ALASKA WORKERS' COMPENSATION BOARD MEETING

October 14-15, 2021

TABLE OF CONTENTS

TAB 1

ALASKA WORKERS' COMPENSATION BOARD MEETING AGENDA

OCT 14-15, 2021

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
Zoom Video Conference: https://us02web.zoom.us/j/88401619248
To participate telephonically: 833-548-0282, Webinar ID: 884 0161 9248

Thursday, Oct 14, 2021

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

9:10am Approval of Agenda

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

9:30am Director's Report

- Division Update
- Legislative Update
- Policy Updates (COVID)
- 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

- Approval of Regulations
  - 8 AAC 45.083 Medical Treatment Schedule for 2022
  - 8 AAC 45.185 Corporate Officers and Members of Limited Liability Companies, from ongoing Board work

12:00pm Lunch Break

1:30pm 2020 Annual Report

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

3:00pm Break

3:15pm New Business

- Proposed Regulation Updates

5:00pm Adjournment

Friday, Oct 15, 2021 (if needed)

9:00am	Call to order
	Roll call establishment of quorum
9:10am	New Business – Open
10:30am	Break
10:45am	New Business – Open
12:00pm	Lunch Break
1:30pm	New Business – Open
3:30pm	Break
3:45pm	New Business - Open
5:00pm	Adjournment

TAB 2

Workers' Compensation Board
Meeting Minutes
May 13, 2021

Thursday, May 13, 2021

I. Call to Order

Workers' Compensation Director Charles Collins called the Board to order at 9:01 am on Thursday, May 13, 2021. Due to concerns related to the COVID-19 public health disaster, the meeting was held by telephone and video conference.

II. Roll call

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

Bradley Austin	Randy Beltz	Micheal Dennis	Bob Doyle
Julie Duquette	Sara Faulkner	Bronson Frye	Christina Gilbert
Anthony Ladd	Sarah Lefebvre	Jason Motyka	Nancy Shaw
David Talerico	Lake Williams		

Director Collins noted that Members Pamela Cline and Robert Weel were excused. Member Sarah Lefebvre arrived after roll call. Quorum was established.

Director Collins introduced new board member Michael Dennis and David Talerico, introduced the senior staff present.

III. Agenda Approval

A motion to approve the agenda was made by member Austin and seconded by member Beltz. The agenda was approved by unanimous vote.

IV. Approval of Meeting Minutes

A motion to adopt the minutes from the January 14, 2021 regular Board Meeting was made by member Beltz and seconded by member Austin. The minutes were adopted without objection.

V. Board Open Forum

Member Shaw asked that Division staff include the injured worker's name in the email subject line when they send documents to the board members for review.

Member Shaw asked that in claims where a party has not followed discovery rules or is allegedly refusing to comply, the case not be dismissed without a hearing so the party may be advised of the consequences to their case. Acting Chief of Adjudications Bill Soule explained that the supreme court and the Appeals Commission have on several occasions stated that the Board must have a graduated approach to dismissing a claim.

Member Shaw also commented that occasionally there are scheduling changes on hearing days and the board members are not notified. She requested that Division staff notify the members of any schedule changes.

Member Frye stated that he and other board members have been receiving extremely abusive, insulting, degrading emails from a particular injured worker. Director Collins stated that trespass orders have been filed and he advised the Board to block the email address of that individual. He also stated that board members may contact Assistant Attorney General Grace Lee if they have any questions.

VI. Director's Report

Director Collins provided updates on the Medical Services Review Committee (MSRC) and Second Independent Medical Evaluation Panel, discussed active legislation, provided an overview of Division staffing, and discussed some potential technology upgrades in the Anchorage hearing room.

Break 9:56am-10:15am

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

Janice Shipman – representing self

- Asked the Board to consider submitting a bill to the legislature to increase the cost for reemployment plans under AS 23.030.041(l).

