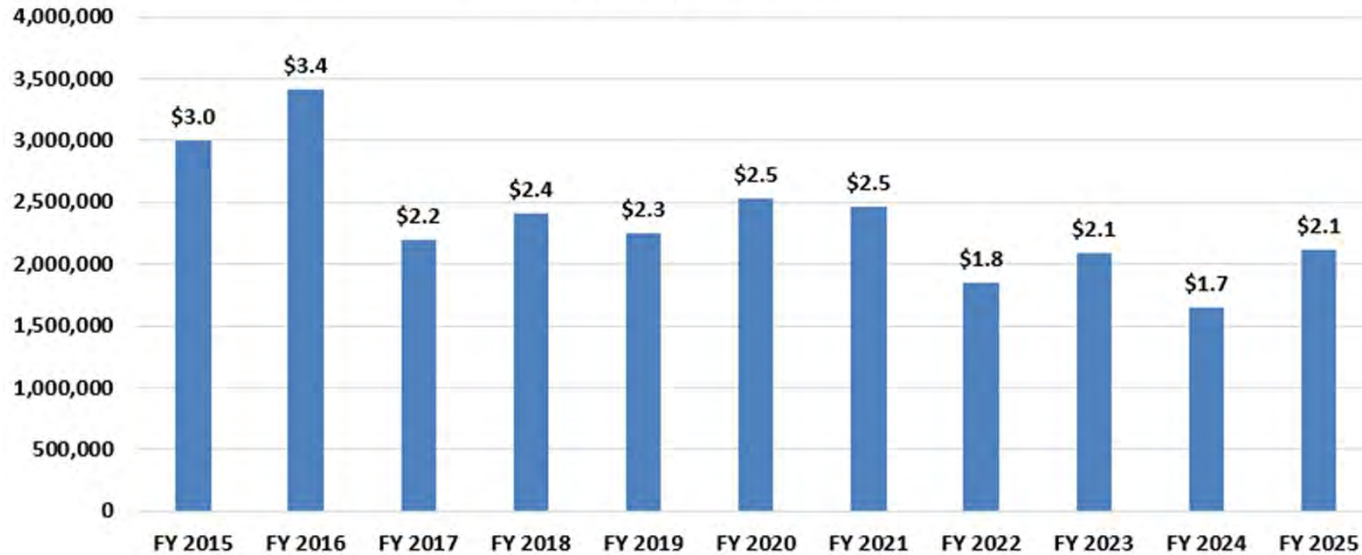
For FY 2025, expenditures totaled \$2,405,477. Expenditures exceeded revenues in the amount of \$599,303. Administration costs totaled \$287,729 or 12.0% of total expenditures and Grant payments totaled \$2,117,749.



Alaska Workers' Compensation Board

Second Injury Fund Reimbursement Benefits Paid to Employer or Insurer

Benefits Paid to Employer/Insurer



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Alaska Workers' Compensation Board

Second Injury Fund

Reimbursement Benefits Paid to Employer or Insurer
Top Ten and Type

Rank	Insurer/Self-Insurer	Amount
1	Commerce & Industry	\$395,426
2	State of Alaska	\$386,012
3	Municipality of Anchorage	\$141,647
4	Alaska Timber Ins Exchange	\$132,100
5	Ace American	\$130,126
6	Indemnity Ins Co of NA	\$130,000
7	Alaska National	\$120,192
8	Arctic Slope Regional Corp	\$84,454
9	National Union Fire Ins	\$65,705
10	Industrial Ind – AIGA	\$59,155

For FY 2025, top ten reimbursement payments totaled \$1.6 million.

#	Type	Amount	%
15	Market Insurers	\$1,253,099	59%
11	Self-Insured Employers	\$864,650	41%
26	Total	\$2,117,749	

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Alaska Workers' Compensation Board

QUESTIONS?

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Alaska Workers' Compensation Board

2024 Annual Report Special Investigation Unit

Michele Wall-Rood, Chief Investigator

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Catherine Muñoz Commissioner

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October 16, 2025



Alaska Workers' Compensation Board

Special Investigation Unit

- Established by Alaska Legislature in 2005 – AS 23.30.280
- Part of Overall Division Budget
- Staffing:
 - Michele Wall-Rood, Chief Inv. – Anchorage (10/2021)
 - Christine Christensen, Inv. 3 – Anchorage (10/2007)
 - Wayne Harger, Inv. 3 – Fairbanks (4/2011)
 - Dave Price, Inv. 3 – Juneau (3/2014)
 - Julie Milazzo, Inv. 3 – Anchorage (2/2022)
 - Vacant, Inv. 2 (7/2024)
 - Marie Dagon, WC Technician – Anchorage (4/2024)

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Alaska Workers' Compensation Board

Mission and Core Values

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

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Alaska Workers' Compensation Board

Challenges

- Criminal Fraud Prosecution
- Employers without Records
- Legal Opinions
- Tech Support (ICERS)
- Proactive Outreach
- Caseloads
- Staffing (Quantity, not Quality)
- Recruiting Issues

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Alaska Workers' Compensation Board

Achievements

- 99 Settlements, Six Decisions & Orders
- Continued Multi-Agency Collaboration
 - Financial Crimes Task Force, Environmental Crimes Task Force
 - Local and State Law Enforcement Agencies
 - Labor Standards & Safety (AKOSH, Wage & Hour)
 - Trainings held for Homeland Security Investigations, Wage and Hour, DHSS Assisted Living Home Orientations, and the 42nd Annual Governor's Safety Conference
 - 158 Onsite Visits to Businesses
- 599 FTI Investigations worked – 424 Opened/465 Closed

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Alaska Workers' Compensation Board

Fraud Hotline and Email Tips

	FY2023	FY2024	FY2025	YTD 1st Quarter FY2026 (7/1/2025 - 9/30/2025)
Total Fraud Tip Calls and Emails	152	105	126	50
Claimant/Injured Worker Tips	19	16	15	6
Employer Tips	73	25	26	21
Care Providers	2	0	3	0
Attorneys/Non-Attorney Reps	1	1	0	0
Insurance Companies/Agents	3	6	0	1
Fish Fund Claimants	0	0	0	0
Law Enforcement Agency Assist Requests	52	57	81	22
Other/Non-Related	2	0	1	0



Alaska Workers' Compensation Board

Failure to Insure Fraud Investigations

ACTIVITY	FY2023	FY2024	FY2025	Year-to-Date First Quarter FY2026
Pending Cases Carried Forward	105	107	175	140
New Cases Opened	388	380	424	111
Cases Closed	386	313	465	129
Total Cases Worked	493	487	599	251
Petitions	114	95	98	17
Pre-Hearings Attended	125	124	139	12
Compliance Reviews	307	420	426	950
Compliance Checks	2359	4200	6150	(Combined above)
Public Inquiries	259	332	363	68
Formal Hearings	4	5	6	1
Stop Work Orders	1	5	0	0
Warning Letters	44	37	63	19
Investigation Only	205	197	277	67
Settlements Paid in Full	112	58	78	18
Settlements with Payment Plans	3	3	21	4
Percentage Closed in 6 Months	83% (321 of 386)	77.036% (242 of 313)	81% (378 of 465)	71% (91 of 129)
Total Penalties	\$1,081,037.96	\$924,922.74	\$915,655.51	\$365,951.48
Total Discounts	\$183,697.40	\$74,326.70	\$145,549.90	\$71,487.66
Total Suspensions	\$279,988.72	\$284,222.71	\$159,576.42	\$110,012.55
Total Payable	\$617,351.84	\$566,373.33	\$610,529.19	\$184,451.27
Uninsured Injuries	11	33	30	2
Interagency Referrals	24	17	37	13

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Alaska Workers' Compensation Board

Failure to Insure FY2025

Investigations Opened/Re-Opened		Investigations Closed	Uninsured Injury Referrals Received	Uninsured Injuries Confirmed	Employers With Uninsured Injuries Petitioned
424		465	30	8	2
FY2025	Assessed By	Total Assessed	Discounted	Suspended	Ordered to Pay
	99 Settlements (21 with payment plans)	\$915,655.51	\$145,549.90	\$159,576.42	\$610,529.19
	6 Decisions & Orders (All Final)	\$81,314.57	n/a	\$10,693.96	\$70,620.61
	TOTALS	\$996,970.08	\$145,549.90	\$170,270.38	\$681,149.80

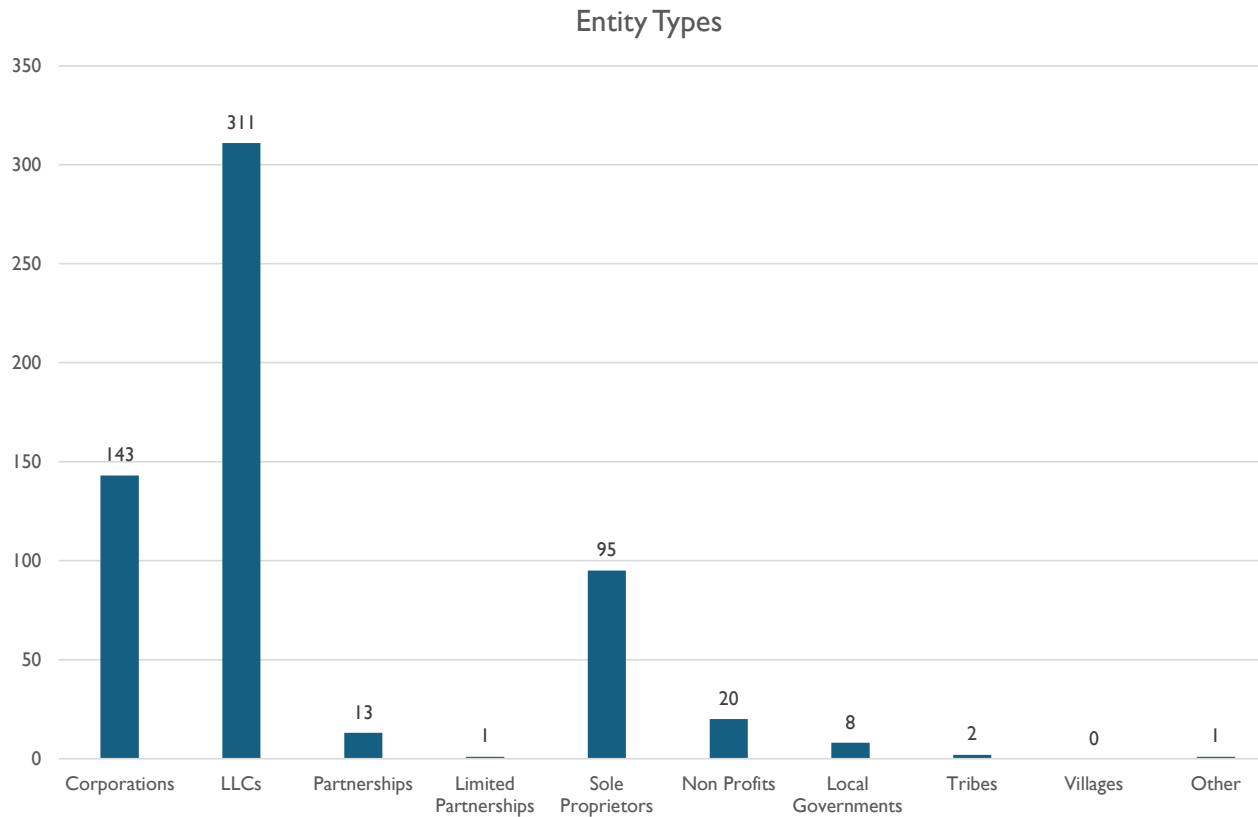
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Alaska Workers' Compensation Board

Industry Data for FTI Investigations

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Catherine Muñoz Commissioner

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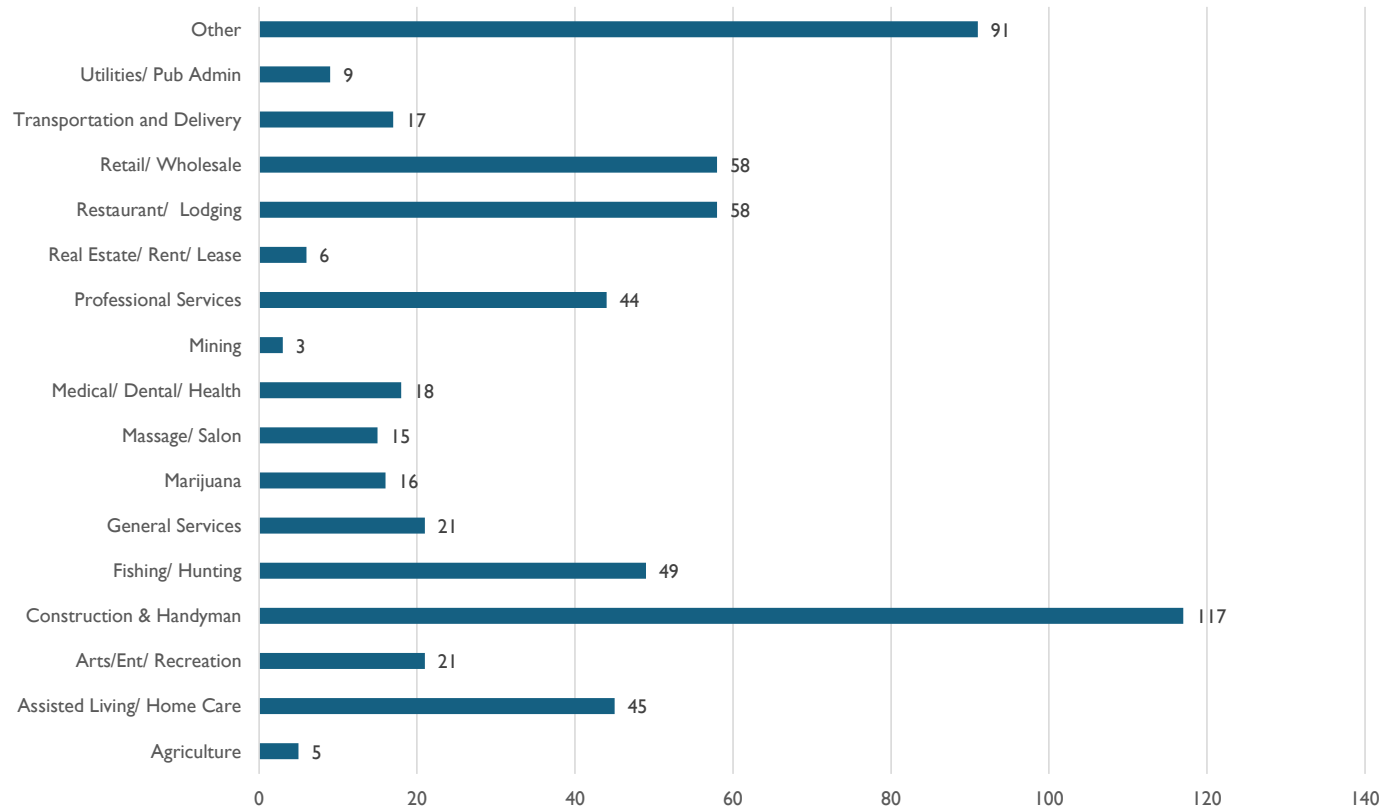
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Alaska Workers' Compensation Board

Industry Data for FTI Investigations

Represented Industries



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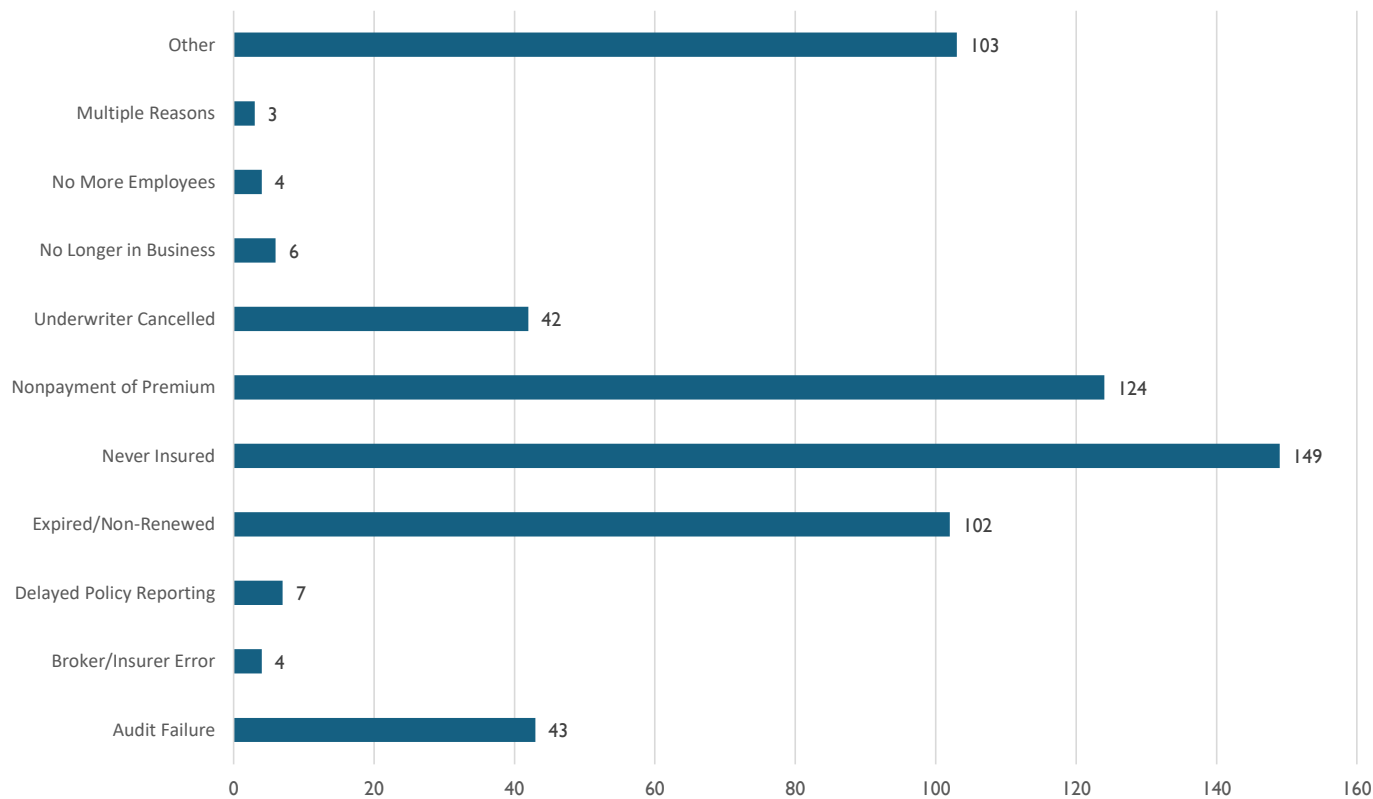
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Lapse Reasons



