ALASKA WORKERS' COMPENSATION BOARD MEETING

October 12-13, 2023

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TAB 1

ALASKA WORKERS' COMPENSATION BOARD MEETING AGENDA

OCT 12-13, 2023

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

DIVISION OF WORKERS' COMPENSATION

Zoom Video Conference: https://us02web.zoom.us/j/87057211027

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

Thursday, Oct 12, 2023

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 18 and 19, 2023, 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 Old Business
- Adoption of Regulations
  - 8 AAC 45.410 Eligibility of rehabilitation specialist
  - 8 AAC 45.420 Rehabilitation specialist application
  - 8 AAC 45.435 Review of rehabilitation specialists
  - 8 AAC 45.440 Removal of rehabilitation specialists
  - 8 AAC 45.500 Reporting requirements
  - 8 AAC 45.083 Medical Treatment Fee Schedule for 2024

12:00pm Lunch Break

1:30pm Old Business Continued

2:00pm 2022 Annual Report
- Workers' Compensation – Velma Thomas, Program Coordinator
- Special Programs - Velma Thomas, Program Coordinator

3:00pm Break

3:15pm 2022 Annual Report Continued
- Reemployment Benefits Overview – Stacy Niwa, Reemployment Benefits Administrator
- Workers' Compensation SIU Overview – Michele Wall-Rood, Chief Investigator of Special Investigations Unit

5:00pm Adjournment

Friday, Oct 13, 2023

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

9:10am 2022 Annual Report Continued
- Annual Report Workers' Compensation Case Review - William Soule
- SIME Annual Report - Dani Byers, SIME Coordinator

10:00am New Business
- Supreme Court Rule No 2012
- Proposed Regulation Updates
- Report from RBA on SAW/RTW project

10:30am Break

10:45am New Business Continued

12:00pm Lunch Break

1:30pm New Business – If Needed

3:30pm Break

3:45pm New Business - If Needed

5:00pm Adjournment

TAB 2

Workers' Compensation Board
Meeting Minutes
May 18-19, 2023

Thursday, May 18, 2023

I. Call to Order

Workers' Compensation Director Charles Collins called the Board to order at 9:03 am on Thursday, May 18, 2023. The meeting was held in Anchorage, Alaska, and by Zoom video conference.

II. Roll call

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

Brad Austin	Randy Beltz	John Corbett	Micheal Dennis
Sara Faulkner	Bronson Frye	Steven Heidemann	Anthony Ladd
Sarah Lefebvre	Marc Stemp	Robert Weel	Lake Williams

Director Collins noted that Pamela Cline and Jonathon Dartt were excused. Members Randy Beltz and Sarah Lefebvre arrived after the roll call. A quorum was established.

III. Agenda Approval

A motion to approve the agenda was made by member Stemp and seconded by member Weel. A unanimous vote approved the agenda.

IV. Approval of Meeting Minutes

A motion to adopt the minutes from the February 23, 2023 Board Meeting was made by member Weel and seconded by member Frye. The minutes were adopted without objection.

V. Director's Report

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

Director Collins reviewed the Board Roster and discussed active legislation. Director Collins provided an overview of the Benefits Guaranty Fund sweep. The Board requested that the Director draft a Resolution for review at the October 2023 Board Meeting, to support legislation to designate the BGF as an unsweepable Designated Fund.

A motion to accept the 2024 Hearing Calendar was made by member Frye and seconded by member Weel. The motion passed unanimously.

Break 10:00am-10:15am

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

Penny Helgeson – Retired Workers' Compensation Officer

- Supported the proposed regulation changes.
- Stated most specialists do their work well and timely, however there are outliers who do not. The burden falls with the Division to ensure statutes and regulations are being followed appropriately and promptly.

Janice Shipman, Rehabilitation Specialist

- Requested training specific to Decisions and Orders.
- Disagreed with requirement to submit bills to the Division. Stated there is no definition of fraudulent billing and no evidence that fraudulent billing occurs.
- Agreed with Ms. Helgeson that RB Specialist was already defined.

Jackie Doerner, Rehabilitation Specialist

- Submitted written public comment.
- Agreed with Ms. Helgeson.
- Supported the proposed regulation changes.

Dan LaBrosse, Rehabilitation Specialist – representing DAL Enterprises, LLC

- Submitted written public comment.
- Opposed the proposed regulation changes.

Josetta Cranston, Rehabilitation Specialist – representing Northern Country Services

- Submitted written public comment.
- Opposed the proposed regulation changes.
- Supported training from the Division.

Patti Wilson – representing UAS Self-Insured Program

- Supported the Board Resolutions related to Reemployment Benefits.

VII. Director's Report Continued

In response to public comment, the Board discussed Resolutions that have been issued regarding the Reemployment Benefits program.

Administrative Officer Alexis Hildebrand provided an overview of Division staffing and the IAIABC Modernization project.

Chief Investigator Rhonda Gerharz announced her retirement and held a Q&A session with the Board.

Lunch Break 12:00pm-1:33pm

VIII. Reemployment Presentation

Reemployment Benefits Administrator Stacy Niwa and Rehabilitation Specialist Loretta Cortis presented the Reemployment Benefits process.

Break 2:43pm-2:55pm

IX. Reemployment Benefits 2022 Annual Report

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

Meeting Adjourned 3:30 pm

Friday, May 19, 2023

I. Call to Order

Director Collins resumed the Alaska Workers' Compensation Board meeting at 9:06 am on Friday, May 19, 2023, in Anchorage, Alaska and by Zoom video conference. The following Board members were present.

Bradley Austin	John Corbett	Mike Dennis	Sara Faulkner
Bronson Frye	Anthony Ladd	Sarah Lefebvre	Marc Stemp
Robert Weel	Lake Williams		

Director Collins noted that members Randy Beltz, Pam Cline, Jonathon Dartt and Steve Heidemann were excused. A quorum was established.

II. Old Business

Amend 8 AAC 45.410 through 45.900, relating to reemployment benefits. Member Lefebvre moved to adopt the amendment of 8 AAC 45.410 through 45.900. Member Weel seconded the motion. The Board discussed the motion.

Break 9:54 am - 10:16 am

Member Lefebvre retracted her original motion and moved to adopt the amendment of 8 AAC 45.410 through 45.900 to include non-substantive grammatical changes, to delete reference to "or (11)" in 8 AAC 45.440(f)(2) and to insert a new subsection under 45.440(f) as follows: "For acts under 8 AAC 45.440(a)(11) of this section, disqualify the rehabilitation specialist until such a time as they are deemed competent by a court of competent jurisdiction." Member Weel seconded. The motion passed unanimously.

Director Collins reminded the Board members that the Joint meeting of the Board and the Medical Services Review Committee is August 25, 2023, and the next regular board meeting is October 12-13, 2023. Motion to adjourn was made by member Frye and seconded by member Weel. The motion passed unanimously.

Meeting Adjourned 10:33am

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	1st Judicial District	Plumbers and Pipe Fitters Local 262
Debbie White	Industry	1st Judicial District	
Randy Beltz	Industry	3rd Judicial District	
Pamela Cline	Labor	3rd Judicial District	Intl. Brotherhood of Electrical Workers LU 1547
Mike Dennis	Industry	3rd Judicial District	
Sara Faulkner	Industry	3rd Judicial District	
Bronson Frye	Labor	3rd Judicial District	Painters and Allied Trades Local 1959
Steven Heidemann	Labor	3rd Judicial District	
Anthony Ladd	Labor	3rd Judicial District	
Mark Sayampanathan	Industry	3rd Judicial District	
Marc Stemp	Industry	3rd Judicial District	
Vacant	Labor	3rd Judicial District	
Sarah Lefebvre	Industry	2nd/4th Judicial District	Colaska
Lake Williams	Labor	2nd/4th Judicial District	Operating Engineers Local 302
Jonathon Dartt	Industry	2nd/4th Judicial District	
John Corbett	Labor	2nd/4th Judicial District	Laborers Local 942
Bob Weel	Industry	At Large	
Vacant	Labor	At Large	

TAB 4

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Labor and Workforce Development

DIVISION OF WORKERS' COMPENSATION

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

BOARD DESIGNEES – October 2023

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

NAME	LOCATION	POSITION TITLE
Charles Collins	Juneau	Director
Vacant	Juneau	Chief of Adjudications
William Soule	Anchorage	WC Hearing Officer II
Janel Wright	Anchorage	WC Hearing Officer II
Vacant	Anchorage	WC Hearing Officer I/II
Vacant	Anchorage	WC Hearing Officer I/II
Kyle Reding	Anchorage	WC Hearing Officer I
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
Shannon Sanderson	Anchorage	WC Officer II
Amanda Johnson	Anchorage	WC Officer I
Rosanna Mallari	Anchorage	WC Officer I
Dani Byers	Juneau	WC Officer II
Amy Bender	Fairbanks	WC Officer II

TAB 5

Workers Compensation Division

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

Board News

AWCB has no new members since our last meeting, vacancies are in the 3rd District or Anchorage area, one Labor and the at large Labor seat is vacant.

Please take time to check with staff on hearing dates and needs for panel members.

Legislative News

This year the Legislature has stayed very active in the operations and outcomes in workers compensation.

Senate Bill 147, "An Act relating to reemployment rights and benefits."

This bill implements many changes in AS 23.30.041, a number of those changes have been pushed by this Board and are finally getting noticed. SB 147 has been assigned to the Senate Labor and Commerce committee and several members of this committee have asked for information about the proposed changes. I worked with Senator Bjorkman and his staff to explain the bill and possible amendments for the committee to consider. Recently, RBA Niwa and I met with Senator Gray-Jackson and supplied those amendments to this bill. Both of those meetings were productive. I met with Senators Kaufman and Bishop to explain our position and I am confident that the Senate is agreeable to amending AS 23.30.041.

House Bill 63 and Senate Bill 60, "An Act 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; repealing rules…"

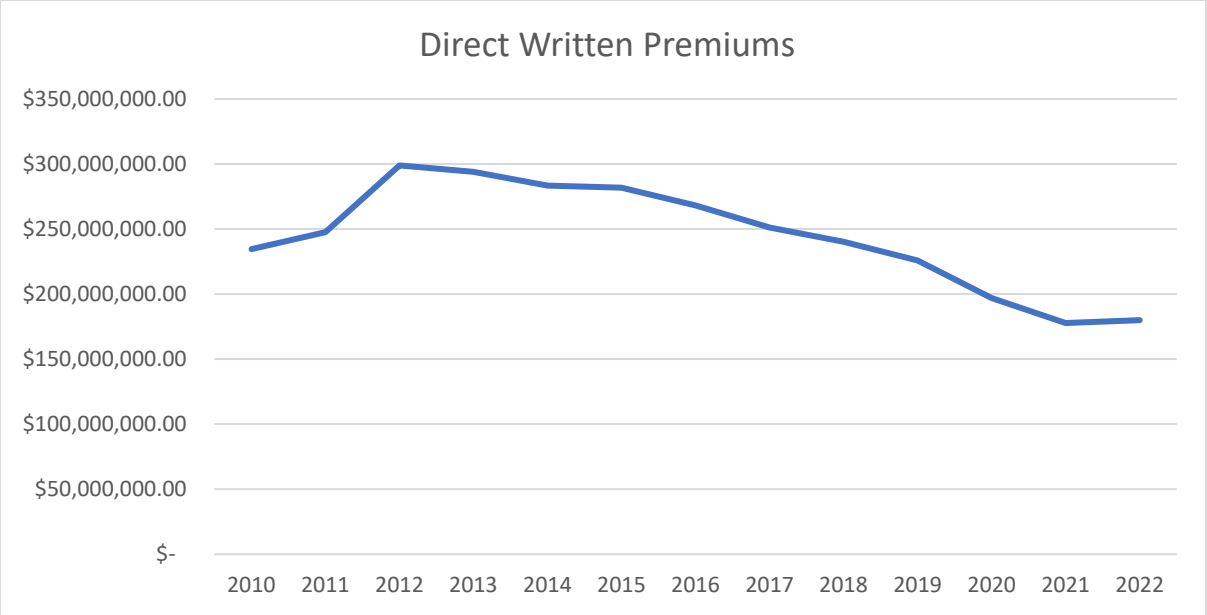
These bills are in the respective judicial committees and have passed the labor and commerce committee of both the House and Senate. Discussion has continued over the summer on both bills as there seems impetus to change from the WCAC to another process, but confusion on the best path forward.

Possible bill action, meetings with Senate labor and commerce committee on protecting the Benefit Guaranty Fund may result in action to protect the Fund from further sweep action.

Division News

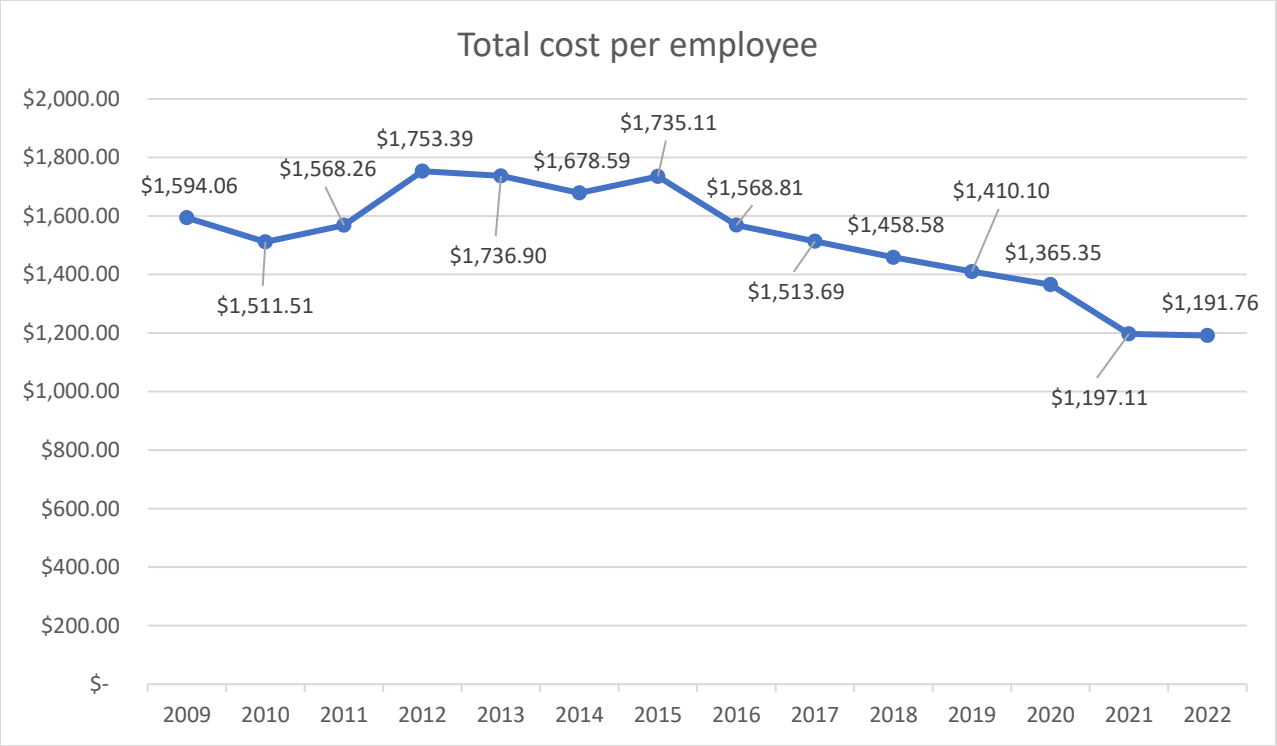
The Division is also concurrently advertising for Hearing Officer positions to fill the openings in Anchorage and Fairbanks. Currently there are three open positions, and the Chief position is also vacant. The Division continues to achieve the goal of resolving at least 90 percent of all claims and petitions without a formal hearing. The less complex issues are resolved at prehearing conferences by Workers' Compensation Officers and Hearing Officers. Many of the more contentious cases with difficult parties are resolved through mediation, which saves the parties and the division hours of hearings and weeks of work for a Hearing Officer and board panel. For example, in FY2023, the division's mediation program successfully mediated all but two of the cases brought to mediation by the parties.

I am monitoring the decision of the Division of Insurance regarding workers' compensation premiums. The National Council on Compensation Insurance, (NCCI), has recommended a -10.4% reduction in the voluntary market and a -12.4% reduction in the assigned risk market for 2024. This will make the fourteenth year of consecutive rate reductions for the voluntary market. This does not mean that a certain business will pay less than the preceding year in premiums as this is only one part of the components that make up the cost of insurance. Classification rates, experience modules, payroll amount, and even payment plans all impact the premium and influence the actual amount a business may pay annually. However, the big picture shows an improvement in costs to employers.



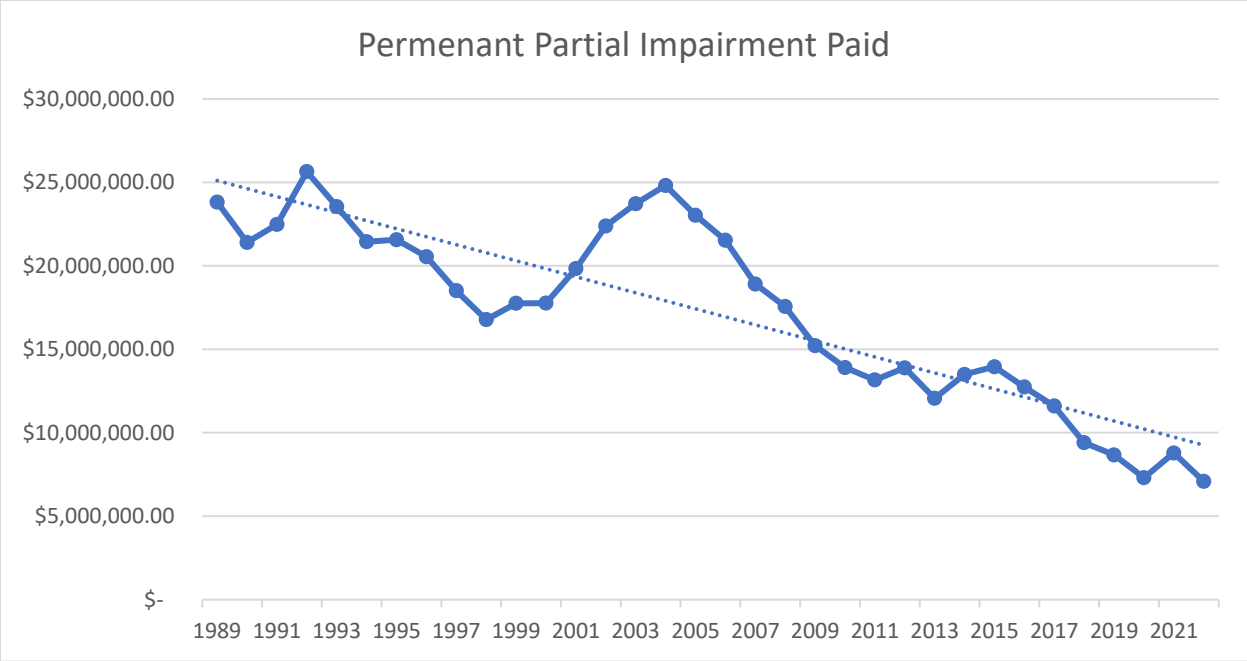
How does affect the division and of course the Workers, Safety and Compensation Administrative Account, (WSCAA)? AS 23.05.067(a)(2) sets a 2.5% service fee on all premiums annually, as premiums decrease the divisional revenue also decreases. WCD is a victim of our success, by saving the system money we also hinder our revenue stream and must continue to budget prudently. As an addendum, the Legislature has these past sessions, swept the WSCAA fund and allocated back General Funds to cover our operating expense. This is a change in how WC has been funded in the past and makes the Division susceptible to funding issues as General Funds become challenging to acquire.

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



While still an expense to employers, however, the facts show that the cost of providing benefits and coverage for Alaskan employees has declined considerably these last seven years. The average cost for benefits and premiums paid annually per $100.00 of payroll has dropped to $1.86. This is the lowest level we have on record in Alaska.

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



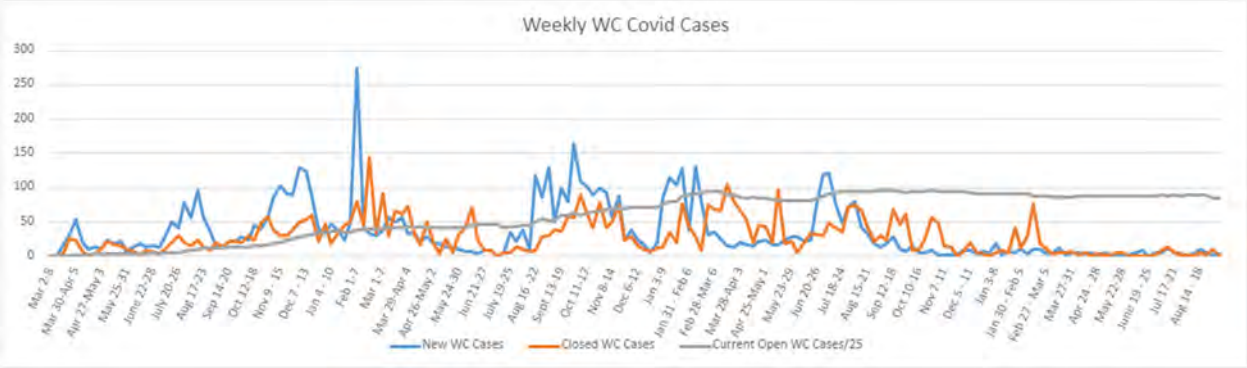
Further cost impacts may manifest with the large infrastructure plans being implemented in the state. With a forecast of more projects requiring heavy labor and trade positions, a workforce that is aging and a possibility of more workers engaging in new careers, the costs to the system and the premiums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

Breaking News

Investigator Christine Christensen followed a lead on an employer who claimed no employees and only using independent contractors at a Home Health Care business and found more than just uninsured employees. Due to Christine's diligent research allegations of fraud were uncovered, this led to Christine alerting the IRS, Medicare Fraud Control, and the Municipality of Anchorage. The principal of the business, Rosalina Mavaega, was an appointed member of the Anchorage Housing and Homelessness Committee and on the Equal Rights Commission. Due to Special Investigator Christine Christensen's investigation, the business and owners now have been indicted for fraudulent use of $1.6 million in COVID-19 relief funds.

COVID

Through September of 2023 Alaska Covid numbers reported under Alaska Workers' Compensation.



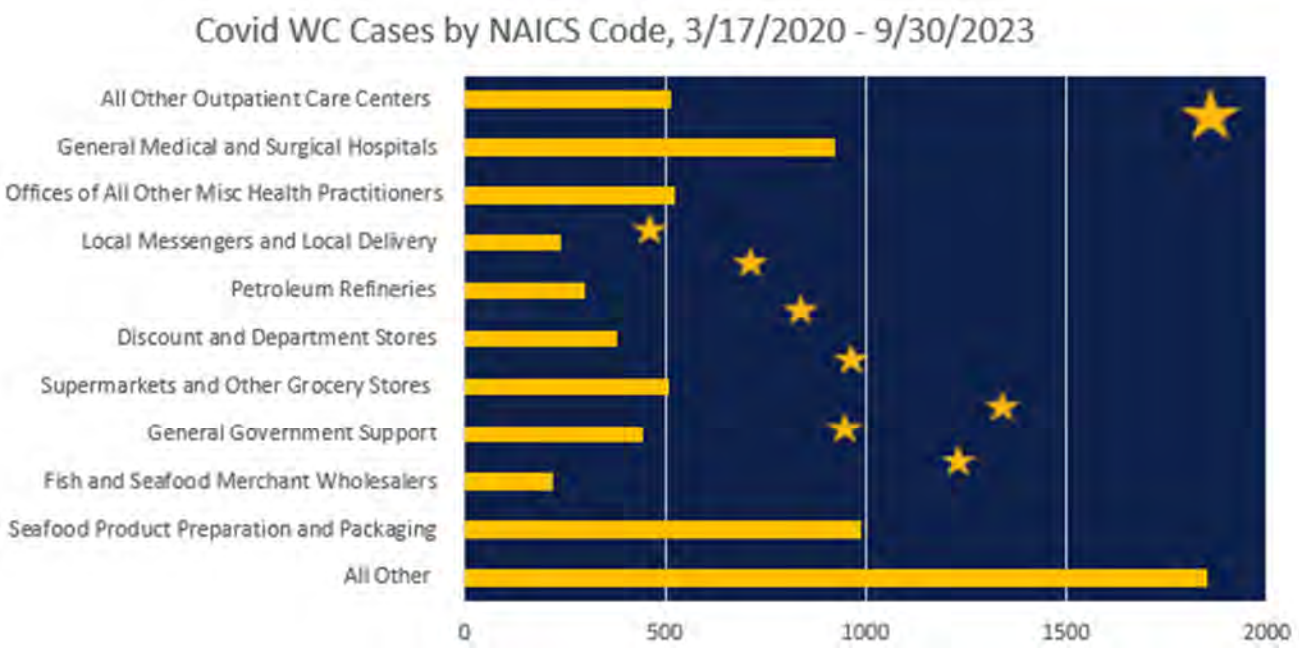
Opened	Closed	Current	Paid	BTC to date	OBT to date	EP to Date	Deaths*
6903	4792	2111	3172	$7,482,229.33	$8,453,286.02	$1,238,073.83	22

BTC – benefit type code such as temporary or permanent disability, death, or lump sum settlements.

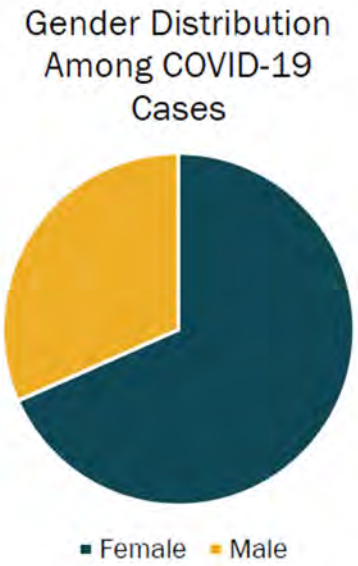
OBT – other benefit type such as penalties, interest, other medical, or rehabilitation evaluation.

EP - employer paid.

As you can see from the chart, Covid claims have dropped to very low levels over this summer season. The Division still monitors the trends as other jurisdictions have inquired about numbers and the increase of long Covid issues. The higher percentage of claims currently is in health care and first responder job classes as shown:

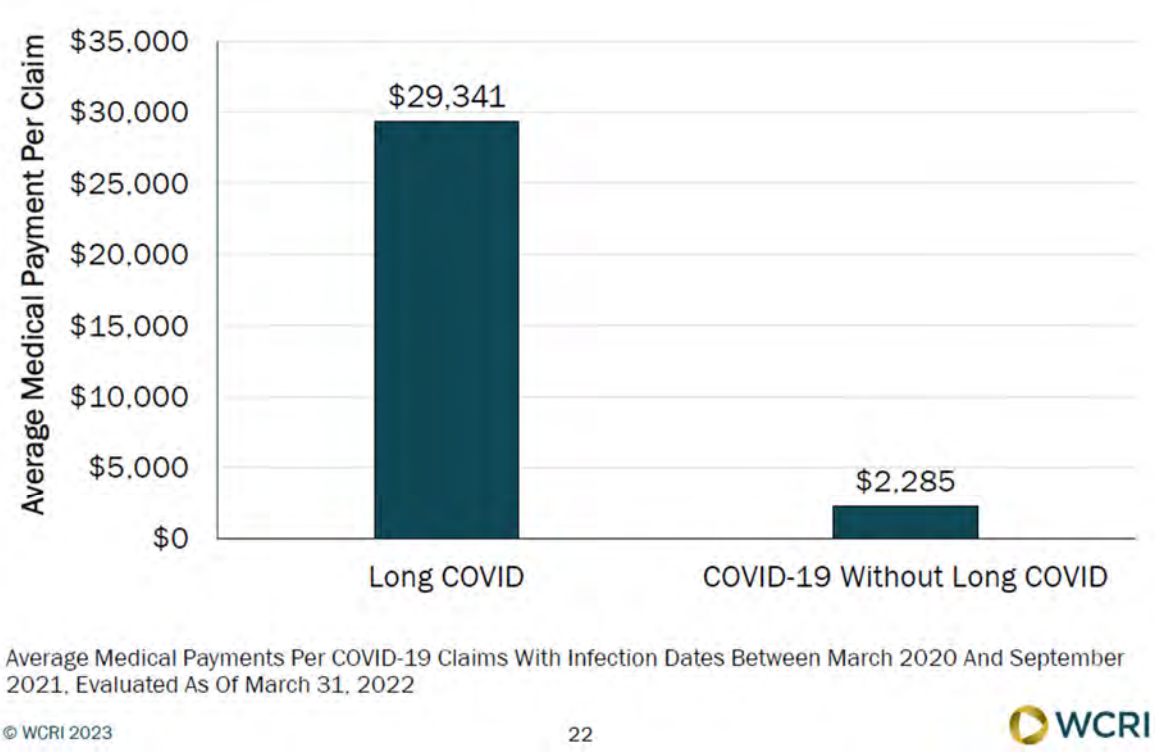


Country wide 68% of Covid claims are from healthcare businesses. This may account for the reason for women to have more claims for Covid related injury than men. Currently, women are over twice as likely to contract Covid in the workplace as men.



The Workers Compensation Research Institute recently released a study on the impact of long Covid upon the Workers Compensation System. The research shows that about 6% of workers that were infected with Covid-19 developed symptoms of long Covid. Another interesting statistic is that the percentage of workers developing long Covid symptoms is

dropping. The concern is the cost of the claim, long Covid has dramatically increased costs over claims for non-long Covid.



Stay-at-Work/Return-to-Work

In 2021 there were 4.26 million workplace medically consulted injuries reflecting a cost of $167.0 billion dollars according to the National Safety Council. The chance of injured workers returning to work drops dramatically with longer absences. A worker off 20 days has a 70% chance of returning to work, this drops to 35% if absent more than 70 days. Early intervention and communication are critical to the return-to-work process.

With the struggles Alaska has with the current system for reemployment and rehabilitation, a critical look at our system is in order. Our RBA, Stacy Niwa, and I have spent this summer working with experts both in state and out of state on a plan for SAW/RTW in Alaska. Recently, we have had conversations with several legislators on formulating a plan for adjusting reemployment to allow for an increase in SAW/RTWQ programs. As we continue to research ideas and plans, both from other states and even private entities, it has become apparent this is a massive undertaking.

Circular

National Council on Compensation Insurance | State Relations—Regulatory Services

AUGUST 23, 2023 | AK-2023-01

LOSS COSTS OR RATE FILING

Alaska–Voluntary Loss Costs, Assigned Risk Rates, and Rating Values, Proposed to Be Effective January 1, 2024

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.