Sandy Travis – representing self

- Commented on board transparency, false information, and perceived barriers for injured workers to receive benefits.
- Stated general opposition to board actions.
- Stated injured workers have a difficult time finding doctors and will be refused service by emergency rooms.
- Asked the board to make regulation changes that help the injured worker.
- Opposes Drug Formulary

VIII. Director's Report Continued

Director Collins reviewed the list of Board Designees. Member Austin motioned to accept the board designees and member Frye seconded. The motion passed unanimously.

Director Collins reviewed the draft 2022 Board Hearing calendar. Chief Soule noted that a date needed to be updated from 2021 to 2022. Member Austin motioned to accept the draft calendar as amended, member Beltz seconded. The motion passed unanimously.

Administrative Officer Alexis Hildebrand provided an update on the FY21 budget performance year-to-date and the Division's Electronic Data Interchange program.

Director Collins provided an overview of Alaska Workers' Compensation Covid-19 statistics.

Director Collins discussed changes from the Centers for Medicaid Services that affect the Alaska Workers' Compensation Fee Schedule, and presented the 2020 Oregon Workers' Compensation premium rate ranking summary.

IX. Reemployment Benefits 2020 Annual Report

Reemployment Benefits Administrator Stacy Niwa presented the 2020 Reemployment Benefits Annual Report. Director Collins discussed potential legislative changes to improve the reemployment process in Alaska. Member Shaw expressed support for taking action to improve the program.

Lunch Break 11:55am-1:30pm

X. Old Business

Chief Investigator Rhonda Gerharz provided an update on the fraud work group, consisting of member Shaw and member Faulkner.

Member Frye provided an update on the drug formulary work group.

Amend 8 AAC 45.030(a)(2), relating to hearing recordings. Member Austin moved to adopt the amendment of 8 AAC 45.030(a)(2). Member Beltz seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.032, relating to the Division's process for establishing case files. Member Shaw moved to adopt the amendment of 8 AAC 45.032. Member Doyle seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.092, relating to Second Independent Medical Evaluations. Member Austin moved to adopt the amendment of 8 AAC 45.092. Member Doyle seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.093, relating to qualifying medical examinations for certain firefighters. Member Shaw moved to adopt the amendment of 8 AAC 45.093. Member Doyle seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.122, relating to permanent impairment ratings. Member Austin moved to adopt the amendment of 8 AAC 45.122. Member Gilbert seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.136, relating to notice of payment or modification of compensation. Chief Soule noted that the word "means" had inadvertently been removed and suggested that it be replaced, which is a non-substantive change. Member Beltz moved to adopt the amendment of 8 AAC 45.136, as amended. Member Doyle seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.174, relating to uninsured employers. Chief Soule noted two instances of improper pronouns and suggested that they be replaced with gender

neutral pronouns, which is a non-substantive change. Member Duquette moved to adopt the amendment of 8 AAC 45.174, as amended. Member Doyle seconded the motion. The motion passed unanimously.

Repeal 8 AAC 45.184, relating to executive officer waivers. Member Beltz moved to adopt the repeal of 8 AAC 45.184. Member Doyle seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.210, relating to weekly compensation rate. Member Doyle moved to adopt the amendment of 8 AAC 45.210. Member Talerico seconded the motion. The motion passed unanimously.

Amend 8 AAC 45.220, relating to gross weekly earnings. Chief Soule noted that the amendment was incomplete as written. Member Doyle moved to table the amendment of 8 AAC 45.220. Member Beltz seconded. The motion passed unanimously.

Amend 8 AAC 45.900, relating to definitions. Chief Soule noted that under 8 AAC 45.900(d), the word "bonus" should have been "bonuses". Chief Gerharz similarly pointed out that under 8 AAC 45.900(k) the word "misclassified" should have been "misclassifies". Both were non-substantive changes. Member Austin moved to adopt the amendment of 8 AAC 45.900, as amended. Member Ladd seconded the motion. The motion passed unanimously.