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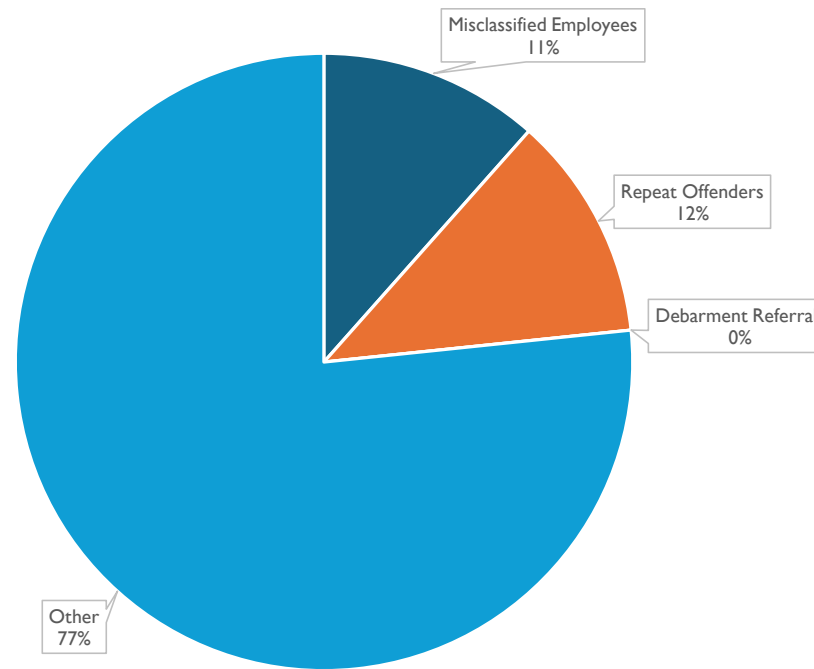
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Alaska Workers' Compensation Board

Industry Data for FTI Investigations

Misclassified/Repeat Offenders/Debarment Referrals



■ Misclassified Employees ■ Repeat Offenders ■ Debarment Referrals ■ Other

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Alaska Workers' Compensation Board

Current Goals/Priorities

- Staffing Level Commensurate with Workload
- Target Realistic Six-Month Case Resolution Percentage
- Continued Collaborative and Multiple-Agency Joint Investigations
- Targeted, Proactive, and Collaborative Engagement with other Agencies and Employers

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Alaska Workers' Compensation Board

QUESTIONS?

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Alaska Workers' Compensation Board

2024 Annual Report Reemployment Benefits

Stacy Niwa, Administrator

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Catherine Muñoz Commissioner

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Alaska Workers' Compensation Board

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

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Alaska Workers' Compensation Board

2024 By the Numbers

- 636 injured workers were referred for evaluations for eligibility for reemployment benefits.
- 1368 eligibility evaluation reports were reviewed.
- 244 suspension letters were issued.
- 626 eligibility determinations were made.
- 72 injured workers were found eligible for reemployment benefits.
- 35 injured workers elected to receive a job dislocation benefit.

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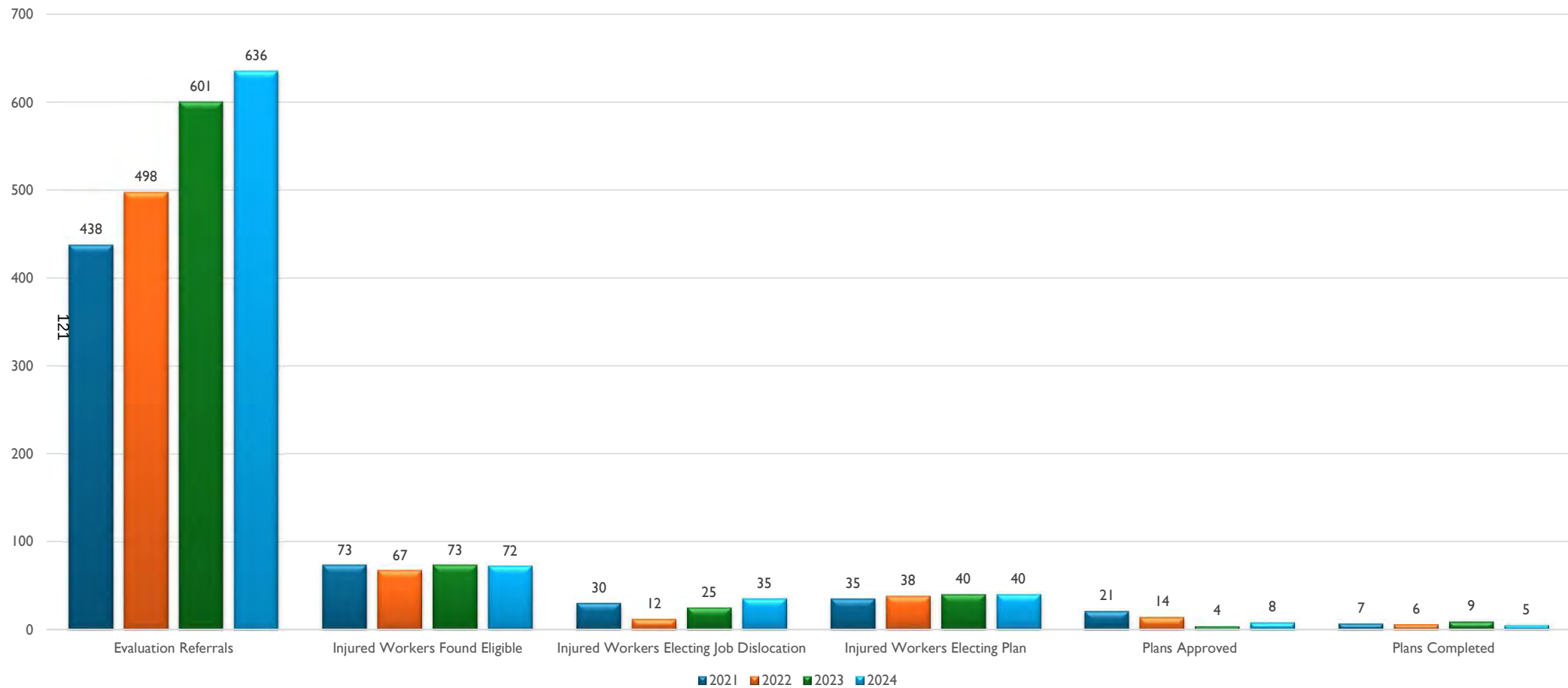
Alaska Workers' Compensation Board

- 40 elected to pursue reemployment benefits.
- 27 reemployment plans were submitted.
- 8 plans were signed by all parties and moved forward as agreed upon plans.
- 1 plan review was completed.
- 9 informal rehabilitation conferences were held to assist the parties in moving forward with reemployment benefits.
- 5 injured workers completed reemployment plans - start dates of completed plans range from 10/04/2021 – 01/16/2023.

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Reemployment Benefit Plans:

- 94 injured workers were in the plan process at some point during 2024.
- 36 injured workers were referred for plan development in 2024.
- 23 injured workers exited the process through a Compromise and Release after plan referral and before plan completion.
- 8 injured workers were in an approved plan at year end.
- 28 injured workers were in plan development, and 16 plans were pending approval at year end.
- 5 injured workers successfully completed plans with an average plan length of 24 months from plan approval to plan completion.

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- 95 plans were stalled or exited for various reasons:
 - Pending approval by the parties
 - Medical suspension
 - Compromise and Release agreement
 - Non-participation of the injured worker
 - Change election to job dislocation benefit
 - Employee passed away
 - D&O or stipulation
 - Rehabilitation specialist unable to develop plan that meets stat/regs

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Alaska Workers' Compensation Board

Outcomes for Workers Completing Plans

- The Reemployment Benefits Section attempted to contact 20 injured workers that had completed plans between 2022 and 2024.
- 14 injured workers responded.
- 11 injured workers had returned to the workforce.
- 3 injured workers reported they had not returned to work:
 - 1 - medically disabled
 - 1 - continuing education
 - 1 - retired

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Alaska Workers' Compensation Board

Reemployment Benefit Costs

	2022	2023	2024
Evaluation Costs	\$1,394,704	\$1,646,132	\$1,745,174
Reemployment Specialist Plan Fees	\$581,264	\$615,758	\$684,179
Plan Costs	\$359,799	\$435,966	\$515,940
Wage Benefits (AS 23.30.041(k))	\$2,479,056	\$3,083,339	\$2,763,301
Job Dislocation Benefits (AS 23.30.041(g))	\$1,674,193	\$1,264,092	\$2,044,222
TOTALS	\$6,489,016	\$7,045,287	\$7,752,817
% Change	19.07%	8.22%	9.56%

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Alaska Workers' Compensation Board

Impact of settlements on reemployment benefits in 2024:

- 131 injured workers exited the reemployment benefits process through Compromise and Release agreements during the reemployment benefits process.
- 30 injured workers had funds designated for reemployment benefits included in settlements approved in 2024, increasing reemployment benefit costs.
- 79 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.

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Alaska Workers' Compensation Board

Alaska Rehabilitation Specialist Performance - Reemployment Benefit Eligibility Evaluations:

- 13 Alaska Rehabilitation Specialists accepted 478 referrals for eligibility evaluations; 158 evaluations were referred to 35 specialists out of state.
- For Alaska Based Specialists:
 - 449 or 94% of the first reports were submitted within 60 days of the referral.
 - 264 or 58% of the evaluations were completed on the first report submission.
 - 210 reports did not meet statutory/regulatory requirements.
- Continued improvements in our process are being made to ensure work complies with statutory and regulatory requirements through suspension letters, discussions, plans of correction and disqualification from providing services under AS 23.30.041.

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Alaska Workers' Compensation Board

Rehabilitation Specialist	# of Referrals received	Average # days to 1 st report	% complete on 1 st report or w/o suspension letter	% of late 1 st reports	% of 1 st reports received in 60 days	# reports not meeting statute or regulation	Median # days to determination
J. Cranston	18	29	50%	11%	100%	35	76
K. Davis	27	37	70%	26%	100%	4	60
J. Doerner	49	32	88%	10%	100%	1	35
R. Hoover	48	29	69%	2%	100%	0	30
T. Hutto	47	32	77%	9%	98%	9	31
S. Krier	51	25	84%	0%	100%	12	30
D. LaBrosse	50	29	62%	4%	98%	96	66
N. Peterson	49	46	90%	24%	98%	10	61



Catherine Muñoz Commissioner



Alaska Workers' Compensation Board

Rehabilitation Specialist	# of Referrals received	Average # days to 1 st report	% complete on 1 st report or w/o suspension letter	% of late 1 st reports	% of 1 st reports received in 60 days	# reports not meeting statute or regulation	Median # days to determination
C. Robbins	45	56	96%	33%	71%	1	45
F. Sakata	6	52	66%	33%	83%	4	47
J. Shipman	24	24	83%	0%	100%	0	27
N. Silta	37	29	46%	0%	100%	29	82
P. Vargas	23	48	91%	39%	74%	3	51



Alaska Workers' Compensation Board

QUESTIONS?



Alaska Workers' Compensation Board

2024 Annual Report

Second Independent Medical Evaluations SIME

Carrie Craig, Workers' Compensation Officer I

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Alaska Workers' Compensation Board

- Panel Members:

- Adam Franklin, Employee Attorney
- Robert Bredesen, Employee Attorney
- Jeffrey Holloway, Employer Attorney
- Rebecca Holdiman Miller, Employer Attorney

- Division Support Staff:

- Janel Wright, Chief of Adjudications
- Alexis Hildebrand, Administrative Operations Manager
- Luma Diaz, Administrative Assistant II
- Carrie Craig, Workers' Compensation Officer I

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Alaska Workers' Compensation Board

2025 SIME Selection Panel Decisions per 8 AAC 45.092(b)(6):

2022 SIME Physicians NOT Re-Selected

- | | | | |
|---------------------------------------|--------------------------------|------------------------|------------------------------|
| • Lucas W. Campos, MD | Anesthesiology & Pain Medicine | Purab Viswanath, MD | Orthopedic Surgery |
| • Adam Brooks, MD | Orthopedic Surgery | Rachyll Dempsey, PsyD | Psychology & Neuropsychology |
| • Rina Jain, MD | Orthopedic Surgery | Jeffrey Brent, MD, PhD | Toxicology |
| • ¹³³ Ardalan Alen Nourian | Orthopedic Surgery | | |

2022 SIME Physicians Re-Selected.:

- | | | | |
|--------------------------|--------------------------------|-------------------|----------------|
| • Benjamin Simon, MD | Internal Medicine – Cardiology | Andrew Berman, MD | Otolaryngology |
| • Vincente R Bernabe, DO | Orthopedic Surgery | | |

2022 SIME Physicians Considered for Removal by a Majority Vote, per 8 AAC 45.092(b)(6)(A):

- None



Alaska Workers' Compensation Board

2025 SIME Selection Panel Decisions per 8 AAC 45.092(b)(5):

NEW SIME Physicians Selected by a Majority Vote:

- | | |
|--------------------------|--------------------------------------|
| • Dean Rider, MD | Internal Medicine - Gastroenterology |
| • Ravinder Bajwa, MD | Internal Medicine - Pulmonology |
| • Omar Tirmizi, MD | Internal Medicine – Pulmonology |
| • Martina Ziegenbein, MD | Internal Medicine - Rheumatology |
| • Khaled A. Anees, MD | Neurology |
| • Yolanta Petrofsky, MD | Occupational Medicine |
| • Andrew Calman, MD, PhD | Ophthalmology |
| • Amy J. Jain, MD | Ophthalmology |
| • John Shuster, MD | Orthopedic Surgery |
| • Jason Phillips, MD | Urology |



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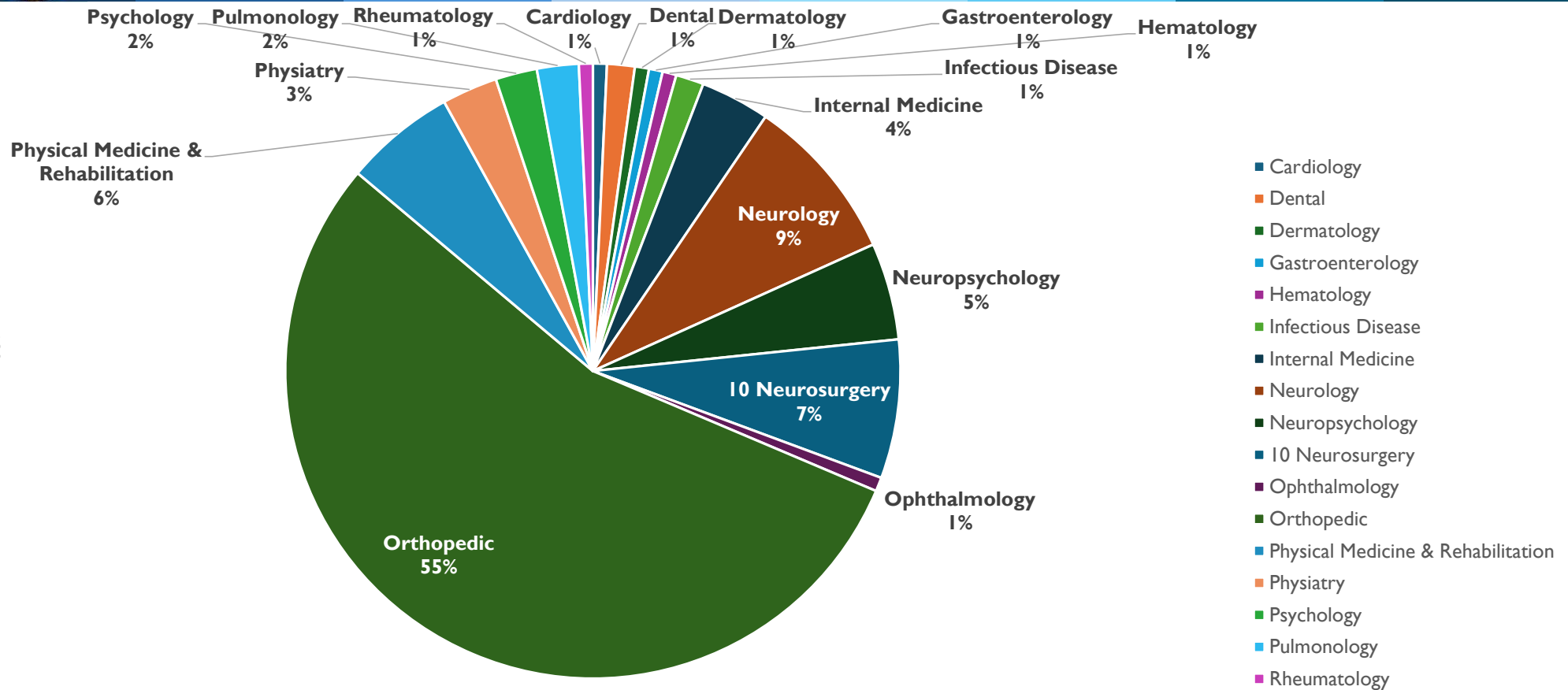
2025 SIME Physician Non-Renewals