The Trend Information—Rate Filing Supplement will soon be posted on **ncci.com** under the Publications/Reports section on the Industry Information page.

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, 2024, for new and renewal policies.

Please note the following in connection with this filing:

- **At the time of filing production, the Servicing Carrier Allowance expense provision of the assigned risk market for Policy Year 2024 was not available due to the servicing carrier bid process timeline, thus this filing does not include assigned risk rates for each job classification code (and other values). The provisional overall assigned risk rate level change reflects a provisional Servicing Carrier Allowance. After the assigned risk Servicing Carrier Allowance is available and the loss cost are approved for Policy Year 2024, NCCI will calculate assigned risk rates by class code (and other values)**
- As a result of Item B-1397, effective January 1, 2008, a single combined loss cost is still calculated for Class Codes 7710 and 7711 via a payroll-weighted average of the separately indicated loss costs for these two class codes.
- The updated experience rating plan parameters reflect the methodology enhancements from Item E-1409.
- As a result of Item E-1410, claims attributable to COVID-19 with accident dates on or after July 1, 2023 will be included in experience rating calculations. Experience modifications calculated using the values on the following pages which are effective beginning July 1, 2024* and subsequent have the potential to be affected by COVID-19 claim experience.
- As a result of Item R-1421, the retrospective rating plan parameters have been updated.

*In certain rare circumstances, a few experience modifications effective as early as March 16, 2024 may be affected.

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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 10.4% in the voluntary loss cost level and a provisional decrease of 12.4% 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

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Department of Law
Anchorage, Alaska
STATE OF ALASKA
PRESS RELEASE

For Immediate Release

Medicaid Provider Abdoulie Lowe Indicted for Fraud Against Alaska Medicaid Program

Aug. 3, 2023 (**Anchorage, AK**) – On Tuesday, the Anchorage grand jury indicted Medicaid provider Abdoulie Lowe who was doing business as Apapa Assisted Living Home for alleged fraud against the Alaska Medicaid program.

The charges stem from conduct between October 2021 and April 2023 when Mr. Lowe is alleged to have:

- obtained nearly $800,000 in Medicaid reimbursements without the legally-required documentation of the services he was claiming to provide

- submitted additional Medicaid claims totaling more than $7,000 for services that Mr. Lowe claimed to provide to recipients in his care when he was actually working elsewhere.

For this conduct, the grand jury indicted Mr. Lowe on six felony counts of medical assistance fraud and one felony count of theft in the second degree. The State of Alaska also charged Mr. Lowe with failing to maintain workers' compensation insurance for his employees.

The charges are only allegations and are not evidence of guilt. Mr. Lowe is presumed innocent and is entitled to a fair trial at which the prosecution must prove guilt beyond a reasonable doubt.

The most severe felony charges of medical assistance fraud against Mr. Lowe carry a possible sentence of up to 10 years in prison, a fine of up to $100,000, and restitution to the State of Alaska Medicaid program. A conviction on any of these charges can lead to Mr. Lowe's exclusion from the Medicaid program.

This case has been jointly investigated by the Alaska Department of Law, Alaska Department of Health - Division of Senior and Disabilities Services, Alaska Department of Health - Division of Health Care Service - Residential Licensing Section, Alaska Department of Labor and Workforce Development - Division of Workers' Compensation, the Federal Bureau of Investigation, and U.S. Customs and Border Protection. This

investigation stands as an example of how state and federal agencies cooperatively and aggressively detect and investigate suspected fraud and are dedicated to vigorous enforcement of the laws that protect the integrity of our public health care programs.

Citizens with information about suspected medical assistance fraud or patient abuse or neglect are encouraged to contact the Alaska MFCU at its website, or by phone at (907) 269-6279.

The Alaska Medicaid Fraud Control Unit (MFCU) is part of the Alaska Department of Law Office of Special Prosecutions. It is responsible for the investigation and prosecution of fraud on the Medicaid program and the abuse, neglect, or financial exploitation of patients in any facility that accepts Medicaid funds. The Alaska MFCU receives 75% of its funding from the U.S. Department of Health and Human Services under a grant award. The remaining 25% is funded by the State of Alaska.

Case Contact: Assistant Attorney General Maeve Kendall at (907) 269-6279 or maeve.kendall@alaska.gov.

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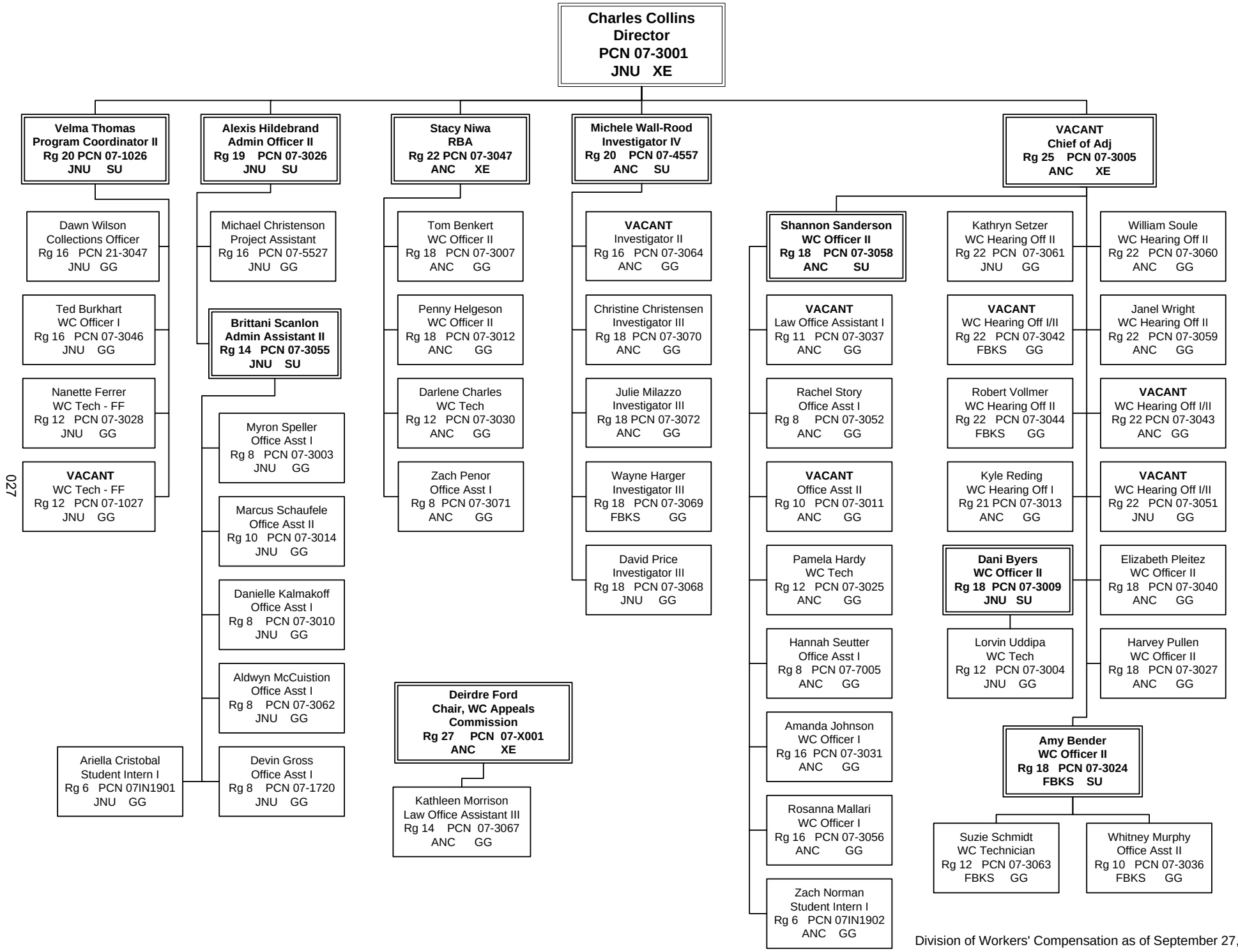
Department Media Contact: Communications Director Patty Sullivan at (907) 269-6368 desk, cell (907) 310-7490 or patty.sullivan@alaska.gov



027

Division of Workers' Compensation as of September 27, 2023

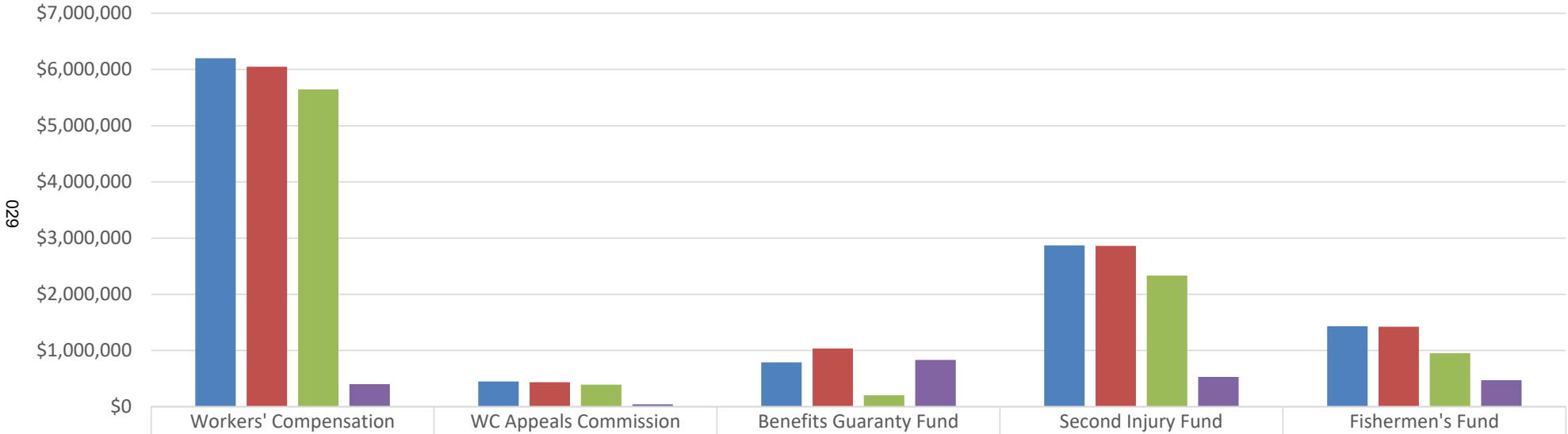
FY2023 Budget Report

Alaska Department of Labor and Workforce Development
Workers' Compensation Division

028

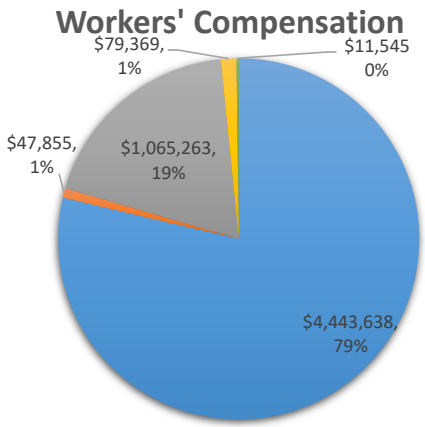
Catherine Muñoz Acting Commissioner

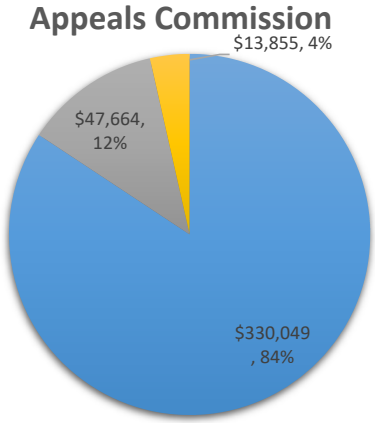
FY2023 Budget
Authority vs Actual Expenditures

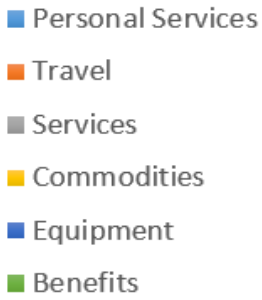


	Workers' Compensation	WC Appeals Commission	Benefits Guaranty Fund	Second Injury Fund	Fishermen's Fund
FY24 Budget	$6,200,200	$447,600	$787,800	$2,870,200	$1,431,400
FY23 Budget	$6,048,600	$435,500	$1,034,400	$2,862,600	$1,423,100
FY23 Actuals	$5,647,670	$391,564	$201,881	$2,332,979	$951,843
FY23 Balance	$400,930	$43,936	$832,519	$529,621	$471,257

FY23 Line Item Breakdown







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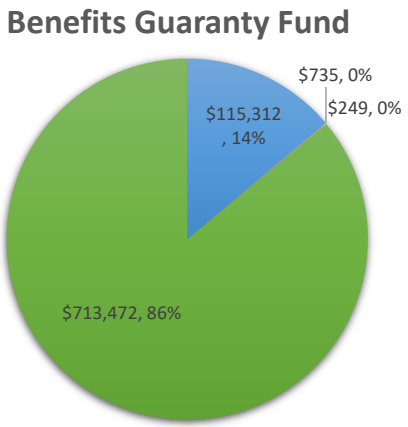
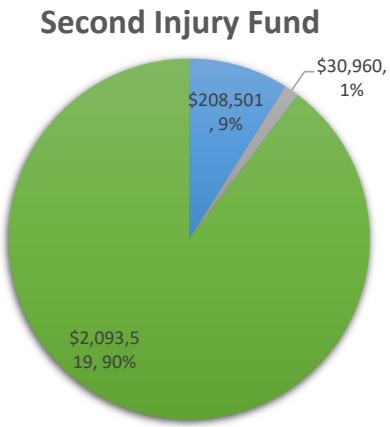
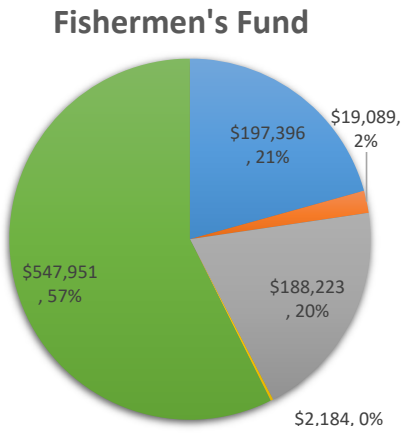
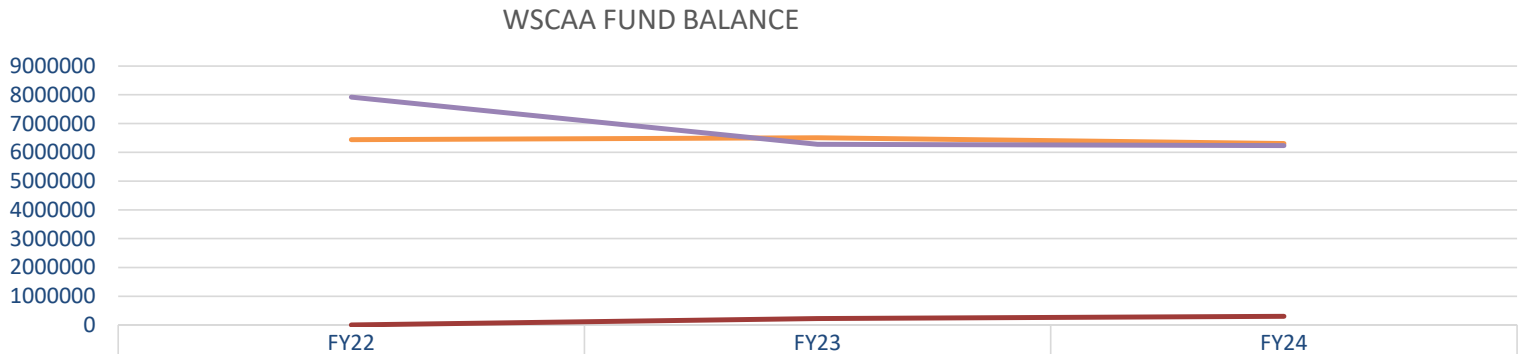




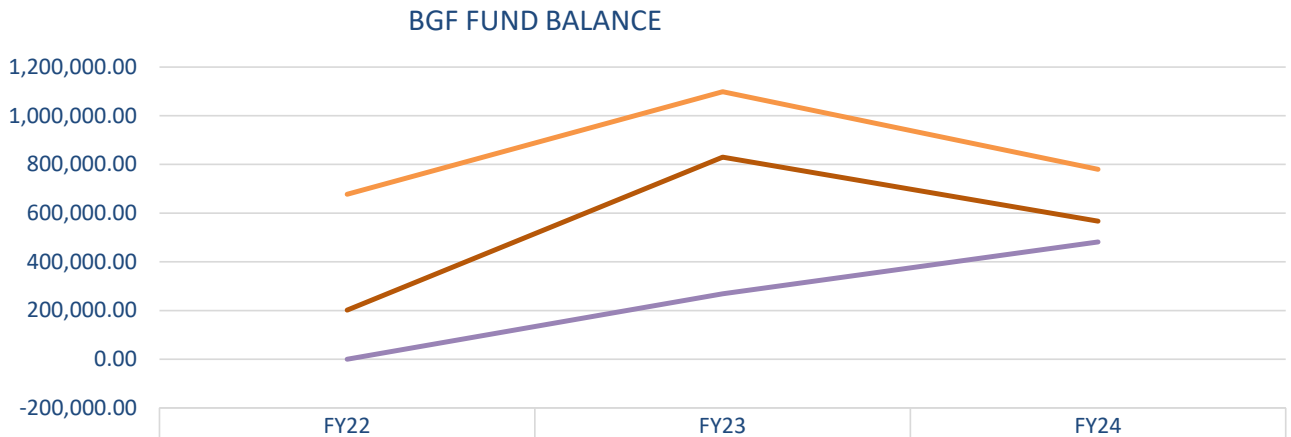


Workers' Safety and Compensation Administrative Account



	FY22	FY23	FY24
REVENUE			
Insurer Premium Tax	4,442,776	4,498,567	4,318,624
Self-Insurer Service Fee	1,684,670	1,486,445	1,527,374
WC Penalties	306,690	520,436	455,639
Misc	5,210	1,850	6,763
Revenue Total	6,439,346	6,507,298	6,308,400
EXPENDITURE			
Workers' Comp	5,568,015	5,647,670	5,558,770
WC Appeals Commission	349,341	391,564	391,000
Labor Market Info	79,270	83,604	83,600
Expenditure Total	7,920,156	6,280,248	6,233,370
FUND BALANCE (year end)	0	227,050	302,080

Benefits Guaranty Fund



	FY22	FY23	FY24
REVENUE			
Uninsured Employer Penalties	742,221	848,255	750,000
Late Fees	0	0	0
Fund Interest	-64,958	29,450	30,000
Supplemental Deposit from GF		221,400	0
Revenue Total	677,262	1,099,105	780,000
EXPENDITURE			
Benefits Guaranty Fund	201,881	830,038	567,114
Expenditure Total	201,881	830,038	567,114
FUND BALANCE (year end)	0	269,066	481,952

032

FY2024 Workers' Compensation Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Pay Periods processed	7	PPE:	9/17/2023
Pay Periods Remaining	19		
Total	26		

Monthly Status Report as of: **10/3/2023** | **Q1** | **FY2024**

Workers' Compensation

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/3/2023 Expend	10/3/2023 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To Date
Personal Services	4,978,800.00	0.00	0.00	0.00	4,978,800.00	927,335.75	0.00	4,051,464.25	0.00	3,399,392.91	4,326,728.66	652,071.34	18.6%
Travel	75,000.00	0.00	0.00	0.00	75,000.00	12,271.14	229.00	62,499.86	0.00	50,628.86	63,129.00	11,871.00	16.7%
Services	1,079,800.00	0.00	0.00	0.00	1,079,800.00	56,886.94	231,774.60	791,138.46	0.00	798,649.05	1,087,310.59	-7,510.59	26.7%
Commodities	74,800.00	0.00	0.00	0.00	74,800.00	14,421.60	5,635.86	54,742.54	0.00	50,000.00	70,057.46	4,742.54	26.8%
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	0.00	0.00	0.00	1,229,600.00	83,579.68	237,639.46	908,380.86	0.00	899,277.91	1,220,497.05	9,102.95	26.1%
Grants	11,600.00	0.00	0.00	0.00	11,600.00	3,848.36	7,696.72	54.92	0.00	0.00	11,545.08	54.92	99.5%
Total Program Expenditures	6,220,000.00	0.00	0.00	0.00	6,220,000.00	1,014,763.79	245,336.18	4,959,900.03	0.00	4,298,670.82	5,558,770.79	661,229.21	20.3%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
General Funds	19,800.0				19,800.00
Revenue Type Workers' Safety	6,200,200.00				6,200,200.00
					0.00
Total Program Funding	6,220,000.00	0.00	0.00	0.00	6,220,000.00

033

FY2024 Appeals Commission Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Pay Periods processed	7	PPE:	9/17/2023
Pay Periods Remaining	19		
Total	26		

Monthly Status Report as of: **10/3/2023** | **Q1** | **FY2024**

WC Appeals Commission

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/3/2023 Expend	10/3/2023 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	356,800.00	0.00	0.00	0.00	356,800.00	70,041.57	0.00	286,758.43	0.00	257,937.15	327,978.72	28,821.28	19.6%
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	111,100.00	0.00	0.00	-6,000.00	105,100.00	1,213.38	4,283.76	99,602.86	0.00	46,871.90	52,369.04	52,730.96	5.2%
Commodities	5,000.00	0.00	0.00	6,000.00	11,000.00	636.81	9,875.62	487.57	0.00	0.00	10,512.43	487.57	95.6%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	116,100.00	0.00	0.00	0.00	116,100.00	1,850.19	14,159.38	100,090.43	0.00	46,871.90	62,881.47	53,218.53	13.8%
Grants	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00			0.0%
Total Program Expenditures	472,900.00	0.00	0.00	0.00	472,900.00	71,891.76	14,159.38	386,848.86	0.00	304,809.04	390,860.18	82,039.82	18.2%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
General Funds	25,300.0				25,300.0
Revenue Type: Workers' Safety	447,600.00				447,600.00
Total Program Funding	472,900.00	0.00	0.00	0.00	472,900.00

034

FY2024 Benefits Guaranty Fund Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Pay Periods processed	7	PPE:	9/17/2023
Pay Periods Remaining	19		
Total	26		

Monthly Status Report as of: **10/3/2023** **Q1** **FY2024**

Benefits Guaranty Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/3/2023 Expend	10/3/2023 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	117,400.00	0.00	0.00	0.00	117,400.00	23,994.97	0.00	93,405.03	0.00	85,640.29	109,635.26	7,764.74	20.4%
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	0.00	0.00	0.00	235,700.00	224.90	32,500.00	202,975.10	0.00	20,454.30	53,179.20	182,520.80	13.9%
Commodities	2,000.00	0.00	0.00	0.00	2,000.00	0.00	0.00	2,000.00	0.00	2,000.00	2,000.00	0.00	0.0%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	237,700.00	0.00	0.00	0.00	237,700.00	224.90	32,500.00	204,975.10	0.00	22,454.30	55,179.20	182,520.80	13.8%
Grants	432,700.00	0.00	0.00	0.00	432,700.00	15,728.70	0.00	416,971.30	0.00	386,571.30	402,300.00	30,400.00	3.6%
Total Program Expenditures	787,800.00	0.00	0.00	0.00	787,800.00	39,948.57	32,500.00	715,351.43	0.00	494,665.89	567,114.46	220,685.54	9.2%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
GF Program Receipts					
Revenue Type: Benefits Guaranty Fund	787,800.00	0.00			787,800.00
Interagency Receipts					
General Funds					
Total Program Funding	787,800.00	0.00	0.00	0.00	787,800.00

035

FY2024 Second Injury Fund Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Pay Periods processed	7	PPE:	9/17/2023
Pay Periods Remaining	19		
Total	26		

Monthly Status Report as of: **10/3/2023** **Q1** **FY2024**

Second Injury Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/3/2023 Expend	10/3/2023 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	224,900.00	0.00	0.00	0.00	224,900.00	44,552.08	0.00	180,347.92	0.00	169,015.39	213,567.47	11,332.53	19.8%
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	0.00	0.00	0.00	72,700.00	1.76	18.24	72,680.00	0.00	30,957.77	30,977.77	41,722.23	0.0%
Commodities	4,300.00	0.00	0.00	0.00	4,300.00	0.00	0.00	4,300.00	0.00	4,000.00	4,000.00	300.00	0.0%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	77,000.00	0.00	0.00	0.00	77,000.00	1.76	18.24	76,980.00	0.00	34,957.77	34,977.77	42,022.23	0.0%
Grants	2,568,300.00	0.00	0.00	0.00	2,568,300.00	305,901.46	0.00	2,262,398.54	0.00	1,570,138.95	1,876,040.41	692,259.59	11.9%
Total Program Expenditures	2,870,200.00	0.00	0.00	0.00	2,870,200.00	350,455.30	18.24	2,519,726.46	0.00	1,774,112.11	2,124,585.65	745,614.35	12.2%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
GF Program Receipts					
Revenue Type Second Injury Fund	2,870,200.00				2,870,200.00
Interagency Receipts					
General Funds					
Total Program Funding	2,870,200.00	0.00	0.00	0.00	2,870,200.00

036

FY2024 Fishermen's Fund Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Pay Periods processed	7	PPE:	9/17/2023
Pay Periods Remaining	19		
Total	26		

Monthly Status Report as of: **10/3/2023** **Q1** **FY2024**

Fishermen's Fund

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/3/2023 Expend	10/3/2023 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	282,100.00	0.00	0.00	0.00	282,100.00	41,021.47	0.00	241,078.53	0.00	219,269.44	260,290.91	21,809.09	14.5%
Travel	58,000.00	0.00	0.00	0.00	58,000.00	0.00	0.00	58,000.00	0.00	15,000.00	15,000.00	43,000.00	0.0%
Services	322,500.00	0.00	0.00	0.00	322,500.00	3,466.23	931.69	318,102.08	0.00	39,468.51	43,866.43	278,633.57	1.4%
Commodities	24,100.00	0.00	0.00	0.00	24,100.00	0.00	0.00	24,100.00	0.00	3,000.00	3,000.00	21,100.00	0.0%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	404,600.00	0.00	0.00	0.00	404,600.00	3,466.23	931.69	400,202.08	0.00	57,468.51	61,866.43	342,733.57	1.1%
Grants	744,700.00	0.00	0.00	0.00	744,700.00	134,331.57	0.00	610,368.43	0.00	450,000.00	584,331.57	160,368.43	18.0%
Total Program Expenditures	1,431,400.00	0.00	0.00	0.00	1,431,400.00	178,819.27	931.69	1,251,649.04	0.00	726,737.94	906,488.90	524,911.10	12.6%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
GF Program Receipts					
Revenue Type Fishermen's Fund	1,431,400.00				1,431,400.00
Interagency Receipts					
General Funds					
Total Program Funding	1,431,400.00	0.00	0.00	0.00	1,431,400.00

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QUESTIONS?

038

TAB 6

2022 Annual Report

Alaska Department of Labor and Workforce Development
Workers' Compensation Division

040

Catherine Muñoz Acting Commissioner

Workers' Compensation Division

Protect Workers

Charles Collins, Director

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

041

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

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

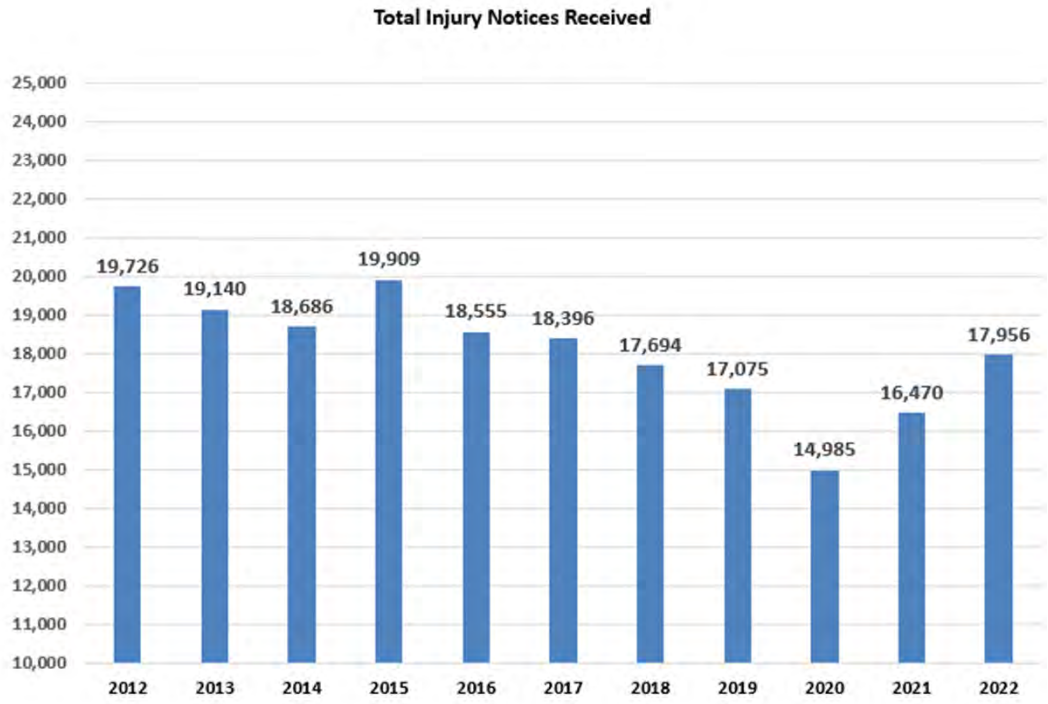
- Manage and reimburse commercial fisherman's injury claims
- Actively manage the "Fisherman's Fund"
- Manage the claims database

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

Analysis of Workers' Compensation Claims Data

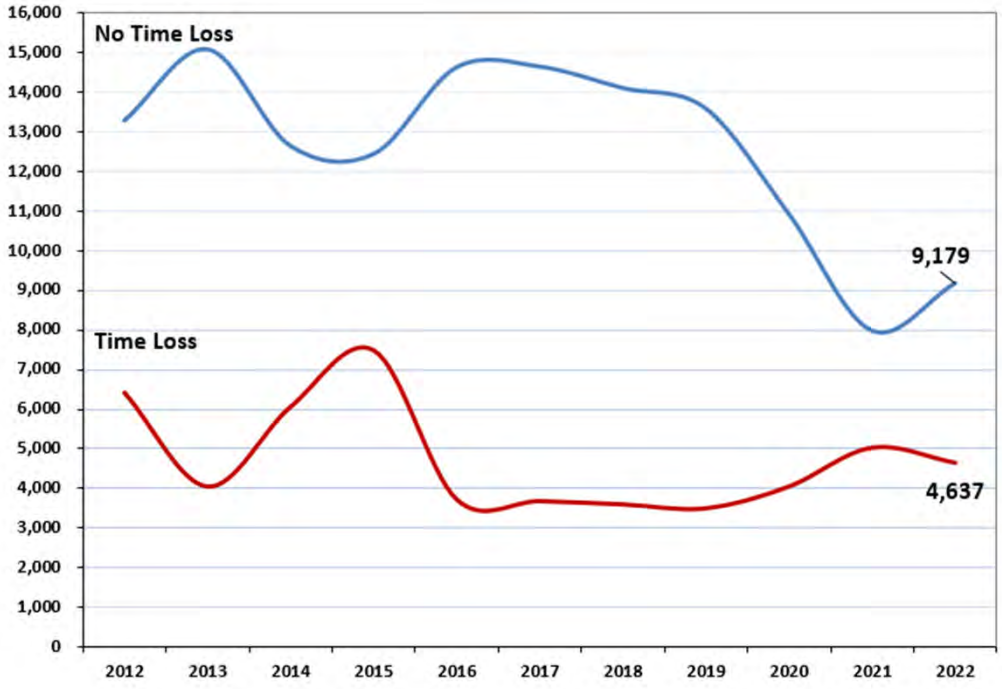
In 2022, there were 17,956 reports of injury and occupational illness filed with the Workers' Compensation Division, a 9.0% increase from 16,470 reports filed in 2021.