XI. New Business

Amend 8 AAC 45.185, relating to corporate officers and members of limited liability companies. Member Austin moved to approve the amendment of 8 AAC 45.185. Member Frye seconded the motion. The board discussed whether to include the word revokable. Director Collins noted that the word revokable was not included in the statute. Member Shaw suggested that the regulation be sent for legal review before being put forth for public comment. The board chose to vote on the amendment as written. The motion passed on an 11 to 3 vote, with members Austin, Beltz, Dennis, Faulkner, Frye, Gilbert, Ladd, Lefebvre, Motyka, Talerico, and Williams voting in favor, and members Doyle, Duquette and Shaw voting against.

Director Collins reminded the Board members the next regular board meeting is October 14-15, 2021. The meeting will be in-person and the division will be presenting its annual report to the Board.

Motion to adjourn was made by Member Doyle. Member Beltz seconded the motion. The motion passed unanimously.

Meeting Adjourned 3:05pm

TAB 3

ALASKA WORKERS' COMPENSATION BOARD

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

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

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 2021

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

NAME	LOCATION	POSITION TITLE
Charles Collins	Juneau	Director
William Soule	Anchorage	Acting Chief of Adjudications
Kathryn Setzer	Juneau	WC Hearing Officer II
Judy DeMarsh	Anchorage	WC Hearing Officer II
William Soule	Anchorage	WC Hearing Officer II
Janel Wright	Anchorage	WC Hearing Officer II
Jung Yeo	Anchorage	WC Hearing Officer II
Cassandra Tilly	Fairbanks	WC Hearing Officer II
Robert Vollmer	Fairbanks	WC Hearing Officer II
Vacant	Anchorage	WC Hearing Officer II
Dani Byers	Juneau	WC Officer II
Melody Kokrine	Fairbanks	WC Officer II
Elizabeth Pleitez	Anchorage	WC Officer II
Harvey Pullen	Anchorage	WC Officer II
Mike Sargent	Anchorage	WC Officer II
Julie Kelley	Anchorage	WC Officer I
Vacant	Anchorage	WC Officer I

TAB 5

2022 WORKERS' COMPENSATION HEARING CALENDAR

	JUNEAU	FAIRBANKS		ANCHORAGE			
	TUE	TUE	TH	TUE	W	TH	FRI
JANUARY							
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FEBRUARY	1	1		1	2	3	
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MARCH	1	1		1	2	3	
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APRIL							
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MAY							
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JUNE					1	2	
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JULY			7				
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AUGUST		2		2	3	4	**5**
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SEPTEMBER						1	
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OCTOBER							
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NOVEMBER			3	1	2	3	
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DECEMBER			1			1	
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NOTES: Hearings may be held twice in Ketchikan during 2022, as needed.

Jan. 13-14, May 12-13 and Oct. 13-14 are AWCB public board meetings, not hearing dates.

May 20, June 24, July 15, August 5, and August 26 are MSRC public meetings, not hearing dates.

Additional hearing days and/or board meetings will be added as necessary.

ANCHORAGE

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT

WORKERS' COMPENSATION 2022 CALENDAR

JANUARY

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AUGUST

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Holiday | Board Meeting | MSRC Meeting | Hearing Day

State Holidays

Date	Holiday
01/01/22	New Year's Day (observed 12/31/2021)
01/17/22	MLK Jr.'s Birthday
02/21/22	Presidents' Day
03/28/22	Seward's Day
05/30/22	Memorial Day
07/04/22	Independence Day

State Holidays

Date	Holiday
09/05/22	Labor Day
10/18/22	Alaska Day
11/11/22	Veterans' Day
11/24/22	Thanksgiving Day
12/25/22	Christmas Day (observed 12/26/2022)

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT

WORKERS' COMPENSATION 2022 CALENDAR

JUNEAU

JANUARY

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Holiday Board Meeting MSRC Meeting Hearing Day

State Holidays

Date	Holiday
01/01/22	New Year's Day (observed 12/31/2021)
01/17/22	MLK Jr.'s Birthday
02/21/22	Presidents' Day
03/28/22	Seward's Day
05/30/22	Memorial Day
07/04/22	Independence Day

State Holidays

Date	Holiday
09/05/22	Labor Day
10/18/22	Alaska Day
11/11/22	Veterans' Day
11/24/22	Thanksgiving Day
12/25/22	Christmas Day (observed 12/26/2022)