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

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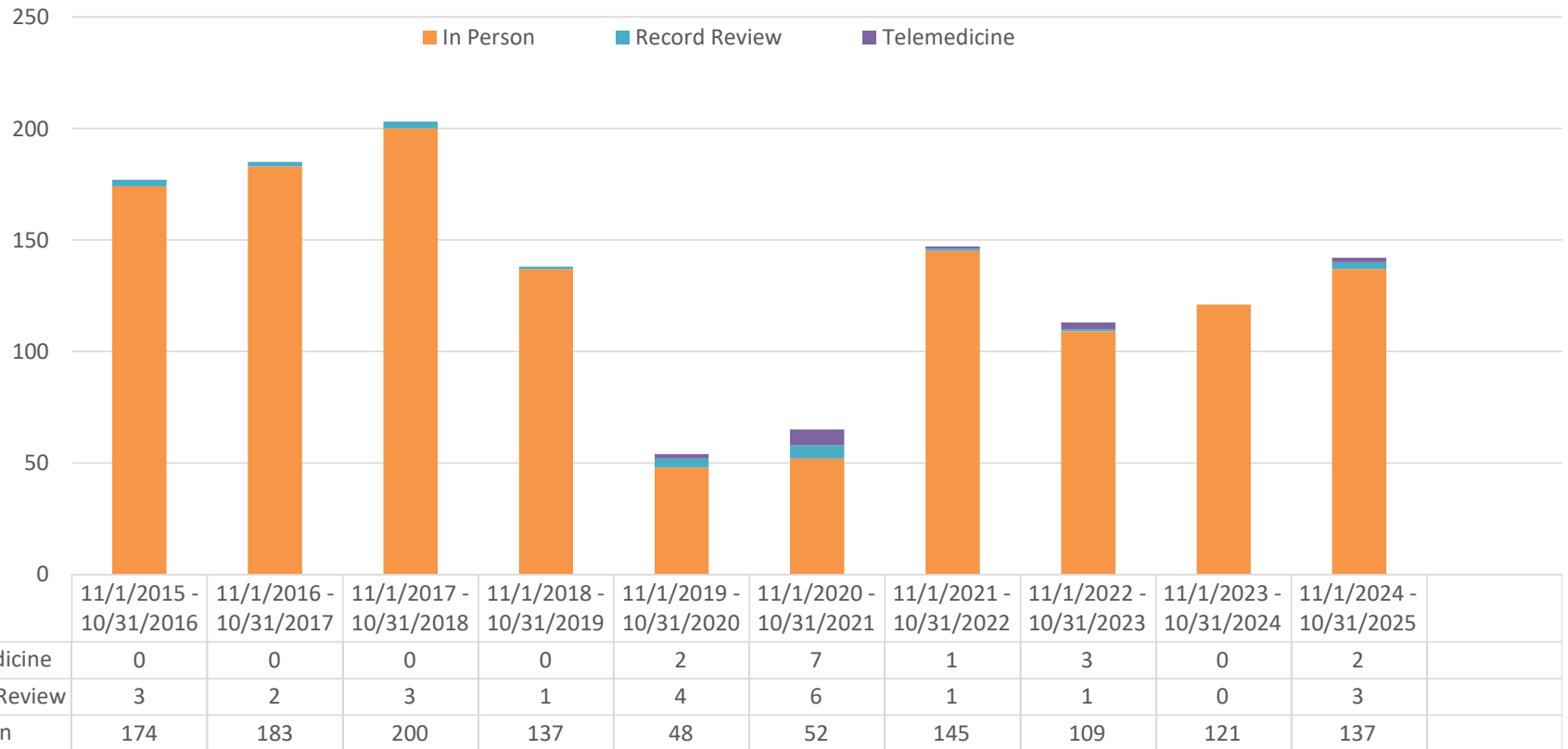
Alaska Workers' Compensation Board





Alaska Workers' Compensation Board

SIME Totals and Methods: 10 Year Comparison



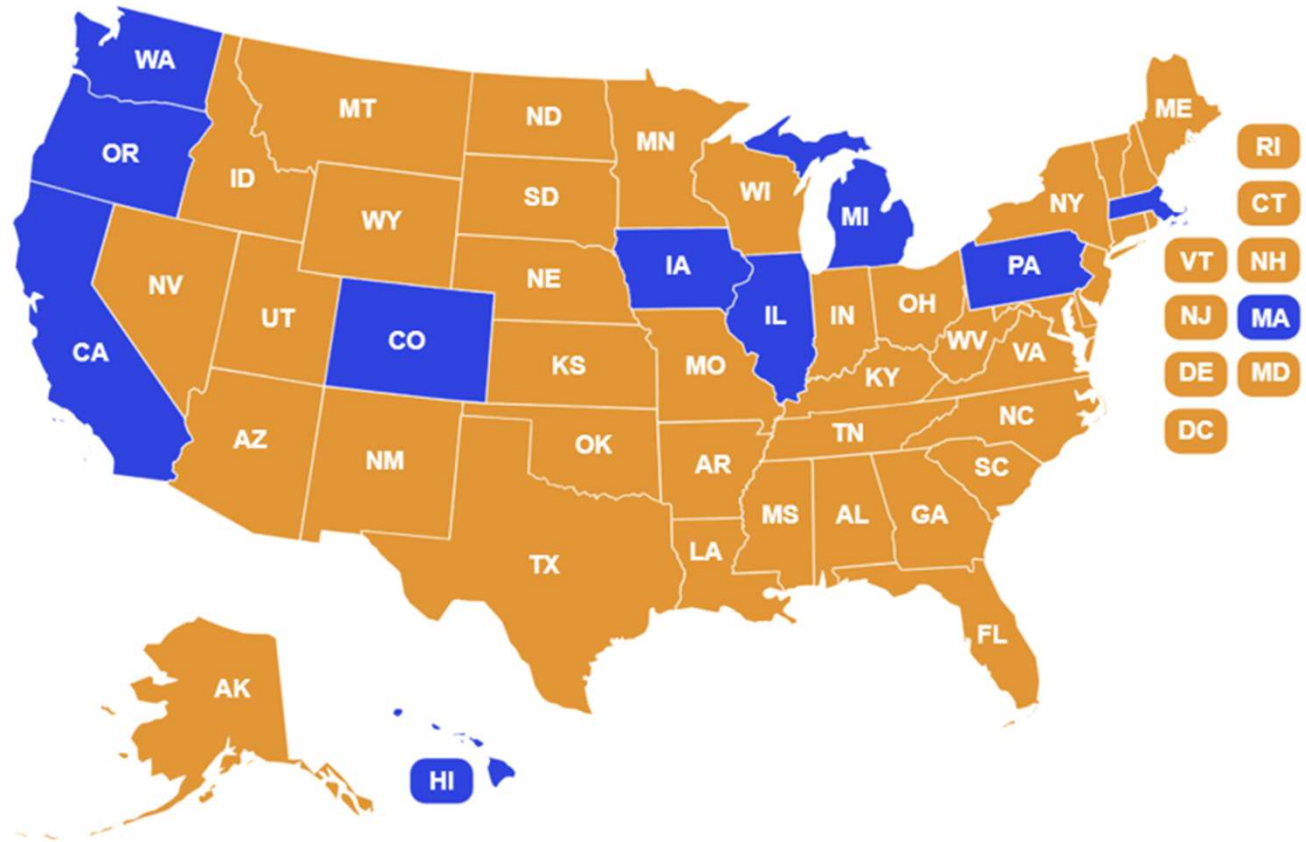


Alaska Workers' Compensation Board

SIME Locations 11/1/24 – 10/31/25:

California: 55
Colorado: 2
Hawaii: 17
Illinois: 3
Iowa (off-list): 1
Massachusetts: 1
Michigan: 7
Oregon: 3
Pennsylvania: 4
Washington: 5

SIME Trips Completed (and pending): 98





Alaska Workers' Compensation Board

QUESTIONS?



Alaska Workers' Compensation Board

Cathy Muñoz, Commissioner

Email: Commissioner.Labor@alaska.gov

Phone: (907) 465-2702

Charles Collins, Director

Email: Charles.Collins@alaska.gov

Phone: (907) 465-6060



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Foreman v. Northstar Construction Mgmt., AWCB Dec. No 25-0041 (July 11, 2025).....

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Woodell v. Alaska Regional Hospital, Slip Op. S-18740 (September 19, 2025).....

Board Panel: William Soule, Sara Faulkner

Representatives: Johnny Nie for Employee
Jeffrey Holloway for Employer

Issues:

- 1) Shall the Board designee's discovery order be affirmed?
- 2) Shall the Board designee remain the prehearing officer in this case?
- 3) Does Employee's "Affidavit of Fact" allow him to fine Employer \$3,000,000 "per alleged violation," punish them for "treason," seize their assets, or expel them from North America?

Results:

- 1) No, in part, but otherwise yes.
- 2) Yes.
- 3) No.

Discussion:

Employee submitted a "lengthy letter," also described as an "Affidavit of Fact," to Employer, accusing it of crimes and asserting rights he does not have. Employer treated this letter as a discovery request. It contended that once Employee filed an Affidavit of Readiness for Hearing (ARH), he was no longer entitled to discovery. After reading the "lengthy letter" and both sides' arguments, the Board's designee denied Employee's discovery requests and issued a protective order for Employer. Employee appealed the discovery order.

Employee also contended that the Board's designee "deceptively" portrayed him "in a poor light" in his prehearing conference discovery order, committed multiple ethical violations, and ultimately committed "a felony" against him. As such, Employee requested that the designee be removed as the prehearing officer on his case.

Finally, Employee's "Affidavit of Fact" alleged he had many rights not granted under the U.S. Constitution or the Alaska Constitution, including the ability to fine Employer \$3,000,000 "per alleged violation" of a peculiar ruleset stated in his affidavit, punish Employer for "treason," seize its assets, and expel it from North America. Notably, the "affidavit of fact" stated that if his affidavit was unrebutted, it would "stand as truth."

1) The Board stated that for information to be discoverable, it must be "reasonably calculated" to lead to admissible facts that will tend to make a dispute in his claims more or less likely. Additionally, it noted that workers' compensation cases favor liberal discovery, more so than discovery in a formal civil action. Most of Employee's discovery requests were not "reasonably calculated" to help his case, and were therefore denied. However, some of Employee's discovery requests could have led to evidence supporting an AS 23.30.250(a) fraud claim, and therefore the Board found that Employee had a right to such information. Addressing Employer's argument about ARH filing, the Board held that a party that files an ARH does not waive further discovery,

as that would contravene both legislative intent and policy behind ARHs. As such, the Board reversed in part, but mostly affirmed, the Board designee's discovery order.

2) The Board held that the Board's designee was correct when he summarized Employee's case in a prehearing conference summary but left out details. This is because Employee did not specify which missing portions affected his discovery order, and the Board could not discern any. Regarding possible crimes or ethical violations, it noted that as an employee for the State of Alaska, the Board's designee was bound under the Alaska Executive Branch Ethics Act (AEBEA). As Employee did not provide any evidence substantiating his claims, the Board found the designee did not violate any aspect of the AEBEA or commit any crime against Employee. Therefore, it held that the Board's designee would remain the prehearing officer for Employee's case.

3) The Board found Employee did not have the rights his "Affidavit of Fact" alleged he had. In discovery disputes, Employee's affidavit was "considered but is not binding."

Board Panel: William Soule, Sara Faulkner, Brian Zematis

Representatives: Yolanda Garoutte for Employee
Justin Tapp for Employer

Issues:

- 1) Should Employee's claim be barred under §105(a)?
- 2) Should Employee's claim be denied under §110(c)?

Results:

- 1) No.
- 2) No.

Discussion:

Employee suffered left-ear hearing loss. Employer contended Employee failed to file her claim timely. It argued that under Alaska Supreme Court precedent, her claim for permanent partial impairment (PPI) and medical benefits comes under the same statute of limitations, just as other benefits. Employer sought an order barring Employee's claim under AS 23.30.105(a). Employee stated her "claim" had been denied, and an adjuster told her she had no proof that her deafness arose out of her exposure at work. As such, she never contacted the Division for years after her incident because she did not think she could do anything about her alleged injury.

Employer also contended that Employee failed to request a hearing, or request more time to request one, timely within the two years after Employer controverted her claim. It sought an order denying her claim under AS 23.30.110(c). Employee conceded she never requested a hearing, nor more time to ask for one, because she felt she would lose due to lack of proof of causation.

1) The Board held that Employee's claim for PPI benefits would be barred under §.105(a), but not her claim for unfair for frivolous controversion, nor her claim for medical benefits. Her claim for PPI benefits was barred because even accounting for the latest possible time §.105(a) could have started to run, she still filed her claim late. The Board found the most reasonable time for §.105(a) to begin running was August 15, 2018. This was when she began to notice her left-ear deafness, and as a medical professional should have recognized the "nature, seriousness, and probable compensable character" of her injury. Applying 8 AAC 45.063(a), the proper day that §.105(a) began running was one day later, August 16, 2018. Even being as generous as possible, using the day she finally stopped curative treatment and implicitly accepted her impairment as "permanent," §.105(a) began running on March 8, 2019. Employee filed her claim March 29, 2022, far past the two-year deadline for any of those dates. Therefore, her PPI claim was barred under §.105(a). However, the Board held that an unfair and frivolous controversion was not an "indemnity benefit," and following *Murphy*, §.105(a) does not apply to non-indemnity benefits. Also following *Murphy*, the Board held that §.105(a) expressly did not apply to medical benefits.

2) The Board held Employee's claim should not be denied under §.110(c), as under current Commission standards, Employee was not given proper notice. Current notice requirements require the Board's designee at a prehearing conference to both advise the *pro se* claimant how to

calculate the §.110(c) client, *and* provide the actual date by which they must request a hearing to preserve the claim. Because Employee did not receive this, and she credibly testified she would have requested a hearing, or more time to request one if she had been advised, her claim was not denied under §.110(c). Instead, the Board granted her 90 days to request a hearing on her claims.

Note that according to the Division's file, Employee never requested a hearing on her claim.

Board Panel: William Soule, Sarah Lefebvre, John Corbett

Representatives: Rickie Foreman for Employee
Brian Weinstock for Employer

Issue:

Shall Employee's Alaska claim be dismissed under *forum non conveniens*?

Result:

Yes.

Discussion:

Employee was allegedly injured while working in Alaska. He then moved back to Missouri, where he pursued a workers' compensation claim in Missouri; he subsequently filed another claim in Alaska and pursued both concurrently. Employee contended that he had the right to pursue "concurrent claims," but his Alaska case citations were apparently AI generated, and did not exist anywhere else other than in his briefing. Employer filed a petition contending that Employee's Alaska claim should be dismissed due to Alaska being an inconvenient forum.

Employer made a number of contentions, including: Employee was "forum-shopping"; filing a claim in Alaska was inconvenient for all parties and witnesses; it would result in "unnecessary and unreasonable costs and expenses"; Employee chose Alaska to harass Employer; and Employee's domiciliary-forum choice should be considered "presumptively correct," as he filed his Missouri claim before his Alaska claim, and filed it while he was domiciled in Missouri.

The Board noted that the issue at hand was not who had proper jurisdiction (as both states did, and that was not contested by either party), but whether the Board should, in its discretion, withhold exercising jurisdiction in this matter and defer to Missouri. The Board found that the presumption of compensability did not apply to the improper forum petition because the petition raised a legal issue, not a factual one, and the relevant facts were undisputed.

The Board found that Employee's cited case law was either AI-generated or irrelevant, or the real caselaw he cited was against his position. In contrast, Employer cited an Alaska decision *Crowson*, and relied on its five factors that a court should consider when declining to exercise jurisdiction in a *forum non conveniens* case:

- 1) Access to proof;
- 2) Availability and cost to obtain witnesses;
- 3) The possibility a forum was chosen to harass an opposing party;
- 4) Judgment enforceability;
- 5) The community's burden from litigating matters with which it is not concerned.

The Board found that all *Crowson* factors weighed heavily in Employer's favor, and that the Alaska Workers' Compensation Act's goals of ensuring "quick, efficient, fair, and predictable" delivery of benefits at a reasonable cost to Employer favored dismissing the Alaska case, especially since Employee was simultaneously pursuing a remedy in Missouri. As such, the Board dismissed Employee's Alaska claim under *forum non conveniens*.

Employee has appealed this decision to the Commission.

Board Panel: William Soule, Anthony Ladd, Debbie White

Representatives: Manuel Hernandez for Employee
Justin Eppler for himself on a fee claim
Krista Schwarting for Employer

Issues:

- 1) Are non-remanded issues in *Hernandez VI* “the law of the case” on remand?
- 2) Is the work injury the substantial cause of any disability or need to treat Employee’s “chronic pain,” “anxiety or panic attacks,” “generalized anxiety,” “depression,” “somatoform disorder,” or a “Somatic Symptoms Disorder?”
- 3) Should the August 11, 2021 oral agreement be revised to reflect the correct temporary total disability (TTD) benefits for the period May 17, 2020, through June 17, 2021, and is Employee entitled to any additional TTD benefits?
- 4) Should the August 11, 2021 oral agreement be modified to reflect or increase benefit payments to Employee under AS 23.30.041(k)?
- 5) Is Employee entitled to permanent total disability (PTD) benefits?
- 6) Is Employee entitled to medical treatment and travel expenses?
- 7) Is Employee entitled to a penalty?
- 8) Is Employee entitled to interest on any benefits?
- 9) Is Employee’s previous counsel entitled to additional attorney fees or costs?

Results:

- 1) Yes.
- 2) No.
- 3) Yes, and no.
- 4) Yes.
- 5) No.
- 6) No.
- 7) No.
- 8) No.
- 9) Yes.