Analysis of Workers' Compensation Claims Data

Of the case files established in 2022, claim type filings and distribution to total claims filed was:

- No-time-loss cases: 9,179 cases, 51% of total claims.
- Time-loss cases: 4,637 cases, 26% of total claims.
- Notification only cases: 4,107 cases, 23% of total claims.
- Fatalities: 33 cases, 0.18% of total claims.



Analysis of Workers' Compensation Claims Data

The Alaska Workers' Compensation Board held 99 hearings in 2022, compared to 161 hearings in 2021, and 188, in 2020.

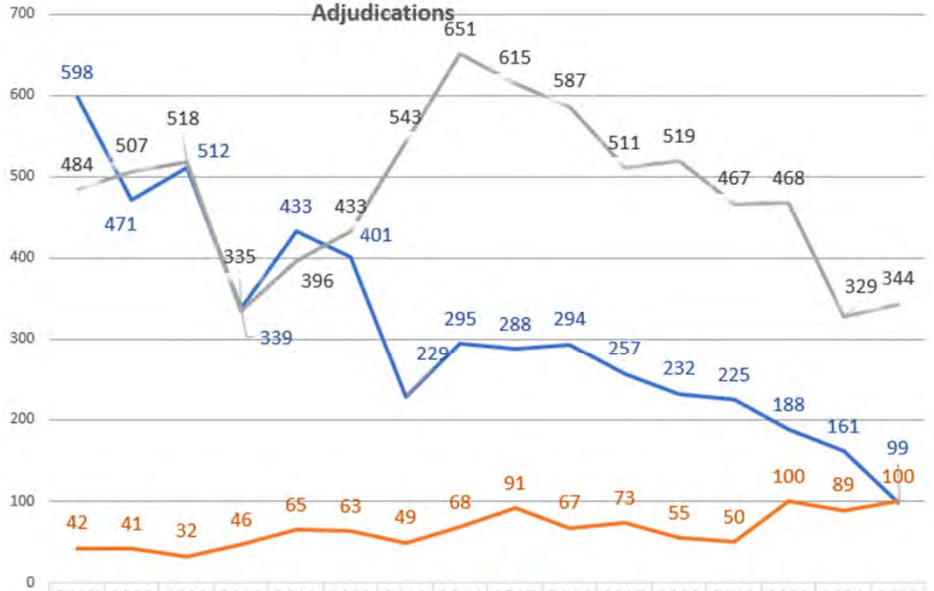
- 1,464 Prehearings were conducted.
- 76 decisions were issued.
- 344 compromise and release agreements were approved.

The Alaska Workers' Compensation Appeals Commission hearing data for CY 2022:

- Hearings: 8
- Oral arguments on the merit of appeals: 6
- Motions for stays of Board orders: 2

AWCAC comparative data for CY 2021:

- Hearings: 9
- Oral arguments on the merit of appeals: 7
- Motions for stays of Board orders: 2



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Hearings	598	471	512	339	433	401	229	295	288	294	257	232	225	188	161	99
Mediations	42	41	32	46	65	63	49	68	91	67	73	55	50	100	89	100
C & R Approved	484	507	518	335	396	433	543	651	615	587	511	519	467	468	329	344

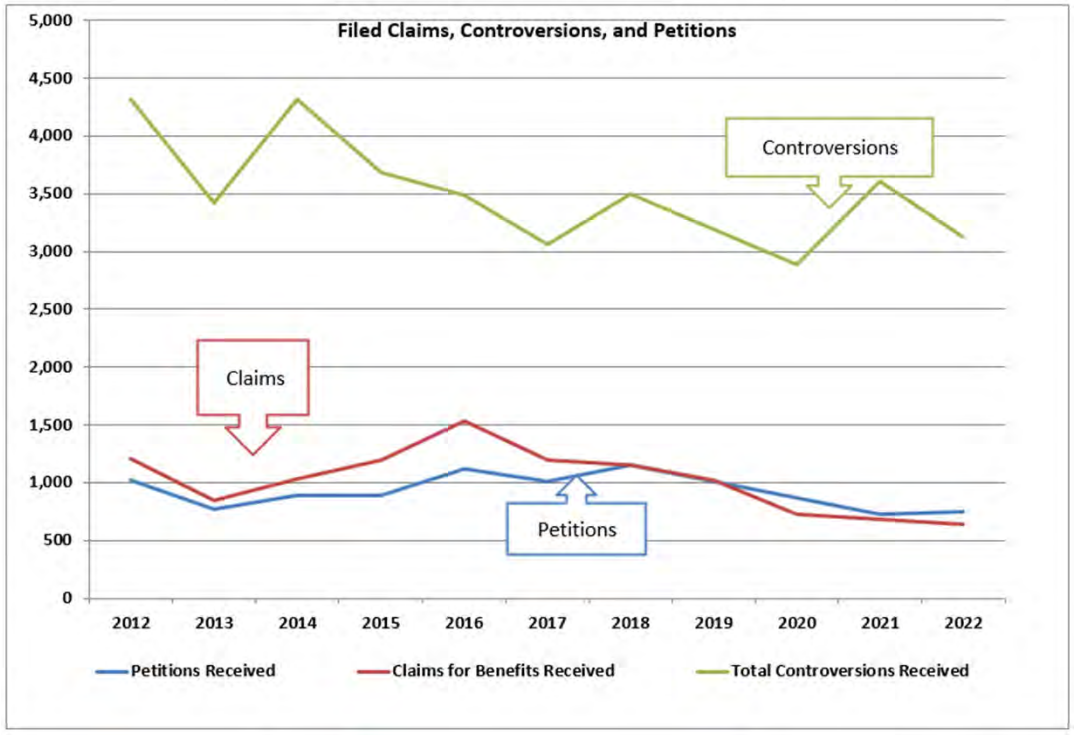
Analysis of Workers' Compensation Claims Data

In 2022, there were 643 claims for benefits filed for 512 cases, a 5.2% decrease from 678 claims filed in 2021.

There were 747 petitions filed for 493 cases in 2022, a 3.3% increase from 723 petitions filed in 2021.

There were 3,126 total controversion received in 2022, a 13.3% decrease from 3,605 in 2021.

The number of injury cases controverted in 2022 totaled 2,546, a 5.5% decrease from 2,694 cases in 2021.



Annual Reporting of Total Compensation Benefits

Financial Reports and Audits

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

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

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

This report covers activity from:

CY = Calendar Year Period from January 1, 2022 to December 31, 2022

FY = Fiscal Period from July 1, 2022 to June 30, 2023

Notes:

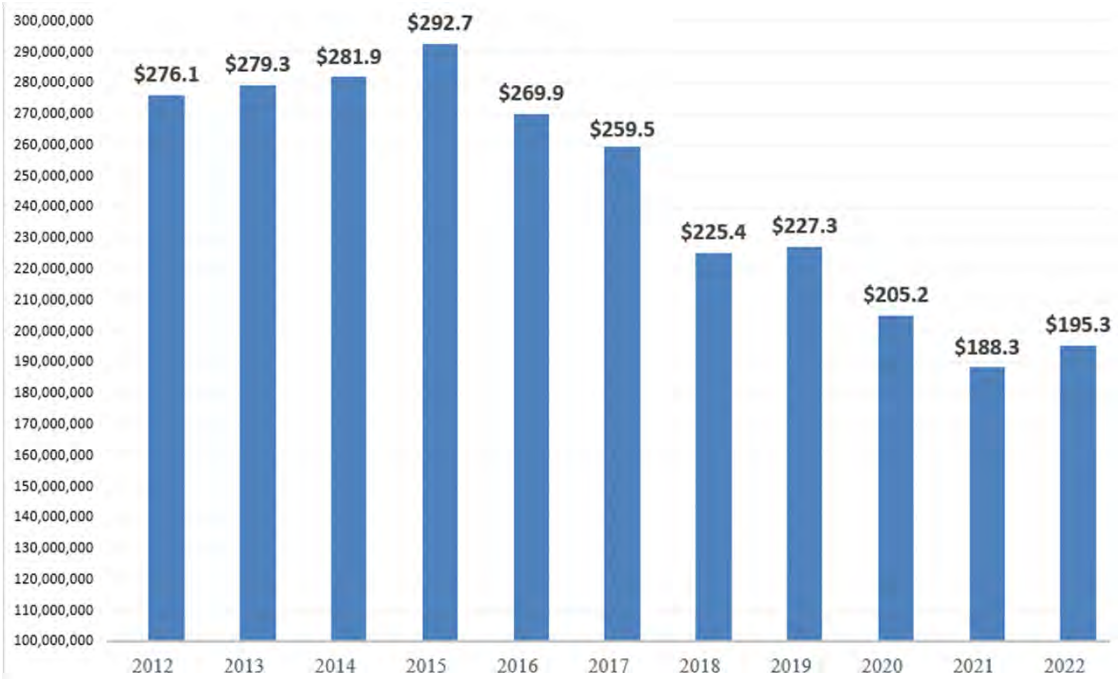
Medical Costs Totals for CY 2022 include the following Medical Costs: Physical Therapy, Chiropractic Fees, Durable Medical expenses, Medical Travel, Employee Medical-Legal Costs. These costs were previously captured in the other category for CY 2014 through CY2017.

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

Other Costs for CY 2022 include: Unspecified Lump Sum Payment/Settlement, interest, penalty and SIF Contribution Fee.

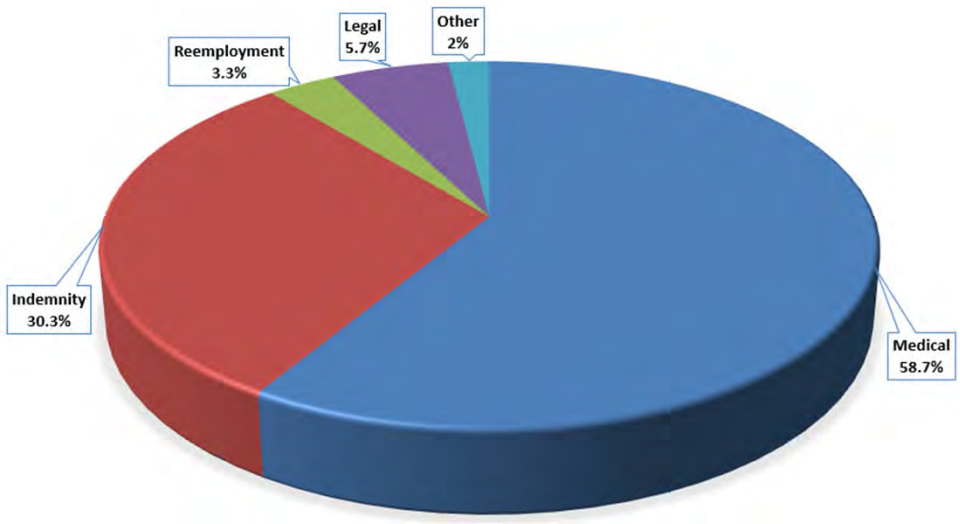
Total Compensation Benefits Paid Alaska Employers

A total of $195.3 million was paid in workers' compensation benefits during calendar year 2022 by market-insured employers and self-insured employers. This is an increase of $7.0 million, up 3.72% from $188.3 million paid in 2021.



Total Compensation Payments Distribution

Benefit Type	Amount Paid	% of Cost to Total Cost
Medical	$114,783,509	58.7%
Indemnity	$59,164,998	30.3%
Reemployment	$6,489,018	3.3%
Legal	$11,080,538	5.7%
Other*	$3,861,634	2.0
Total	$195,379,695	



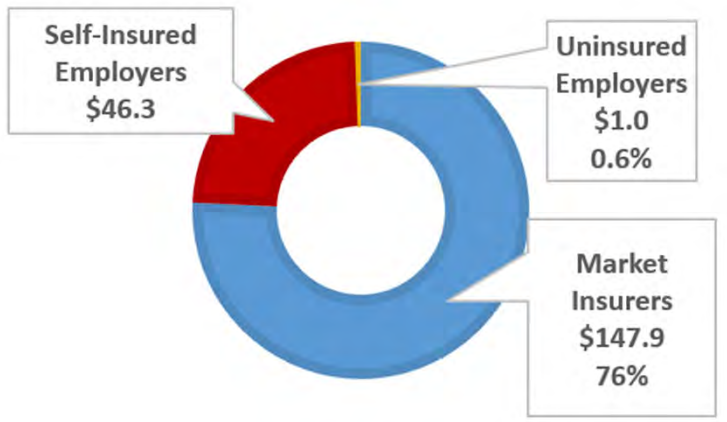
*Other costs include interest, penalty, Second Injury Fund contribution.

Total Benefits Paid by Market Distribution

Of total benefits paid, market-insured employers paid $147.9 million (75.7%) and self-insured employers paid $46.3 million (23.7%).

Compared to 2021, market-insured employers paid $140.7 million (74.8%) and self-insured employers paid $46.9 million (25.0%).

Insurer Type	Total Benefits Pd	% of Cost to Total Cost
Market Insurers	$147,990,452	75.7%
Self-Insured Employers	$46,311,238	23.7%
Uninsured Employer Fund	1,077,844	0.6%
Total	$195,379,534	



049

Active Self-Insured Employers

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

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

050

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

The top twenty insurers and self-insured employers paid $130.8 million, or 67.0% of total workers' compensation benefits paid in 2022. This compares to $127.3 million, or 67.7%, in 2021.

Rank	Insurer	Benefits Paid	Rank	Insurer	Benefits Paid
1.	ALASKA NATIONAL INS CO	$ 34,527,005	11.	ACE AMERICAN INSURANCE COMPANY	$ 4,552,035
2.	ALASKA, STATE OF	$ 13,180,199	12.	LM INSURANCE CORP	$ 4,337,969
3.	AMERICAN ZURICH INS CO	$ 7,910,643	13.	EVEREST NATIONAL INS CO	$ 4,299,480
4.	ANCHORAGE, MUNICIPALITY OF	$ 6,789,549	14.	ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOC	$ 4,084,626
5.	UMIALIK INSURANCE CO	$ 6,587,460	15.	ALASKA TIMBER INS EXCHANGE	$ 3,577,921
6.	INDEMNITY INS CO OF NORTH AMERICA	$ 5,526,912	16.	ANCHORAGE SCHOOL DISTRICT	$ 3,527,163
7.	REPUBLIC INDEMNITY CO OF AMERICA	$ 4,950,868	17.	ALASKA AIRLINES, INC.	$ 3,324,927
8.	AMERICAN INTERSTATE INSURANCE CO	$ 4,850,917	18.	BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY	$ 3,233,608
9.	LIBERTY INSURANCE CORP	$ 4,681,248	19.	PROVIDENCE HEALTH SYSTEM – WASHINGTON	$ 3,174,466
10.	ARCTIC SLOPE REGIONAL CORP	$ 4,642,528	20.	EMPLOYERS INS CO OF WAUSAU	$ 3,073,652
				TOTAL	**$130,833,178**

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Total Benefits Paid by Top Ten Self-Insured Employers

Self-Insured Employer	Medical	Indemnity (TTD, TPD, PPI, PTD)	Death	Reemp	Legal	Other	Total	% To Total Benefits
ALASKA, STATE OF	$ 5,310,981	$ 4,519,334	$ 485,376	$ 313,729	$ 2,018,787	$ 531,992	$ 13,180,199	7%
ANCHORAGE, MUNICIPALITY OF	$ 3,973,410	$ 1,889,922	$ 204,667	$ 306,232	$ 323,578	$ 91,741	$ 6,789,549	3%
ARCTIC SLOPE REGIONAL CORP	$ 1,681,540	$ 1,790,632	$ 627,461	$ 235,424	$ 235,366	$ 72,106	$ 4,642,528	2%
ANCHORAGE SCHOOL DISTRICT	$ 2,238,812	$ 856,869	$ -	$ 165,190	$ 170,631	$ 95,662	$ 3,527,163	2%
ALASKA AIRLINES, INC.	$ 1,773,090	$ 1,111,375	$ 136,110	$ 158,023	$ 31,422	$ 114,907	$ 3,324,927	2%
PROVIDENCE HEALTH SYSTEM - WASHINGTON	$ 1,800,395	$ 883,866	$ 34,375	$ 45,776	$ 140,852	$ 269,202	$ 3,174,466	2%
FRED MEYER STORES, INC. (Kroger)	$ 763,573	$ 337,562	$ -	$ 35,380	$ 156,723	$ 106,583	$ 1,399,821	1%
FEDERAL EXPRESS CORP.	$ 675,774	$ 478,177	$ 51,324	$ 41,556	$ 46,502	$ 39,991	$ 1,333,323	1%
FAIRBANKS, NORTH STAR BOROUGH & SD	$ 840,740	$ 242,380	$ -	$ 72,885	$ 81,565	$ 11,128	$ 1,248,697	1%
KENAI PENINSULA BOROUGH	$ 653,083	$ 265,322	$ -	$ -	$ -	$ 67,657	$ 986,062	1%
Total							**$ 39,606,738**	

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Workers' Compensation Division

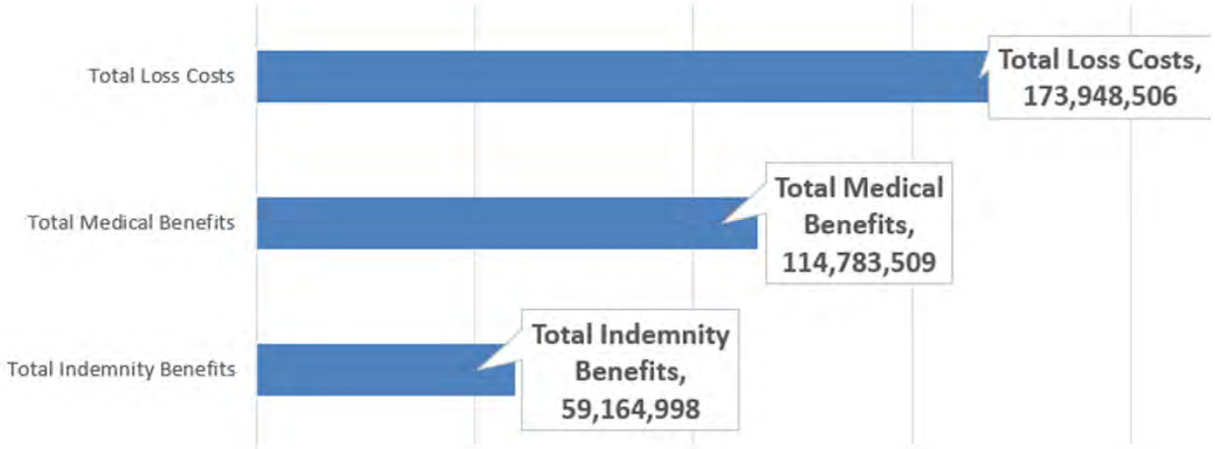
Loss Cost Distribution

Total loss costs were $173.9 million in 2022 compared to $166.9 million in 2021, an increase of 4.54%.

Indemnity costs were $59.1 million in 2022 which was 65.99% of total costs, compared to $58.5 million in 2021, 64.83% of total costs.

Medical costs were $114.7 million in 2022 which was 34.01% of total costs , compared to $107.8 million in 2021, 35.17% of total costs.

Year	Total Loss Costs	% Change
2022	$173,948,506	4.54%
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%

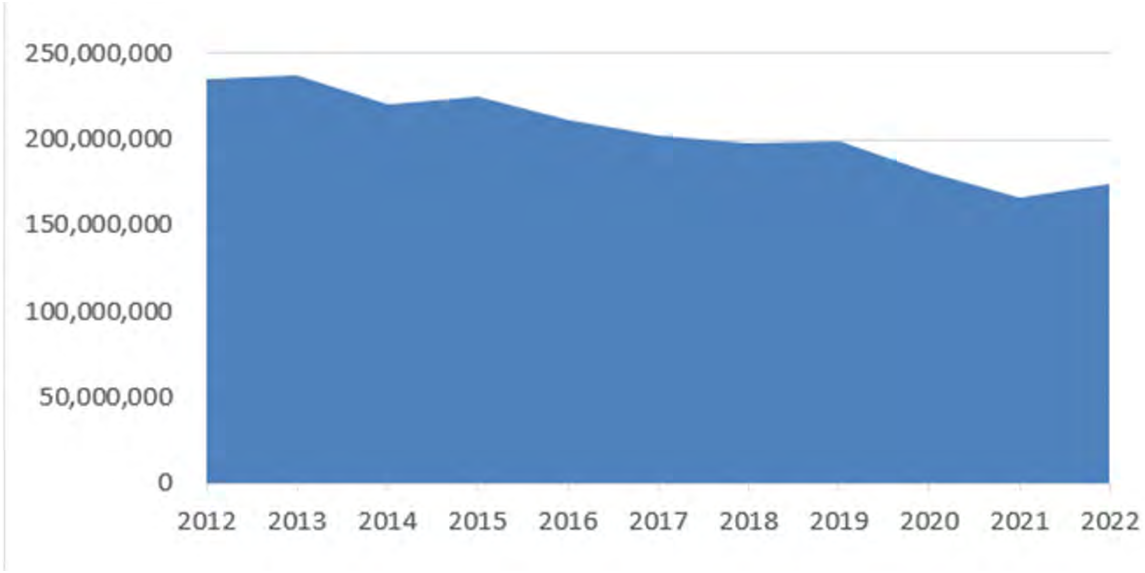


"Loss Costs" = medical and indemnity benefit costs only.

053

Loss Costs: 10-year review (in millions)

Year	Total Loss Costs	% Change
2022	$173,948,506	4.54%
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%
2013	$237,559,679	0.97%
2012	$235,277,679	6.38%

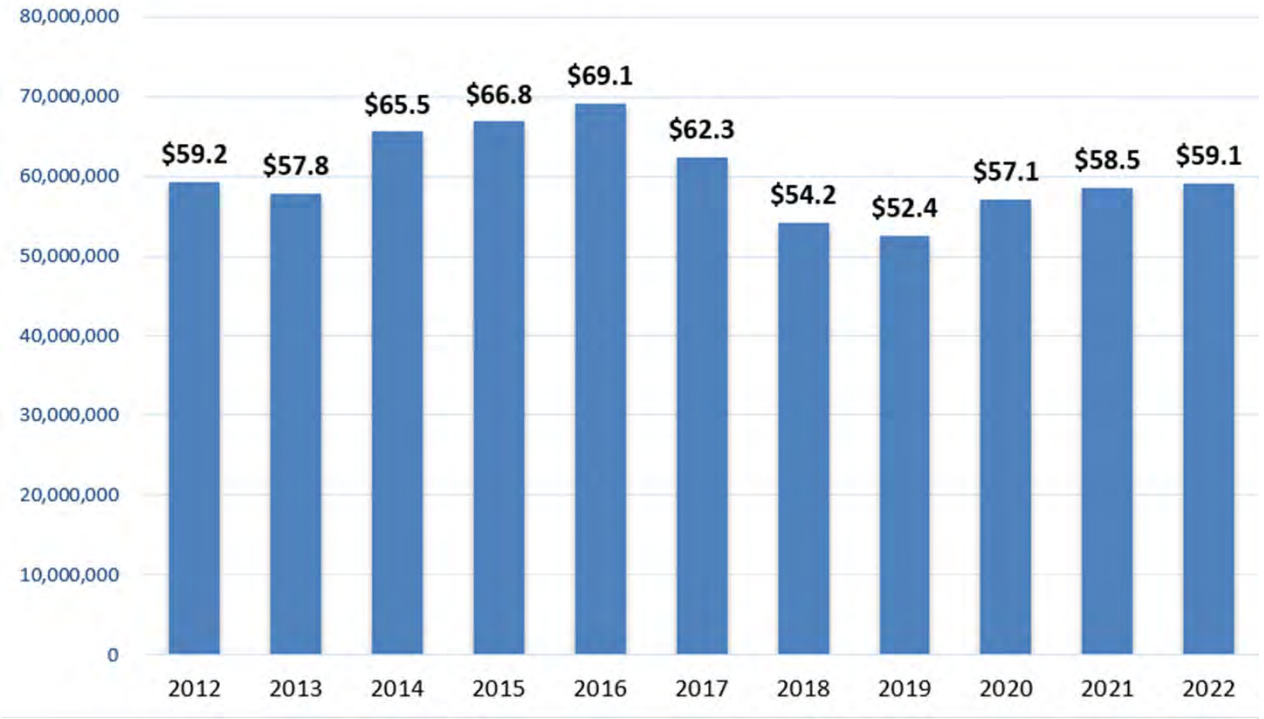


"Loss Costs" = medical and indemnity benefit costs only.

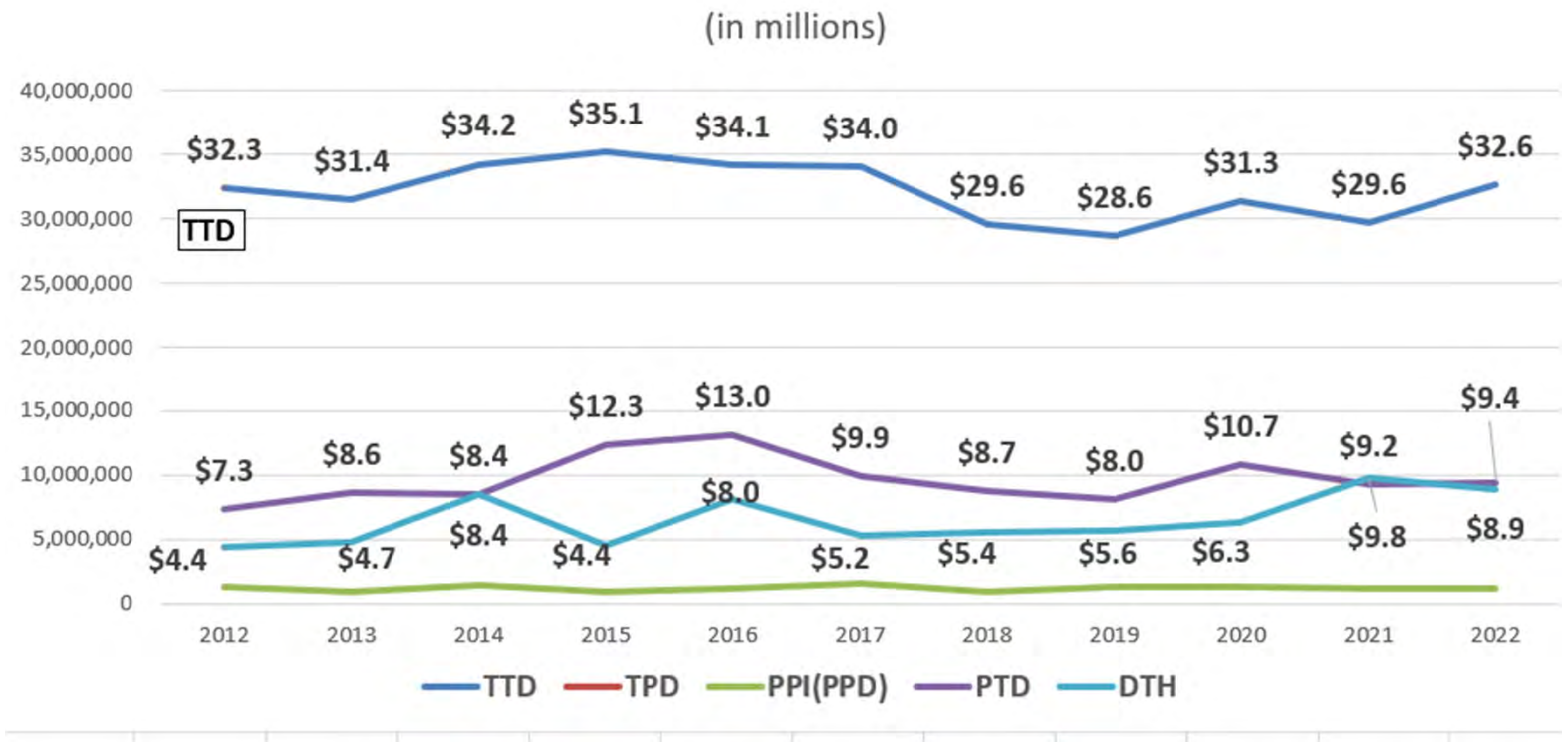
Indemnity Benefit Payments

For calendar year 2021 indemnity benefits (TTD, TPD, PPI, PTD & Death Benefits) totaled $59.1 million, a 1.10% increase from $58.5 million in 2021.

- TTD benefits totaled $32.6 million in 2022, a 9.82% increase from $29.6 million in 2021.
- TPD benefits totaled $1.14 million in 2022, a 0.49% decrease from $1.15 in 2021.
- PPI benefits totaled $7.08 million in 2022, a 17.49% decrease from $8.5 million in 2021.
- PTD benefits totaled $9.4 million in 2022, a 1.4% increase from $9.2 million in 2021.
- Death benefits totaled $8.9 million in 2022, a 9.17% decrease from $9.8 million in 2021.