FAIRBANKS

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT

WORKERS' COMPENSATION 2022 CALENDAR

JANUARY

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JULY

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AUGUST

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SEPTEMBER

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NOVEMBER

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DECEMBER

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Holiday **Board Meeting** **MSRC Meeting** **Hearing Day**

State Holidays

Date	Holiday
01/01/22	New Year's Day (observed 12/31/2021)
01/17/22	MLK Jr.'s Birthday
02/21/22	Presidents' Day
03/28/22	Seward's Day
05/30/22	Memorial Day
07/04/22	Independence Day

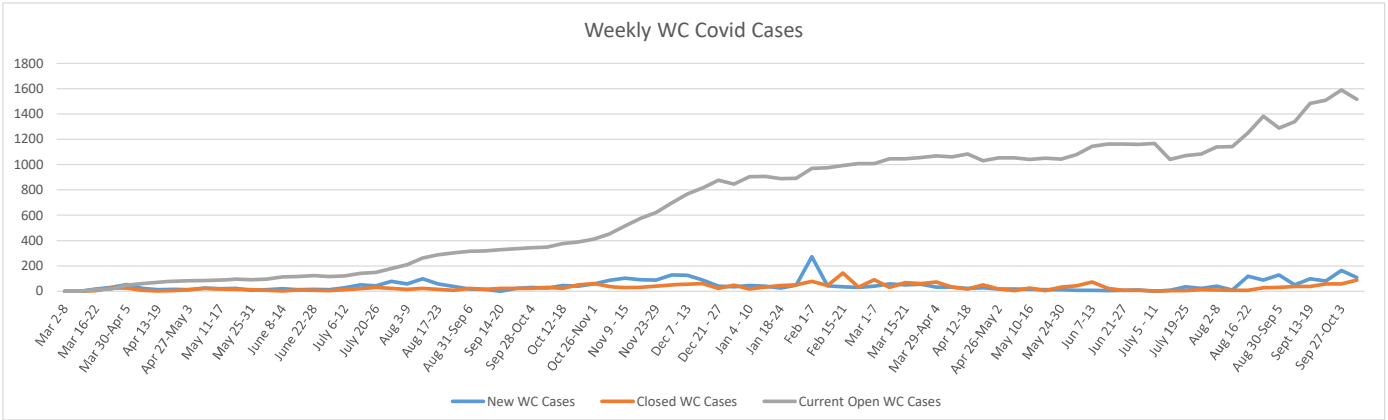
State Holidays

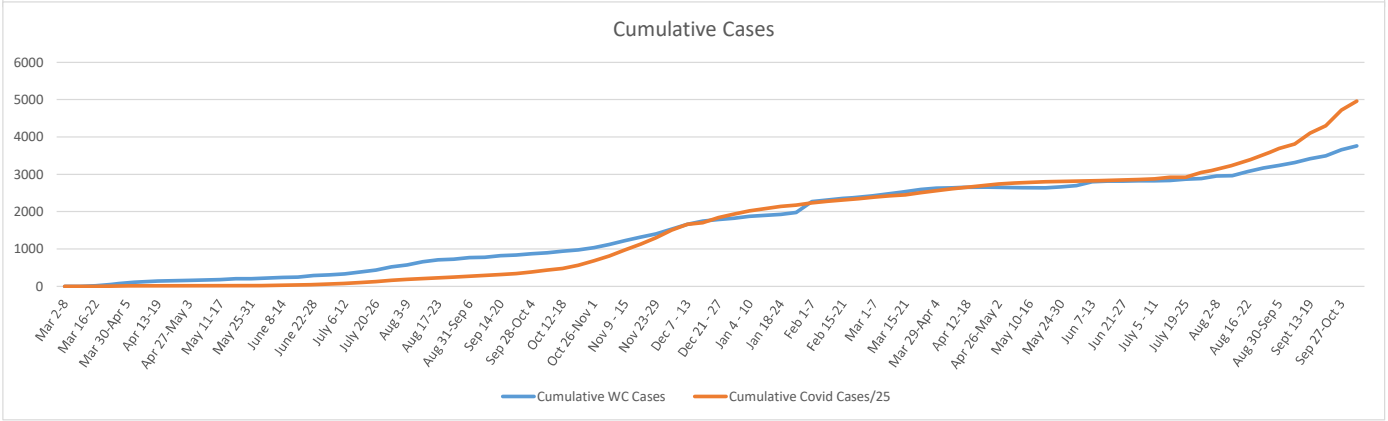
Date	Holiday
09/05/22	Labor Day
10/18/22	Alaska Day
11/11/22	Veterans' Day
11/24/22	Thanksgiving Day
12/25/22	Christmas Day (observed 12/26/2022)