Discussion:

Employee was injured working at a seafood facility. His work-related physical injuries resolved; but his physician said there were “some psychosocial issues not relevant to work comp injury that might be precluding [Employee’s] return to work.” Employee’s hearing testimony was inconsistent with statements to his physicians regarding stress, depression, and other issues. Notably, many years before his work injury, Employee’s brother had stabbed him in the back. He told several doctors that his pain emanated from that same area. Employee received treatment from mental health professionals to pain management specialists. Despite extensive treatment, Employee’s condition did not improve long-term, possibly due to “self-limiting behavior.”

Employee said he suffered extensively from “depression,” although most physicians and experts stated that his depression was not related to his work injury. According to the experts, Employee’s self-reporting appeared unreliable, with his claims of pain fluctuating dramatically between different doctors, examinations, and self-report tests. One physician said his pain claims “[do] not make rational sense” given his normal physical examination.

1) On the last remand, *Hernandez VI*, the Commission only remanded two issues to the Board. Employer argued the remand was narrow, only to address identified issues. Employee contended the issues were “intertwined.” The Board found that the Commission expressly enumerated remanded issues. It held that the Board’s rulings against Employee on numerous issues would not be revisited because the Commission had not remanded those issues and the Board’s undisturbed decision on those issues was the “law of the case.”

2) Employee had credibility problems. A number of his claims were either exaggerated, incredulous, or highly doubted by physicians. Two physicians that supported him offered opinions that were either conclusory or relied on Employee’s inconsistent reports. As such, the Board found their opinions “not credible” and entitled to little weight. Employee testified that he never had similar physical or mental issues before his work injury. When confronted with statements he had made to his physician to the contrary, he stated those physicians were both “crazy.” “Overwhelming” medical evidence showed that Employee’s stab wound was the “substantial cause” of his pain, if he actually had pain at all. As such, the Board found that, even setting aside Employee’s credibility problems, his “chronic pain” was not work-related. As the pain was not work related, the Board also found that because Employee’s panic attacks, anxiety, depression, and possible somatoform disorder were, according to him, a direct result of his “pain,” those claims were likewise not work-related. Therefore, Employee’s claims were all denied.

3) At a previous Board hearing, Employer and Employee had stipulated that Employer would pay Employee \$24,801 in exchange for a hearing continuance. The next day, Employer realized it had erred in its TTD calculation and rather than pay the stipulated amount, it paid a few thousand dollars less. The Board at the instant hearing found that because Employee became medically stable earlier than the parties previously thought when making their stipulation, Employer had overpaid him by \$15,483 in TTD benefits. Despite that overpayment, Employee contended that the Board should hold Employer to the stipulation, which would have required Employer to pay an extra \$5,778. But there was no “credible evidence” suggesting Employee became medically *unstable* and disabled, and therefore he was not entitled to more TTD benefits that would justify holding Employer to the stipulation. The Board found “good cause” to relieve Employer from their previous stipulation. To do otherwise would make Employer pay Employee money it did not owe and could never recover as an overpayment.

4) Employee argued that because Employer did not provide proper notice to the RBA that he had been disabled for more than 90 days, he was entitled to additional §041 stipend benefits. The Board agreed in part, finding that Employer owed an additional 227 weeks and 3 days’ worth of “stipend.” However, it also calculated that factoring in the TTD paid, prorated PPI, and already-paid “stipend” benefits, Employer had still overpaid Employee by 13 weeks and one days’ worth of stipend. As such, the Board ruled that the oral agreement should be modified to account for the overpayment to Employee, as required under AS 23.30.041(c).

5) Employee argued that he was PTD status because he was unable to work more than a few hours occasionally at any job, making him an “odd-job” worker. Employer disagreed, stating that there was no evidence he was permanently and totally disabled. The Board found overwhelming evidence that Employee’s work-related injury had resolved and he was able to work. Additionally, it found that Employee could not prove he had a mental health condition that precluded him from work. The Board denied his PTD claim.

6) As previously determined, the Board held that any unresolved pain Employee had was related to his stab wound and not a work injury, so he was not entitled to ongoing care.

7) Employee raised several penalty claims under AS 23.30.070(f) and AS 23.30.155(e). The Board held that since it denied these penalties and the Commission did not remand them, they would not be revisited. Employee had filed a new claim, which included discrimination. The Board held these claims related back to his previous claims, which Employer had properly controverted. The only new claim was discrimination, which the Board held was outside of its jurisdiction. The Board held that Employee filed certain “claims” not on claim forms, and therefore did not give Employer adequate notice of its duty to controvert or pay any associated benefits. The Board held that it would be unfair to penalize Employer simply because it did not controvert or pay benefits associated with “claims” that were not readily identifiable as claims.

8) Because the Employee was awarded no additional benefits, the Board denied his claim for interest.

9) At some point, Employee had fired his lawyer, who had done a good job. He had gotten Employee at least the stipulated \$24,801 and some medical care; he filed his own claim. Analyzing Rule 1.5(a) factors, the Board found that all factors either supported or did not affect Employee’s prior counsel’s request for attorney fees. Therefore, they awarded his prior counsel his requested amount and additional fees for pursuing his own attorney fee claim.

However, the Board noted that, regarding factor #1, when the panel asked Employee’s prior counsel to justify the time he spent on various legal tasks, his prior counsel argued that he spent the time “required” to do the task. It noted the irrebuttable presumption created by prior counsel’s argument, and that the first Rule 1.5(a) factor (*i.e.*, “the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly”), was both difficult to quantify, and there was no practical guidance from the Court.

No party appealed this decision.

Board Panel: William Soule, Brad Austin

Representatives: David Graham for Employee
Rebecca Holdiman-Miller for Employer

Issues:

- 1) Shall Employee's request for a cost-of-living-adjustment (COLA) be granted in part?
- 2) Shall Employer's request for a Social Security disability (SSD) offset be granted?
- 3) Shall Employee's February 6, 2025 and April 1, 2025 discovery petitions be denied?
- 4) Shall Employee's February 27, 2025 petition to "preserve evidence" be denied?
- 5) Shall Employee's March 25, 2025 petition for additional time to request a hearing on her January 25, 2022 claim be denied?
- 6) Shall Employee's May 8, 2025 petition to accept Graham's appearances be granted?
- 7) Shall Employee's May 22, 2025 petition to strike medical records that exceeded her medical releases be denied?

Results:

- 1) Yes.
- 2) Yes.
- 3) Yes in part.
- 4) Yes.
- 5) Yes.
- 6) Yes.
- 7) Yes.

Discussion:

Employee was injured while operating a compactor. After her injury, she moved from Alaska to Hawaii, then to Florida, and then back to Hawaii. Thus, she requested a COLA because it is much more expensive to live in Hawaii than in either Alaska or Florida. Employer agreed that Employee may be entitled to a COLA, but the COLA weekly rate would be limited by statute to the rate she received while living in Alaska. Moreover, it contended that Employee never provided evidence of her physical addresses while living in each jurisdiction, and if she provided that evidence, Employer would calculate the COLA as required by law.

Additionally, Employee made a February 6, 2025 discovery petition, a February 27, 2025 petition to preserve evidence, a March 25, 2025 petition for additional time to request a hearing, an April 1, 2025 discovery petition, a May 8, 2025 petition to accept her attorney, David Graham's "limited" appearances, and a May 22, 2025 petition to strike medical records that exceeded her releases.

Employer requested a Social Security offset, given Employee's SSD award. Employee opposed.

1) Regarding the COLA, the Board held that Employee's prior lawyer's July 6, 2020 letter to Employer's attorney provided exact dates and places Employee lived to which the COLA would apply. Even though Employee did not specify the exact city in Hawaii where she physically resided, that was immaterial to her COLA, as Hawaii has the same COLA ratio across the entire state. It also held that the Division "Change of Address" form 07-6138's purpose was to advise parties and the Division of a change for serving process, and was not required to be used to inform the Division or Employer that Employee's physical residence address had changed. The form existed "for the parties' convenience" in changing a mailing address but "any written notice would suffice for providing a new mailing or residence address." The Board also held that AS 23.30.175(b) did not require specific proof of address for an insurance company to apply a COLA to recipients not residing in Alaska, if benefits are payable. As Employee proved that she resided in Hawaii under a preponderance of the evidence standard, using the presumption of compensability, the Board granted Employee's COLA, and capped it to her Alaska rate in accordance with §.175(b)(5).

2) In calculating the Social Security offset, the Board relied on 8 AAC 45.225(b), which specifies the offset reduction process. Using the standard formula, the Board calculated Employee's reduced weekly compensation rate under the Act. Moreover, in fairness given that Employer had "significantly overpaid" Employee's total temporary disability (TTD) benefits, the Board granted Employer's request for a 50 percent recoupment rate to account for her SSD benefits. This further reduced her weekly rate under the Act. But Employee would still receive her military disability benefits as well as her SSD at its full rate.

3) In considering Employee's numerous discovery-related petitions, the Board found Employee's discovery petitions to be either moot, baseless, confusing, unsupported by evidence, or a combination of all four.

4) The petition for evidence preservation was denied because the only evidence known to have been destroyed was not destroyed by a party to this case, but by an EME's office. Moreover, Employee had photographs of the documents she contended the EME had destroyed.

5) Employee's petition for more time to request a hearing was denied as unnecessary and moot, because she had already filed numerous hearing requests on all pending issues. The Board designee at a prehearing conference had previously held Employee's timely hearing requests in abeyance because they were not yet ripe.

6) Despite Employer's objections to Graham's appearances, the Board held that, although uncommon, Graham's limited appearances were not prohibited by any statute or regulation. It also noted that allowing Graham's limited appearances would serve "the Court's preference to encourage attorneys to represent injured workers in workers' compensation proceedings."

7) The Board denied Employee's petition to strike medical records, primarily because she failed to identify the records she wanted removed or recovered. Moreover, the Board held it would have been impossible for the panel to review all of Employee's medical releases, assuming they were even in the file, and compare them to every medical record in her file. Further, if Employee signed limited medical record releases, and Employer used those unaltered releases to request Employee's

limited medical records, Employer is not responsible if a medical provider releases records that exceed the scope of Employee's signed releases. If Employee's petition was seeking a protective to "recover" medical records that were unrelated under AS 23.30.108(d), she should list the offending records, provide the list to the Employer, and serve Employer a petition for a protective order in accordance with §.108(d).

Sadly, attorney Graham passed away shortly after the Board issued this decision.

Board Panel: William Soule, Sara Faulkner

Representatives: Adam Franklin for Employee
Adam Sadoski for Employer

Issues:

- 1) Was the RBA-designee's ineligibility decision an abuse of discretion?
- 2) Should the RBA-designee's determination be remanded?
- 3) May this panel reconsider the RBA-designee's ineligibility decision?

Results:

- 1) No.
- 2) Yes.
- 3) No.

Discussion:

Employee was injured after slipping while getting into his work truck. Employee's reemployment specialist submitted an eligibility report recommending him eligible for reemployment benefits. In her report, she incorrectly identified a PA-C, who treated Employee's spine, as an MD. Employer objected to the eligibility evaluation, given AS 23.30.041, which required Employee to present predictions from "a physician," and urged the RBA-designee to find Employee not eligible for reemployment. The RBA-designee considered Employee's entire file, and determined he was *not eligible* for reemployment benefits, based *not* on the PA-C versus MD mistake, but simply on giving greater weight to the EME physician. Employee appealed the RBA-designee's decision to the Board.

1) On appeal, Employee contended the RBA-designee abused her discretion by finding him not eligible for reemployment. He sought an order either modifying the finding so that he is eligible, or a remand to consider new, additional medical evidence not initially considered. Employer contended there was no abuse of discretion, as the designee's determination was supported by substantial evidence and it had followed the law. Even though some medical evidence upon which the RBA-designee relied could be interpreted differently than the RBA-designee read it, the Board declined to insert its own interpretation and instead found that the RBA designee's decision was not an abuse of discretion because no evidence suggested the decision was "arbitrary, capricious, manifestly unreasonable," or stemmed "from an improper motive." The designee also properly applied controlling law and applicable regulations.

2) Employee alternatively contended that the physician upon whom RBA-designee and relied had changed his opinion. Therefore, Employee contended the matter should be modified or at least remanded to the RBA-designee for potential modification under AS 23.30.130. Employer contended that Employee never requested "modification," and only "appealed" the RBA-designee's determination. Therefore, it contended that the subject physician's revised opinions could not be considered at that hearing. In other words, if Employee wanted the Board to review

and potentially modify the RBA-designee's decision, he should have specifically asked for "modification." The Board rejected Employer's argument, citing *Hodges*, *Hulsey* and *Metcalf* Alaska Supreme Court precedent to support its findings. It held that to deny Employee's petition based on semantics would run counter to the purpose of the Act under AS 23.30.001, which requires quick, fair and efficient litigation at a reasonable cost to employers. The Board also emphasized its power under AS 23.30.110 to "hear and determine 'all questions'" in claims. As such, the Board found it "[could not] ignore the fact that the opinion upon which the RBA-designee relied . . . had changed," and *remanded* the decision to the RBA-designee to take another look at the evidence. The Board reminded the RBA-designee that AS 23.30.395(3)(D) states that an "attending physician" means "a licensed physician assistant acting under supervision of a licensed medical doctor," and the PA-C was therefore qualified to offer a prediction under §041(e).

3) Employee contended that the RBA-designee should reconsider her ineligibility determination. Employer did not directly address this, but maintained that the RBA-designee properly exercised her discretion. The Board found it could not "reconsider" the RBA-designee's decision, as the Board did not make it. It also noted the instant decision remanding the case to the RBA-designee rendered Employee's request asking the RBA-designee to reconsider her decision moot.

Board Panel: William Soule, Anthony Ladd, Mark Sayampanathan

Commission Panel: James Rhodes, Steve Hagedorn, Andrew Hemenway

Representatives: Eric McDonald for Appellant
Colby Smith for Appellees

Issues:

- 1) Did the Board have authority to find that Employee did not settle his third-party lawsuit, even if a judge in the third-party lawsuit ruled otherwise?
- 2) Did collateral estoppel bar Employee from contesting the existence of a settlement agreement in subsequent litigation of a different claim (his workers' compensation claim), in a different forum (the Board), against a different party (Employer and its insurer)?

Results:

- 1) Yes.
- 2) No.

Discussion:

On June 6, 2014, Appellant was injured in a workplace incident. Employee concurrently litigated his claim against Employer, and filed a third-party lawsuit against two third-parties he alleged were liable for his injuries. In 2019, Appellant's third-party attorneys withdrew and the Superior Court later granted the third-parties' motion to dismiss the lawsuit due to an alleged settlement agreement. About a year later, Appellant filed a motion to set-aside the dismissal, and a different judge granted the motion on grounds that the third-parties had not established the existence of the alleged settlement agreement. The third-parties appealed, and the Alaska Supreme Court declined to answer whether an agreement existed. Instead, the Court reversed the second judge's decision and ruled that the third-party case could not be heard because Employee's motion for relief was improper under Civil Rules due to an unreasonably late filing. That left the first judge's order dismissing the third-party case as the only effective order.

Employer petitioned the Board to dismiss Employee's claim under AS 23.30.015(h) because he had compromised the third-party suit without its written consent, as required by law. The Board granted the petition and dismissed the claim, ruling that the Superior Court's order finding the compromise, *i.e.*, settlement's existence was binding on the Board. Employee appealed.

1) The Commission held that the Board has jurisdiction to decide for itself if there was a compromise under §.015(h) because it was not asked to overturn the Superior Court's ruling, but to make a factual determination as to whether Employee had settled his third-party suit. The Board has authority to do this, and therefore has jurisdiction.

2) The Commission held that the third-party issue was "not actually litigated" for purposes of collateral estoppel. Despite the order of dismissal having no mention of an untimely opposition, there was a court order stating it would sign the dismissal if Employee did not file a response by a

certain date, and the court did not possess a response on the date the order of dismissal was signed. Additionally, the online docket said the case was “dismissed by stipulation or unopposed motion[,]” and the court denied a motion for additional time. Therefore, the motion to dismiss was best seen as “uncontested” and “not actually litigated.” As such, collateral estoppel did not apply.

Moreover, even if collateral estoppel did apply, this case’s situation precludes it. Collateral estoppel may be avoided when “[t]he determination relied on as preclusive was itself inconsistent with another determination of the same issue[.]” As the two previous Superior Court decisions were inconsistent as to whether a settlement existed, applying collateral estoppel here would have been improper. To apply collateral estoppel here would defeat its purpose and the fundamental fairness underlying it as an equitable doctrine.

Therefore, the Appeals Commission *vacated* the Board’s decision, and *remanded* the case back to the Board for additional fact-finding on Employer’s §.015(h) dismissal request.

Rusch I:

Rusch v. SEARHC, 453 P.3d 784 (Alaska 2019).

Representatives: John Franich for Employee
Michael Budzinski for Employer

Issues: (1) Did the Commission err in affirming the Board’s attorney fee award?
(2) How do fact-finders determine how much to award in attorney fees?

Results: (1) Yes.
(2) Good question.

Discussion:

This line of three Supreme Court decisions began in *Rusch I* addressing how to calculate attorney fees in a case where the parties settled everything at mediation, except the two claimants’ attorney fees. These decisions morphed into fees for the claimants’ successful appeals of the Board’s fee decisions. Now it appears these cases apply to attorney fees at all levels in workers’ compensation cases. It is complicated law and requires some historical explanation to try to understand it:

A mediator resolved two claims by two different workers, represented by the same attorney, against the same employer, with both workers receiving “substantial settlements.” The parties could not agree on attorney fees, so the fee issue went to the Board. After a hearing, the Board in December 2016 significantly reduced the claimants’ fees but still made substantial awards. The Board based some hourly rate reductions for David Graham, who represented Employee before the Board, by comparing Graham’s workers’ compensation experience with seasoned workers’ compensation lawyers. *Note* that comparing a lawyer’s workers’ compensation experience to experienced workers’ compensation lawyers was the primary way the Board and Commission had decided attorney fee awards for decades.