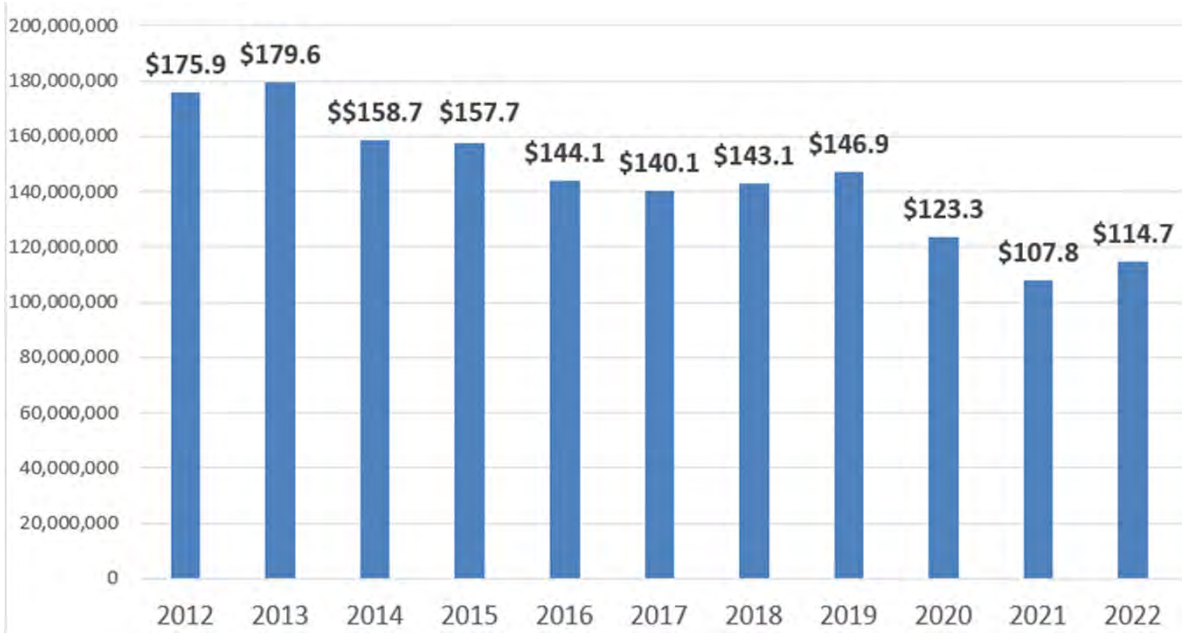
Indemnity Benefit Payments Distribution and 10-year review



Medical Benefit Payments

In the calendar year 2022, medical benefits totaled $114.7 million, a 6.4% increase from $107.8 million in 2021.

Medical benefits were 58.7% of total benefits paid and 65.99% of loss costs in 2022, compared to 57.2% of total benefits paid and 64.83% of loss costs in 2021.



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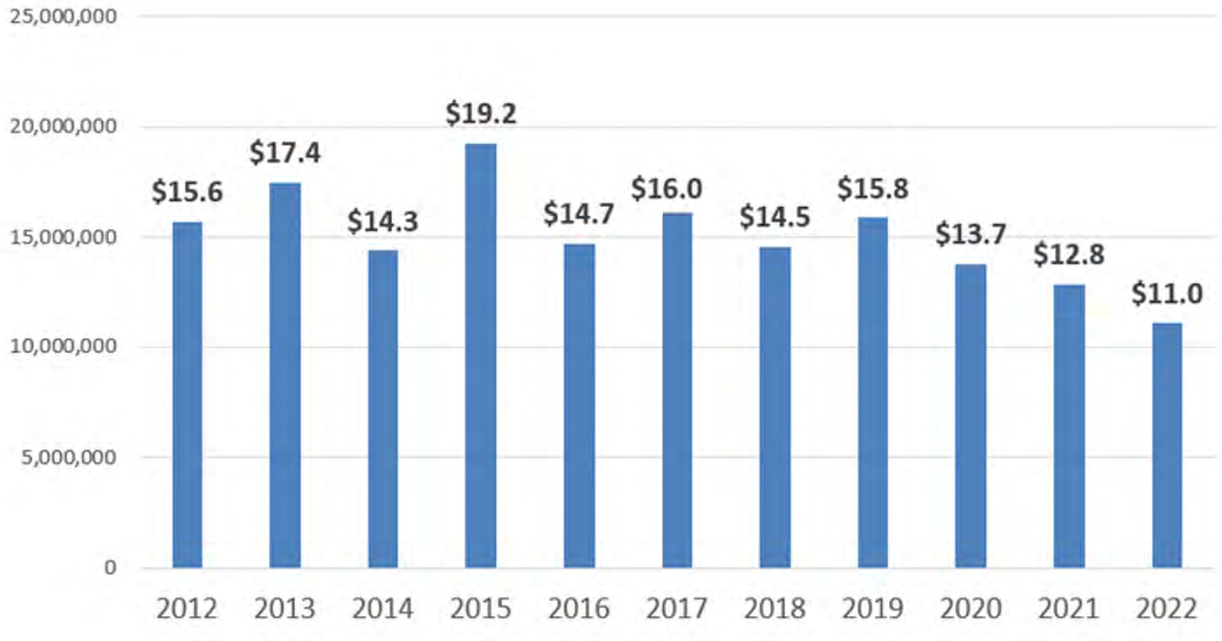
Legal Costs

For calendar year 2022, legal expenses totaled $11.0 million, a 13.77% decrease from $12.8 million in 2021.

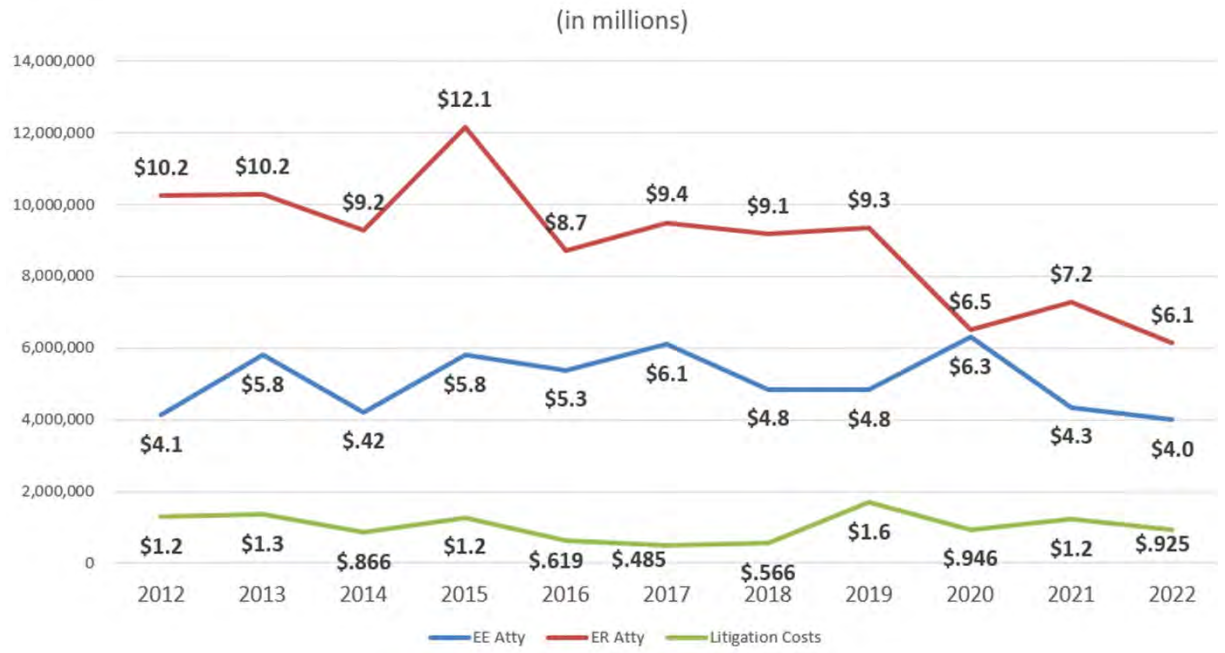
- Employee attorney fees were $4.0 million in 2022, an 8.07% decrease from $4.3 million in 2021.
- Employer attorney fees were $6.1 million in 2022, a 15.44% decrease from $7.2 million in 2021.
- Litigation costs totaled $925,688 in 2022, a 24.16% decrease from $1.2 million in 2021.
- Litigation costs include:
  - Total Expert Witness Fees
  - Total Court Reporter Fees
  - Total Private Investigator Fees

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



Legal Costs Distribution

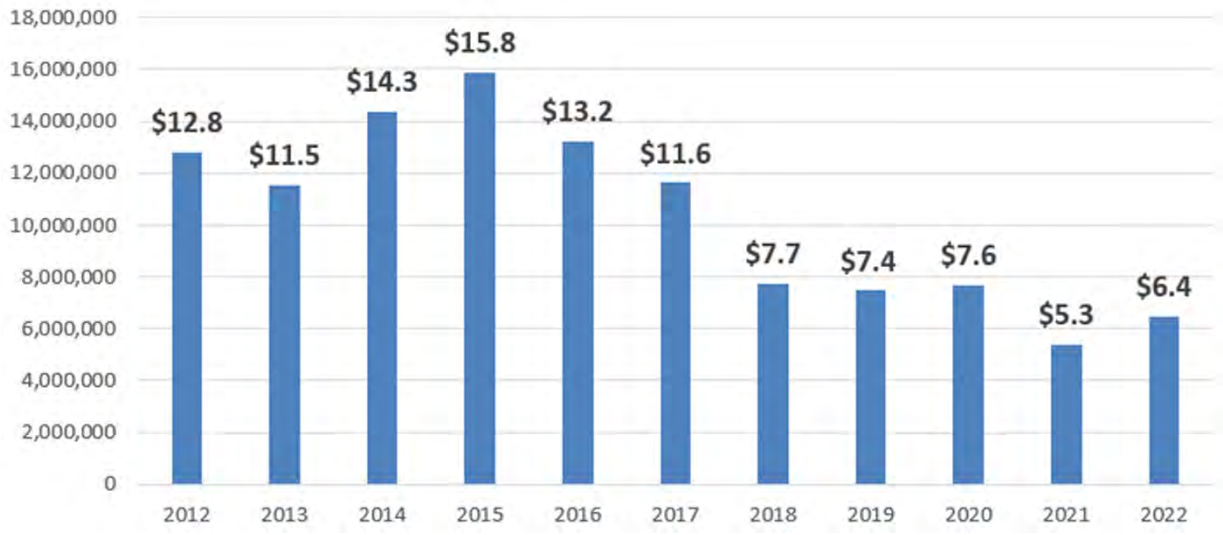
Legal Costs for 2022	Payment Amount	%
Employee Attorney Costs	$4,002,876	36%
Employer Attorney Costs	$6,151,974	56%
Litigation Costs	925,688	8.4%
Total	$11,080,538	



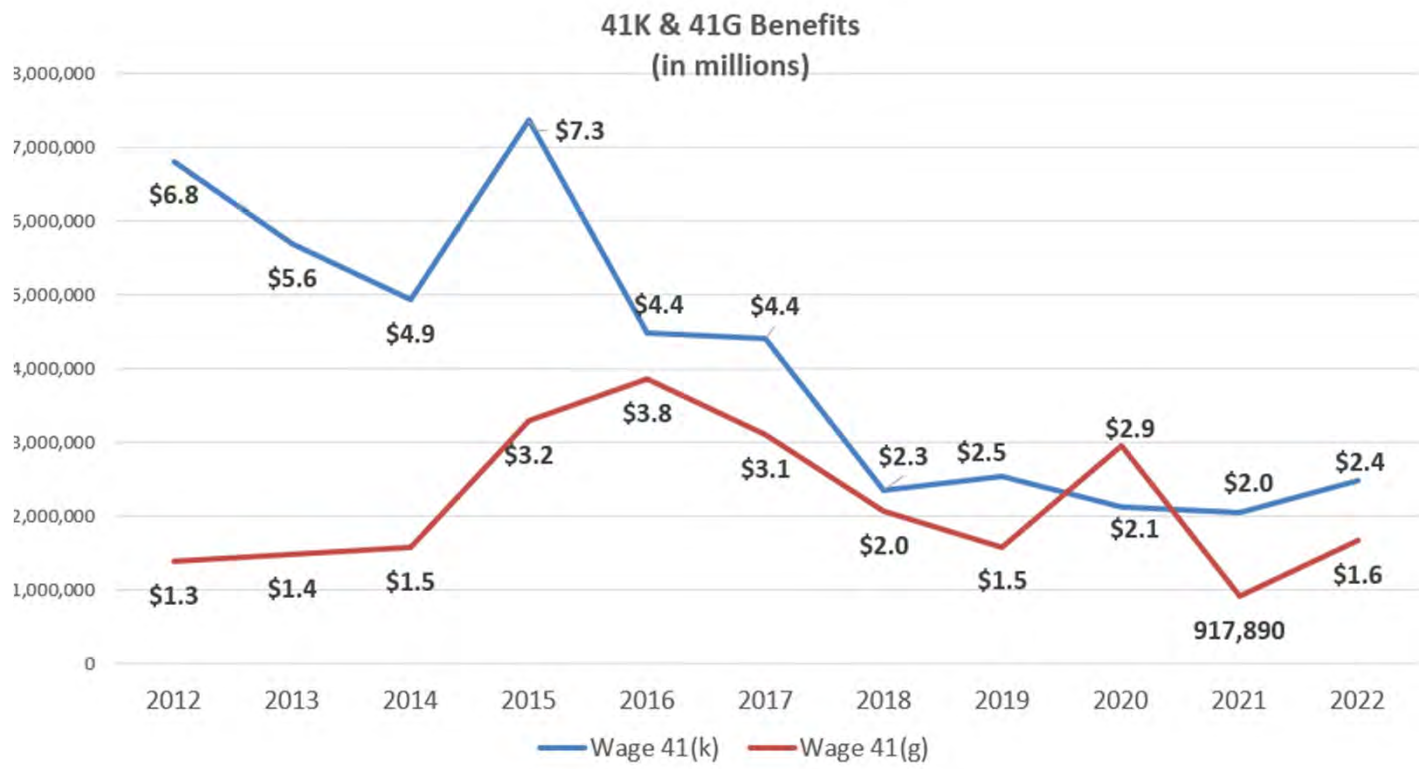
Reemployment Benefits

Total reemployment benefit payments totaled $6.4 million in 2022, a 20.9% increase from $5.3 million in 2021.

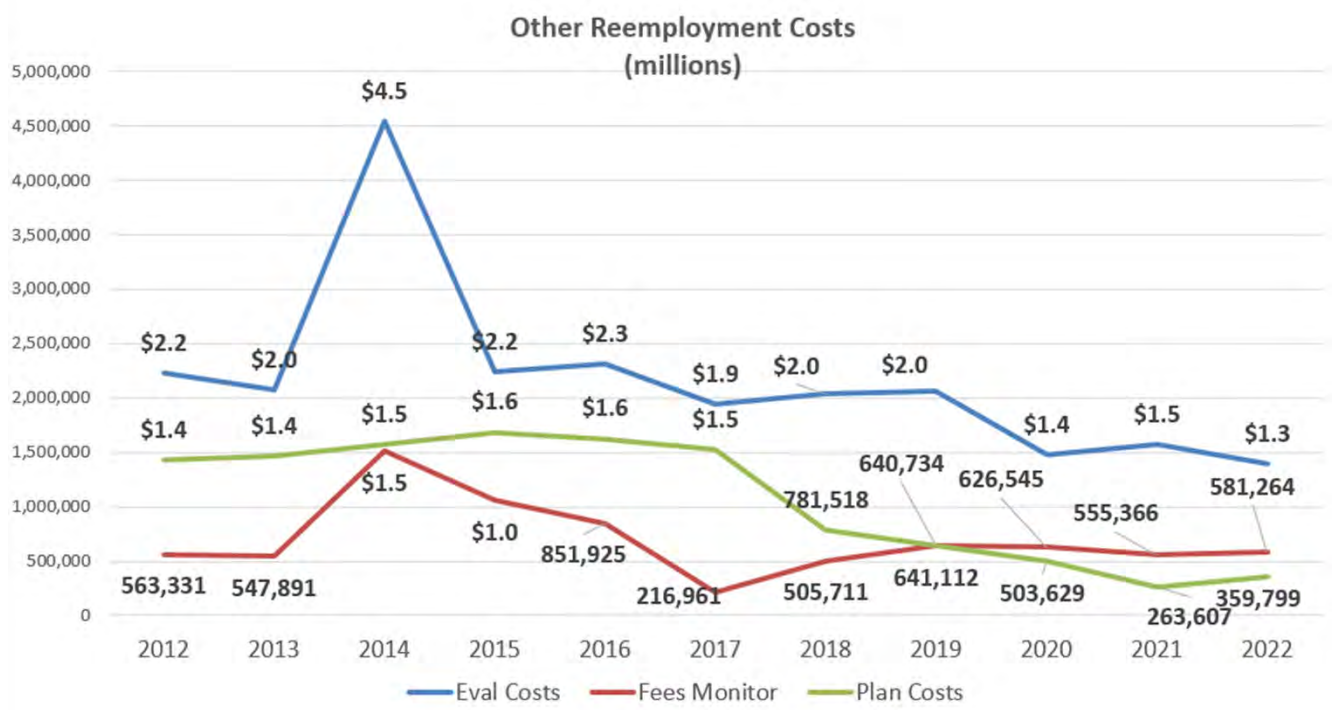
- Rehabilitation benefit costs under AS 23.30.041(k) totaled $2.4 million in 2022, a 20.74% increase from $2.0 million in 2021.
- Rehabilitation benefit costs under AS 23.30.041(g) totaled $1.6 million in 2022, an 82.4% increase from $917,890 in 2021.
- Employee evaluation costs totaled $1.3 million in 2022, a 11.34% decrease from $1.5 million in 2021.
- Rehabilitation specialist fees/plan monitoring fees totaled $581,264 in 2022, a 4.66% increase from $555,366 in 2021.
- Plan development costs totaled $359,799 in 2022, a 36.49% increase from $263,607 in 2021.



Reemployment Benefit Costs Distribution



Reemployment Benefit Costs Distribution



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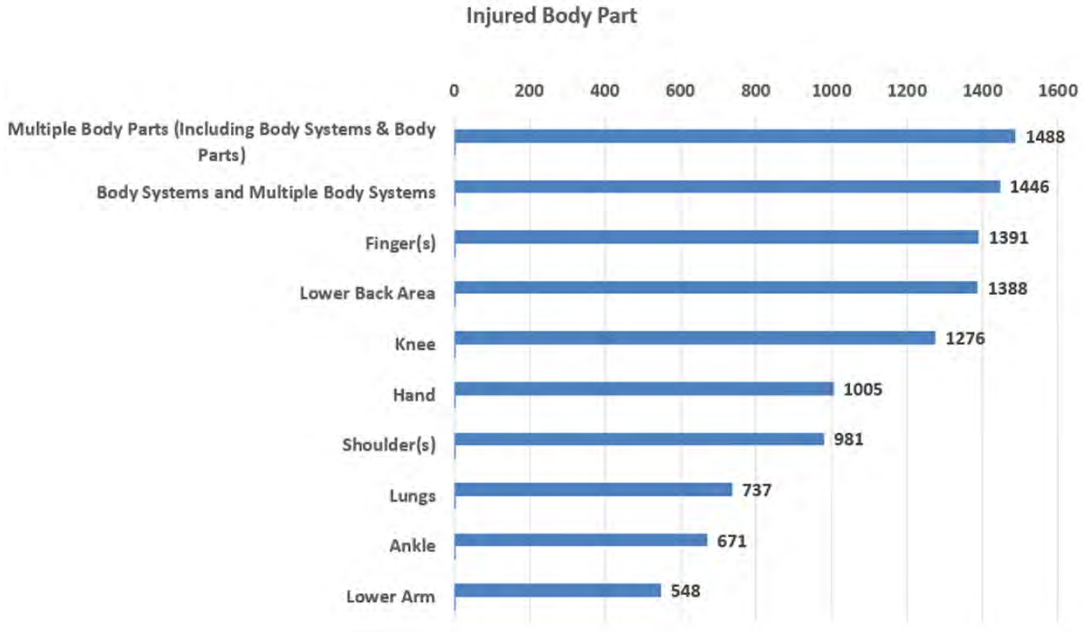
Top Ten Injuries by Body Part

	Body Part Injured	Cases	%*
1.	Multiple Body Parts	1,488	8.3%
2.	Body Systems & Multiple Body Systems	1,446	8.1%
3.	Finger(s)	1,391	7.7%
4.	Lower Back	1,388	7.7%
5.	Knee	1,276	7.1%
6.	Hand	1,005	5.6%
7.	Shoulder(s)	981	5.5%
8.	Lungs	737	4.1%
9.	Ankle	671	3.7%
10.	Lower Arm	548	33.1%
	Total	10,931	60.9%



*Percentage to total injury cases reported in 2022 of 17,956.

Alaska Injury Frequency

In 2022, 17,956 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 6.0%.

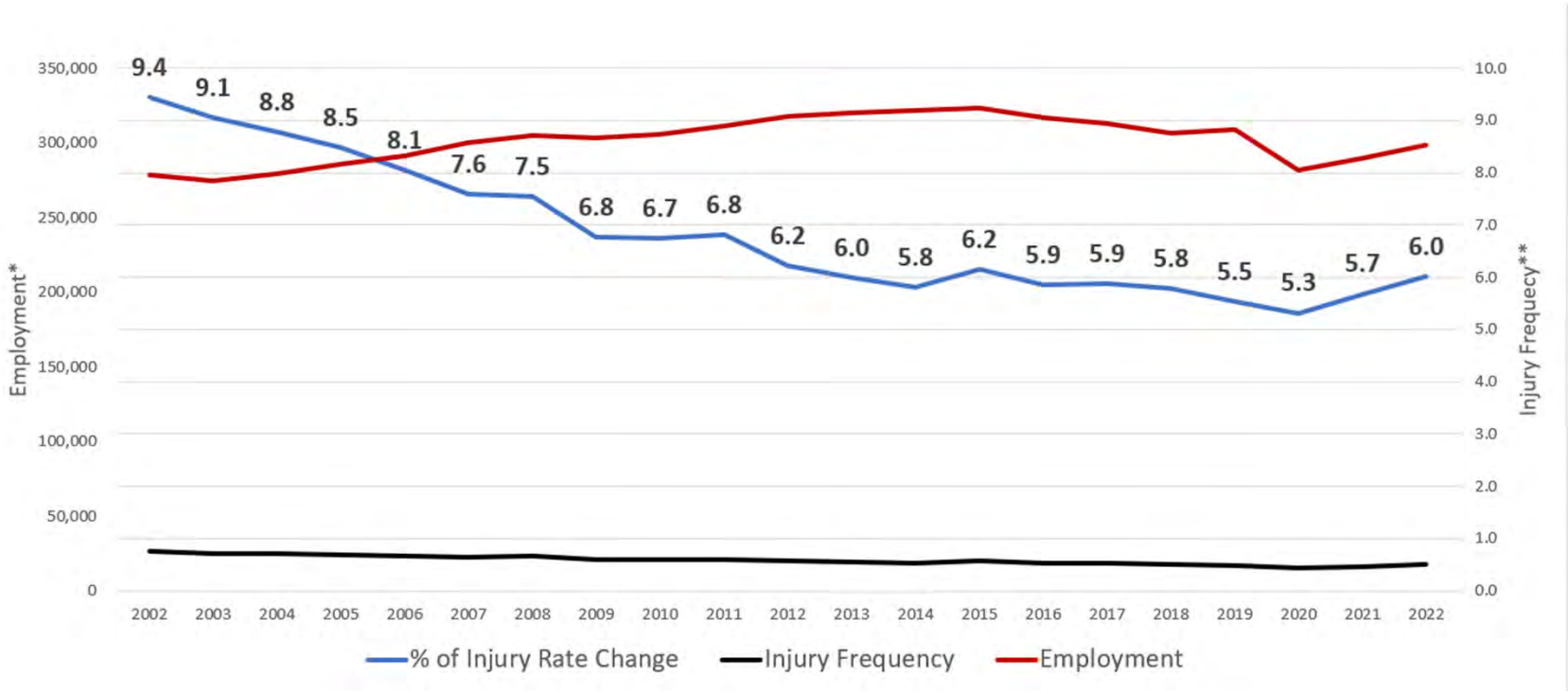
- In 2021, 16,470 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.7%.
- In 2020, 14,985 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.3%.

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment, Statewide totaled 313,765 in 2022, 305,004 in 2021, and 297,389 in 2020. Excluding federal employees, the number of workers covered under the Alaska Workers' Compensation Act in 2022 was approximately 298,762 an 3.04% increase from 289,946 in 2021 which was a 2.56% increase from 281,976 in 2020.

Year	Reported Injuries	Employment	Frequency Rate
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
2013	19,140	319,893	6.1
2012	19,726	317,562	6.3
2011	21,213	311,529	7.0
2010	20,628	305,852	6.9
2009	20,516	303,200	6.9

Alaska Injury Frequency

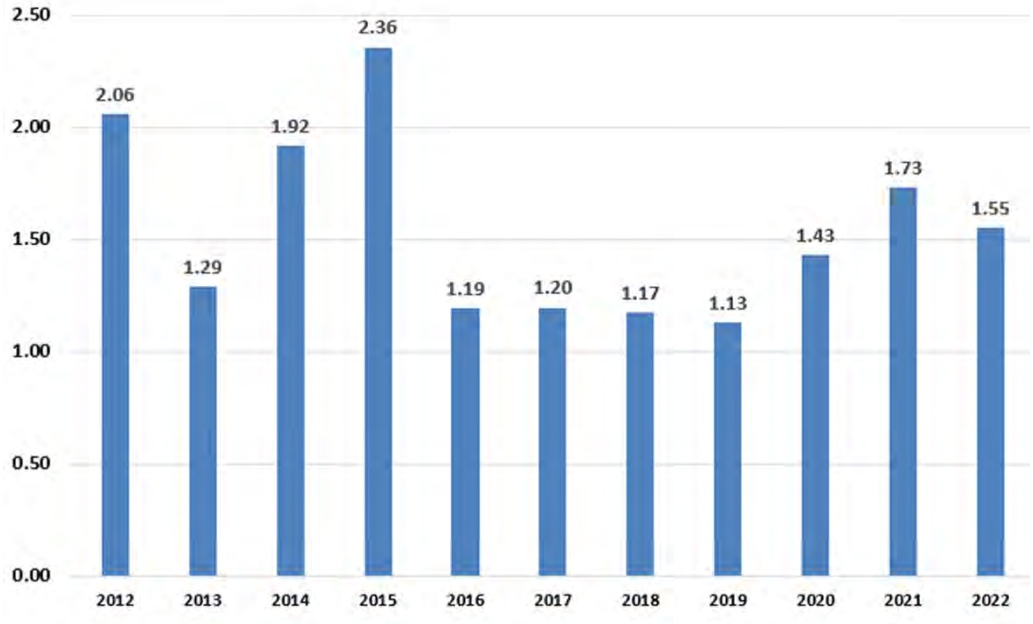
Employment in Alaska ↑ Alaska Injury Frequency ↑



Time Loss Rate

Using the number of 4,637 time-loss claims reported in 2022 divided by average monthly employment statewide of 298,762 (Total Alaska average employment less Federal Government employment (313,765 -15,003 = 298,762) multiplied by 100. The time loss rate per 100 employees in 2022 was 1.55, a 10.32% decrease from a time loss rate of 1.73 in 2021.

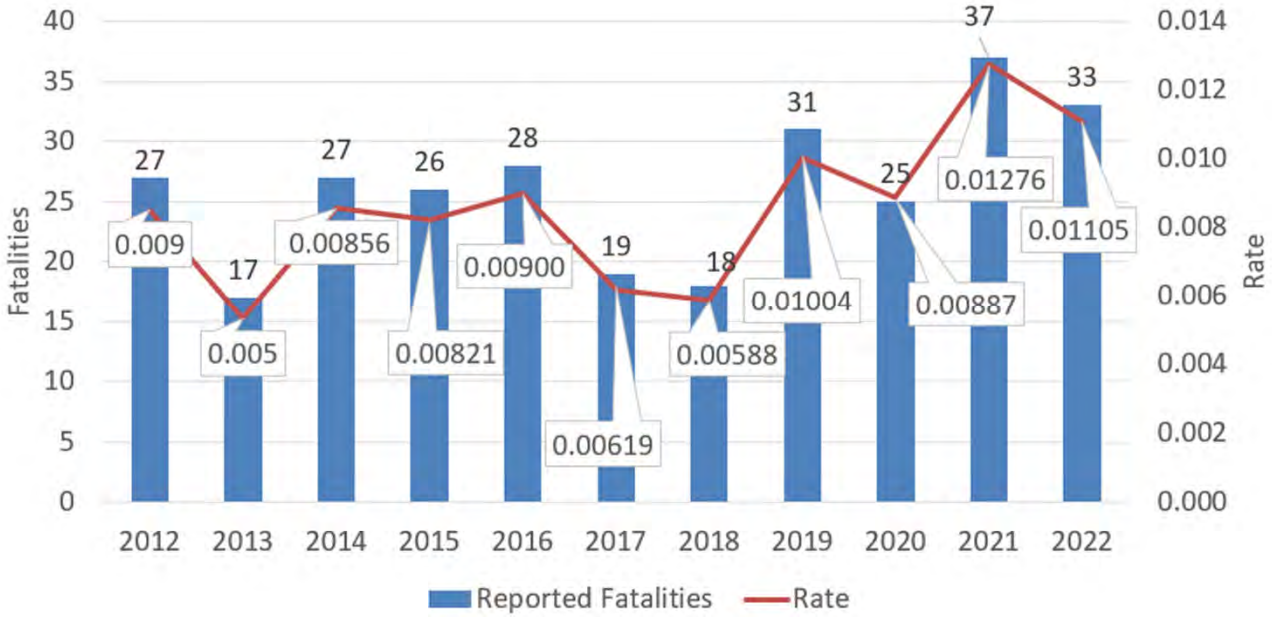
Year	Alaska Average Employment	Time Loss Cases	Rate
2022	298,762	4,637	1.55
2021	289,946	5,018	1.73
2020	281,976	4,037	1.43
2019	308,796	3,488	1.13
2018	306,211	3,573	1.17
2017	312,886	3,750	1.2
2015	316,979	3,688	1.19
2014	323,619	7,467	2.36
2013	319,893	6,046	1.92
2012	317,562	4,036	1.29



Fatality Rate

There were 33 fatalities reported in 2022, a 10.8% decrease from 37 fatalities reported in 2021. The fatality rate per 100 employees in 2022 was 0.01105, a 13.44% decrease from 0.01276 in 2021.

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



Note: The agency received a total of 33 reports of injured workers that passed away in 2022. Trading partners reported that 12 deaths were not work-place injuries.

Direct Written Premiums

Calendar Year	Direct Written Premiums * (000s)
2022	$182,520
2021	$179,252
2020	$196,813
2019	$225,779
2018	$240,150
2017	$251,110
2016	$268,052

Under regulatory order no. R22-04, on August 23, 2022, the Division of Insurance received and approved the 2023 Alaska Workers' Compensation Filing for Voluntary Loss Costs and Assigned Risk Rates from the National Council on Compensation Insurance, Inc. (NCCI). The filing proposed an overall 6.5% decrease in voluntary loss costs and an overall 4.1% decrease in assigned risk rates from current approved levels.