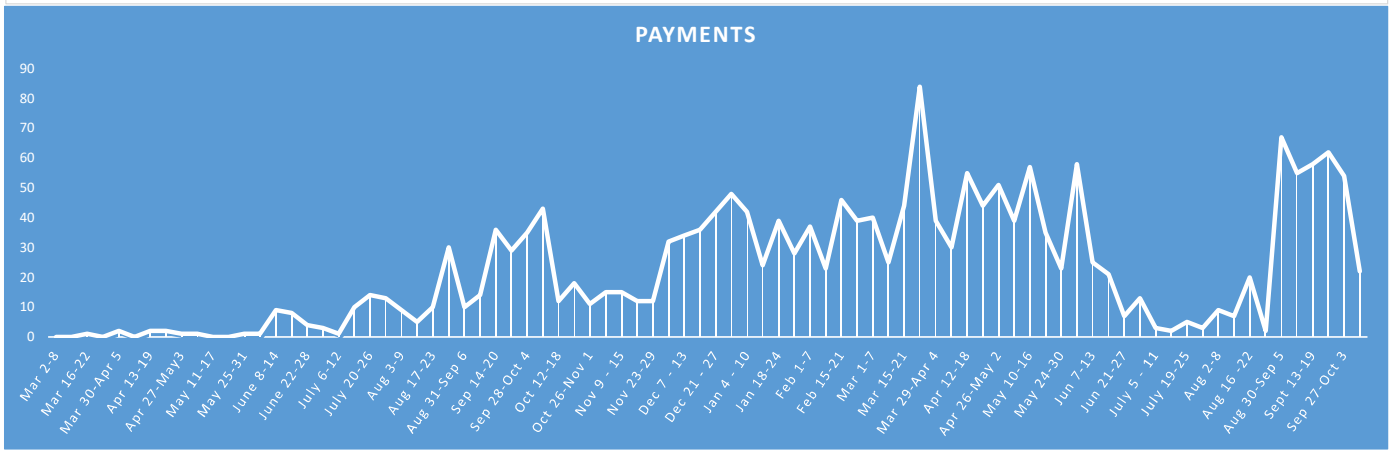
TAB 6

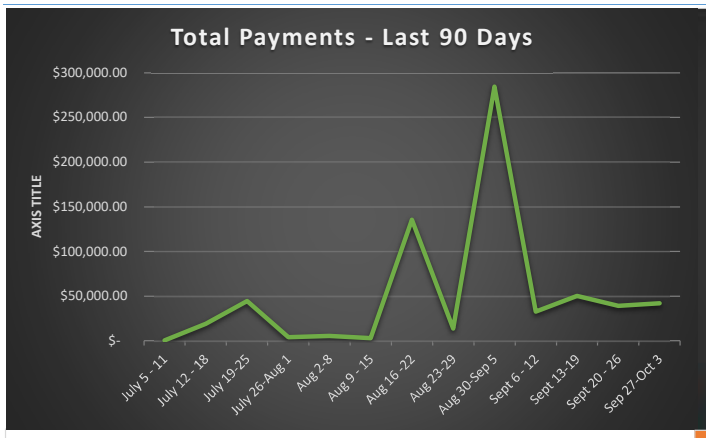
Opened	Closed	Current	Paid	BTC to date	OBT to date	EP to Date	Denials (04)
3764	2249	1515	1690	$1,909,485.94	$1,459,446.98	$659,609.75	308