The claimants appealed the Board’s award to the Commission, and the Commission affirmed.

The claimants appealed the Commission’s fee award to the Alaska Supreme Court. The Court in *Rusch I* reminded us that fee awards must be “adequate to ensure that competent counsel are available to represent injured workers.” It decided that the Board should have used the *Singh* analysis to evaluate a claimant’s success on an issue in a workers’ compensation settlement. *Rusch I* stated *Singh* “places the burden on the party opposing attorney’s fees to show lack of merit.”

Thus, in a workers’ compensation settlement where the parties dispute the issues on which a claimant prevailed for purposes of attorney’s fees, the employer “who contends that [its] conduct was a wholly gratuitous response to a [claim] that lacked colorable merit, must demonstrate the worthlessness of the . . . claim[] and explain why [it] nonetheless voluntarily gave the [claimant] the requested relief.

Rusch I made new law that changed how the Board must decide attorney fees:

- All a lawyer's legal experience must be considered.
- "... the Board must consider all of the factors set out in Alaska Rule of Professional Conduct 1.5(a) when determining a reasonable attorney's fee."
- "... the Board must consider each [Rule 1.5] factor and either make findings related to that factor or explain why that factor is not relevant."
- "... the Board needs to explain how decreasing Graham's hourly fee is consistent with the contingent nature of workers' compensation attorney's fees. . . ."
- The Board must consider evidence of all cases in which an attorney has assisted an injured worker, and not just those in which he or she entered an appearance.
- If the Board considers an attorney's fee affidavit "inadequate" for some reason, the Board should inform the attorney before or at the hearing and allow him or her an opportunity to modify the affidavit before ruling on his or her attorney fee request.
- Extra-record information about attorney fees derived from the Division's database cannot be used to reduce attorney fees without giving the claiming attorney an opportunity to see and respond to it.
- The "reasonableness" of a final attorney fee award is not in itself a factual finding. However, considering and applying various factors may involve factual determinations.
- Attorneys who do not employ a paralegal can bill the attorney's "paralegal services" at the attorney's hourly rate.
- "The Act is to be construed and applied in a manner that encourages, not discourages, attorney representation of injured workers."
- Reducing attorney time based on how the attorney breaks up a one-hour period, or for "block-billing," is inappropriate because no statute or regulation prevents billing in these manners.
- "Common injuries" do not support a finding that a particular case is "not complex."
- The Court "noted that employees' attorneys need to earn more than a 'normal hourly fee' on successful cases because they receive nothing on unsuccessful cases."

Rusch I cited Rule 1.5(a), which sets out eight non-exclusive "factors to be considered in determining the reasonableness of a fee," specifically:

- (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly;
- (2) the likelihood, that the acceptance of the particular employment will preclude other employment by the lawyer;
- (3) the fee customarily charged in the locality for similar legal services;
- (4) the amount involved, and the results obtained;
- (5) the time limitations imposed by the client or by the circumstances;
- (6) the nature and length of the professional relationship with the client;
- (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
- (8) whether the fee is fixed or contingent.

***Rusch I* reversed and remanded, finding the Board and the Commission had made errors.**

Rusch II:

Rusch v. SEARHC, 517 P.3d 1157 (Alaska 2022).

Representatives: John Franich for Employee
Michael Budzinski for Employer

Issues: (1) Did the Commission err again in awarding appellate attorney fees?
(2) How do fact-finders determine how much to award in attorney fees?

Results: (1) Yes.
(2) Good question.

Discussion:

With the win in *Rusch I*, the claimants were entitled to full, reasonable attorney fees at the Supreme Court level and at the Commission level too. When the claimants were not happy with the Commission’s attorney fee award, they appealed that order to the Supreme Court. *Rusch II* addressed the Commission’s attorney fee decision for work done at the Commission level. It revealed that the Court had awarded Graham and Franich \$60,000 in attorney fees (\$30,000 each) for the *Rusch I* appeal to the Court. So, the claimants moved for a fee award from the Commission. To understand *Rusch II*, one needs to understand the “modified lodestar” fee approach.

Just before *Rusch I* was issued, the Court issued *Adkins v. Collens*, 444 P.3d 187 (Alaska 2019). *Adkins* found “the superior court’s attorney’s fee award was unreasonable.” The Court was “convinced” the trial court “should” use the “modified lodestar” attorney fee approach in “fee-shifting” cases, “may” apply the *Johnson-Kerr* factors in applying it, and remanded the case to the trial court to recalculate the attorney fee award. The *Johnson-Kerr* factors, include the same factors from Rule 1.5(a), but added:

- (9) the “undesirability” of the case;
- (10) awards in similar cases.

Adkins stated the “modified lodestar” method is a way for a court to “calculate reasonable attorney fees” in cases involving “fee-shifting” provisions. The modified lodestar method works like this: The judge in **step one** determines reasonable hours the attorney worked in representing the client and then determines a reasonable hourly rate. Reasonable hours times reasonable hourly rate = the lodestar attorney fee. To help determine the lodestar in **step one**, the judge may use some or all of the Rule 1.5(a) and *Johnson-Kerr* factors. In **step two**, the judge decides if there is a reason to “modify” the lodestar by either enhancing or decreasing the award. *Adkins* states that to help determine **step two**, the judge may use some but not all of the same *Johnson-Kerr* factors in step one or two (lodestar fee + or - applicable factors = modified lodestar attorney fee award). *Adkins* said this method “does not invite a situation in which fees could vary widely depending on the plaintiff’s recovery.” It is unclear what the Court meant by that statement. It added:

For one, we agree . . . that a contingency enhancement in the **second step** of the lodestar determination can provide a “risk premium” necessary to induce competent

counsel to litigate claims when payment for legal services is contingent on success in the case. We thus leave it within the trial court's discretion to consider the contingent nature of a fee agreement when calculating an attorney's fee award under the modified lodestar approach, and to incorporate considerations about this factor into **either** the **first** or **second step** of the modified lodestar calculation.

The claimants after *Rusch I* asked the Commission to adopt the “modified lodestar approach to awarding fees,” and to enhance its requested fee for prevailing on appeal. The claimants had sought a \$450 per hour “lodestar” amount for hours their attorneys documented for the Commission appeal. The claimants argued that their “lodestar rate” did not consider the contingent nature of workers’ compensation appeals and argued it was therefore not fully compensable. Moreover, why would they handle workers’ compensation appeals on a contingency fee basis, if they could do other appeals and earn \$450 per hour without risk? They argued that \$600 per hour, a one-third enhancement from \$450, was required as the “modified lodestar” amount.

The employer in *Rusch* countered by noting the previous hourly rates awarded to the attorneys were already enhanced for the contingency factor and therefore their enhancement was not justified. The employer also argued that \$600 per hour would be 240% above fees commonly charged by defense counsel, although they did not supply any supporting evidence.

In its attorney fee order, the Commission declined to apply the modified lodestar approach, primarily finding *Rusch I* had not “mandated” it. The Commission decided that \$400 to \$450 per hour was a reasonable contingent hourly rate for Commission appeals, and enhancing fees above this “lodestar” amount would contravene the Act’s mandate that claims be resolved in part “at a reasonable cost to the employer.” It further considered that allowing enhanced fees in a no-fault system would have a “chilling effect” on employers’ willingness to appeal decisions, and improperly encourage employees to appeal minor or frivolous issues because they could receive large attorney fee awards. The Commission interpreted the Act to not allow enhanced fees using the modified lodestar method at least for attorney fees on appeal before the Commission.

The Commission awarded \$450 per hour to both attorneys. The claimants appealed again to the Supreme Court, which gave rise to *Rusch II*.

Rusch II stated a claimant must prevail on “a significant issue on appeal” to be awarded fees for an appeal, whereas Board-awarded fees depend on success on the “claim itself.” “In both instances, however, fee awards depend on success and are thus contingent fees.” “We have consistently construed the Act as requiring attorney’s fee awards for claimants in both court and administrative proceedings to be ‘fully compensable and reasonable so that competent counsel will be available to furnish legal services to injured workers.’”

Rusch II agreed with the claimants and rejected the Commission’s statutory interpretation that the Act did not allow for enhanced attorney fees under the modified lodestar approach. The Court noted that “employer costs” is but one consideration when construing the Act, but not the only one. There has to be a “balancing of competing interests.” The Court decided this was especially true in Juneau and Fairbanks where finding attorneys to represent injured workers is more difficult. As for the Commission’s “lack-of-a-mandate” conclusion, *Rusch II* fees must “be fully compensatory and reasonable,” and had “explicitly stated” in *Bignell* that “full compensation is not necessarily

limited to an award of an hourly fee.” Here, the claimants argued for a “multiplier of two” be used in all cases “to account for contingency.” They acknowledged that the “modified lodestar method does not always enhance, and sometimes even decreases” baseline hourly fees.

Rusch II stated “. . . at times enhancement of a lodestar fee may be appropriate to fully compensate attorneys representing claimants in difficult cases.” It found that the Commission “did not explain in any detail” how it weighed the Rule 1.5(a) factors to come to its \$450 per hour result as “fully compensatory and reasonable.” *Rusch II* rejected the “tiered approach” to awarding attorney fees, based on experience as attorneys moved to higher levels as they represented more claimants. Thus, on remand the Commission should consider the possible impact this tiered approach may have on unavailability of representation for people living in Juneau, for example. *Rusch II* stated:

On remand the Commission should evaluate the claimants’ requests and evidence, and make findings that explain how it considered the Professional Conduct Rule 1.5(a) factors in determining fees, understanding that it is permitted, but not required, to enhance fees under a modified lodestar approach.

However, to muddy the waters a lot, in footnote 16, *Rusch II* referred back to *Adkins* and stated:

In *Adkins* we explicitly distinguished federal law and allowed courts to consider a contingency enhancement when deciding whether to adjust the lodestar *even if* contingency was a factor in determining the baseline lodestar amount because we recognized that such an enhancement “can provide a ‘risk premium’ necessary to induce competent counsel to litigate claims” (emphasis added).

Note that according to this footnote, claimants can use the contingency factor *twice*, once to establish their lodestar rate, and again to support modifying and enhancing that rate. But the above statement from *Rusch II* footnote 16 is not what the Court said in *Adkins*, where it actually stated, “We thus leave it within the trial court’s discretion to consider the contingent nature of a fee agreement when calculating an attorney’s fee award under the modified lodestar approach, and to incorporate considerations about this factor into *either* the first *or* second step of the modified lodestar calculation” (emphasis added).

Note that primarily for practitioners’ benefit, *Rusch II* also clarified procedural law. It determined that because the Board’s underlying attorney fee award was final, and was appealed, the Commission’s fee order was also appealable as a “final decision.” Ordinarily, if the Commission remands a case to the Board at conclusion of an appeal, its attorney fee order is not “final” for appeal purposes. Under these circumstances, it is. A successful claimant on appeal has to appeal the Commission’s fee award within 30 days or risk losing the right to appeal it altogether.

Rusch III:

Rusch v. SEARHC, 563 P.3d 2 (Alaska 2025).

Representatives: John Franich & David Graham for Appellants
Michael Budzinski for Appellee

Issues: (1) Did the Commission err again in awarding appellate fees after *Rusch II*?
(2) How do fact-finders determine how much to award in attorney fees?

Results: (1) Yes.
(2) Good question.

Discussion:

As for *Rusch II*'s direction that the Commission on remand consider that small-town lawyers might have a different hourly rate than lawyers in larger communities, the Commission had noted the prevalence of "the Internet, Zoom, and multiple other electronic products available almost anywhere in Alaska." The Commission had decided that technology mitigated the distance and "smallness factors" as deterrents to finding a lawyer in smaller communities. It did not discuss amounts involved in the underlying claims that were settled. As for "the experience, reputation and ability of the claimants' attorneys," the Commission had agreed they were experienced, and their experience justified the "modified lodestar rate of \$450 per hour." It had further found the contingency factor was implicitly recognized in the \$450 hourly rate. The claimants appealed again to the Supreme Court.

Rusch III held that the Commission mistakenly conflated the "lodestar" with "modified lodestar" concepts and did not change its original attorney fee award and decided \$450 per hour was a reasonable and fully compensatory hourly rate for work before the Commission. It again reviewed *Adkins* and noted, "In cases about both appellate fees and Board-awarded fees, we have applied the principle that fees awarded to claimants' attorneys should be adequate to compensate for unsuccessful claims." *Rusch III* stated again that employers' attorney fees were not an adequate measure of the market rate for claimants' attorneys. It stated that if a claimant on appeal wins only "minor" or "side issues," they may recover a lower fee. "But claimants are entitled to an appellate fee award even when they do not win all points on appeal: they must simply succeed on a significant issue."

As to the so-called "tier system" *Rusch III* suggested an "individualized analysis" that considers "risk, difficulty, novelty, skill, or any other factor specific to a given case" needs to apply. In an apparent effort to clarify *Adkins* without resorting to a footnote, *Rusch III* expanded upon footnote 16 in *Rusch II* and stated:

In *Adkins* . . . we decided that an adjudicator using the modified lodestar method can use *any* of the *Johnson-Kerr* factors *when considering an enhancement, even if that factor has been used to determine the lodestar fee*. Contingency can thus be considered both when establishing the lodestar and when determining whether enhancement of a lodestar fee is justified in specific litigation. We adopted this

approach because “a contingency enhancement in the second step of the lodestar determination can provide a ‘risk premium’ necessary to induce competent counsel to litigate claims when payment for legal services is contingent on success in the case.” This is consistent with our goal of awarding adequate fees in workers’ compensation cases so that competent counsel are available to represent injured workers (emphasis added).

Note that to the extent *Adkins* did not say what footnote 16 in *Rusch II* says it said, the Court has now expressly stated the above. A claimant can use the contingency factor *twice* in the modified lodestar attorney fee method. With this revised framework in mind, *Rusch III* reviewed the Commission’s fee award decision the Commission made on remand:

Rusch III found the “fees awarded were an abuse of discretion in light of the findings the Commission made” applying the Rule 1.5(a) factors. *Rusch III* did not find the Commission’s consideration of its own prior attorney fee awards in addressing some Rule 1.5(a) factors in itself an error. The Commission was still free to consider its own prior awards, “which are accessible to the public,” in analyzing the relevant Rule 1.5 factors. *Note* it is not clear to the Division where the Commission’s attorney fee awards are accessible to the public; they are not published.

Rusch III found that the Commission had focused on only three Rule 1.5(a) factors, even though the parties disagreed about applicability of the other factors. In such case, the modified lodestar method requires that the Commission consider more than just those three factors. The Court found the Commission’s repeated reliance on fees awarded in past cases to other experienced attorneys supported the claimant’s assertion “that the Commission was resisting compliance with our directions on remand.” *Rusch III* further found that the Commission discounted the claimants’ “new law about attorney’s fee awards” before the “Board and the Commission,” as ever being an enhancement factor in this or any other case. “This factor can distinguish cases involving routine application of substantial evidence review, with little impact on the legal rules governing future cases, from cases that create new precedent.”

On remand, the Commission must enhance the fee awards to account for the findings it has already made. The Commission is not required to award the precise hourly rate the claimants seek, but it must award some enhancement to account for factors that favored enhancement. We leave to the Commission the choice of enhancing the hourly rate, at the first stage of the modified lodestar method, or the overall fee award, at the second stage of the modified lodestar method, or both. But the Commission must adhere to its own findings supporting enhancement. And to be clear, it must apply the modified lodestar method. Moreover, to the extent that the *Johnson-Kerr* factors are not fully captured in the Rule 1.5(a) factors, we clarify now that the Commission must consider all relevant *Johnson-Kerr* factors in applying the modified lodestar method.

As an aside, in footnote 88 *Rusch III* stated:

The Commission is not required to make findings about factors that the parties agree do not affect the case. Similarly, if the parties agree on an hourly rate or the employer does not oppose a requested hourly rate, neither the Board nor the

Commission needs to make findings about factors related to fee awards. The Board is required to make findings of fact about issues that are *contested* and material (emphasis in original).

In footnote 101 it stated:

Attorneys for claimants are not required to seek enhanced fees, nor is the Commission required to use the modified lodestar method if the parties agree to an hourly rate. Also, the Commission does not need to make findings about factors that the parties agree are irrelevant.

Rusch III vacated and remanded back to the Commission again, for redetermination of an appropriate attorney fee award for work the claimants did before the Commission. With their most recent successful appeal in *Rusch III*, the claimants are entitled to full reasonable attorney fees as successful appellant's before both the Supreme Court, and before the Commission, yet again. The claimants requested in excess of \$300,000 for an enhanced attorney fee under the modified lodestar approach just for services rendered on appeal before the Supreme Court for prevailing in *Rusch III*. The Division anxiously awaited to see how the Court applied its own modified lodestar approach to the claimants' request for the Court to award attorney fees for their successful appeal; i.e., how the Court determined reasonable hours for the attorneys' work, how it determines a reasonable hourly rate, and if it enhances the resultant lodestar fee.

Note that not addressed in the *Rusch* series is the question of how a mediator's expertise in any given case, and the claimant's lawyer's inexperience, interacted to result in a "substantial settlement." In other words, excluding the instant case or any case in particular, one could argue that it is "unreasonable" for a claimant's attorney to receive a substantial attorney fee award when a mediator's expertise is what actually results in the claimant's "substantial settlement," in spite of the lawyer's experience or inexperience.

Note that the most perplexing issue for the Board remains how to determine if a lawyer's time on a specific legal service was "reasonable." The Division hoped that the Court's analysis and order on the claimants' lawyers' request for modified lodestar fees for work done on appeal would inform the Board and others how to determine a fair, reasonable and fully compensatory fee.

UPDATE! The Alaska Supreme Court, after several months, ordered that the attorneys would get \$500 per hour for their services before the Court. There was no analysis.

Travelers Property Casualty Co. of America v. Keluco General Contractors, 572 P.3d 537 (Alaska 2025).