*Based on The Division of Insurance Calendar Year reconciliation reports for Workers' Compensation Service Fee.

Direct Written Premiums

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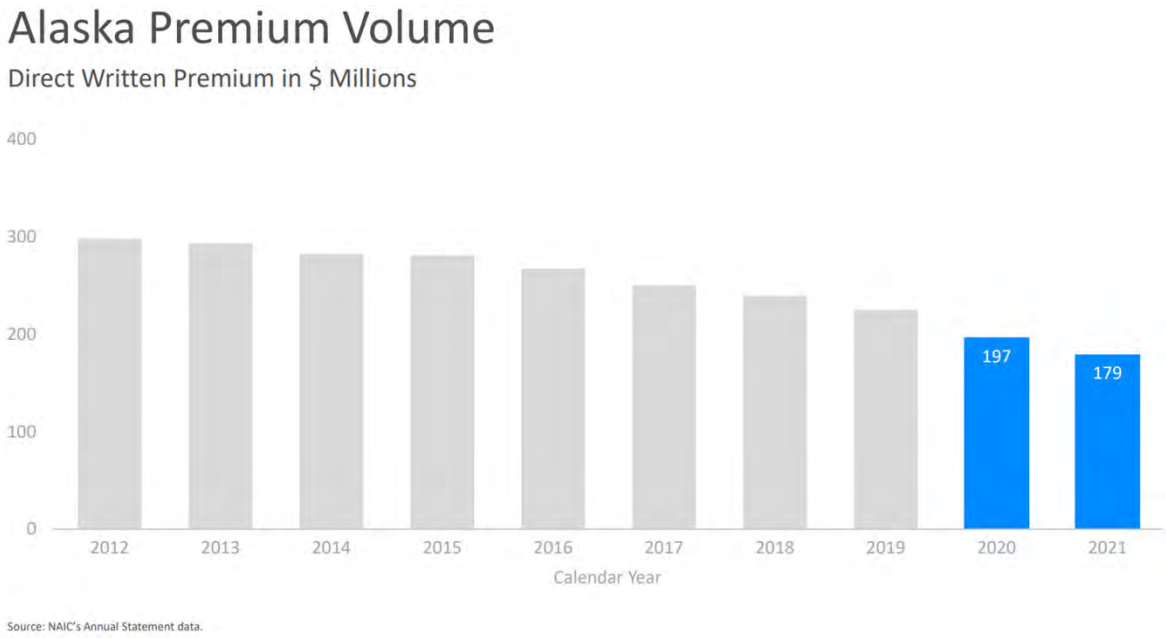

Courtesy of NCCI, Alaska State Advisory Resources, Alaska Workers Compensation System Overview, October 2022

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Direct Written Premiums

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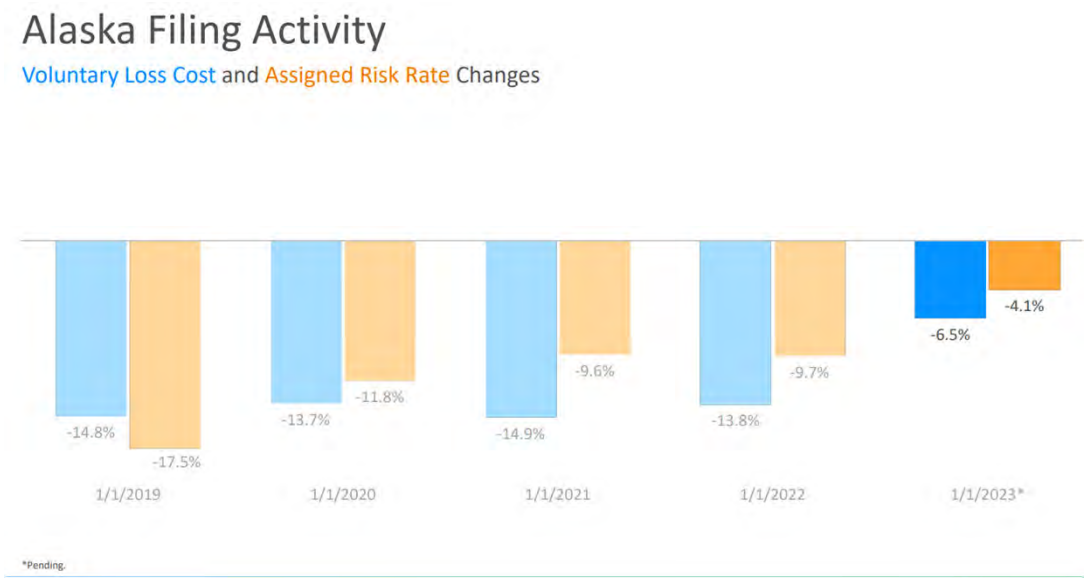
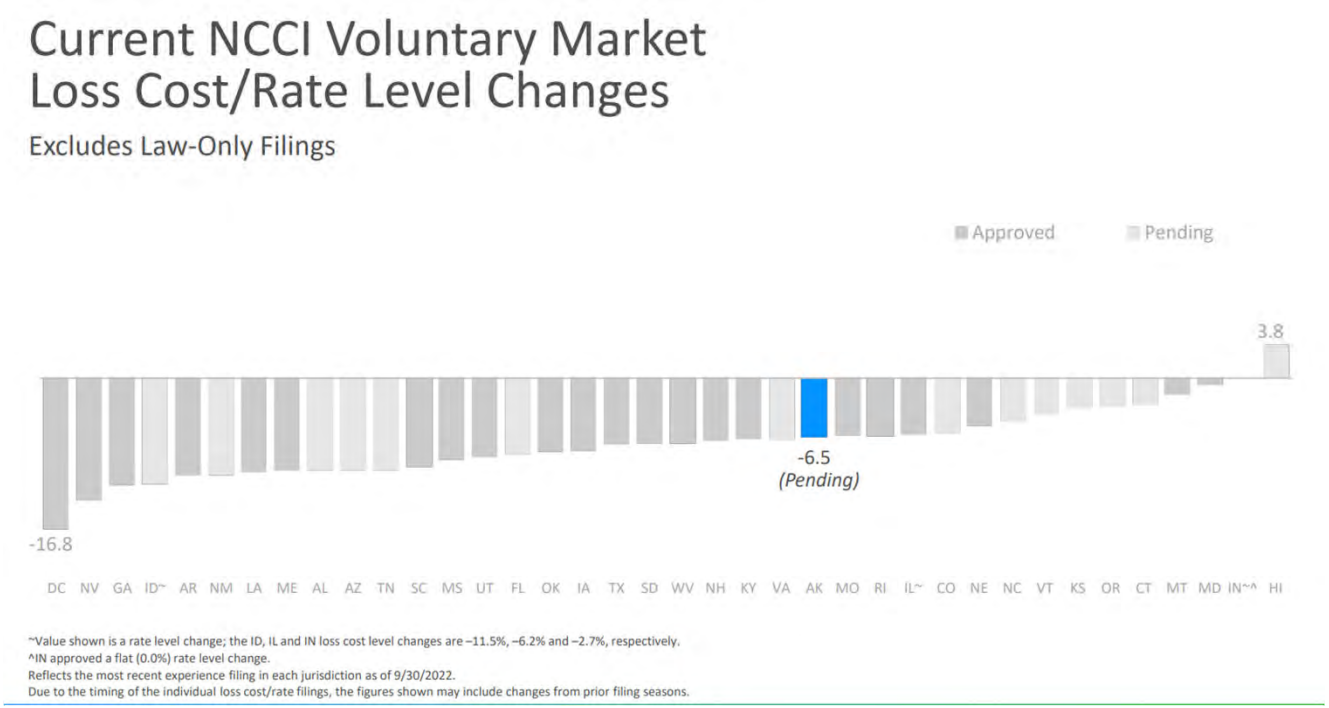


Courtesy of NCCI, Alaska State Advisory Resources, Alaska Workers Compensation System Overview, October 2022

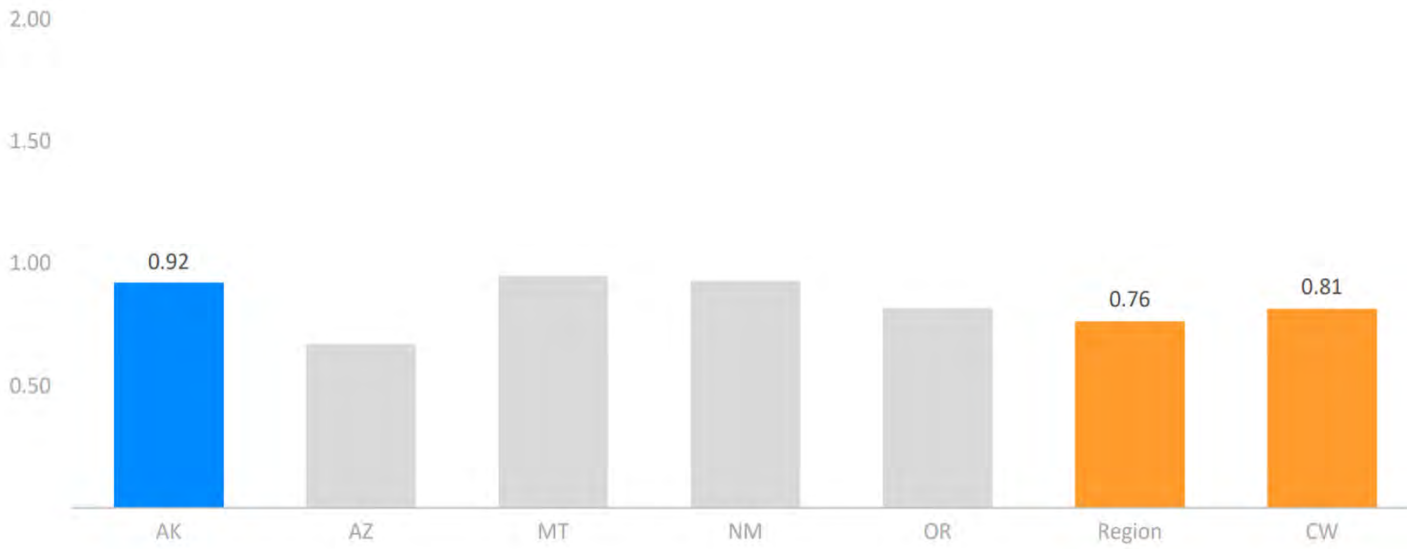
National Loss Cost Comparison



Courtesy of NCCI, Alaska State Advisory Resources, Alaska Workers Compensation System Overview, October 2022

Average Voluntary Pure Loss Costs

Using Alaska Payroll Distribution



Based on approved rates and loss costs in various jurisdictions from filings using data valued as of 12/31/2020.

Courtesy of NCCI, Alaska State Advisory Resources, Alaska Workers Compensation System Overview, October 2022

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Table 2. Workers' compensation premium rate ranking

2022 Rank	2020 Rank	State	Index Rate	Percent of Study Median	Effective Date
1	1	New Jersey	2.44	192%	January 1, 2022
2	5	Hawaii	2.27	178%	January 1, 2021
3	4	California	2.25	178%	September 1, 2021
4	2	New York	2.15	169%	October 1, 2021
5	8	Louisiana	2.13	167%	May 1, 2021
6	3	Vermont	1.98	156%	April 1, 2021
7	26	Wyoming	1.86	146%	January 1, 2022
8	11	Wisconsin	1.67	132%	October 1, 2021
9	16	Maine	1.67	131%	April 1, 2021
10	6	Connecticut	1.64	129%	January 1, 2022
11	9	Rhode Island	1.62	128%	August 1, 2021
12	17	Minnesota	1.55	122%	January 1, 2022
13	14	Missouri	1.54	121%	January 1, 2022
14	21	Iowa	1.52	120%	January 1, 2022
15	12	Montana	1.46	115%	July 1, 2021
16	15	Idaho	1.43	112%	January 1, 2022
17	13	Oklahoma	1.41	111%	January 1, 2022
18	28	New Hampshire	1.39	109%	January 1, 2022
19	24	Illinois	1.39	109%	January 1, 2022
20	30	Alabama	1.38	108%	March 1, 2021
21	10	Alaska	1.37	107%	January 1, 2022
22	19	South Carolina	1.35	106%	April 1, 2021
23	7	Delaware	1.34	106%	December 1, 2021
24	22	Washington	1.31	103%	January 1, 2022
25	23	South Dakota	1.30	102%	July 1, 2021
26	20	Pennsylvania	1.27	100%	April 1, 2021
27	29	New Mexico	1.27	99%	January 1, 2022
28	27	Florida	1.26	99%	January 1, 2022
29	25	Nebraska	1.25	98%	February 1, 2021
30	31	North Carolina	1.16	91%	April 2, 2021
31	15	Georgia	1.15	90%	March 1, 2021
32	35	Massachusetts	1.05	83%	July 1, 2020
33	37	Maryland	1.04	81%	January 1, 2022
34	43	Tennessee	1.03	81%	March 1, 2021
35	39	Kansas	1.02	80%	January 1, 2022
36	32	Virginia	1.01	79%	April 1, 2021
37	42	Nevada	1.00	79%	March 1, 2021
38	37	Michigan	1.00	78%	January 1, 2021
39	34	Mississippi	0.98	77%	March 1, 2021
40	44	District of Columbia	0.95	75%	January 1, 2021
41	33	Colorado	0.93	73%	January 1, 2022
42	**45**	**Oregon**	**0.93**	**73%**	**January 1, 2022**
43	46	Texas	0.88	69%	July 1, 2021
44	43	Arizona	0.87	69%	January 1, 2022
46	38	Kentucky	0.86	67%	January 1, 2022
47	40	Ohio	0.83	66%	July 1, 2021
48	49	Indiana	0.77	60%	January 1, 2022
45	47	Utah	0.86	68%	January 1, 2022
49	50	Arkansas	0.65	51%	July 1, 2021
50	48	West Virginia	0.63	50%	January 1, 2021
51	51	North Dakota	0.56	45%	July 1, 2021

Special Funds Reports – Fiscal Year

Velma Thomas – Program Coordinator II

Administrator for the following:

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

Supervise direct report staff positions:

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

074

Special Funds Report - Benefits Guaranty Fund

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

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

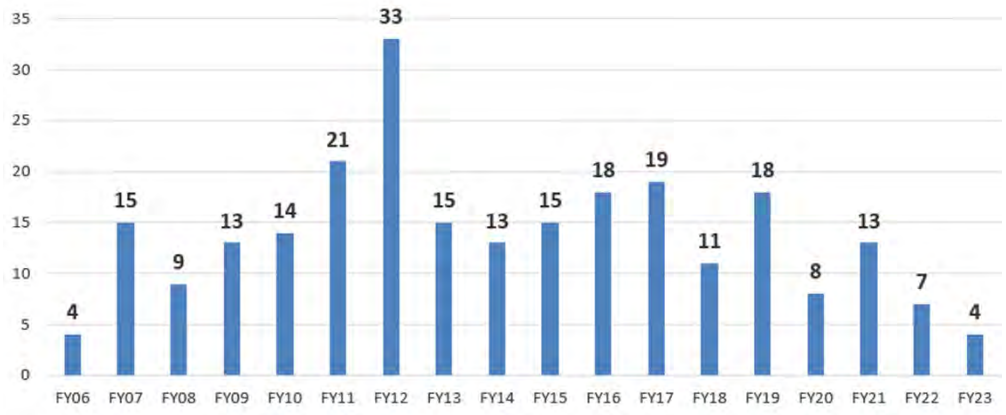
- Requirements:
  1. The injured worker must be an employee of the uninsured employer at the time of injury.
  2. The employee's work for the employer must be the substantial factor in the cause of the injury or illness.
  3. The injured worker must file a claim for benefits against the employer and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

075

Special Funds Reports Benefits Guaranty Fund

Claim Data

For FY2023, there were 9 reports of uninsured injuries. This compares to 9 reports of uninsured injuries in 2022.
In FY2023, 4 employees filed claims for benefits against the fund compared to 7 in FY2022 and 13 in FY2021.



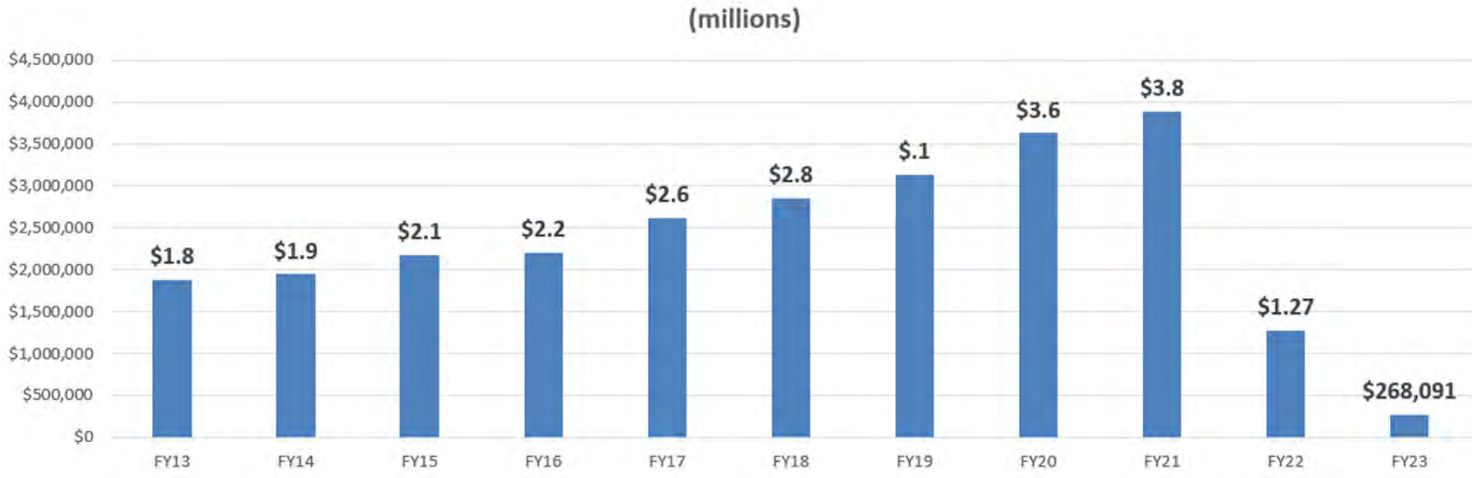
Fiscal Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Uninsured Injury Reports	40	17	15	21	21	16	27	38	38	21	9	7
New Claims Filed	33	15	13	15	18	19	12	24	8	13	7	4

076

Special Funds Reports Benefits Guaranty Fund

Fund Balance

For FY2023, the fund ending balance was $268,091, a 79% decrease, down $1.0 million from a FY2022 fund balance of $1.27 million.



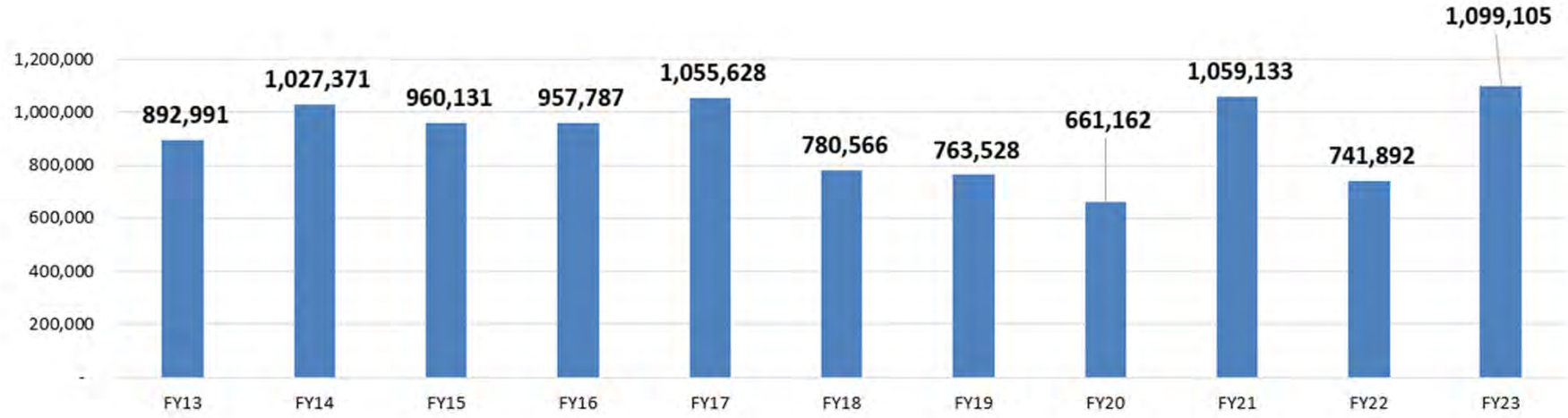
Fiscal Year	2020	2021	2022	2023
Fund Balance	$3,626,699	$3,886,050	$1,277,363	$268,091

*Decrease is attributed to sweep on 11/9/2021 of sub-funds into the unassigned repayment of Constitutional Budget Reserve Fund (CBRF) in the amount of $3,100,950.10. There are no provisions to move funds back into designated accounts.

Special Funds Reports Benefits Guaranty Fund

Revenue

For FY2023, total revenues increased by 14.7%, $106,138 from $741,892 in FY2022 to $1,099,105. The Fund earned interest in the amount of $29,450, received a supplemental deposit from General Funds in the amount of $221,400, and collected $848,255 in employer penalties and repayments.



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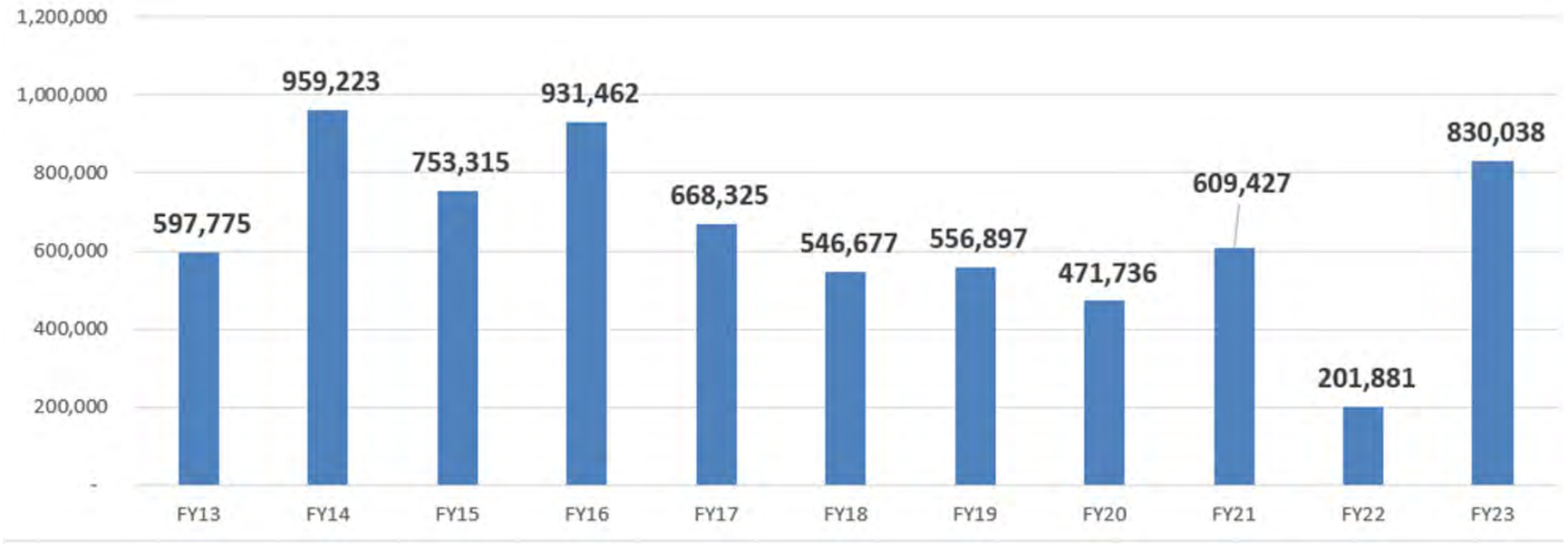
Special Funds Reports Benefits Guaranty Fund

Revenue – by Type

Fiscal Year	2021	2022	2023
Civil Penalty - Stipulation	$179,460	$139,347	$104,451
Civil Penalty - Settlement	$464,936	$335,200	$593,388
Civil Penalty – D&O	$177,231	$73,952	$27,157
BGF- Uninsured Employer Reimbursements	$70,317	$36,729	$58,105
Judgments	$176,564	$160,825	$77,886
Less Adjustments (NSF Checks)	$(9,442)	$(3,783)	$(10,057)
Total Revenues	**$1,059,113**	**$741,892**	**$850,929**
% from Civil Penalties	61%	63%	82%
% from Employer Reimbursements	7%	5%	6.8%
% from Judgements	17%	22%	9.2%

Special Funds Reports Benefits Guaranty Fund

Total Fund Expenditures



The Fund began paying PTD benefits to an injured worker for a 2012 claim filing.

Special Funds Reports Benefits Guaranty Fund

Expenditures

Expenditure Details	FY2019	FY2020	FY2021	FY2022	FY2023
# of Employees Receiving Benefits	6	8	11	5	8
Benefit Payments by Type					
Indemnity Costs	$56,525	$40,356	$97,111	$17,264	293,316
Medical Costs	$244,681	$120,066	$169,215	$13,815	$163,728
Reemployment Costs	$55,621	$14,089	$4,542	$22,237	$14,778
Employee Legal Costs	$9,856	$61,578	$82,343	$0.00	$169,456
Case Costs			$4,517	$9,326	$3,442
Total EE Benefits	**$336,684**	**$236,088**	**$362,257**	**$62,642**	**$728,741**
Administration Costs	$190,298	$235,648	$247,170	$139,239	$184,739
Total Expenses	**$556,897**	**$471,736**	**$609,427**	**$201,881**	**$830,038***
% of Benefit Payments to Total Costs	65.8%	50%	59%	31%	81.3%
% of Admin. Costs to Total Costs	34.1%	50%	41%	69%	18.6%

*includes ASD fiscal adjustments of $83,442.

081

Special Funds Reports Benefits Guaranty Fund

Potential Fund Liabilities for Open and Pending Claims Only

Report reflects liability on open & pending claims.

Open claim for 2010 – the fund is paying death benefits to two minors.

Open claim for 2012 – PTD benefits.

Fiscal Year	Total Claims Filed	No. of Claims (open & pending)	Closed Claims	Potential Liability	Paid Expenses	Balance Due (reserve)
2023	4	4	0	$592,500	$ -	$592,500
2022	7	1	6	$135,000	$2,218	$132,782
2021	13	10	1	$890,272	$110,764	$779,508
2020	8	7	1	$653,852	$438,226	$215,626
2019	24	23	1	$1,926,998	$106,987	$1,820,012
2017	19	18	1	$1,926,998	$106,987	$1,820,012
2012	33	32	1	$2,523,300	$1,399,398	$1,123,903
2010	14	13	1	$1,069,819	$760,725	$309,094
Total			**12**	**$9,718,740**	**$2,925,304**	**$6,793,436**

Special Funds Report – Second Injury Fund

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

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

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

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

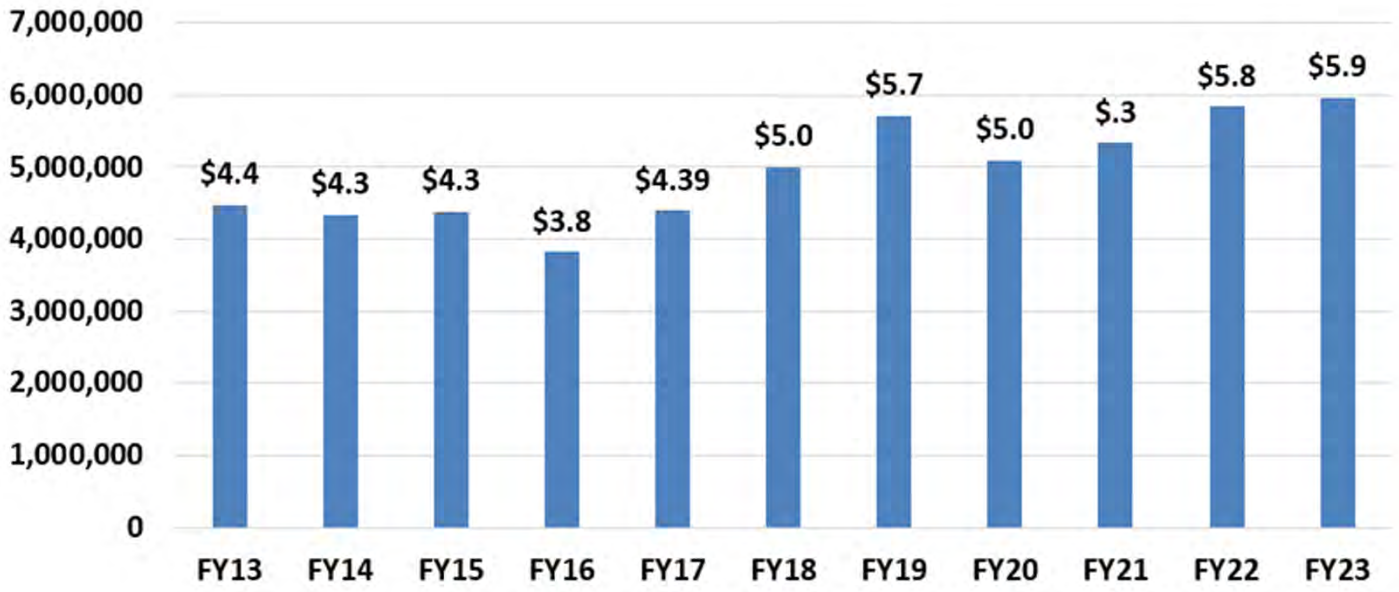
083

Special Funds Report – Second Injury Fund

Fund Balance

Fiscal Year	Balance
2023	$5,951,037
2022	$5,833,430
2021	$5,328,646
2020	$5,092,860
2019	$5,713,621
2018	$5,003,206
2017	$4,390,500
2016	$3,817,700
2015	$4,369,141
2014	$4,468,000
2013	$4,847,700

Second Injury Fund balance increased by $117,607 in FY2022, an 2% increase from $5.8 million to $5.95 million.