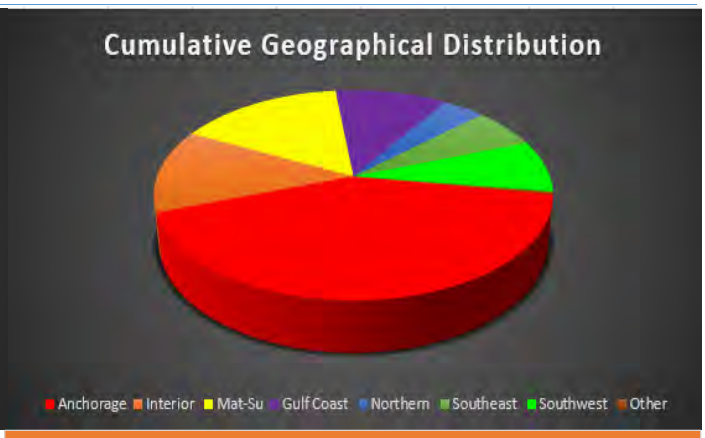
as of 10/11/2021

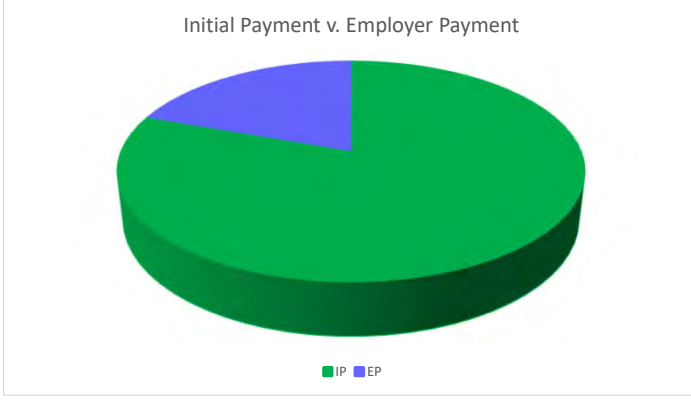


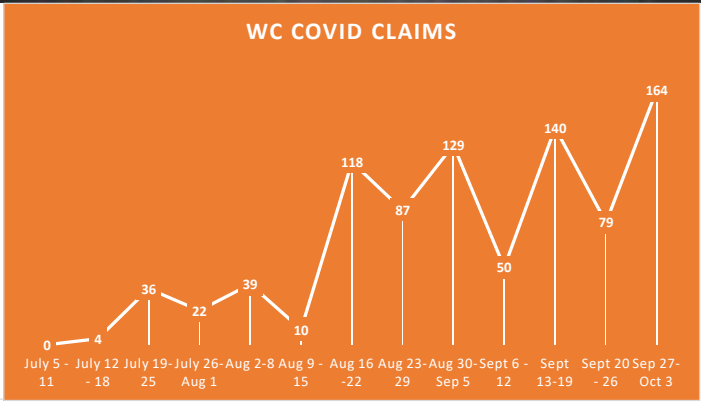






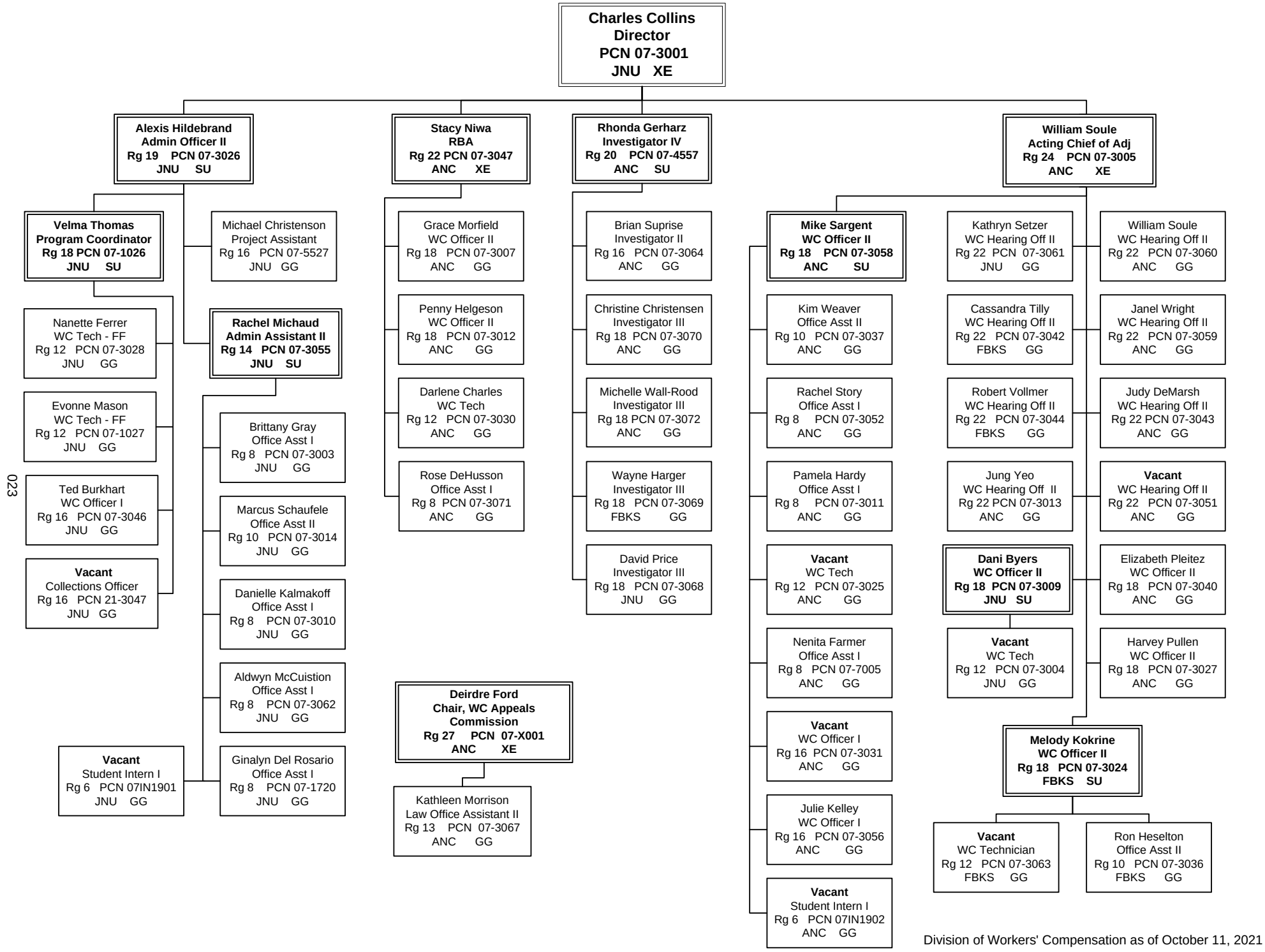






Region	Pop (2019 est.)[1]	% Pop	Covid Cases [2]	% Cases	WC Claims[3]	% Claims	WC Payments[3]	% Pymts
Anchorage / Mat-Su Region	398,283	54%	64513	58%	1951	56%	$1,448,258.53	44%
Anchorage, Municipality of	291,845	40%	46803	42%	1750	50%	$1,275,986.86	39%
Matanuska-Susitna Borough	106,438	15%	17710	16%	201	6%	$ 172,271.67	5%
Gulf Coast Region	80,866	11%	11970	11%	184	5%	$ 39,722.85	1%
Interior Region	109,847	15%	14366	13%	216	6%	$ 29,216.86	1%
Northern Region	27,432	4%	4472	4%	225	6%	$ 474,084.66	15%
Southeast Region	72,373	10%	6889	6%	226	6%	$ 56,686.61	2%
Southwest Region	42,206	6%	9018	8%	650	18%	$ 883,982.50	27%
Out-of State/Other			386	0%	63	2%	$ 324,273.43	10%
Total	731,007		111614		3515		$3,256,225.44	