Representatives: Thomas Lether for Appellant
Debra Fitzgerald and Jonathan Katcher for Appellees

Issue:

Did the insurer provide proper notice of cancellation of a workers' compensation policy to the employer policyholder?

Result:

No.

Discussion:

Keluco, general contractor, secured a workers' compensation policy through Travelers. The policy was effective for one year. In 2017 a few months after the one-year period, a Keluco worker fell 20 feet from a roof onto concrete and fractured his skull, among other serious injuries; he has never returned to work and has a guardian. Keluco made a claim for the injured worker on its policy, but Travelers denied it because, come to find out, the policy had expired prior to the worker's injury. Keluco claimed it never received a renewal notice or notice that its policy was set to expire, as required under Title 21: "If notice is required from an insurer under this chapter, the insurer shall . . . mail the notice by first class mail to the last known address of the insured *and obtain a certificate of mailing from the United States Postal Service.*"

The Division's SIU went after Keluco as an uninsured employer and Keluco ended up paying a \$3,375 civil penalty. The injured worker hired an attorney who filed a claim, which included the Guaranty Fund. After litigation before the Board, Keluco was ordered to pay all past benefits, and substantial penalties, plus attorney fees and costs. Eventually, the injured worker settled for an additional \$1.2 million and \$129,010 more to his attorney in fees and costs. Keluco had to sell some of its real property to satisfy this agreement.

Not too surprisingly, in 2019 Keluco sued its insurance agent for breach of contract; the agent added Travelers as another defendant. The agent settled by paying about \$250,000. Keluco moved for summary judgment against Travelers claiming it failed to obtain a USPS "certificate of mailing" for the nonrenewal and expiration notice. In other words, Travelers had failed to follow the statute, which by Alaska law became part of its insurance contract with Keluco. Travelers contended its "internal mailing records" were proof-of-mailing. Its protocol was to send mail "First Class with Affidavit" combined with USPS form 3877, which qualifies as proof of mailing when a stamp is affixed to the form. However, Travelers' form 3877 contained no stamp and no certification by a postmaster confirming receipt of mail. Travelers nonetheless said that its internal records should still suffice. The trial court rejected the "internal records" theory noting that the legislature had amended the statute to require the USPS "certificate of mailing" to address this very issue, and to accept an insurer's "internal records" would nullify the statute.

The trial court granted Keluco summary judgment on these facts. Considering Travelers' failure to obtain proof of mailing when it sent its nonrenewal notice to Keluco, and absent any verification from the USPS that Travelers sent the notice as it claimed, the trial court found Travelers breached its contract with Keluco by (1) failing to provide the required nonrenewal notice, and (2) by failing to defend Keluco against the workers' compensation claim and pay the benefits.

But wait! There's more! Since Travelers failed to provide a proper nonrenewal notice under AS 21.36.240(c), *the policy remained in effect at the time the worker was injured and Travelers was responsible for any benefits owed under the workers' compensation policy.*

Faced with this, Keluco and Travelers stipulated to Keluco's damages, but disagreed on the prejudgment interest start date. Ultimately, after the appeal, the Supreme Court ended up affirming the trial court's summary judgment, clarified the start date for interest, and Travelers ended up paying Keluco approximately \$3.9 million (\$2.7 million in principal damages + \$1.2 million in prejudgment interest). The extra USPS fee for the "certificate of mailing" was around \$.65. . . .

Note that AS 23.30.030(5) similarly has a litigation landmine in plain sight for the unwary employer or insurer:

AS 23.30.030. Required policy provisions. A policy of a company insuring the payment of compensation under this chapter is considered to contain the provisions set out in this section. . . .

5) A termination of the policy *by cancellation is not effective as to the employees of the insured employer covered by it until 20 days after written notice of the termination has been received by the division.* If the employer has a contract with the state or a home rule or other political subdivision of the state, and the employer's policy is cancelled due to nonpayment of a premium, *the termination of the policy is not effective as to the employees of the insured employer covered by it until 20 days after written notice of the termination has been received by the contracting agency,* and the agency has the option of continuing the payments on behalf of the employer in order to keep the policy in force. If, however, the employer has secured insurance with another insurance carrier, cancellation is effective as of the date of the new coverage.

Woodell I:

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 19-0077 (July 26, 2019).

Representatives: Joe Kalmarides for Employee on *Woodell I* through *IV*
Employee represented beginning in *V*
Krista Schwarting for Employer

Employee a nurse on September 21, 2018, unknowingly cared for a *Clostridium Difficile* (C. Diff) patient while not wearing “personal protective equipment” (PPE). “Contact precaution” signs were not posted; on his next shift, Employee saw “contact precaution” for that patient. He developed symptoms and tested positive for “hospital-acquired” C. Diff in December 2018.

He claimed for TTD and medical benefits, an unfair or frivolous controversy, fees, costs, and a penalty. Employer controverted solely on grounds he failed to report his injury timely under §.100. An EME physician stated he could not “determine the commencement of C. Diff infection.” He neither confirmed nor excluded the September 21, 2018 exposure as a cause for the C. Diff.

Issues:

- 1) Was Employee’s claim barred for failure to give timely notice?
- 2) Is Employee entitled to attorney fees and costs?

Results:

- 1) No.
- 2) Yes.

Discussion:

The parties agreed to hear only timeliness of Employee’s injury “notice” as a preliminary, dispositive issue, along with attorney fees if he won.

(1)Employee testified that after seeing contact precaution signs in a patient’s room, he told the charge nurse that he had cared for that same C. Diff patient while not wearing PPE the prior day. Employer’s witness Miller testified about “causation”; she had reviewed patients’ charts and said she could not identify a patient with C. Diff during the relevant time. She did not produce evidence contrary to Employee’s testimony that he reported his exposure to his charge nurse on the next shift; Employer did not even interview the charge nurse. The Board found Employee developed a C. Diff infection on September 21, 2018. It also found that Employer had actual knowledge of his injury when he advised the charge nurse that he had treated a C. Diff patient while not wearing PPE. Employee’s claim was not barred for failure to give timely notice of his injury. *Note:* the only issue for hearing was notice and related attorney fees -- not causation.

(2) Employee requested attorney fees and costs, and the Board awarded them.

Employer petitioned the Commission for a stay on attorney fee payment, and for Commission review on the untimely notice issue.

Woodell II.

Alaska Regional Hospital v. Woodell, AWCAC Order on Motion for Stay and Order on Petition for Review (October 15, 2019).

Commission Panel: Dee Ford, James Rhodes, Steve Hagedorn

Representatives: Joe Kalmarides for Employee
Krista Schwarting for Employer

Issues:

- 1) Should *Woodell I*'s attorney fee award be stayed and the case remanded for credibility findings?
- 2) Was Employee's claim for benefits barred for failure to give timely notice?

Results:

- 1) Yes.
- 2) The Commission retained jurisdiction over issue (2) pending the remand on (1).

Discussion:

1) The Commission determined that if Employer paid the *Woodell I* attorney fee award, and if the Commission ultimately agreed with Employer's position on its petition for review on the notice issue, Employer could never recover the over-payment because there would be no benefits from which it could recoup. Therefore, the Commission stayed the attorney fee payment.

2) The Commission also determined that witness credibility was not sufficiently developed. Specifically, it remanded the matter so the Board could make credibility findings about Employer's witness Miller. It retained jurisdiction to rule on Employer's petition for review on the timely notice issue until after the Board made explicit credibility findings on Employer's witness.

Note that since Employer's witness Miller (who was not the charge nurse) said nothing about the notice issue, which was the only issue heard in *Woodell I*, it is curious why the Commission thought the Board's view of her credibility on a non-issue (causation) was relevant to the notice issue. Perhaps the Commission considered that *Woodell I* had also apparently decided causation; if so, the Commission did not say so, but this is the only explanation that makes sense.

The case went back to the Board for credibility findings.

Woodell III.

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 19-0122 (November 27, 2019).

Board Panel: Jung Yeo, Kimberly Ziegler, Nancy Shaw

Representatives: Joe Kalmarides for Employee
Krista Schwarting for Employer

Issue:

Should Employer's witness from *Woodell I* be accorded any weight?

Results:

No.

Discussion:

On remand, the Board reviewed the record and found: Employer's hearing witness for *Woodell I*, Miller, was Vice President of its Human Resources Department. She had stated that Employer reviewed patient records and could not identify a patient with C. Diff that Employee had cared for, or any patient in the unit that had C. Diff during the time he became ill. Employer did not produce patient records or summaries of records it allegedly reviewed. That witness had also admitted at the *Woodell I* hearing that Employer's investigation did not include speaking to the charge nurse. The reason: they thought she would not be able to remember. The Board noted that Miller never said the charge nurse was not available for interview. The Board found it was unreasonable for Employer's investigation to assume the charge nurse would not be able to accurately recall information, and instead chose to conduct an incomplete investigation. The witness had further testified that she was not "an expert in the patient side of things." The Board gave her testimony no weight; *Woodell I* remained unchanged.

Note that in addition to reviewing notice evidence, the panel revisited the hearing testimony from *Woodell I* and again discussed evidence that addressed causation (*i.e.*, the Miller testimony that alleged an absence of a patient who had C. Diff).

After the Board issued *Woodell III*, Employer's petition asking the Commission to review the notice issue was now ripe for the Commission's decision.

Woodell IV.

Alaska Regional Hospital v. Woodell, AWCAC Order on Petition for Review (January 21, 2020).

Commission Panel: Dee Ford, James Rhodes, Steve Hagedorn

Representatives: Joe Kalmarides for Employee
Krista Schwarting for Employer

Issue:

Was Employee’s claim barred for failure to give timely notice?

Results:

No.

Discussion:

The Commission found the Board’s credibility findings were binding. Moreover, it said, “In addition to the lack of credibility must be added to the information that [Employer] is not able to provide an alternative source for the C. Diff exposure.” The Commission held that Employee provided oral notice to his charge nurse the day after his exposure. This created “actual notice.” Substantial evidence supported the Board’s notice decision. The Commission denied Employer’s petition for review, affirmed the “decisions and orders of the Board” and vacated the stay on attorney fees.

Note again that the only issue set for hearing in *Woodell I* was timely notice and associated attorney fees. Causation was not yet an issue, but so far all four decisions addressed it. The Commission had also expressly accepted the Board’s factual findings and conclusions regarding causation.

The case was now on track to eventually progress to a merits hearing.

Woodell V.

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 20-0018 (April 2, 2020).

Board Panel: Jung Yeo, Sara Faulkner, Nancy Shaw
Representatives: Kade Waddell represented himself
Krista Schwarting for Employer

Issues:

- 1) Should Employee's claim be dismissed for his failure to obey a discovery order?
- 2) Did the Board's designee abuse her discretion on Employer's discovery request?

Results:

- 1) No.
- 2) Yes and no.

Discussion:

- 1) The Board found Employee's attorney had withdrawn, and gave him lenience with procedural requirements. It excused Employee's two-day late appeal from a discovery order as Employer was not prejudiced by the minor tardiness.
- 2) The Board designee had ordered Employee provide discovery. The Board found that the designee's order requiring Employee to identify any C. Diff patients to which he was exposed violated HIPAA statutes, and reversed that order. While affirming the Board designee's order granting discovery of the charge nurse's identity and other information, it added, "However, discovery shall not be conducted, and evidence discovered may not be used, to revisit the notice issue already litigated and decided in *Woodell I* and *Woodell II* because the notice issue is barred by collateral estoppel."

Note that as a practical matter, collateral estoppel probably would not have barred the use of any new information on the notice issue, because no prior decision had been "final," which is a requirement for collateral estoppel to apply. But modification rules under AS 23.30.130 prevented additional discovery from being used to change the outcome on the notice issue, because Employer could have and should have obtained that evidence before the *Woodell I* hearing.

Discovery continued. . . .

Woodell VI.

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 20-0060 (July 21, 2020).

Board Panel: Jung Yeo, Randy Beltz, Nancy Shaw

Representatives: Employee represented himself
Krista Schwarting for Employer

Issues:

- 1) Was the oral order denying Employee's appeal from a discovery order correct?
- 2) Was the oral order compelling Employee to sign an updated medical release correct?

Results:

- 1) Yes.
- 2) Yes.

Discussion:

The Board denied Employee's appeal from another discovery order and found the designee had not abused his discretion when he denied Employee's request for a protective order regarding medical releases. It properly ordered him to promptly sign appropriate releases.

Discovery continued. . . .

Woodell VII.

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 20-0081 (September 21, 2020).

Board Panel: Jung Yeo, Diane Thompson, Nancy Shaw

Representatives: Employee represented himself
Krista Schwarting for Employer

Issues: Finally, the merits of his claim (with one preliminary issue)!

- 1) Was the order declining to honor Employer's untimely *Smallwood* objections correct?
- 2) Did Employee's C. Diff infection arise out of and in the course of his employment?
- 3) Is Employee entitled to a PTD benefit award?
- 4) Is Employee entitled to a TTD benefit award?
- 5) Is Employee entitled to medical care and related transportation costs?
- 6) Is Employee entitled to a late-payment penalty?
- 7) Was Employer's July 20, 2020 controversion notice unfair or frivolous?
- 8) Is Employee entitled to interest?
- 9) Is Employee entitled to attorney fees and costs?

Results:

- 1) Yes.
- 2) Yes.
- 3) No.
- 4) Yes.
- 5) Yes.
- 6) No.
- 7) No.
- 8) Yes.
- 9) No.

Discussion:

1) The Board found Employer's three requests for cross-examination (*Smallwood* objections) were untimely because none were filed within 10 days of Employee's affidavit of readiness for hearing (ARH). It relied on 8 AAC 45.052(c)(2) and found that two requests were filed prematurely and one was filed late. The relevant regulations state in part:

- All parties have to file medical records on Medical Summaries and serve the summaries and the records on the opposing parties. Each party has a continuing duty to do this within five days of receiving new records.
- If a party files an ARH that party also has to simultaneously file a *Smallwood* objection on any medical report listed on any Medical Summaries that had been filed to that date.

- If a party served with an ARH wants to *Smallwood* medical reports listed on any Medical Summaries that had been filed to that service date, that party has to file and serve a *Smallwood* objection within 10 days after service of the ARH.
- After an ARH has been filed and until the claim is heard or otherwise resolved, all updated Medical Summaries must be accompanied by a *Smallwood* objection if the party filing the Medical Summary wants to *Smallwood* a report on it. A party served with an updated Medical Summary with the medical records listed attached wants to *Smallwood* anything on it they must do so within 10 days after service of the updated Medical Summary.
- But the main thing is, if your *Smallwood* objection “is not in accordance with this section, the party **waives** the right to request cross-examination regarding a medical report listed on the updated medical summary.”
- If you mess up and waive your right to cross-examine a medical report’s author, you can still at hearing present as your witness the medical record’s author’s testimony. In other words, you can pay for the doctors’ time and direct-examine them.

Therefore, the Board held Employer had waived its right to cross-examine those doctors on their reports that were favorable to Employee, and the reports could be considered.

2) Causation: Employee queried why the Board thought that was still an issue, since *Woodell I* and the Commission in *Woodell II* had already found that he contracted C. Diff on September 21, 2018, while at work. The chair simply told the parties to proceed. The Board found Employee raised the presumption of compensability with his testimony and with his physicians’ opinions, including those that came in because Employer had waived its *Smallwood* objections. It found that Miller’s testimony and an additional witness’ testimony were hearsay and could not support a decision. It found the EME physician’s opinions were also uncertain and inconclusive and not substantial evidence to overcome the presumption. The Board found the EME physician failed to give an alternative explanation for Employee’s C. Diff infection. He also failed to rule out work as the substantial cause of his infection. The Board found Employer did not meet the negative-evidence or the affirmative-evidence tests under *Huit*. Thus, Employee prevailed solely on the raised but un rebutted presumption.

3) The Board found Employee failed to raise the presumption on his PTD claim and had no evidence to support it; it denied his request for PTD benefits.

4) Since the Board found the C. Diff infection was work-related, Employee was entitled to TTD benefits. It ordered Employer to calculate and pay TTD benefits in accordance with the Act.

5) Employee was entitled to medical care and transportation costs and Employer was directed to provide it and reimburse other entities that had paid Employee’s work-related bills.

6) The Board found Employer’s Controversion Notice was filed in good faith and Employee was not entitled to a penalty on unpaid TTD benefits.

7) Since the Board found the controversion was in good faith, Employee’s request for an unfair or frivolous controversion finding was denied.

8) Interest is mandatory; the Board awarded it in accordance with the Act.

9) The Board found that since Employee was not represented by an attorney, he was not entitled to attorney fees or costs.

Note that one could wonder why, when the Board found that Employer failed to rebut the presumption on causation that it also found Employer's Controversion Notice was filed in "good faith." The answer is that *Woodell VII* relied on a Commission decision (*Ford*), which had interpreted an "unfair or frivolous" controversion to include an element of "subjective bad faith" on the controverter's part. About five weeks after *Woodell VII* issued, the Court in *Vue* expressly overruled that part of the Commission's analysis in *Ford*. Under *Harp*, *Runstrom* and *Vue*, when there is inadequate evidence to rebut the presumption, or to support a controversion, the Board finds an unfair or frivolous controversion and awards an associated penalty.

Employer appealed *Woodell VII*, which was a final decision, to the Commission primarily on grounds that the Board erred by not allowing Employer to cross-examine treating physicians whose reports Employer had *Smallwooded*, and in finding the evidence presented about non-existent C. Diff cases in the hospital at the time Employee asserted he contracted the disease was "contradictory and unreliable."

Woodell VIII.

Alaska Regional Hospital v. Woodell, AWCAC Dec. No. 288 (June 16, 2021).

Commission Panel: Dee Ford, James Rhodes, Steve Hagedorn

Representatives: Employee represented himself
Krista Schwarting for Employer

Issue:

Did *Woodell VII* violate Employer’s due process rights by finding it had waived its *Smallwood* objections?

Results:

Yes.