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Special Funds Report – Second Injury Fund

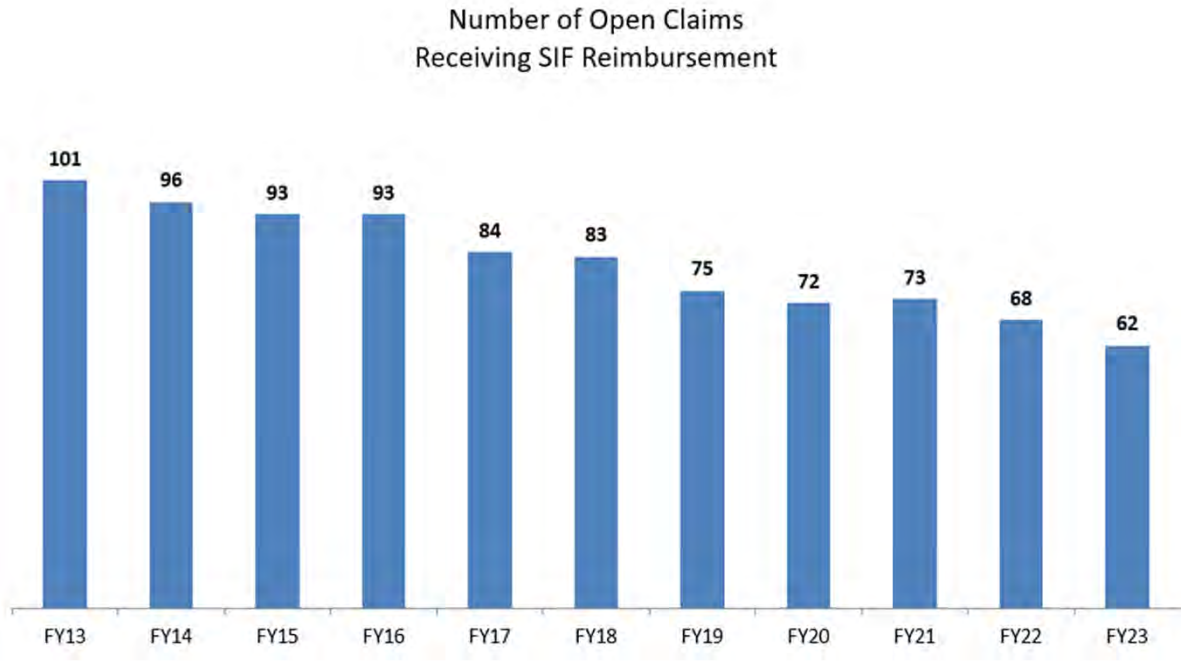
Revenues

Fiscal Year	Balance
2023	$2,456,080
2022	$2,591,282
2021	$2,593,298
2020	$2,452,494
2019	$3,190,588
2018	$3,257,228
2017	$2,984,507
2016	$3,067,905
2015	$3,274,682
2014	$3,146,551
2013	$3,171,694

Second Injury Fund revenues decreased by $135,202 in FY2023, an 5.2% decrease from $2.59 million to $2.45 million.

Special Funds Report – Second Injury Fund

Claim Data



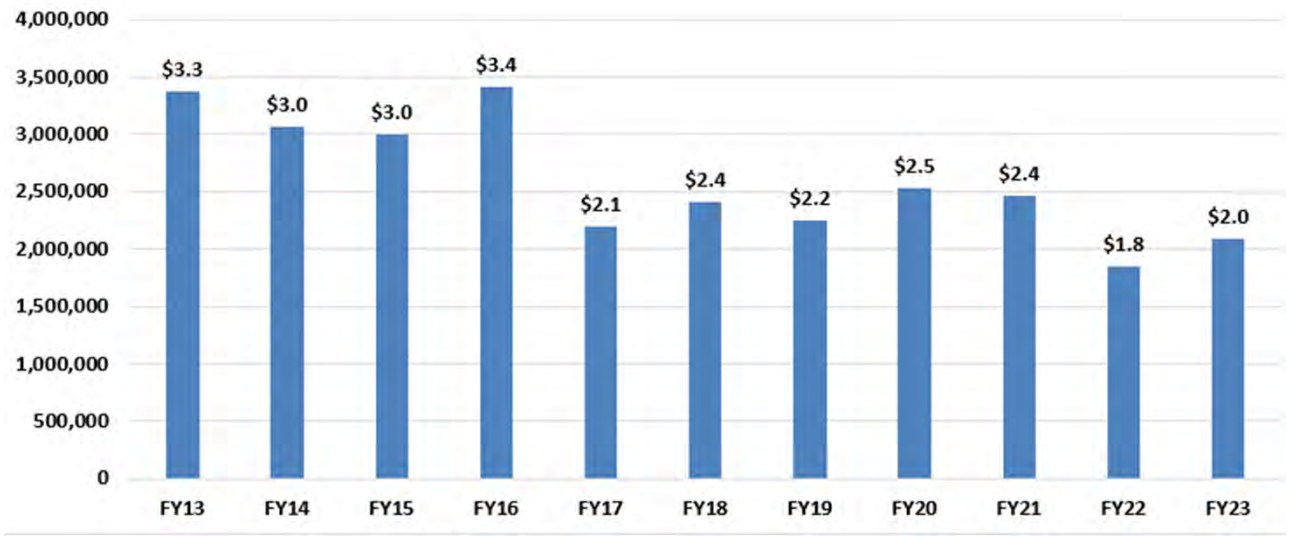
In FY2023, Trading Partners reported that 7 employees passed away.

Special Funds Report – Second Injury Fund

Claim Data

Benefits Paid to Employer or Insurer

Fiscal Year	Grant Payments
2023	$2,093,519
2022	$1,845,461
2021	$2,467,064
2020	$2,526,796
2019	$2,256,245
2018	$2,408,649
2017	$2,195,316
2016	$3,412,273
2015	$3,001,912
2014	$3,064,978
2013	$3,373,995



087

Special Funds Report – Second Injury Fund

Claim Data

Benefits Paid Insurer/Employer

Top Ten Reimbursement Recipients		
Rank	**Insurer/Self-Insurer**	**Amount**
1.	State of Alaska	**$360,382**
2.	Arctic Slope Regional Corporation	**$261,699**
3.	Municipality of Anchorage	**$255,004**
4.	Alaska National Insurance	**$143,085**
5.	Indemnity Insurance Co of NA	**$130,000**
6.	Alaska Timber Insurance Exchange	**$120,467**
7.	National Union Fire Insurance	**$104,095**
8.	Ace American Insurance	**$98,781**
9.	Liberty Mutual Insurance	**$82,460**
10.	Liberty Insurance Corp	**$65,911**
	Total	**$1,626,885**

088

For FY2022, top ten employer reimbursement payments totaled $1.6 million compared to $1.2 million in FY2022.

Reimbursement Recipients by Type			
#	**Type**	**Amount**	**%**
21	Market Insurer	$1,010,712	48.3%
11	Self-Insureds	$1,082,806	51.7%
32	**Total**	**$2,093,519**	

Supplemental

Concerns:

- Late payments of agency assessed civil penalties and fees
  - Approximately 36 trading partners submitted SIF contributions totaling $643,461 after March 1.
  - Approximately 4 self-employed insurers submitted WSCAA fees totaling $139,114 after March 1.

- Benefits Guaranty Fund
  - Low fund balance to pay benefits to injured workers.

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QUESTIONS?

STATE OF ALASKA
DIVISION OF WORKERS' COMPENSATION

REEMPLOYMENT BENEFITS Annual Report
Calendar Year 2022

091

Stacy Niwa
Reemployment Benefits Administrator

Reemployment Benefits Section

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

092

2022 By the Numbers

- 498 injured workers were referred for evaluations for eligibility for reemployment benefits.
- 1020 eligibility evaluation reports were reviewed.
- 146 suspension letters were issued.
- 489 eligibility determinations were made.
- 67 injured workers were found eligible for reemployment benefits.
- 23 injured workers elected to receive a job dislocation benefit.

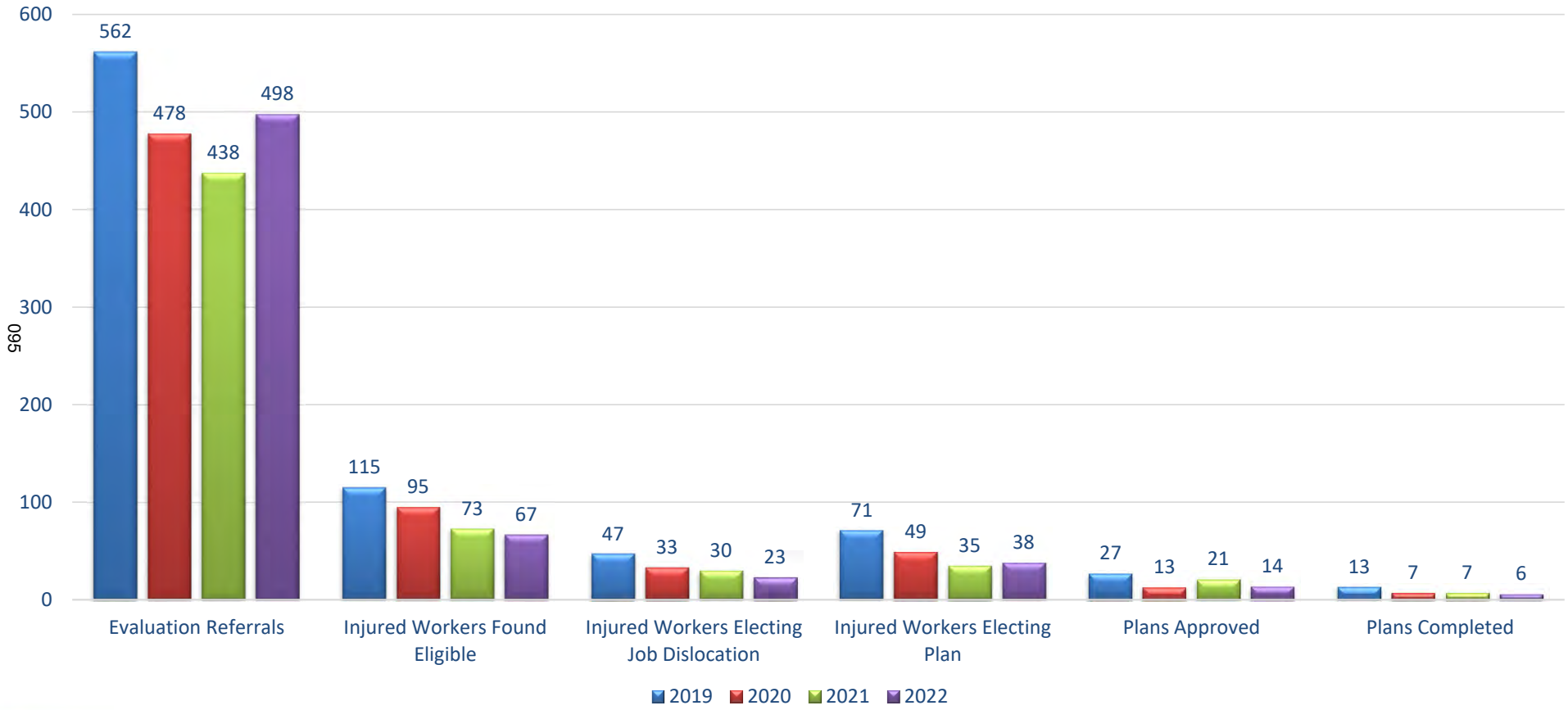
093

2022 By the Numbers, Cont.

- 38 elected to pursue reemployment benefits.
- 35 reemployment plans were submitted.
- 14 plans were signed by all parties and moved forward as agreed upon plans.
- 4 plan reviews were completed.
- 6 informal rehabilitation conferences were held to assist the parties in moving forward with reemployment benefits.
- 6 injured workers completed reemployment plans.
  - start dates of completed plans range from 1/6/2020 – 1/6/2022

094

2022 By the Numbers, Cont.



Reemployment Benefit Plans

- 109 injured workers were in the plan process at some point during 2022.
- 39 injured workers were referred for plan development in 2022.
- 22 injured workers exited the process through a Compromise and Release after plan referral and before plan completion.
- 14 injured workers were in an approved plan at year end.
- 12 injured workers were in plan development and 20 plans were pending approval at year end.
- 6 injured workers successfully completed plans with an average plan length of 18 months from plan approval to plan completion.

960

Reemployment Benefit Plans, Cont.

- **48 plans were stalled or exited for various reasons.**
  - 5 injured workers' plan process was medically suspended.
  - 23 injured workers exited through a Compromise and Release agreement.
  - 12 plans were controverted or a petition to terminate reemployment benefits was filed.
  - 2 plan was unable to be developed to meet statutory requirements.
  - 5 plan processes were halted because the injured worker was non-participatory.
  - 1 plan was unsuccessful because the time had expired.

097

Outcomes for Workers Completing Plans

- The Reemployment Benefits Section attempted to contact 20 injured workers that had completed plans between 2020 and 2022.
- 5 injured workers responded.
- 0 injured workers had returned to the workforce.
- 5 injured workers reported they had not returned to work.
  - 2 reported they were medically disabled
  - 1 reported they needed additional medical treatment
  - 1 reported the training did not prepare them for the occupational goal
  - 1 reported they are continuing their education

Reemployment Benefit Costs

	2020	2021	2022
Evaluation Costs	$1,472,596	$1,573,099	$1,394,704
Reemployment Specialist Plan Fees	$626,545	$555,366	$581,264
Plan Costs	$503,629	$263,607	$359,799
Wage Benefits (AS 23.30.041(k))	$2,135,149	$2,053,267	$2,479,056
Job Dislocation Benefits (AS 23.30.041(g))	$2,961,687	$917,890	$1,674,193
TOTALS	$7,699,606	$5,359,016	$6,489,016
% Change	-3.10%	-38.85%	19.07%

660

Reemployment Benefits in Settlements

Impact of settlements on reemployment benefits in 2022

- 47 injured workers exited the reemployment benefits process through Compromise and Release agreements during the reemployment benefits process.
- 62 injured workers had funds designated for reemployment benefits included in settlements approved in 2022, increasing reemployment benefit costs.
    - 45 of these injured workers had never been determined eligible for reemployment benefits, many had never entered the reemployment process or had been found not eligible for reemployment benefits.
- 22 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.

100

Rehabilitation Specialists

- 15 Alaska Rehabilitation Specialists accepted 372 referrals for eligibility evaluations; 126 evaluations were referred to 43 specialists out of state.
- 1 Alaska specialist retired
- For Alaska Based Specialists:
  - 306 or 82% of the first reports were submitted within 60 days of the referral.
  - 141 or 38% of the evaluations were completed on the first report submission.
  - 223 or 60% of the evaluations were completed prior to a suspension letter from a Reemployment Benefits Administrator Designee.
  - 159 reports did not meet statutory/regulatory requirements.
- Continued improvements in our process are being made to ensure work is in compliance with statutory and regulatory requirements through suspension letters, discussions, plans of correction and disqualification from providing services under AS 23.30.041.

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Alaska Rehabilitation Specialist Performance

2022 Reemployment Benefit Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1st report	% complete on 1st report or w/o suspension letter	% of late 1st reports	# 90 day gaps in reporting	# reports not meeting stat/reg	Median # days to determ
L. Cortis	22	57	62%	30%	6	3	57
J. Cranston	20	28	42%	10%	5	25	56
K. Davis	22	38	57%	9%	1	6	58
J. Doerner	35	33	75%	0%	0	3	32
R. Hoover	40	29	58%	5%	5	1	30
T. Hutto	18	32	69%	33%	1	2	34
N. Kates	13	30	64%	0%	0	4	41
S. Krier	20	27	72%	0%	0	9	43

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Alaska Rehabilitation Specialist Performance

2022 Reemployment Benefit Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1st report	% complete on 1st report or w/o suspension letter	% of late 1st reports	# 90 day gaps in reporting	# reports not meeting stat/reg	Median # days to determ
D. LaBrosse	19	31	53%	16%	0	24	50
C. Robbins	35	34	78%	17%	1	2	28
B. Roberts	18	43	38%	69%	0	28	131
F. Sakata	35	56	46%	41%	6	38	51
J. Shipman	21	25	90%	0%	0	1	26
N. Silta	19	27	53%	0%	0	13	90
P. Vargas	35	37	81%	16%	0	0	33

QUESTIONS?

SPECIAL INVESTIGATIONS UNIT ANNUAL REPORT

Michele Wall-Rood
Chief Investigator

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)
  - William Keen, Inv. 2 – Anchorage (10/2023)

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Mission and Core Values

- SIU – Dedicated, Responsible, Diligent and Resilient

- **Mission Statement**: SIU is dedicated to enforcing compliance with the Alaska Workers' Compensation Act. SIU conducts thorough and fair fraud investigations, holds violators accountable, and strives to prevent uninsured injuries through proactive public education.

- **Core Values:**
  - **Integrity** – We do the right thing, for the right reason, even when no one is looking. We act with honesty, honor, impartiality, fairness, and transparency. We never compromise the truth.
  - **Respect** – We treat others how we expect to be treated, with dignity and compassion. We operate in the spirit of cooperation with our fellow team members, our colleagues inside and outside the state, and our community. We embrace diversity and each other's unique talents.
  - **Dedication/Commitment** – We serve the people of Alaska by going above and beyond as much as possible, while staying within the scope of our own division duties and program boundaries.
  - **Accountability** – We are each responsible for our words, our actions, and our results. We pursue excellence.
  - **Family** – We care for each other. We support each other in creating an exceptional work environment, and encourage a healthy work-life balance

Challenges

- Criminal Fraud Prosecution
- Employers Without Records
- Legal Opinions
- Tech Support (ICERS)
- Proactive Outreach
- Caseloads
- Staffing (would benefit from additional staff)
  - Recruited Chief Investigator and Inv. 3
  - Recruiting Issues

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Achievements

- 115 Settlements, three Decisions & Orders
- Continued Multi-Agency Collaboration
  - FBI Healthcare & Financial Crimes Fraud Task Force
  - Local and State Law Enforcement Agencies
  - Labor Standards & Safety (AKOSH, W&H)
  - Trainings held for DHSS Assisted Living Home Orientations and the American Payroll System
  - Hosted a Verbal Judo Training for Multiple Agencies
- 493 FTI Investigations worked – 388 Opened/386 Closed
- Worked on a pending WC Fraud Indictment under AS 23.30.075 with the Office of Special Prosecutions and the Medicaid Fraud Control Unit.

Fraud Hotline and Email Tips

	FY2021	FY2022	FY2023	Year-to-Date First Quarter FY2024 (7/1/2023-9/30/2023)
Total Fraud Tip Calls and Emails	143	116	152	24
Claimant/Injured Worker Tips	13	18	19	7
Employer Tips	66	41	73	9
Care Providers	2	2	2	0
Attorneys/Non-Attorney Reps	0	1	1	0
Insurance Companies/Agents	0	2	3	1
Fish Fund Claimants	0	0	0	0
Law Enforcement Agency Assist Requests	60	51	52	7
Other/Non-Related	2	1	2	0

Failure to Insure Fraud Investigations

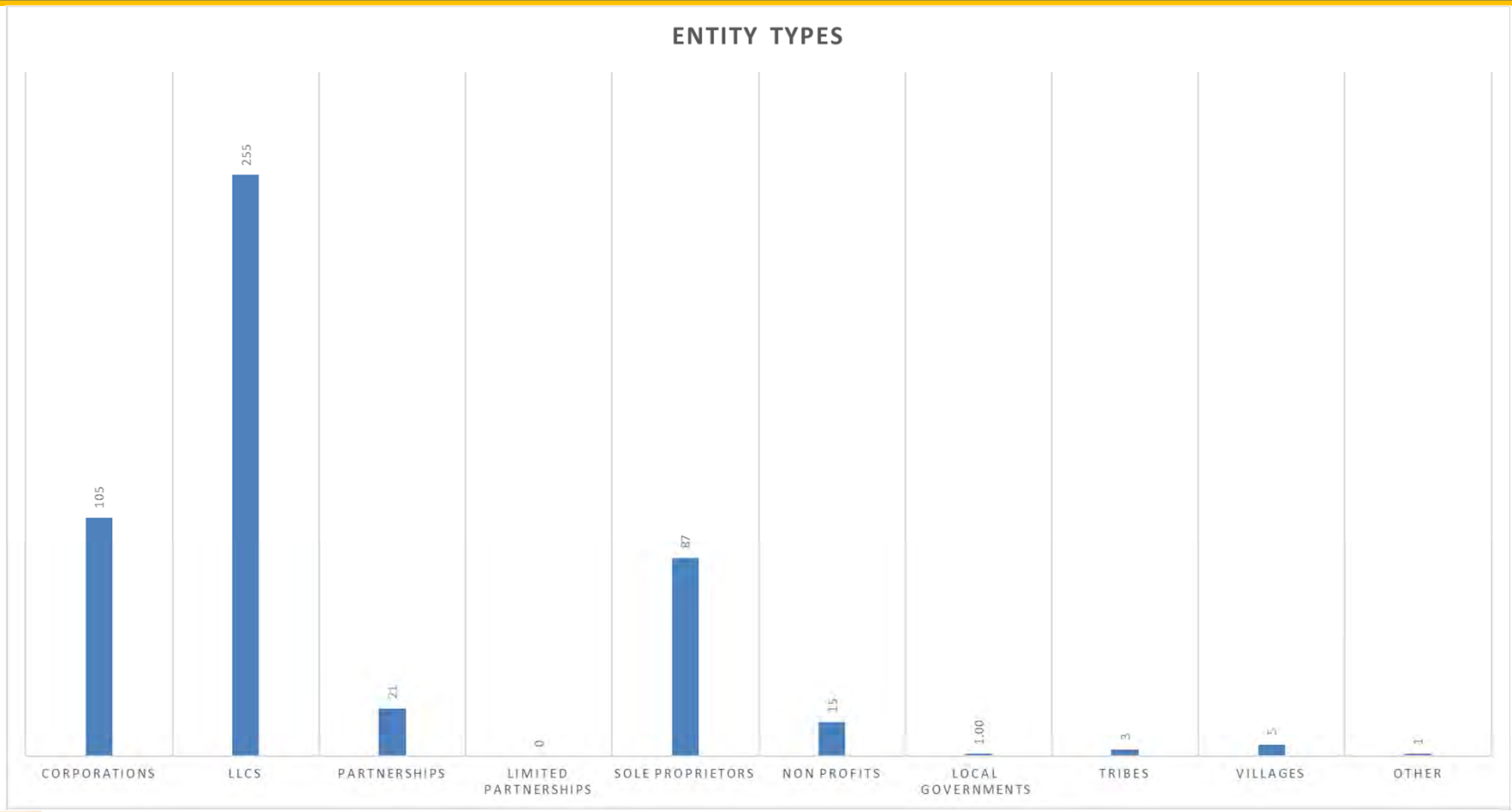
ACTIVITY	FY2021	FY2022	FY2023	Year-to-Date First Quarter FY2024 (7/1/2023-9/30/2023)
Pending Cases Carried Forward	116	87	105	108
New Cases Opened	235	254	388	91
Cases Closed	240	257	386	68
Total Cases Worked	323	363	493	199
Petitions	93	101	114	17
Pre-Hearings Attended	126	116	125	10
Compliance Checks	368	350	307+2359	155 + 1657
Public Inquiries	255	254	259	44
Formal Hearings	7	5	4	0
Warning Letters	19	43	44	2
Investigation Only	115	125	205	50
Settlements Paid in Full	66	59	112	11
Settlements with Payment Plans	15	11	3	1
Percentage Closed in 6 Months	67.23% (158 of 235)	76.65% (197 of 257)	83.1% (321 of 386)	73.5% (50 of 68)
Total Penalties	$1,728,592	$4,535,255	$1,081,037	$97,931
Total Discounts	$260,930	$164,586	$183,697	$14,125
Total Suspensions	$598,928	$3,757,865	$279,988	$19,710
Total Payable	$868,734	$612,804	$617,351	$64,094
Uninsured Injuries	21	9	9	13
Interagency Referrals	27	18	24	2

Failure to Insure FY2023

Investigations Opened/Re-Opened	Investigations Closed	Uninsured Injury Referrals Received	Uninsured Injuries Confirmed	Employers With Uninsured Injuries Petitioned
388	386	11	7	3

	Assessed By	Total Assessed	Discounted	Suspended	Ordered to Pay
FY2023	115 Settlements (3 with payment plans)	$1,081,037.96	$183,697.40	$279,988.72	$617,351.84
	3 Decisions & Orders (All Final)	$148,662.32	n/a	$38,100.00	$110,562.32
	TOTALS	**$1,229,700.28**	**$183,697.40**	**$318,088.72**	**$727,914.16**

Industry Data for FTI Investigations



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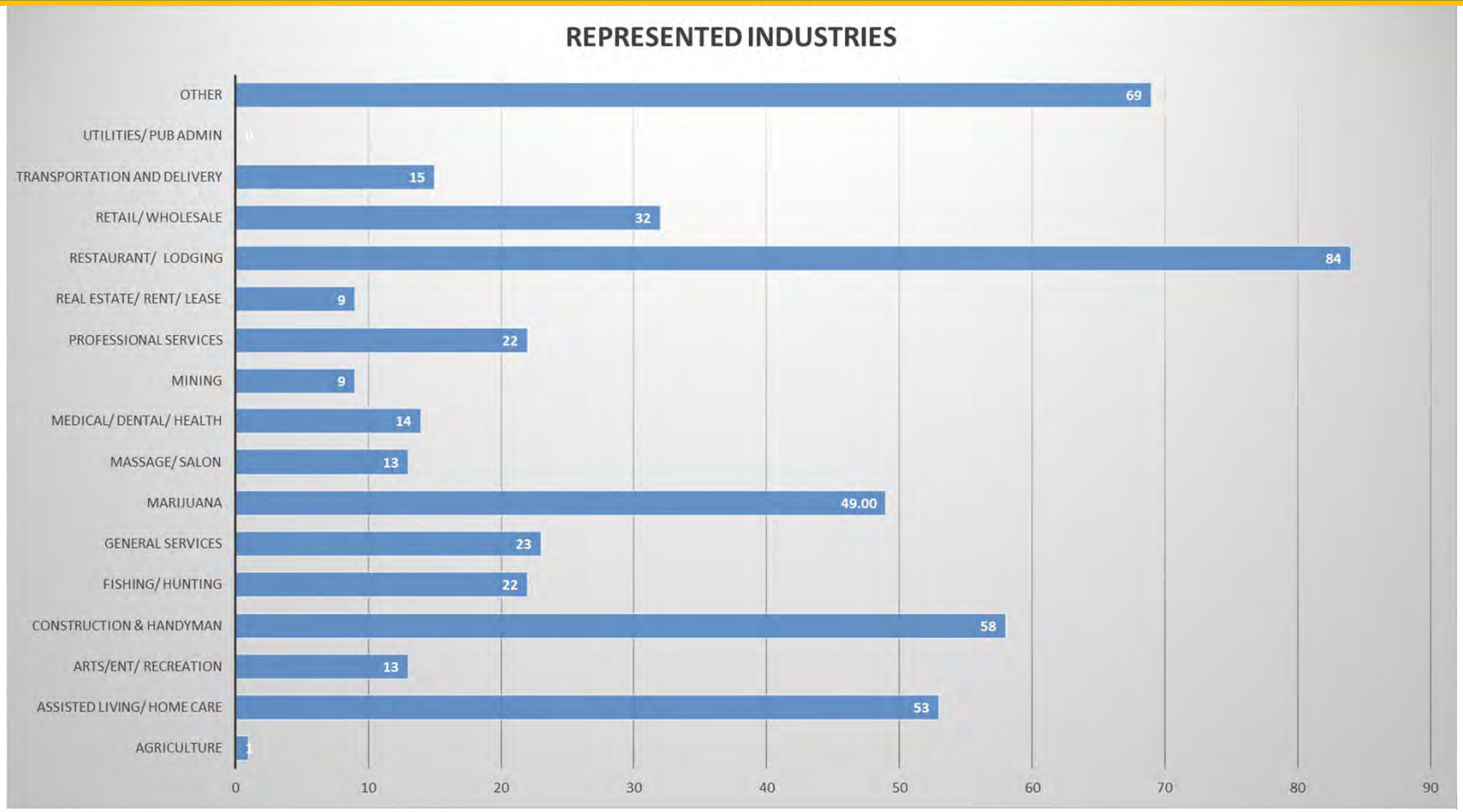
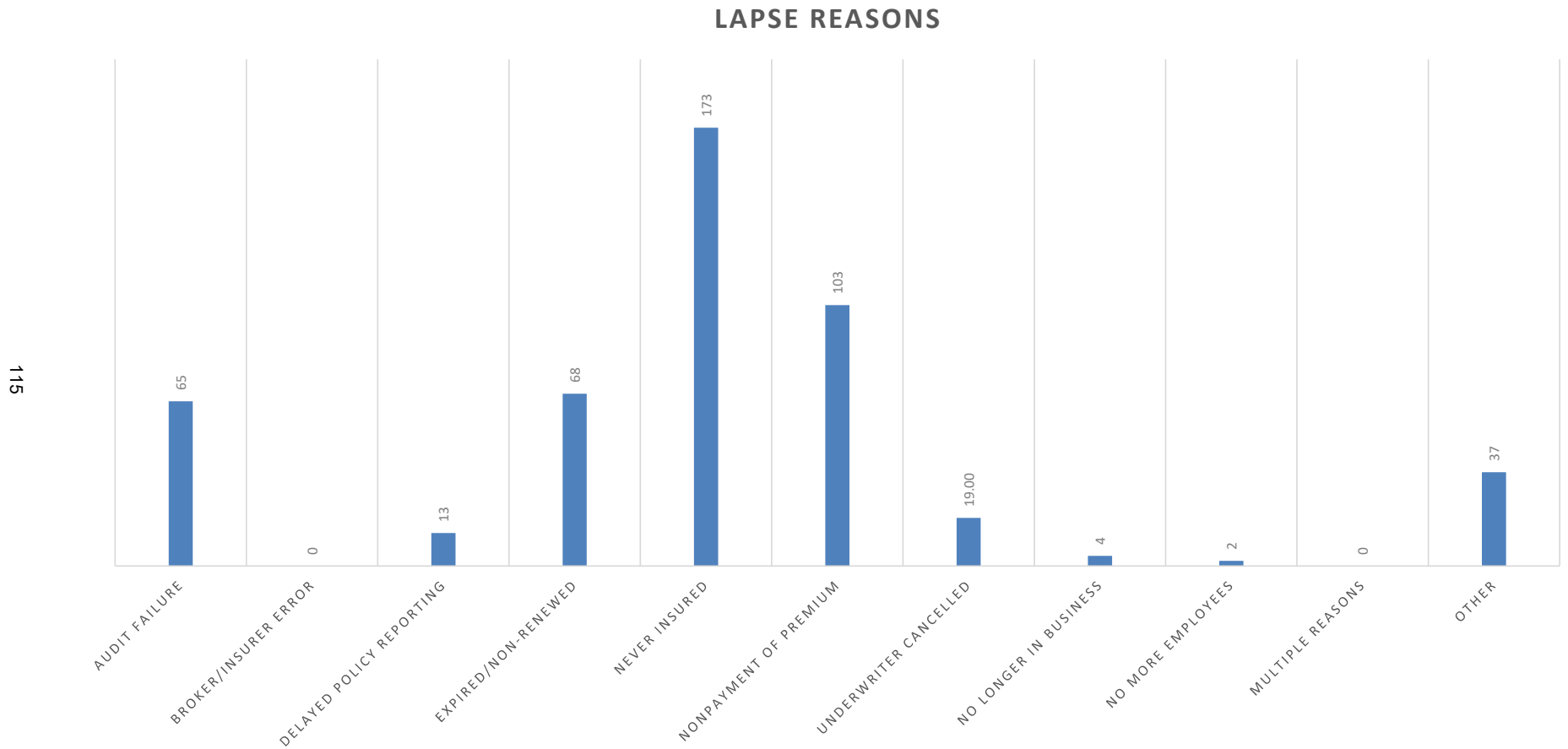
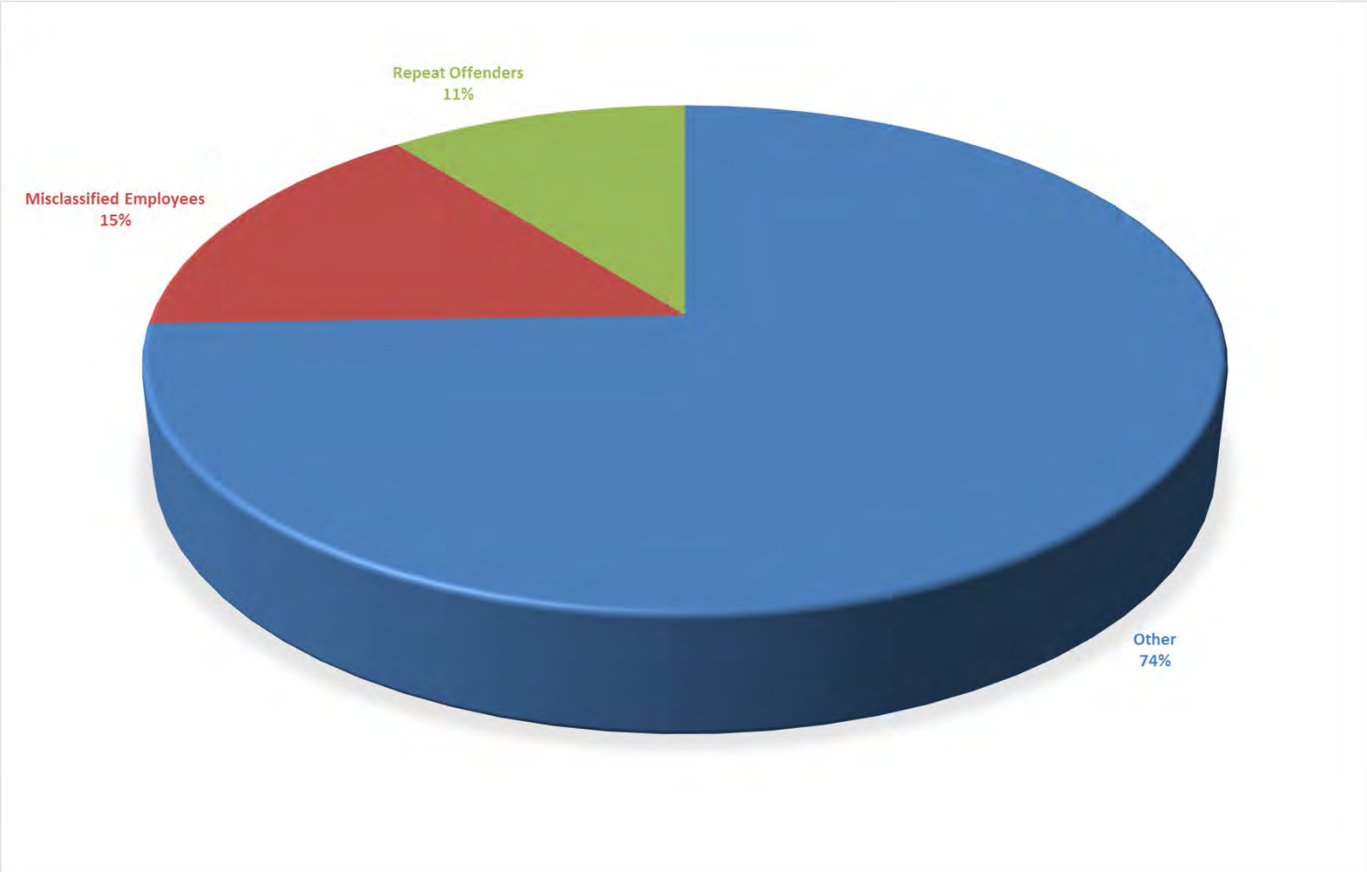
Industry Data for FTI Investigations