Discussion:

The Commission’s *Woodell VIII* decision, titled “final,” admitted that *Woodell I* made factual findings that were not “explicitly appealed.” Among those was a finding that on September 21, 2018, Employee “developed a C. Diff infection while working for” Employer. It further noted, “The Commission [in *Woodell II*] accepted the Board’s findings of fact in *Woodell I*.” Referring to *Woodell IV*, the Commission again stated that it “accepted the Board’s findings of fact that [Employee] contracted C. Diff while working for” Employer. The Commission cited Employee’s question at the *Woodell VII* hearing about why the Board was hearing new causation evidence when the Board [twice] had previously found that he contracted his C. Diff at work for Employer and the Commission [twice] had accepted those findings on petitions for review. It noted that the designated chair at the *Woodell VII* hearing never addressed Employee’s question.

Employer eventually had admitted Employee had C. Diff, but continued to dispute it was related to his work. Employee contended that *Woodell VII* had correctly awarded him benefits and pointed out that the Board had previously found [twice] that his C. Diff was contracted at work and that the Commission had [twice] accepted that finding. For the third time, the Commission in *Woodell VIII* “accepted the Board’s findings of fact,” which it said it had to do as they were supported by substantial evidence. It stated that at the *Woodell VII* hearing, the Board did not allow Employee to develop his argument about Employer getting a third bite at the causation apple.

The Commission said, “Although [Employer] categorized this as a question of causation, the Board, in *Woodell I*, already had made that finding of fact when it stated that [Employee] was exposed to C. Diff while working at [Employer] on September 21, 2018, in determining his notice of injury was timely.”

The Commission addressed the “law of the case” doctrine, which prohibits reconsideration of issues that had already been adjudicated in a previous appeal in the same case absent exceptional

circumstances. Here the Commission's analysis began to become more difficult to follow. It correctly noted that *Woodell I, II and III* were "focused" on the notice issue. Nevertheless, it stated, "However many of the same facts or evidence are necessary to determine whether he gave timely notice of his injury and whether his work at the hospital was the source of his C. Diff diagnosis."

Note that even if Employee was mistaken and it was ultimately determined at a merits hearing that there was no patient with C. Diff in the hospital, he was still required to give timely notice that he thought he was exposed to somebody with C. Diff. If the parties had wanted the issues in the *Woodell I* hearing to be "notice," and "causation," they could have and should have set both issues for hearing. But they did not.

The Commission continued, "Therefore, while [Employee] did attempt to raise the issue at hearing, and the doctrine of law of the case would appear to be applicable, thus, entitling him to the benefits awarded by the Board, the Commission, nonetheless, does not base its decision on this issue."

It then moved on to the question of substantial evidence to support the Board's decision at the *Woodell VII* hearing and stated, "The Commission must accept the credibility findings of the Board. Since the Board implicitly found [Employer's witnesses] not credible, the Commission must affirm the Board's award of benefits" to Employee.

The Commission then addressed the *Smallwood* issue. Employer relied on 8 AAC 45.120, which is the regulation regarding requests to cross-examine authors of *non*-medical documents. The Commission accepted Employer's argument on §.120, which states that, with exception of medical records which fall under §.052, the Board at hearing can rely on any filed and served document in the Board's possession 20 or more days before hearing, unless those documents are subject to a request for cross-examination, at least 10 days before the hearing. The Commission held that "to whom it may concern" letters are not kept in the ordinary course of a physician's practice, and while physicians sign them they are not "medical records," which would ordinarily fall under §.052 for *Smallwood* purposes. It concluded that under §.120, which applied to *non*-medical documents, Employer's three *Smallwood* objections were all timely, and *Woodell VII* violated Employer's due process rights by not allowing it the right to cross-examine the *Smallwooded* physicians. It remanded the case to the Board to allow Employer the right to cross-examine these doctors.

Note: Woodell VIII did not reverse *Woodell VII*. It remanded it to give Employer the right to cross-examine the subject medical record authors. Because it remanded to the Board, *Woodell VIII* was not a "final" decision. It was actually interlocutory according to the Court in *Huit*.

The case went back to the Board for another hearing and some cross-examination of those *Smallwooded* medical report authors.

Woodell IX.

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 22-0019 (March 16, 2022).

Board Panel: Judith Demarsh, Randy Beltz, Nancy Shaw
Representatives: Kade Woodell represented himself
Krista Schwarting for Employer

Issues:

Was the oral order continuing the hearing correct?

Results:

Yes.

Discussion:

Employee requested another hearing on his claim in October 2021. Employer had obtained two additional EMEs in October and December 2021. The Board scheduled a hearing for January 20, 2022, on Employee's remanded claim and on his request to strike the second EME's report and deposition because he had not had a fair opportunity to conduct a complete cross-examination at that physician's deposition in December.

At the January 2022 hearing, Employee testified that he had not understood that it was his responsibility to make the physicians subject of Employer's *Smallwood* objections available for cross-examination. The Board continued the hearing when Employer agreed to make its second EME available for a longer deposition in February 2022. Employer continued to assert that its due process rights had been violated because Employee had still not made physicians who wrote "to whom it may concern" opinion letters available for cross-examination.

Given the above analysis, *Woodell IX* decided that its oral order continuing the January 2022 hearing was correct. It further informed Employee that if he wanted to rely on any of his physicians' letters, he had to present the physicians for cross-examination either by deposition or at the next hearing. In other words, he had to pay for Employer's opportunity to cross-examine his physicians on their letters.

The remand hearing was continued and then rescheduled.

Woodell X.

Woodell v. Alaska Regional Hospital, AWCB Dec. No. 22-0051 (July 14, 2022).

Board Panel: Judith Demarsh, Michael Dennis, Bronson Frye

Representatives: Kade Woodell represented himself
Krista Schwarting for Employer

Issues:

- 1) Was the oral order excluding Employee's physicians' letters correct?
- 2) Does the "law of the case" doctrine apply?
- 3) Did Employee's C. Diff infection arise out of and in the course of his employment with Employer?

Results:

- 1) Yes.
- 2) No.
- 3) No.

Discussion:

The Board in *Woodell X* found that new EME physicians had performed record reviews and determined that work injury was not the substantial cause of Employee's C. Diff. Their opinions ruled out Employee's work with Employer as a substantial factor and said he was probably just a chronic carrier. Employer also presented testimony about its protocol for alerting staff if a patient has C. Diff, and how it found Employee was never exposed to a C. Diff patient. The Board found this credible; Employee had inconsistencies in his testimony that detracted from his credibility.

1) On the first issue, relying on the last Commission decision, the Board found Employee's physicians' letters were inadmissible because he had not provided cross-examination.

2) Employee contended the findings of fact, conclusions of law and orders in *Woodell VII* "cannot be altered on remand." Employer contended the "law of the case" doctrine did not apply because its due process rights had been violated in *Woodell VII*. The Board concluded that, as *Woodell VII* had relied on *Smallwooded* reports, Employer had a right to a hearing *de novo*.

3) On the causation issue, the Board applied the presumption analysis, found Employee had raised the presumption, Employer had rebutted it, and the medical evidence weighed in Employer's favor. Of course, the attending physician's reports that supported Employee's position were not considered based upon *Woodell VIII*. The Board found Employee's reports to his physicians and his testimony were not credible and gave him and his physicians' admissible opinions no weight. It found Employee was unable to prove by a preponderance of the evidence that his work injury arose out of and in the course of his employment or that employment was the substantial cause of his disability and need for medical treatment. The Board denied Employee's claim.

Undaunted, Employee appealed this decision to the Commission.

Woodell XI.

Woodell v. Alaska Regional Hospital, AWCAC Dec. No. 302 (April 19, 2023).

Commission Panel: Dee Ford, James Rhodes, Steve Hagedorn

Representatives: Employee represented himself
Krista Schwarting for Employer

Issues:

- 1) Did *Woodell X* properly apply the “law of the case” doctrine.
- 2) Was *Woodell X* supported by substantial evidence?
- 3) Was the hearing officer biased against Employee?

Results:

- 1) Yes.
- 2) Yes.
- 3) No.

Discussion:

1) The Commission in *Woodell XI* held that the “law of the case” generally applied to issues determined on appeal. Therefore, it did not apply to a hearing on remand of a prior Board decision. It considered that the Commission’s *Woodell VIII* remand “undid the findings of fact and credibility findings” in *Woodell VII*, and held that the Board properly granted a hearing *de novo*.

2) The Commission held that the Board had properly applied the presumption analysis and Employee could not prove his claim by a preponderance of the evidence. And it found that the Board had properly excluded the previously *Smallwooded* doctors’ letters. It affirmed the Board’s decision.

3) Lastly, the Board found Employee had provided no evidence that the hearing officer was biased against him. In summary, *Woodell XI* affirmed *Woodell X* in all respects.

Employee appealed this decision to the Alaska Supreme Court.

Woodell XII.

Woodell v. Alaska Regional Hospital, Slip Op. S-18740 (September 19, 2025).

Representatives: Employee represented himself
Krista Schwarting for Employer

Issues:

- 1) Was the Commission’s *Woodell VIII* decision properly before the Court?
- 2) Was the Board’s *Woodell VII* interpretation of §.052 reasonable?
- 3) If the Court reversed the Commission’s *Woodell VIII* decision, what is the proper remedy?

Results:

- 1) Yes.
- 2) Yes.
- 3) Reinstate the Board’s 2020 *Woodell VII* decision.

Discussion:

1) The Court held that the Commission’s *Woodell VIII* decision was properly before it. Even though the Commission titled that decision “final,” it was not and therefore not appealable because it remanded the case. Only after the Commission’s final decision did Employee have a right to appeal; when he did, all previous interlocutory decisions were before the Court.

2) The Court next held that *Woodell VII*’s interpretation of §.052 was reasonable. It went through a detailed explanation of the rule-making process that resulted in the Board adopting §.052, which clarified and simplified the rules related to filing evidence and requesting cross-examination of authors of different kinds of evidence. The Court found the Board’s interpretation of §.052 made more sense than the Commission’s given this history and decades of usage.

3) The Court had asked the parties to provide briefing on a remedy if the Court decided to reverse *Woodell III*. Employer insisted that *Woodell III* was not properly before the Court and the Court could not review it. Employee said that the right thing to do would be to reinstate *Woodell VII* and award a penalty against Employer for a frivolous controversion.

The Court found Employer waived any argument about the proper remedy. The Court concluded that “the Board’s 2020 decision awarding benefits should be reinstated.” However, if he wanted to pursue a penalty or other claims, Employee must use the Board process. It reversed in part the Commission’s 2021 decision (*Woodell VIII*), vacated the 2022 Board decisions entered after the Commission’s remand (*Woodell IX and X*), vacated the Commission’s 2023 decision (*Woodell XI*) and remanded to the Commission to remand to the Board with instructions to reinstate the 2020 award of compensation (*Woodell VII*) and “for further proceedings consistent with this decision.”

TAB 8



Official

ALASKA

WORKERS' COMPENSATION



MEDICAL FEE SCHEDULE

Effective January 1, 2026



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.

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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.

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

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

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

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

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

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

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

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 in 2021, 2023, 2024, and 2025 are discussed in more detail in the Evaluation and Management section of this fee schedule.

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

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

SERVICES BY OUT-OF-STATE PROVIDERS

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

DRUGS AND PHARMACEUTICALS

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

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

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

Modifier — a two-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.

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

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

Procedure — a unit of health service.

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

Properly submitted bill — is a request by a provider for payment of health care services submitted to an insurer. The provider must submit its bill and completed medical report in a form prescribed by 8 AAC 45.086. Alternately, a Physician's Report form can be found in the Fee Schedule Appendix A or at <https://www.labor.alaska.gov/wc/forms/wc6102.pdf>. The report must be submitted within 14 days after each service, see 8 AAC 45.086. Medical providers' bills must be paid within 30 days after the date the bill and a completed report are received by the insurer, whichever is later, see AS 23.30.097. Physician reports must include the information outlined in 8 AAC 45.086.

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

Prosthesis — an artificial substitute for a missing body part.

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

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

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

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

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

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

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

General Information and Guidelines

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

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

BILLING AND PAYMENT GUIDELINES

FEES FOR MEDICAL TREATMENT

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

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.03	1.500	1.545
Non-facility Practice Expense RVU x Practice Expense GPCI	1.84	1.081	1.98904
Malpractice RVU x Malpractice GPCI	0.15	0.592	0.0888
Total RVU			3.62284

Data for the purpose of example only

Calculation using example data:

$$1.03 \times 1.500 = 1.545$$

$$+ 1.84 \times 1.081 = 1.98904$$

$$+ 0.15 \times 0.592 = 0.0888$$

$$= 3.62284$$

$$3.62284 \times \$119.00 \text{ (CF)} = 431.11796$$

Payment is rounded to \$431.12

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

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

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

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

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

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

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

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

RBRVS STATUS CODES

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

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

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

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

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

ADD-ON PROCEDURES

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

The same physician or other 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 may be reported with CPT codes 99202-99215 with modifier 93 or 95 as appropriate, or may be reported with codes 98000-98015. Telehealth services should be reported with modifier 93 or 95 appended.

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

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

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

SUPPLIES AND MATERIALS

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

MEDICAL REPORTS

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

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

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

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

TREATMENT PLANS

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

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

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

MEDICAL EVALUATIONS

Medical Evaluations include Independent Medical Evaluations (IMEs), Employer Medical Evaluations (EMEs), and Second Independent Medical Evaluations

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

OFF-LABEL USE OF MEDICAL SERVICES

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

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

PAYMENT OF MEDICAL BILLS

Medical bills for treatment are due and payable within 30 days of receipt of both the medical provider's bill, and the completed medical report, that complies with regulation 8 AAC 45.086, as prescribed by the Board under Alaska Statute 23.30.097. If the medical provider's bill and medical report are not submitted at the same time, the requirement that the bill is due and payable does not begin to run until the insurance carrier has received both. Unless the treatment, prescription charges, and/or transportation expenses are disputed, the employer shall reimburse the employee for such expenses within 30 days after receipt of the bill, chart notes, and medical report, itemization of prescription numbers, and/or the

dates of travel and transportation expenses for each date of travel. A provider of medical treatment or services may receive payment for medical treatment and services under this chapter only if the bill for services is received by the employer or appropriate payer within 180 days after the later of: (1) the date of service; or (2) the date that the provider knew of the claim and knew that the claim was related to employment, see AS 23.30.097(h).

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

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

SCOPE OF PRACTICE LIMITS

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

HOME HEALTH AND IN-HOME CARE SERVICES

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

REIMBURSEMENT BY AGREEMENT

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

REIMBURSEMENT BY FEE SCHEDULE

In contrast, qualified providers, including skilled nursing services or therapies (e.g., physical therapy, occupational

therapy, or speech-language pathology), rendering care services in the home shall be subject to the Fee Schedule if they:

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

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

BOARD FORMS

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific modifiers shall be reimbursed as follows:

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

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

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

the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure.

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

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

APPLICABLE HCPCS MODIFIERS

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

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

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

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

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

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

Data for the purpose of example only

MODIFIER TC—TECHNICAL COMPONENT

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

MODIFIER QZ—CRNA WITHOUT MEDICAL DIRECTION BY A PHYSICIAN

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

STATE-SPECIFIC MODIFIERS

MODIFIER PE—PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

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

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

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

Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

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

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

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

When exact text of the AMA 2025 CPT guidelines is used, the text is either in quotations or is preceded by a reference to the CPT book, CPT instructional notes, or CPT guidelines.

BILLING AND PAYMENT GUIDELINES

TELEHEALTH SERVICES

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

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

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

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

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

MEDICAL EVALUATIONS

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

NEW AND ESTABLISHED PATIENT SERVICE

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

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

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

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

E/M SERVICE COMPONENTS

E/M COMPONENT GUIDELINES FOR CPT CODES

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

History and exam should still be documented but will be commensurate with the level required by the practitioner to evaluate and treat the patient. Prolonged E/M visit will be a covered service with CPT codes 99358-99359, 99415-99418, or HCPCS codes G0316-G0318 and G2122.

The MDM for E/M codes is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2025 MDM table are:

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

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

Straightforward: minimal number and complexity of problems addressed, minimal or no amount and/or complexity of data reviewed and analyzed, and minimal

risk of complication and/or morbidity or mortality.

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

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

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

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

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

PROBLEM

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

SUBCATEGORIES OF EVALUATION AND MANAGEMENT

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

TELEHEALTH SERVICES (98000-98016)

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

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

- Provided by a physician or qualified health care provider (QHP) who can report E/M services

- Provided to an established patient
- Initiated by the patient
- Not related to a service provided in the previous 7 days
- Does not result in an E/M or procedure within 24 hours or soonest available
- Medical discussion of 5-10 minutes duration

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

OFFICE OR OTHER OUTPATIENT SERVICES (99202–99215)

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

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

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

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

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

Only one hospital visit per day shall be payable. Hospital visit codes shall be combined into the single code that

best describes the service rendered when more than one visit by a particular provider occurs on the same calendar date in the same setting.

CONSULTATIONS (99242–99245, 99252–99255)

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

- A consultation is “a type of evaluation and management service provided at the request of another physician, or other qualified healthcare professional, or appropriate source to recommend care for a specific condition or problem.”
- Most requests for consultation come from an attending physician or other appropriate source, and the necessity for this service must be documented in the patient’s record. Include the name of the requesting physician on the claim form or electronic billing.
- The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.
- The opinion rendered and services ordered or performed must be documented in the patient’s medical record and a report of this information communicated to the requesting entity.
- Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

- When the consultant assumes responsibility for the management of any or all of the patient's care, consultation codes are no longer appropriate. Report the appropriate code for the site of service (office, home or residence, hospital inpatient or observation).
- Follow-up visits with the consultant should be reported with the appropriate subsequent or established patient codes, depending on the location.

EMERGENCY DEPARTMENT SERVICES (99281–99288)

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

CRITICAL CARE SERVICES (99291–99292)

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

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

- Critical care codes include evaluation and management of the critically ill or injured patient, requiring constant attendance of the physician.
- Care provided to a patient who is not critically ill but happens to be in a critical care unit should be identified using Subsequent Hospital Care codes or Inpatient Consultation codes as appropriate.

- Critical care of less than 30 minutes should be reported using an appropriate E/M code.
- Critical care codes identify the total duration of time spent by a physician on a given date, even if the time is not continuous. Code 99291 reports the first 30-74 minutes of critical care and is used only once per date. Code 99292 reports each additional 30 minutes of critical care per date.
- Critical care of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes should not be reported.

NURSING FACILITY SERVICES (99304–99316)

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

HOME OR RESIDENCE SERVICES (99341–99350)

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

PROLONGED SERVICES (99358–99360, 99415–99418)

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

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

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

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

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

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

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

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

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

Physician Standby Services

Code 99360 reports the circumstances of a physician who is requested by another physician to be on standby, and the standby physician has no direct patient contact. The standby physician may not provide services to other patients or be proctoring another physician for the time to be reportable. Also, if the standby physician ultimately provides services subject to a surgical package, the standby is not separately reportable.

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

CASE MANAGEMENT SERVICES (99366–99368)

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

CARE PLAN OVERSIGHT SERVICES (99374–99380)

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

TELEPHONE SERVICES

(See Telehealth Services 98000-98016)

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

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

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

99455	10.63
99456	21.25

OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

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

MODIFIERS

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

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

STATE-SPECIFIC MODIFIER

MODIFIER PE: PHYSICIAN ASSISTANTS AND
ADVANCED PRACTICE REGISTERED NURSES

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

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

Anesthesia

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

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

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

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

TIME FOR ANESTHESIA PROCEDURES

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

CALCULATING ANESTHESIA CHARGES

The following scenario is for the purpose of example only:

01382 Anesthesia for diagnostic arthroscopic procedure of knee joint

Dollar Conversion Unit = \$100.00

Base Unit Value = 3

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

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

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

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

ANESTHESIA SUPERVISION

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

ANESTHESIA MONITORING

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

OTHER ANESTHESIA

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

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

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

ANESTHESIA MODIFIERS

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

PHYSICAL STATUS MODIFIERS

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

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

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

QUALIFYING CIRCUMSTANCES

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

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

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

MODIFIERS

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

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

APPLICABLE HCPCS MODIFIERS

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

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

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

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

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

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

Modifier QX CRNA service: with medical direction by a physician—This modifier is appended to CRNA or 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

CONVERSION FACTOR

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

GLOBAL REIMBURSEMENT

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

In addition to the surgical procedure, global reimbursement includes:

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

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

FOLLOW-UP CARE FOR DIAGNOSTIC PROCEDURES

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

FOLLOW-UP CARE FOR THERAPEUTIC SURGICAL PROCEDURES

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

ADDITIONAL SURGICAL PROCEDURE(S)

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

INCIDENTAL PROCEDURE(S)

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

SUTURE REMOVAL

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

ASPIRATIONS AND INJECTIONS

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

SURGICAL ASSISTANTS

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

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

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

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

Procedure 1 (Modifier 80, AS)	\$1,350.00
Procedure 2 (Modifier 80, AS, 51)	\$1,100.00
Reimbursement	\$285.00 [(\$1,350.00 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.

PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

Procedure 1 (Modifier PE)	\$150.00
Procedure 2 (Modifier PE, 51)	\$130.00
Reimbursement	\$182.75 [(\$150.00 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 add-on code although modifiers RT or LT may be appended.

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

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

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

Example of two procedures during same surgical session:

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

Data for the purpose of example only

ENDOSCOPIC PROCEDURES

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

Example:

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

Data for the purpose of example only

ARTHROSCOPY

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific modifiers shall be reimbursed as follows:

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

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

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

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

APPLICABLE HCPCS MODIFIERS

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

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

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

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

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

Data for the purpose of example only

STATE-SPECIFIC MODIFIERS

MODIFIER PE—PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES

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

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

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

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

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

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

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

CONVERSION FACTOR

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

PROFESSIONAL COMPONENT

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

TECHNICAL COMPONENT

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

REVIEW OF DIAGNOSTIC STUDIES

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

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

WRITTEN REPORTS

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

MULTIPLE RADIOLOGY PROCEDURES

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

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

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

See example below under Reimbursement Guidelines for CPT Modifiers.

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

Data for the purpose of example only

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

Technical Component:

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

Professional Component:

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

Global Reimbursement:

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

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT—

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

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

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	0.43	1.500	0.645
Practice Expense RVU x Practice Expense GPCI	0.36	1.081	0.38916
Malpractice RVU x Malpractice GPCI	0.02	0.592	0.01184
Total RVU			1.046

Data for the purpose of example only

Calculation using example data:

$$0.43 \times 1.500 = .645$$

$$+ 0.36 \times 1.081 = 0.38916$$

$$+ 0.02 \times 0.592 = 0.01184$$

$$= 1.046$$

$$1.046 \times \$122.00 \text{ (CF)} = 127.612$$

Payment is rounded to \$127.61

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

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

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

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

BILLING AND PAYMENT GUIDELINES

PROFESSIONAL COMPONENT

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

TECHNICAL COMPONENT

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

ORGAN OR DISEASE ORIENTED PANELS

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

DRUG SCREENING

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

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT

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

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

Medicine

GENERAL INFORMATION AND GUIDELINES

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

BILLING AND PAYMENT GUIDELINES

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

CONVERSION FACTOR

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

MEDICAL REPORTS

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

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

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

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

TREATMENT PLANS

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

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

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

MEDICAL EVALUATIONS

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

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 1.66.

TELEHEALTH SERVICES

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

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

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

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

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

PHYSICAL MEDICINE

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

The initial evaluation of a patient is reimbursable when performed with physical medicine services. Follow-up evaluations for physical medicine are covered based on the conditions listed below. Physicians should use the appropriate code for the evaluation and management section, other providers should use the appropriate physical medicine codes for initial and subsequent evaluation of the patient. Physical medicine procedures include setting up the patient for any and all therapy services and an E/M service is not warranted unless reassessment of the treatment program is necessary or another physician in the same office where the physical therapy services are being rendered is seeing the patient.

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

- There is a definitive change in the patient's condition

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

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

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

TENS UNITS

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

PUBLICATIONS, BOOKS, AND VIDEOS

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

FUNCTIONAL CAPACITY EVALUATION

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

WORK HARDENING

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

HOME HEALTH AND IN-HOME CARE SERVICES

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

REIMBURSEMENT BY AGREEMENT

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

REIMBURSEMENT BY FEE SCHEDULE

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

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

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

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

Specific modifiers shall be reimbursed as follows:

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

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

The multiple procedure payment reduction (MPPR) on diagnostic cardiovascular, ophthalmology, and therapy procedures apply when multiple services are furnished to the same patient on the same day. The MPPRs apply independently to cardiovascular, ophthalmology, and physical therapy services. 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	\$598.63
93303-TC	\$400.96
93303-26	\$197.68
93351	\$650.12
93351-TC	\$384.14
93351-26	\$265.99

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

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

Alaska MAR:

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

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

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	\$36.78
[(.18 x 1.5) + (0.17 x 1.081) + (0.01 x .592)] x 80	
97024	\$20.65
[(.06 x 1.5) + (0.15 x 1.081) + (0.01 x .592)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	\$29.42
[(.18 x 1.5) + ((0.17 x 1.081) x .5) + (0.01 x .592)] x 80	
97024	\$14.16
[(.06 x 1.5) + ((.15 x 1.081) x .5) + (0.01 x .592)] x 80	

Example:

97016	\$36.78
97016 (2nd unit same date)	\$29.42
97024 (additional therapy same date)	\$14.16

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 an ending value of “T” for temporary.

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

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

CATEGORY III MODIFIERS

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

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 1.66 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 submitted manufacturer/supplier’s invoice plus 20 percent or billed charges.

DME items without a code or unvalued (i.e., \$0.00) in the DMEPOS fee schedule are still reported with the correct HCPCS code. If no code identifies the supply, bill using the appropriate unlisted HCPCS code or CPT code 99070. An invoice is required for items without stated value and reimbursement shall be the lower of the submitted manufacturer/supplier’s invoice plus 20 percent or billed charges. Rental items are reported with

modifier RR. The monthly reimbursement is the value as calculated using the invoice multiplied by 0.10. Only those DME rental items calculated using the invoice may be reimbursed at a daily rate based on the monthly reimbursement divided by 30 (multiplied by 0.0333).

Example:

Invoice amount E0218

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

Data for the purpose of example only

Alaska MAR

$\$4,219.00 \times 1.20 = \$5,062.80$

(Total Invoice $\times$ 1.20 = Alaska MAR)

Alaska MAR Rental Amount (Modifier RR)

$\$5,062.80 \times 0.10 = \506.28

(Alaska Invoice MAR $\times$ 0.10 = Alaska Invoice MAR Monthly Rental)

Alaska MAR Daily Rental Amount

$\$506.28 \times 0.0333 = \16.86

(Alaska Invoice MAR Monthly Rental $\times$ 0.0333 = \$16.86)

DME items identified in the DMEPOS schedule with a value that are rented, but listed in the DMEPOS schedule without the RR modifier should be reimbursed at the lesser of the non-modified or modified with NU value multiplied by .10 or the billed charges for each month of rental.

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician’s prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare

multiplied by 1.66. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

HEARING AIDS

The injured worker must be referred by the treating medical physician with proof of medical necessity for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes all related evaluations, tests, adjustments, repairs, or reprogramming for the life of the hearing aids. Testing conducted by the physician or clinic dispensing the hearing aids (or ordered at the request of the physician or clinic dispensing the hearing aids) to determine necessity for hearing aids is not separately reimbursable. New hearing aids may be dispensed 1) once every four years or 2) when the new medical evaluation by a treating physician and testing documents changes necessitate a new device prescription as related to the work-related injury or 3) replacement of a nonworking device that is no longer covered by warranty. Extended warranties are not reimbursable. Repairs will not be paid when a device is still under the manufacturer's warranty. An evaluation and management service shall not be billed at the time of any hearing aid evaluations or testing. The dispensing of hearing aids is reported with appropriate HCPCS Level II codes and a copy of the manufacturer/supplier's invoice. Reimbursement for hearing aids is the lower of the manufacturer/supplier's invoice cost plus 30 percent or billed charges including related testing, dispensing, evaluations, and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V5110, V5160, V5240, and V5241 are not separately reimbursed services. All accessories and supplies are reimbursed at 20 percent above manufacturer's/supplier's submitted invoice.

HEARING AID SERVICES

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

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

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

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

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

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

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

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

SURGICAL SERVICES

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

- Anesthesia administration materials and supplies
- Blood, blood plasma, platelets, etc.
- Drugs and biologicals
- Equipment, devices, appliances, and supplies

- Use of the outpatient facility
- Nursing and related technical personnel services
- Surgical dressings, splinting, and casting materials

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

DRUGS AND BIOLOGICALS

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

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

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

EQUIPMENT, DEVICES, APPLIANCES, AND SUPPLIES

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

Example:

- Syringe for drug administration
- Patient gown
- IV pump

SPECIALTY AND LIMITED-SUPPLY ITEMS

Particular surgical techniques or procedures performed in an outpatient facility require certain specialty and limited-supply items that may or may not be included in

the comprehensive outpatient facility fee allowance. This is because the billing patterns vary for different outpatient facilities.

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

DURABLE MEDICAL EQUIPMENT (DME)

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

Example:

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

See the HCPCS section for DME reporting guidelines.

USE OF OUTPATIENT FACILITY AND ANCILLARY SERVICES

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

NURSING AND RELATED TECHNICAL PERSONNEL SERVICES

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

SURGICAL DRESSINGS, SPLINTING, AND CASTING MATERIALS

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

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

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

Example of Implant Outlier:

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

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

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

Any additional payments for high-cost acute care inpatient admissions are to be made following the methodology described in the Centers for Medicare and Medicaid Services (CMS) final rule 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, 2026, 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
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.

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

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

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

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

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

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

DATE OF SERVICE RECOMMENDATION

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

EXAMPLE

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

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

CMS.gov

Web Pricer

Inpatient PPS

Enter claim

Estimate

Clear

1. Required Fields

Provider number (Required)

between 6 - 13 characters, for example: 01W234

020001

Admit date (Required)

For example: 04/01/2020

01/20/2025

Discharge date (Required)

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

01/23/2025

Covered charges (Required)

For example: \$50,000.00

\$35,000.00

Covered days (Required)

Must be greater than lifetime reserve days

3

Diagnosis related group (DRG) (Required)

3 digit code, for example: 123

462

2. Additional Codes

National drug code (NDC)

9 to 11 digit code

NDC #1

NDC #2

Procedure Code

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

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The IPPS Web Pricer instructions are included below:

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

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

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

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

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

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

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

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

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

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

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

CONDITION CODE – Enter the condition code when required

LIFETIME RESERVE DAYS – not required to be entered.

TRANSFER STATUS – Select the correct option from

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

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

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

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

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

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

Review results

Edit ClaimClear

Summary

Calculation version2025.1

Return code14

Description: PAID DRG WITH PERDIEM

Key claim information

Provider number020001

Effective date10/01/2024

Diagnosis related group (DRG)462

Claim estimate

Claim estimate with provider adjustments\$26,435.75

Outlier calculation\$0.00

Grand total amount\$26,435.75

The estimate is based on submitted claim info

Download CSV

Provider details

Provider type00

Geographic CBSA11260

Reclassification CBSA--

Capital amounts

Capital federal specific portion\$1,690.63

Capital outlier--

Capital disproportionate share hospital\$147.42

Capital indirect medical education\$35.92

Claim information

Admit date01/20/2025

Discharge date01/23/2025

Length of stay3

Covered days3

Lifetime reserve days0

Regular days3

Covered charges\$35,000.00

Review code00

National drug code (NDC)--

Procedure Code--

Diagnosis Code--

Condition Code--

Cost outlier thresholdNo

HMO paid claimNo

Operating amounts

Operating federal specific portion\$21,815.93

Operating hospital-specific payment\$0.00

Operating outlier\$0.00

Operating disproportionate share hospital\$1,269.14

Operating indirect medical education\$605.12

Uncompensated care amount\$614.05

Readmission adjustment\$-8.73

Value-based purchasing adjustment\$107.12

New technology--

Review results

Edit ClaimClear

PPS factors & adjustments	
Operating cost to charge ratio	0.193
Capital cost to charge ratio	0.012
Operating disproportionate share hospital percent	0.2327
Capital disproportionate share hospital percent	0.0872
National labor	\$4,478.09
National non labor	\$2,145.30
Inpatient Wage Index	1.1164
Inpatient DRG Weight	2.6638
Inpatient DRG geometric mean average length of stay	2.2
Readmission adjustment factor	0.9996
Value-based purchasing adjustment factor	1.0049100576
Bundle percent	0
Electronic health record reduction indicator	--
Hospital-acquired condition reduction indicator	N
Cost outlier threshold amount	\$0.00

Pass-through amounts	
Capital	--
Direct medical education	\$53.05
Organ acquisition	\$0.00
Allogeneic Stem Cell Acquisition	\$0.00
Supply Chain Costs	--
Total pass-through & miscellaneous	\$53.05
Estimated total pass-through amount	\$159.15

Other PPS amounts	
Hospital acquired condition adjustment	--
Low-volume payment adjustment factor	--
Islet add-on	--
Electronic health record adjustment	--
Bundle adjustment	--

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

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

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

DETERMINING THE FINAL MAXIMUM ALLOWABLE REIMBURSEMENT (MAR)

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

CMS IPPS Web Pricer Grand Total Amount	\$26,435.75
Multiplied by Providence Alaska Medical Center multiplier	<u>x 2.38</u>
Alaska Workers' Compensation Payment	\$62,917.09

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, Division of Health Care Services.

Appendix A

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

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

PHYSICIAN'S REPORT

AWCB Case Number

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

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

SEE INSTRUCTIONS ON BACK

INSTRUCTIONS TO PHYSICIANS:

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

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

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

INSTRUCTIONS TO EMPLOYEE:

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

[illegible]

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

Appendix B

Workers' Compensation Medical Fee Schedule Acronyms

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

TAB 9

Alaska Department of Labor and Workforce Development
Division of Workers' Compensation
Submitted via email to workerscomp@alaska.gov



October 16, 2025

Re: Solicitation for Public Input – Workers' Compensation Regulatory Revisions

MyMatrixx, an Evernorth Company, appreciates the opportunity to submit comments in response to the Division of Workers' Compensation's recent solicitation for public input on potential workers' compensation regulatory revisions. By way of background, MyMatrixx provides pharmacy benefit management services to several insurers, self-insured employers and third-party administrators specifically in the workers' compensation market. Our strategic approach includes structuring customized client solutions around best-in-class core services, supported by advanced trend-management and clinical-review programs, to ensure safety for injured workers, while aggressively controlling costs.

MyMatrixx recommends the Division remove the following statement found in 8 AAC 45.081(e): "The Alaska Medicaid Preferred Drug List, Version 111809, revised as of November 18, 2009, is adopted by reference as the preferred drug list for purposes of the Act." That statement refers to an old version of the state's Medicaid Preferred Drug List (PDL). While we support the use of evidence-based medicine in workers' compensation, including the use of drug formularies, we do not believe there is any practical reason for still referencing this outdated Medicaid PDL. Should the Division consider potential adoption of a current and relevant drug formulary for use in workers' compensation claims, we would be happy to assist as an interested stakeholder with years of experience using drug formularies in workers' compensation systems across the country.

MyMatrixx thanks the Division for seeking stakeholder input, and we appreciate your consideration of our comments. If you have any questions regarding our comments, please contact me for further discussion.

Sincerely,

Adam Fowler
Director, Workers' Compensation Regulatory Affairs
MyMatrixx by Evernorth
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