Industry Data for FTI Investigations



Industry Data for FTI Investigations



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Current Goals/Priorities

- Increased Staffing
- Continued Six Month Case Resolution
- Continued Multiple Agency Referrals and Joint Investigations
- Resume Targeted Proactive and Collaborative Education

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QUESTIONS?

Second Independent Medical Evaluations (SIME)

AS 23.30.095
8 AAC 45.092

Dani Byers
Workers' Compensation Officer II

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2023 SIME Selection Panel

Panel Members:

- Kennan Powell, Employee Attorney
- Joseph Kalamarides, Employee Attorney
- Jeffrey Holloway, Employer Attorney
- Aaron Sandone, Employer Attorney

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Division Support Staff:

- Z. Kent Sullivan, Chief of Adjudications
- Alexis Hildebrand, Administrative Officer II
- Dani Byers, Workers' Compensation Officer II

2023 SIME Selection Panel Decisions:

New SIME Physicians Effective 11/01/23:

• Kamran Samakar, MD	General Surgery
• Rajeev Saggar, MD	Pulmonology & Internal Medicine
• William W. Faloon Jr., MD	Orthopedic Surgery
• James F. Scoggin III, MD	Orthopedic Surgery
• Roger Kasendorf, DO	Physical Medicine & Rehabilitation
• Evan Marlowe, MD	Physical Medicine & Rehabilitation
• Ryan Davis, MD	Psychiatry

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2023 SIME Selection Panel Decisions:

2020 SIME Physicians Re-Selected:

• Carla Scheel, DC	Chiropractic Medicine
• Boban Joseph, MD	Ophthalmology
• Steven A. Ornish, MD	Psychiatry
• Matthew E. Karlovsky, MD	Urology & Urogynecology
• Danny Keiller, MD	Urology

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SIME Physicians Removed:

• Rebecca Bay, MD	Psychiatry

2023 SIME Physician Non-Renewals:

Long-time SIME Physicians:

- William P. Curran, MD — Orthopedic Surgery (since 2011, passed away)
- Lorne Direnfeld, MD — Neurology (since 2012, retiring)
- Alan C. Roth, MD — Physiatry (since 2001, retiring)

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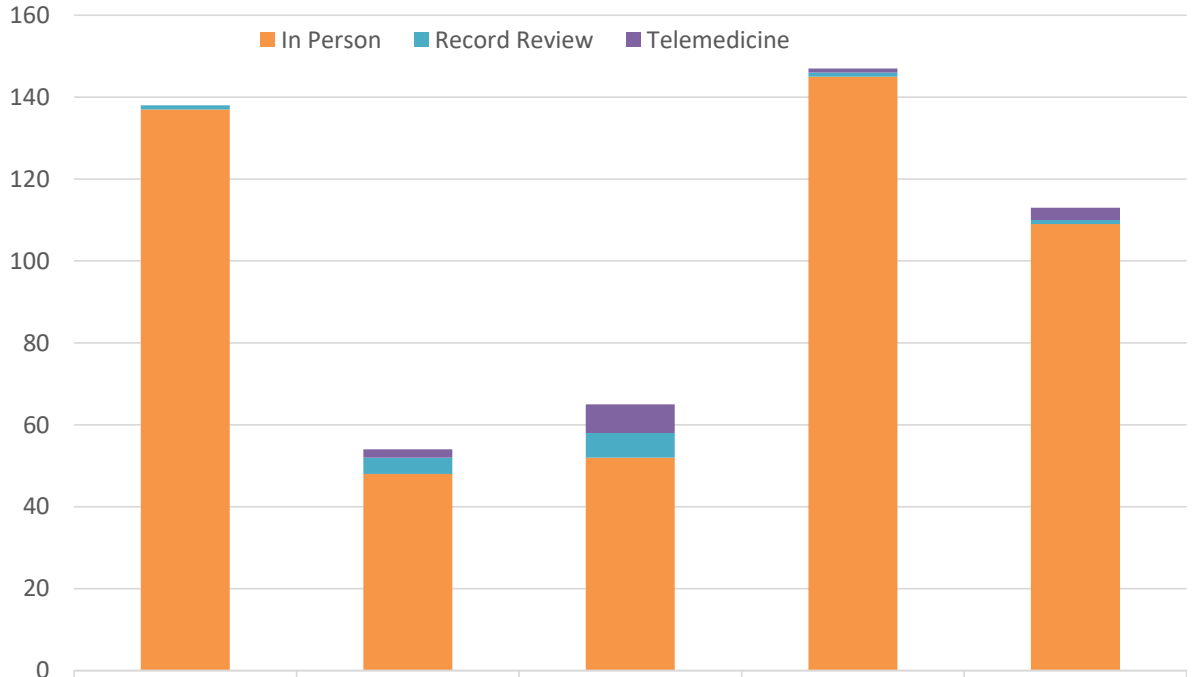
Other SIME Non-Renewals:

- Raj Ahluwalia, MD — Orthopedic Surgery (since 2022)
- Stewart Lonky, MD — Pulmonology & Internal Medicine (since 2021)

SIME Totals and Methods: 5 Year Comparison:



	11/1/2018 - 10/31/2019	11/1/2019 - 10/31/2020	11/1/2020 - 10/31/2021	11/1/2021 - 10/31/2022	11/1/2022 - 10/31/2023
Telemedicine	0	2	7	1	3
Record Review	1	4	6	1	1
In Person	137	48	52	145	109

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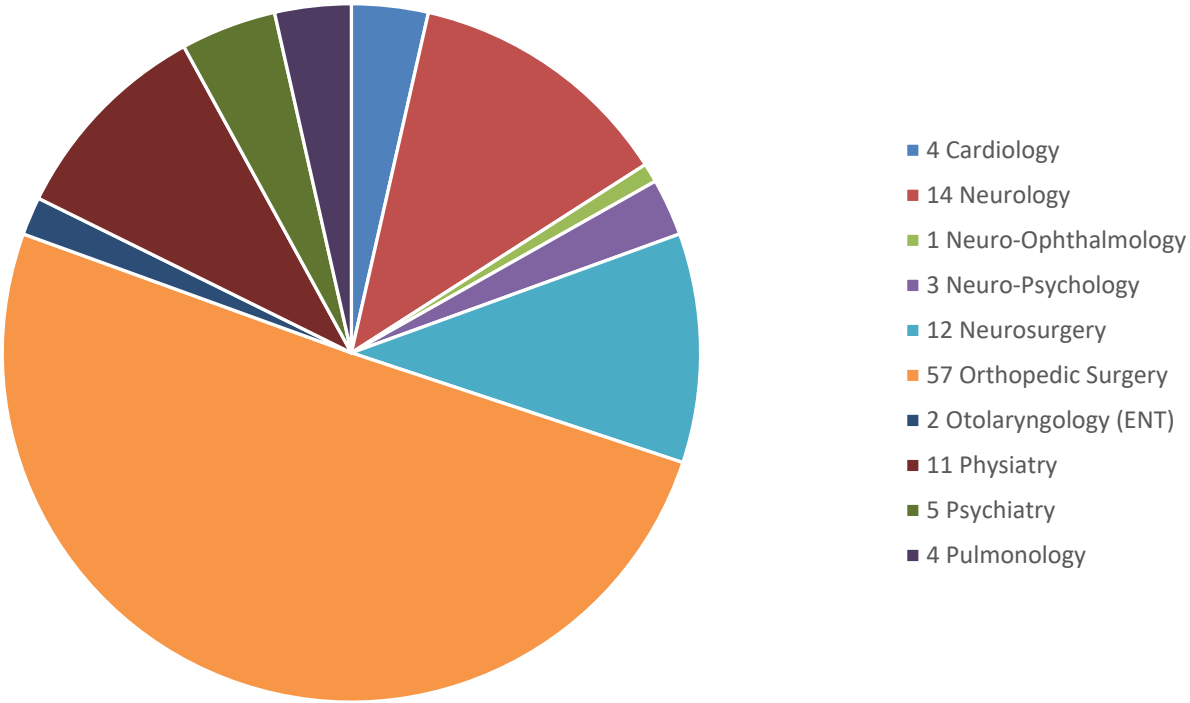
SIME Specialties Used 11/1/22 – 10/31/23:

Total SIME Appointments: 113



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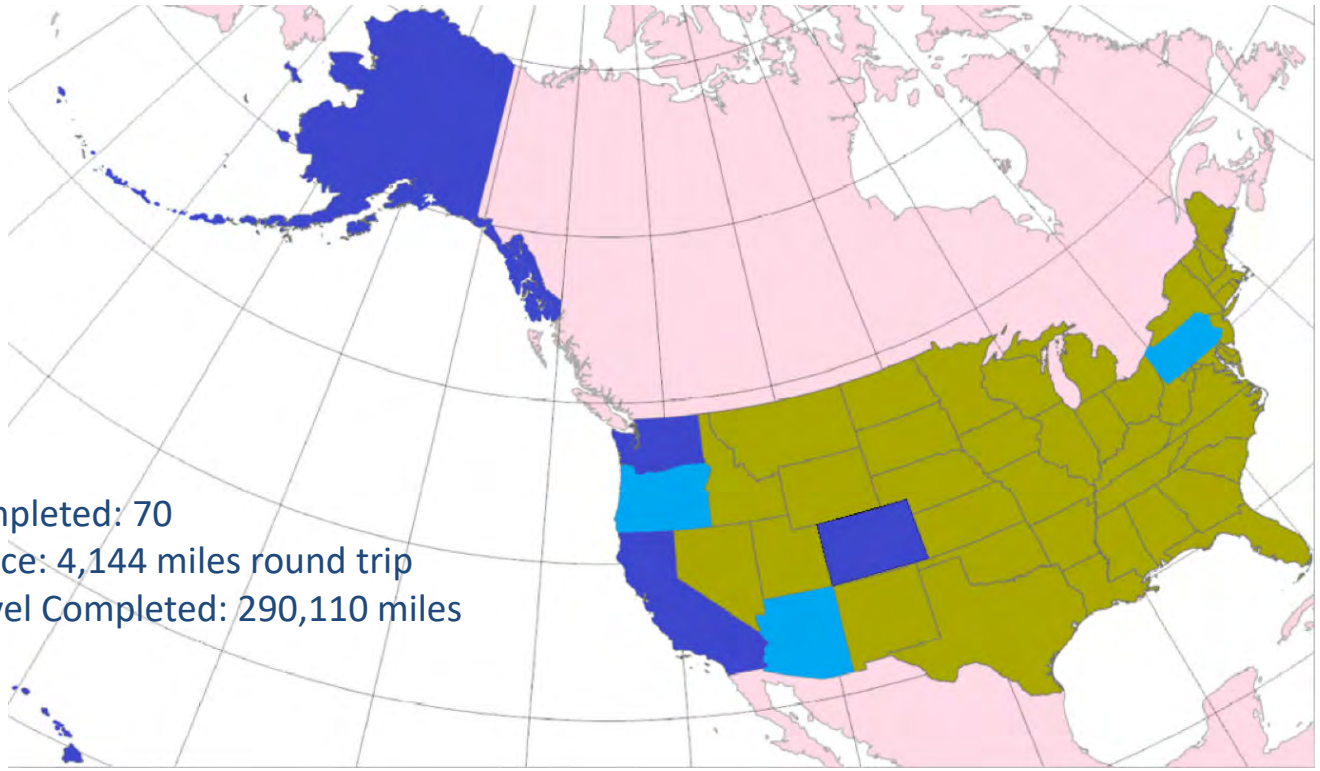
SIME Locations 11/1/22 – 10/31/23:

Alaska: 2
Arizona: 2
California: 32
Colorado: 1
Hawaii: 6
Oregon: 3
Pennsylvania: 1
Washington: 3



SIME Trips Completed: 70
Average Distance: 4,144 miles round trip
Total SIME Travel Completed: 290,110 miles

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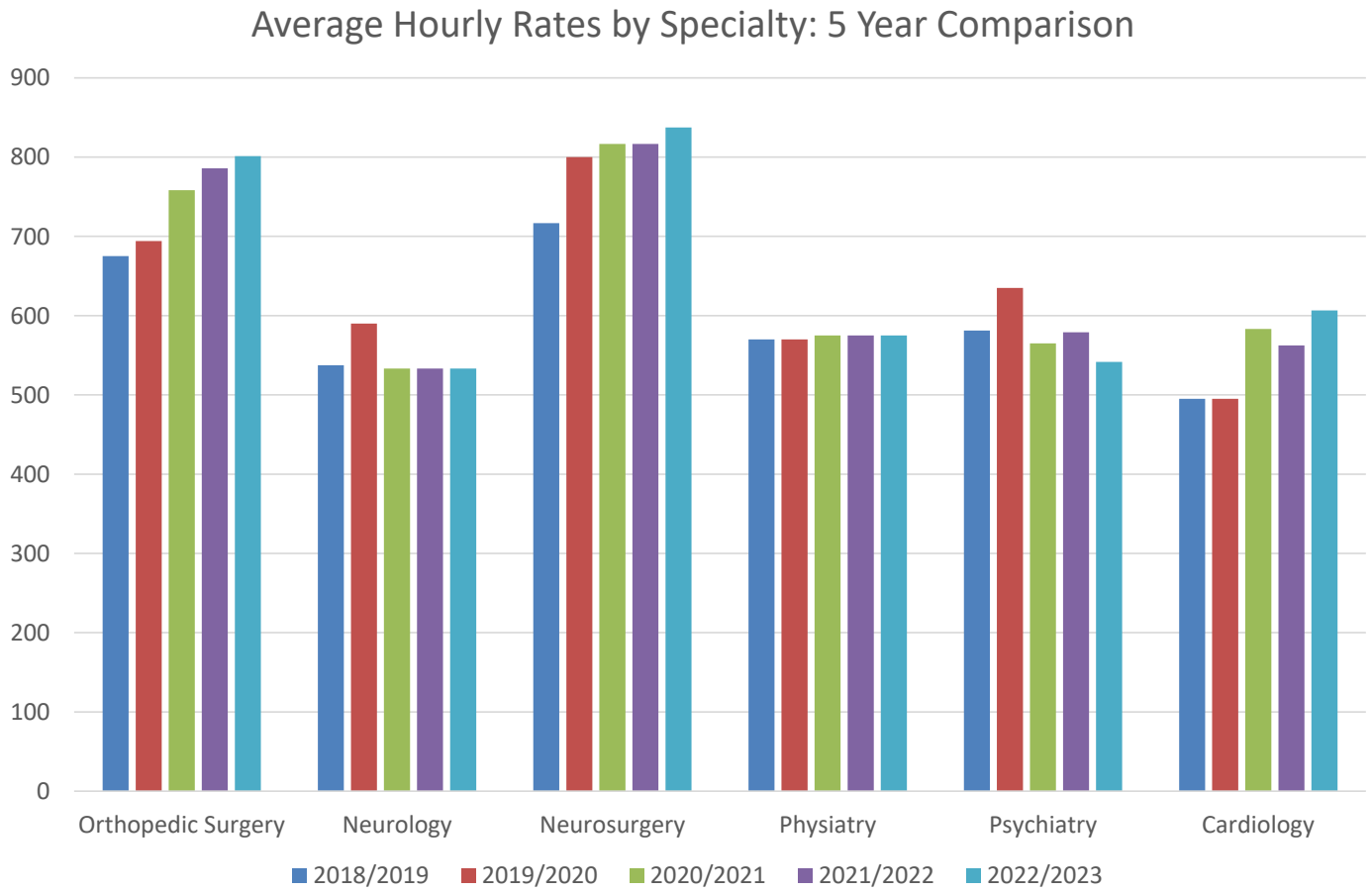
SIME Fees



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QUESTIONS?

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TAB 7

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

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

(8) provided on or after January 29, 2023, **but before January 1, 2024,** may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, January 1, 2023 edition, and adopted by reference**;** [.]

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

(9) provided on or after January 1, 2024, may not exceed the maximum allowable reimbursement established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, January 1, 2024 edition, and adopted by reference.

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

(10) *Hospital Outpatient Prospective Payment System*, dated January 1, **2024** [2023], produced by the federal Centers for Medicare and Medicaid Services;

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

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

Chapter 45.

Compensation, Medical Benefits, and Proceedings

Before the Alaska Workers' Compensation Board.

8 AAC 45.410 is amended by adding a new subsection to read:

(d) A person who is added to the rehabilitation specialist list after July 1, 2023 shall be placed on probationary rotation as set out in 8 AAC 45.420(d). During probationary rotation, the rehabilitation specialist shall undergo training with the administrator and the administrator's staff on the requirements of AS 23.30.041 and other related statutes and regulations. At any time during the probationary rotation, the administrator may decline to permanently add the rehabilitation specialist to the rehabilitation specialist list, for reasons set out under 8 AAC 45.440(a). The administrator may release a rehabilitation specialist from probationary rotation if, after considering the totality of the circumstances and the factors set out under 8 AAC 45.420(d), the administrator determines that the rehabilitation specialist understands and can comply with AS 23.30 and this chapter. (Eff. 7/1/88, Register 107; am 10/28/88, Register 108; am 7/20/97, Register 143; am 7/2/98, Register 146; am ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.041

8 AAC 45.420(b) is amended to read:

(b) Names will be added to the geographical listing in order of the receipt date of the completed application. If more than one completed application is received in a day, the names for that day will be placed on the list in alphabetical order. If a person's name is not added to the list, the administrator will notify the person and state in writing the reason for exclusion. Reasons

for exclusion include an incomplete or illegible application or accompanying documents, misrepresentation, [OR] not meeting the requirements of AS 23.30.041(r)(6)**, or demonstrating unsuitable behavior within the meaning given in 8 AAC 45.440**.

8 AAC 45.420 is amended by adding a new subsection to read:

(d) The administrator shall give a rehabilitation specialist on probationary rotation not more than two cases at a time for a six-month period. The administrator may increase the number of referrals if, after considering the totality of the circumstances, the administrator determines that an increase in referrals is warranted. In determining whether to increase the number of referrals given to a rehabilitation specialist on probationary rotation, the administrator shall consider

(1) the specific facts of the individual case;

(2) whether during the applicable period the rehabilitation specialist has demonstrated unsuitable behavior within the meaning given in 8 AAC 45.440;

(3) the rehabilitation specialist's prior experience in other jurisdictions;

(4) the quality of the rehabilitation specialist's work product;

(5) any complaints or positive feedback from employees, employers, insurers, adjusters, attorneys, division staff, or other relevant stakeholders regarding the rehabilitation specialist's performance; and

(6) any other relevant considerations specific to the rehabilitation specialist or the performance of the rehabilitation specialist's duties under AS 23.30 and this chapter. (Eff. 7/1/88, Register 107; am 7/20/97, Register 143; am 7/2/98, Register 146; am 4/16/2010, Register 194; am ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.041

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

8 AAC 45.435. Review of rehabilitation specialists. (a) An administrator shall review a rehabilitation specialist's work at least once each calendar year.

(b) If the administrator determines that the work completed by a rehabilitation specialist during the review period does not meet the standards of 8 AAC 45.440(a)(1) or (2)(A) or (B), the administrator shall identify the deficiencies in the rehabilitation specialist's work in writing to the rehabilitation specialist. The administrator shall schedule a meeting to discuss the concerns in the letter with the rehabilitation specialist.

(c) After a meeting as set out in (b) of this section, the administrator may

(1) put the rehabilitation specialist on a probationary rotation as set out under 8 AAC 45.420(d);

(2) put the rehabilitation specialist on a plan of correction as set out under 8 AAC 45.440(b); or

(3) take no further action.

(d) If a rehabilitation specialist is placed on probationary rotation under (b) of this section and the rehabilitation specialist's work does not improve after two cases or 90 days, whichever comes first, the administrator shall propose disqualification under 8 AAC 45.440. (Eff. ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.041

8 AAC 45.440 is repealed and readopted to read:

8 AAC 45.440. Removal of rehabilitation specialists. (a) The administrator may disqualify a rehabilitation specialist from providing services under AS 23.30.041 if the rehabilitation specialist

(1) demonstrates unsuitable behavior;

(2) fails to(A) timely file two or more eligibility evaluations, eligibility evaluation reports, or plan reports during a three-month period;

(B) provide rehabilitation services;

(C) adhere to statutory or regulatory requirements; or

(D) maintain workers' compensation insurance if the rehabilitation specialist has employees;

(3) engages in unethical conduct as defined by the ethics committee of an appropriate professional rehabilitation organization;

(4) knowingly falsifies information provided in connection with the rehabilitation specialist's application;

(5) is subject to disciplinary action or decertification by an appropriate certifying agency or professional organization;

(6) commits fraudulent billing or reporting;

(7) is convicted in a state or federal court of any offense involving moral turpitude; or

(8) is declared mentally incompetent by a court of competent jurisdiction.

(b) If the administrator is considering disqualifying a rehabilitation specialist under (a)(1) or (2)(A) - (C) of this section, the administrator may meet with the rehabilitation specialist and develop a plan of corrective action.

(c) If the administrator believes that a rehabilitation specialist has engaged in unethical practices or activity, the administrator may refer the issue to the ethics committee of an appropriate professional rehabilitation organization for recommendations after sending written notification to the rehabilitation specialist.

(d) Before disqualifying a rehabilitation specialist under this section, the administrator shall notify the rehabilitation specialist of the proposed disqualification in writing. A notification under this subsection must be served by personal service, certified mail, or electronic mail if the rehabilitation specialist has explicitly requested electronic mail service on a form prescribed by the administrator. A rehabilitation specialist who has been notified of a proposed disqualification may file a written request with the administrator to meet and to discuss the proposed disqualification not more than 30 days after the specialist receives the notice. The requested meeting must be set not later than 30 days after the administrator receives the written request unless otherwise agreed to by both the administrator and the rehabilitation specialist.

(e) The administrator shall issue a written decision not later than 30 days after a meeting requested under (d) of this section. If no meeting is requested, the administrator shall issue a written decision not later than 45 days after the written notice of proposed disqualification was served under (d) of this section.

(f) The administrator's written decision under (e) of this section must

(1) require the rehabilitation specialist to change unsuitable behavior or upgrade skills by putting the rehabilitation specialist on a probationary rotation as described in 8 AAC

45.420(d);

(2) disqualify the rehabilitation specialist for at least one year for the first disqualification and at least five years for the second disqualification for acts arising under (a)(1), (2)(A) - (C), (3), or (8) of this section; the decision must explain the reasons for the action and the conditions under which the rehabilitation specialist may reapply, if any;

(3) permanently remove the rehabilitation specialist from the list for acts arising under (a)(2)(D) or (4) - (7) of this section; or

(4) state that no grounds for disqualification or disciplinary action were found.

(g) The administrator's decision must be served upon the rehabilitation specialist or the rehabilitation specialist's representative. A decision under this subsection must be served either personally, by certified mail, or electronic mail if the rehabilitation specialist or the rehabilitation specialist's representative has explicitly requested electronic mail service on a form prescribed by the administrator. A copy must be sent to the employee or employer who requested that the administrator consider disqualifying or removing the rehabilitation specialist, if any. A disqualification or removal decision is effective 10 days after the date of the decision. If a written request for board review is filed with the board and is served in accordance with (h) of this section not more than 10 days after service of the administrator's decision, the disqualified or removed rehabilitation specialist will keep any assigned cases but not be assigned new cases.

(h) A disqualified rehabilitation specialist, an employee, or an employer, may request board review of the administrator's decision. If the

(1) disqualified rehabilitation specialist requests review, the rehabilitation specialist must serve a copy of the review request on any other person the administrator served with a copy of the decision; or

(2) employee or employer requests board review, the employee or employer must serve a copy of the review request on the disqualified rehabilitation specialist.

(i) Upon a request under (h) of this section, the board will schedule and hold a hearing in accordance with AS 23.30.110 and 8 AAC 45.070. The board's decision is final upon filing in accordance with AS 23.30.110.

(j) In this section, "unsuitable behavior" includes

(1) failure to promptly and professionally respond to the administrator or the administrator's staff;

(2) refusal to engage with the administrator or the administrator's staff;

(3) failure to file complete and accurate reports required under AS 23.30 or this chapter;

(4) repeated failure to adhere to the administrator's directives with respect to the rehabilitation specialist's performance under AS 23.30 or this chapter; or

(5) a pattern of abusive behavior toward injured workers, employers, medical professionals, attorneys, the administrator, department personnel, or other persons involved in the reemployment process. (Eff. 7/1/88, Register 107; am 10/28/88, Register 108; am 4/16/2010, Register 194; am ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.041

8 AAC 45.500(b) is amended to read:

(b) An itemized billing statement must reflect, for each activity, the date of service, the activity performed, the name of the individual who performed the activity, and the fee charged for the activity. The original billing statement shall be submitted to the employer for payment

and copied to the employee **and the administrator**. Billing statements not in compliance with this subsection will not be processed for payment. (Eff. 7/20/97, Register 143; am 4/16/2010, Register 194; am ____/____/_____, Register _____)

Authority: AS 23.30.005 AS 23.30.041

Official

ALASKA

WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2024

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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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Made in the USA

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Contents

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Introduction

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

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

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

An employee shall not be required to pay a fee or charge for medical treatment or service provided under this chapter including prepayment, deposit, or balance billing for services (Alaska Statute 23.30.097(f)).

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

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

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

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

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

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

SCOPE OF PRACTICE LIMITS

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

ORGANIZATION OF THE FEE SCHEDULE

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

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

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

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

Changes to the Evaluation and Management (E/M) section of codes effective January 1, 2021 and January 1, 2023 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 fees are used for physicians' services furnished in a hospital, skilled nursing facility (SNF), or ambulatory surgery center (ASC). The non-facility total fees are used for services performed in a practitioner's office, patient's home, or other non-hospital settings such as a residential care facility. For these services, the practitioner typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the practitioner's service. Where the fee is the same in both columns, the service is usually provided exclusively in a facility setting or exclusively in a non-facility setting, per CMS guidelines. Those same guidelines apply to workers' compensation.

SERVICES BY OUT-OF-STATE PROVIDERS

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

DRUGS AND PHARMACEUTICALS

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

The maximum allowable reimbursement for prescription drugs is as follows:

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

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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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Optometrist — an individual licensed to practice optometry.

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

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

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

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

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

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

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

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Procedure — a unit of health service.

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

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

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

Prosthesis — an artificial substitute for a missing body part.

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

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

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

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

Special report — a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

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

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.

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General Information and Guidelines

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

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

BILLING AND PAYMENT GUIDELINES

FEES FOR MEDICAL TREATMENT

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

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

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

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

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	1.03	1.500	1.545
Practice Expense RVU x Practice Expense GPCI	1.88	1.100	2.068
Malpractice RVU x Malpractice GPCI	0.14	0.603	0.08442
Total RVU			3.69742

DATA FOR THE PURPOSE OF EXAMPLE ONLY

Calculation using example data:

1.03 x 1.500 = 1.545

+ 1.88 x 1.100 = 2.068

+ 0.14 x 0.603 = 0.08442

= 3.69742

3.69742 x $119.00 (CF) = 439.99298

Payment is rounded to $439.99

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

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

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

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

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

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

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

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

ADD-ON PROCEDURES

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

The same physician or other health service worker that performed the primary service/procedure must perform the add-on service/procedure. Add-on codes describe additional intra-service work associated with the primary service/procedure (e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)). Add-on codes are not subject to reduction and should be reimbursed at the lower of the billed charges or 100 percent of MAR. Do not append modifier 51 to a code

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identified as an add-on procedure. Designated add-on codes are identified in Appendix D of the CPT book. Please reference the CPT book for the most current list of add-on codes.

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

EXEMPT FROM MODIFIER 51 CODES

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

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

PROFESSIONAL AND TECHNICAL COMPONENTS

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

GLOBAL DAYS

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

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

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

XXX Designates services where the global concept does not apply.

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

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

TELEHEALTH SERVICES

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

SUPPLIES AND MATERIALS

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

MEDICAL REPORTS AND TREATMENT PLANS

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 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.

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;

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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. Providers Report form can be found in the Fee Schedule Appendix at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

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).

OFF-LABEL USE OF MEDICAL SERVICES

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

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

PAYMENT OF MEDICAL BILLS

Medical bills for treatment are due and payable within 30 days of receipt of the medical provider's bill, or a completed medical report, as prescribed by the Board under Alaska Statute 23.30.097. Unless the treatment, prescription charges, and/or transportation expenses are disputed, the employer shall reimburse the employee for such expenses within 30 days after receipt of the bill, chart notes, and medical report, itemization of prescription numbers, and/or the dates of travel and transportation expenses for each date of travel. A provider of medical treatment or services may receive payment for medical treatment and services under this chapter only if the bill for services is received by the employer or appropriate payer within 180 days after the later of: (1) the date of service; or (2) the date that the provider knew of the claim and knew that the claim was related to employment.

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

SCOPE OF PRACTICE LIMITS

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

BOARD FORMS

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

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

APPLICABLE HCPCS MODIFIERS

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

When assistant at surgery services are performed by a physician assistant or nurse practitioner, the service is reported by appending modifier AS.

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

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

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

Procedure 1 (Modifier 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

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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 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 2023 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 utilizing telephone only should be reported using the identified CPT codes or telephone codes (99441–99443). Telehealth services should be reported with modifier 93 or 95 appended.

NEW AND ESTABLISHED PATIENT SERVICE

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

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

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

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

E/M SERVICE COMPONENTS

E/M COMPONENT GUIDELINES FOR CPT CODES

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

History and exam should still be documented but will be commensurate with the level required by the practitioner to evaluate and treat the patient. Prolonged E/M visit will be a covered service with CPT codes 99417, 99418, or HCPCS code G2212.

The MDM for E/M codes is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2024 MDM table are:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed

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- 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 re-viewed and analyzed, and high risk of complications and/or morbidity or mortality.

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

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

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.

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 not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals such as other physicians, nursing staff, respiratory therapists, and so on.

If the patient is admitted to a facility on the same day as 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/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 except when documentation describes the medical necessity of more than one visit by a particular provider. Hospital visit codes shall be combined into the single code that best describes the service rendered where appropriate.

CONSULTATIONS (99242-99245 AND 99252–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient 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

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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 subsequent to the consultation encounter, consultation codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

EMERGENCY DEPARTMENT SERVICES (99281–99288)

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

CRITICAL CARE SERVICES (99291–99292)

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

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

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

NURSING FACILITY SERVICES (99304–99316)

Nursing facility E/M services have been grouped into two subcategories: Initial Nursing Facility Care and Subsequent Nursing Facility Care. Included in these codes are E/M services provided to patients in psychiatric

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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 three service categories:

Prolonged Service With or Without Direct Patient Contact on the 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.

Services lasting less than 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For codes 99205, 99215, 99245 99345, 99350, and 99483, prolonged services are reported with CPT code 99417 or codes 99205, 99215, or 99483 may report HCPCS code G2212. Prolonged services for codes 99223, 99233, 99236, 99255, 99305, and 99310 are reported with code 99418.

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

These prolonged physician services without direct (face-to-face) patient contact may include review of extensive records and tests, and communication (other than telephone calls) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided. 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.

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 (99441–99443, 99446–99449, 99451–99452)
Telephone services are reported for telehealth services where only audio communication is available. Usually initiated by the patient or guardian, these codes are not reported if the telephone call results in a face-to-face encounter within 24 hours or the next available visit. Telephone services are not reported if provided within seven days of a face-to-face encounter or during the follow-up time associated with a surgical procedure.

SPECIAL EVALUATION AND MANAGEMENT SERVICES (99450, 99455–99456)
This series of codes reports physician evaluations in order to establish baseline information for insurance certification and/or work related or medical disability.

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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.

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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.

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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.

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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.

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Surgery

GENERAL INFORMATION AND GUIDELINES

DEFINITIONS OF SURGICAL REPAIR

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

BILLING AND PAYMENT GUIDELINES

GLOBAL REIMBURSEMENT

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

In addition to the surgical procedure, global reimbursement includes:

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

FOLLOW-UP CARE FOR DIAGNOSTIC PROCEDURES

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

FOLLOW-UP CARE FOR THERAPEUTIC SURGICAL PROCEDURES

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

ADDITIONAL SURGICAL PROCEDURE(S)

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

INCIDENTAL PROCEDURE(S)

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

SUTURE REMOVAL

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

ASPIRATIONS AND INJECTIONS

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

SURGICAL ASSISTANTS

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

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

Data for the purpose of example only

ANESTHESIA BY SURGEON

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

MULTIPLE OR BILATERAL PROCEDURES

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

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

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

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

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

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Example:

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

Data for the purpose of example only

ENDOSCOPIC PROCEDURES

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

Example:

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

Data for the purpose of example only

ARTHROSCOPY

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

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific modifiers shall be reimbursed as follows:

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

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

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

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

APPLICABLE HCPCS MODIFIERS

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

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

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

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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

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Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

PROFESSIONAL COMPONENT

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

TECHNICAL COMPONENT

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

REVIEW OF DIAGNOSTIC STUDIES

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical provider or other medical personnel. Neither the professional component value (modifier 26) nor the radiologic consultation code (76140) is reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

WRITTEN REPORTS

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

MULTIPLE RADIOLOGY PROCEDURES

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

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

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

See example below under Reimbursement Guidelines for CPT Modifiers.

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

Specific CPT modifiers shall be reimbursed as follows:

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

Modifier 51—Reimbursement is the lower of the billed

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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	$1,224.93
72142-TC	$806.71
72142-26	$418.21
72147	$1,215.61
72147-TC	$798.73
72147-26	$416.88

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	$806.71	100% of the TC
72147-TC	$399.37	(50% of the TC for the second procedure)
Total	$1,206.08	

Professional Component:

72142-26	$418.21	100% of the 26
72147-26	$396.04	(95% of the 26 for the second procedure)
Total	$814.25	

Global Reimbursement:

72142	$1,224.93	100% of the global
72147-51	$795.41	($399.37 + $396.04 TC and 26 above)
Total	$2,020.34	

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.

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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	0.35	1.10	0.385
Malpractice RVU x Malpractice GPCI	0.02	0.603	0.01206
Total RVU			1.04206

Data for the purpose of example only

Calculation using example data:

0.43 x 1.500 = .645

+ 0.35 x 1.10 = 0.385

+ 0.02 x 0.603 = 0.01206

= 1.04206

1.04206 x $122.00 (CF) = 127.1313

Payment is rounded to $127.13

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.

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DRUG SCREENING

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

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

APPLICABLE HCPCS MODIFIERS

TC TECHNICAL COMPONENT

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

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

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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 MAR for codes 97014 and 97810–97814.

MEDICAL REPORTS AND TREATMENT PLANS

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 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.

Treatment plan 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. Providers Report form can be found in the Fee Schedule Appendix at https://www.labor.alaska.gov/wc/forms/wc6102.pdf.

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).

MULTIPLE PROCEDURES

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

See modifier section below for examples of the reduction calculations.

SEPARATE PROCEDURES

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

MATERIALS SUPPLIED BY PHYSICIAN

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), are reported using HCPCS Level II codes and the Alaska value in effect at the time of treatment in the Medicare DMEPOS fee schedule multiplied by 1.75.

TELEHEALTH SERVICES

Telehealth services are covered and reimbursed at the lower of the billed amount or non facility MAR. Telehealth services are identified in CPT with a star

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

PHYSICAL MEDICINE

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

The initial evaluation of a patient is reimbursable when performed with physical medicine services. Follow-up evaluations for physical medicine are covered based on the conditions listed below. Physicians should use the appropriate code for the evaluation and management section, other providers should use the appropriate physical medicine codes for initial and subsequent evaluation of the patient. Physical medicine procedures include setting up the patient for any and all therapy services and an E/M service is not warranted unless reassessment of the treatment program is necessary or another physician in the same office where the physical therapy services are being rendered is seeing the patient.

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

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

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

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

TENS UNITS

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician's prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

PUBLICATIONS, BOOKS, AND VIDEOS

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

FUNCTIONAL CAPACITY EVALUATION

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

WORK HARDENING

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

97545	3.41
97546	1.36

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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.

MODIFIERS

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

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

REIMBURSEMENT GUIDELINES FOR CPT MODIFIERS

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

Specific modifiers shall be reimbursed as follows:

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

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

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

Cardiovascular services—Full payment is made for the TC service with the highest MAR. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day.

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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	$618.34
93303-TC	$419.93
93303-26	$198.41
93351	$661.86
93351-TC	$395.29
93351-26	$266.57

Data for the purpose of example only

Technical Component:

93303-TC	$419.93	100% of the TC
93351-TC	$296.47	(75% of the TC for the second procedure)
Total	$716.40	

Global Reimbursement:

93303	$618.34	100%
93351	$563.04	(75% of the TC for the second procedure + 100% of the 26) (296.47 + $266.57 = $563.04)
Total	$1,181.38	

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	$186.72
92060-TC	$70.00
92060-26	$116.72
92132	$91.52
92132-TC	$40.08
92132-26	$51.44

Data for the purpose of example only

Technical Component:

92060-TC	$70.00	100% of the TC
92132-TC	$32.06	(80% of the TC for the second procedure)
Total	$102.06	

Global Reimbursement:

92060	$186.72	100% of the global
92132	$83.50	(80% of the TC for the second procedure + 100% of the 26) ($32.06 + $51.44 = $83.50)
Total	$270.22	

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	$36.16
[(.18 x 1.5) + (.16 x 1.10) + (0.01 x 0.603)] x 80	
97024	$20.88
[(.06 x 1.5) + (0.15 x 1.10) + (0.01 x 0.603)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

97016	$29.12
[(.18 x 1.5) + ((.16 x 1.10) x .5) + (0.01 x .603)] x 80	
97024	$14.28
[(.06 x 1.5) + ((.15 x 1.10) x .5) + (0.01 x .603)] x 80	

Example:

97016	$36.16
97016 (2nd unit same date)	$29.12
97024 (additional therapy same date)	$14.28

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.

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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.

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Category III

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

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

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

CATEGORY III MODIFIERS

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

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HCPCS Level II

GENERAL INFORMATION AND GUIDELINES

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

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

MEDICARE PART B DRUGS

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

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

DURABLE MEDICAL EQUIPMENT

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

TENS (transcutaneous electrical nerve stimulation) must be FDA-approved equipment and provided under the attending or treating physician's prescription. (See Off-label Use of Medical Services in the General Information and Guidelines Section.) An annual assessment of the patient is required to renew a prescription for use of the TENS unit and supply of electrodes. Each TENS unit will be rented for two months followed by a re-evaluation to determine if it is appropriate to continue rental or purchase of the unit. TENS unit price shall be the HCPCS code DMEPOS value as published by Medicare multiplied by 1.75. Unlisted HCPCS codes are not valid for billing TENS units. Electrodes and supplies will be provided for two months and then as needed by the patient. Reimbursement of electrodes and supplies shall be the lower of invoice plus 20 percent or billed charges and supersedes the use of HCPCS DME values.

HEARING AIDS

The 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.

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HEARING AID SERVICES

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

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

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

NU New equipment

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

UE Used durable medical equipment

AMBULANCE SERVICES

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

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

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

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

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

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

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

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

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

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Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

(2) status indicator codes C, E1, E2, and P are the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer;

(3) two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the maximum allowable reimbursement (MAR) and all other status indicator code T items paid at 50 percent;

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

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

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

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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. *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.*
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. *Alaska Specific Guideline: May be performed in the outpatient or ASC setting if beneficial to the patient and as negotiated by the payer and providers. Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
D	Discontinued codes	Not paid under OPPS.
E1	Items, codes and services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary	Not paid under OPPS. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.* *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
E2	Items and services for which pricing information and claims data are not available	Not paid under OPPS. Status may change as data is received by CMS. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
F	Corneal tissue acquisition; certain CRNA services	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	Pass-through device categories	Separate cost-based pass-through payment. *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19.

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INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
J2	Hospital Part B services that may be paid through a comprehensive APC	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services, services assigned to a new technology APC, self-administered drugs, all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned OPSI J1. (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radio pharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine; 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.
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
P	Partial hospitalization	Paid under OPPS; per diem APC payment. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
Q1	STV packaged codes	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same 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.
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.

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

SURGICAL SERVICES

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

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

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

DRUGS AND BIOLOGICALS

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

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

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.

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

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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.

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Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

Example of Implant Outlier:

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

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

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

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

EXEMPT FROM THE MS-DRG

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

SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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

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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, 2024 remains in effect, unless the Alaska Workers' Compensation Division publishes a notice that a new version is in effect. Besides the IPPS Web Pricer, two additional elements are required to determine a payment:

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

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

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

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

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

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

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

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

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

DATE OF SERVICE RECOMMENDATION

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

EXAMPLE

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

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

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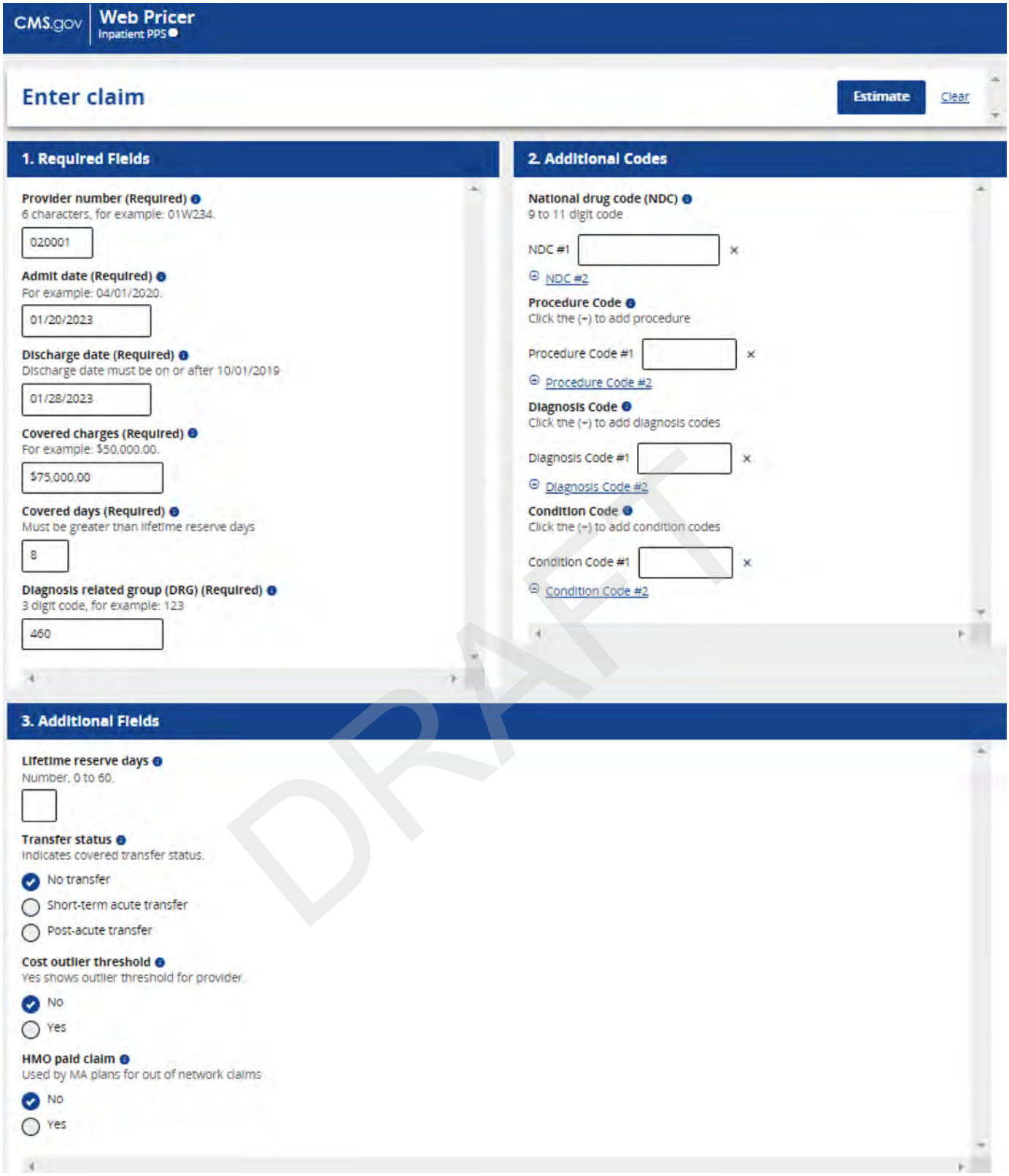
CMS.gov
Web Pricer
Inpatient PPS
Enter claim
Estimate
Clear
1. Required Fields
Provider number (Required)
6 characters, for example: 01W234.
020001
Admit date (Required)
For example: 04/01/2020.
01/20/2023
Discharge date (Required)
Discharge date must be on or after 10/01/2019
01/28/2023
Covered charges (Required)
For example: $50,000.00.
$75,000.00
Covered days (Required)
Must be greater than lifetime reserve days
8
Diagnosis related group (DRG) (Required)
3 digit code, for example: 123
460
2. Additional Codes
National drug code (NDC)
9 to 11 digit code
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.

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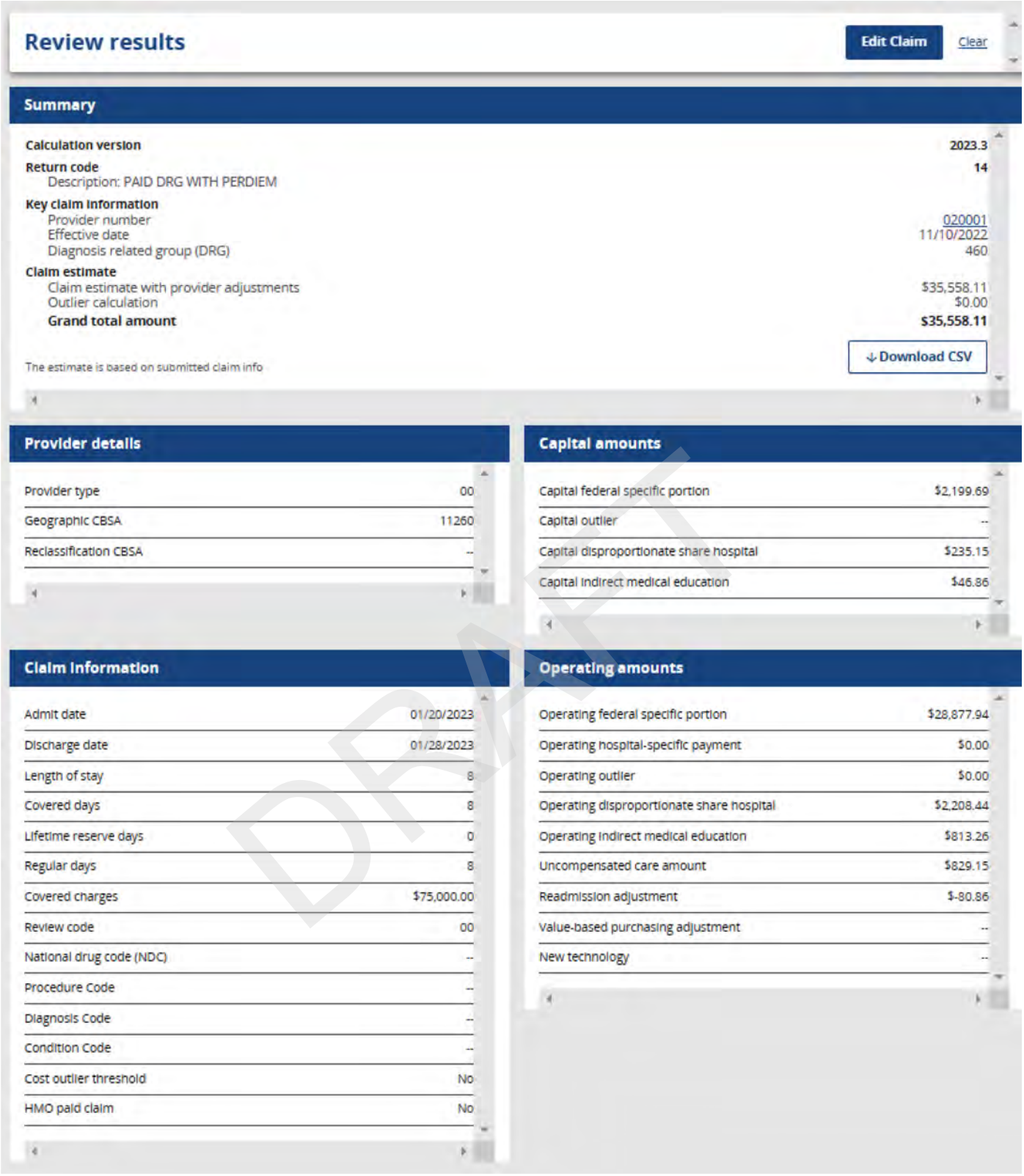

Review results

Edit Claim Clear

Summary

Calculation version	**2023.3**
Return code	**14**
Description: PAID DRG WITH PERDIEM	
Key claim information	
Provider number	020001
Effective date	11/10/2022
Diagnosis related group (DRG)	460
Claim estimate	
Claim estimate with provider adjustments	$35,558.11
Outlier calculation	$0.00
Grand total amount	**$35,558.11**

The estimate is based on submitted claim info

↓ Download CSV

Provider details

Provider type	00
Geographic CBSA	11260
Reclassification CBSA	--

Capital amounts

Capital federal specific portion	$2,199.69
Capital outlier	--
Capital disproportionate share hospital	$235.15
Capital indirect medical education	$46.86

Claim information

Admit date	01/20/2023
Discharge date	01/28/2023
Length of stay	8
Covered days	8
Lifetime reserve days	0
Regular days	8
Covered charges	$75,000.00
Review code	00
National drug code (NDC)	--
Procedure Code	--
Diagnosis Code	--
Condition Code	--
Cost outlier threshold	No
HMO paid claim	No

Operating amounts

Operating federal specific portion	$28,877.94
Operating hospital-specific payment	$0.00
Operating outlier	$0.00
Operating disproportionate share hospital	$2,208.44
Operating indirect medical education	$813.26
Uncompensated care amount	$829.15
Readmission adjustment	$-80.86
Value-based purchasing adjustment	--
New technology	--

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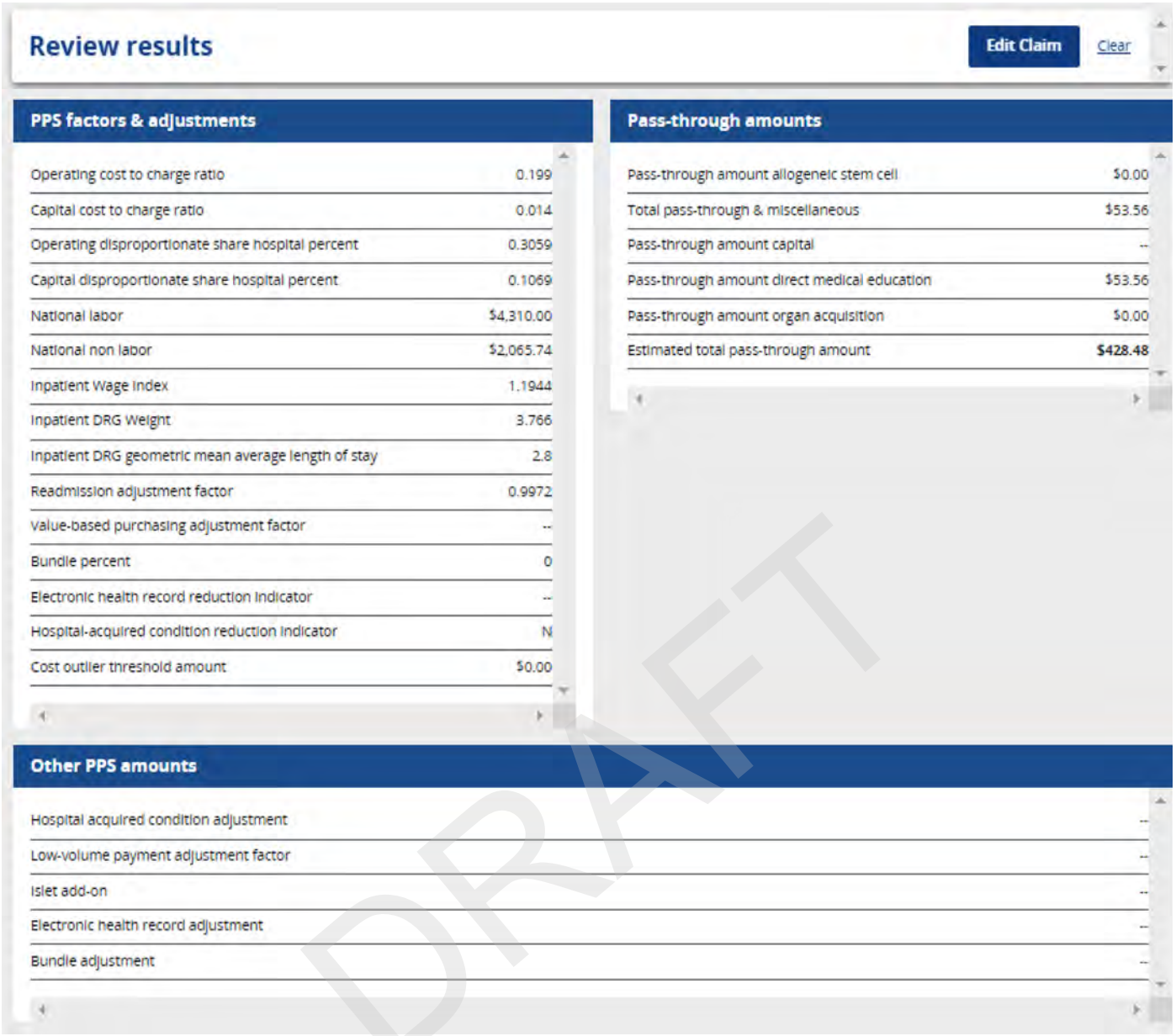

Review results

Edit Claim Clear

PPS factors & adjustments

Operating cost to charge ratio	0.199
Capital cost to charge ratio	0.014
Operating disproportionate share hospital percent	0.3059
Capital disproportionate share hospital percent	0.1069
National labor	$4,310.00
National non labor	$2,065.74
Inpatient Wage Index	1.1944
Inpatient DRG Weight	3.766
Inpatient DRG geometric mean average length of stay	2.8
Readmission adjustment factor	0.9972
Value-based purchasing adjustment factor	--
Bundle percent	0
Electronic health record reduction indicator	--
Hospital-acquired condition reduction indicator	N
Cost outlier threshold amount	$0.00

Pass-through amounts

Pass-through amount allogeneic stem cell	$0.00
Total pass-through & miscellaneous	$53.56
Pass-through amount capital	--
Pass-through amount direct medical education	$53.56
Pass-through amount organ acquisition	$0.00
Estimated total pass-through amount	**$428.48**

Other PPS amounts

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

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

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

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

DETERMINING THE FINAL MAXIMUM ALLOWABLE REIMBURSEMENT (MAR)

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

CMS IPPS Web Pricer Grand Total Amount	$35,558.11
Multiplied by Providence Alaska Medical Center multiplier	x 2.38
Alaska Workers' Compensation Payment	$84,628.30

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

GENERAL INFORMATION AND GUIDELINES

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

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

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Appendix

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

PHYSICIAN'S REPORT

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

AWCB Case Number

SECTION 1

1. Employee's Name (Last, First, Middle Initial) | 2. Insurer Claim Number | 3. Date of Injury
4. Address | 5. Sex ☐ Male ☐ Female | 6. Social Security Number
City State Zip Code Telephone | | 7. Date of Birth
8. Employer | 9. Insurer
10. Address | 11. Address
City State Zip Code Telephone | City State Zip Code Telephone

SECTION 2

12. Date Last Worked | 13. Was Body Part Injured Before ☐ No ☐ Yes If yes, when and describe:
14. Describe Injury and Tell How It Happened:
15. Have You Seen Any Other Doctor for This Injury? ☐ No ☐ Yes If yes, list name and address: | 16. Hospitalized As Inpatient? ☐ No ☐ Yes Name of Hospital:

SECTION 3

17. YOUR First Treatment Date | 18. Describe Complaints:
19. Fully Describe Findings on First Examination (Specify Right or Left):
20. Diagnosis:
21. X-Rays? ☐ No ☐ Yes X-Ray Diagnosis:
22. Is Condition Work Related ☐ No ☐ Yes Explain: ☐ Undetermined (Explain):

SECTION 4

23. Treatment Date(s) Since Last Report | 24. Next Treatment Date | 25. Estimate Length of Further Treatment Days Weeks Months
26. Medically 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 ☐ Regular Work (Date): ☐ Modified Work (Date): Give Limitations:
33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.
34. Describe Treatment (and/or Attach 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

Form 07-6102 (Rev 01/2013) Page 1 of 2

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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).

42. Employee's Name (Last, First, Middle Initial)	43. Report Date
44. REMARKS (or Treatment Plan continuation)	

DRAFT

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.

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