[1] Alaska Department of Labor and Workforce Development, Research and Analysis Section
[2] Alaska Department of Health and Social Services Coronavirus Response (9/30/2021)
[3] ADOL-WD, Division of Workers' Compensation (ICERS, 9/30/2021)



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Division of Workers' Compensation as of October 11, 2021

ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

Division of
Workers' Compensation
2021

1 EXECUTIVE SUMMARY

This past year has been a challenge to most of us due to the pandemic. Never have most of us given a thought to not being able to find goods or services in today's world. But on recent trips to my favorite retail stores, I find some empty shelves. Even Iced Tea at one local grocer was sold out on one visit.

The entire country realized a shift in employment practices. Kitchen tables became offices, video cameras sold like hotcakes and became necessary tools for the workplace. Business casual became just casual and telework expanded like never before in our history. This led to many new type of injury claims, claims based on ergonomic issues and communicable disease causes. The line between workplace injury and personal injury became blurred as claims submitted pointed to causes not normally seen in a workplace. Both insurance adjusters and work comp officers were forced to navigate a new path to find the proper solution to address these claims.

At the Division of Workers' Compensation, we too have had our challenges. How to provide service in a safe and social distance environment. I want to take this opportunity to recognize my team for meeting these challenges and overcoming them. Expanding our knowledge of virtual hearings, becoming experts and remotely conferencing and researching claims, working with constantly changing dates and deadlines for hearings along with attempting to maintain professional relationships with our partners and stakeholders.

Never has my model of flat management style been more important. The idea of placing good people in decision making roles and then believing in them allowed DWC to succeed during the crisis brought on by COVID. I am proud to say that DWC continued and shall continue to meet out metrics as stated in Alaska Statute in 2020 and the future.

> **Sec. 23.30.001. Legislative intent.**
> It is the intent of the legislature that
>
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
>
> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;
>
> (3) this chapter may not be construed by the courts in favor of a party;
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

I would also like to take this opportunity to express my gratitude to the Alaska Workers' Compensation Board for persevering through this time of uncertainty. Many of you served on adjudication panels, worked on Board projects and participated in Board meetings from remote locations and through virtual means. Without the assistance and support of the AWCB the Division and the Department of Labor and Workforce Development would be unable to provide the much-needed service Alaska's injured employees deserve.

Thank you.

2 WHAT IS WORKERS' COMPENSATION?

Workers' compensation or workers' comp is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue his or her employer for the tort of negligence. The trade-off between assured, limited coverage and lack of recourse outside the worker compensation system is known as "the compensation bargain". One of the problems that the compensation bargain solved is the problem of employers becoming insolvent as a result of high damage awards. The system of collective liability was created to prevent that, and thus to ensure security of compensation to the workers.

While plans differ among jurisdictions, provision can be made for weekly payments in place of wages (functioning in this case as a form of disability insurance), compensation for economic loss (past and future), reimbursement or payment of medical and like expenses (functioning in this case as a form of health insurance), and benefits payable to the dependents of workers killed during employment.

General damage for pain and suffering, and punitive damages for employer negligence, are generally not available in workers' compensation plans, and negligence is generally not an issue in the case. (wikipedia, n.d.)

Stated more succinctly:

KEY TAKEAWAYS

- Workers' compensation is a form of insurance that pays workers who are injured or become disabled as a result of their job.
- Accepting workers' comp benefits means the employee waives the right to sue their employer.
- Most compensation plans offer coverage of medical fees related to injuries incurred as a direct result of employment.
- Workers' comp is not the same as unemployment benefits or disability insurance.

(Kagan, n.d.)

Alaska workers' compensation benefits are contained in the Alaska Statutes. Title 23, Section 30 contains the Alaska Workers' Compensation Act, (The Act), and guides the work of the Division of Workers' Compensation.

Regulation policy is contained in Title 8, Part 3, Chapter 45 of the Alaska Administrative Code.

3 MAKE-UP

The Division of Workers' Compensation, (DWC), is composed of:

- Special Investigation Unit.
- Reemployment Benefits.
- Adjudications.
- Administrative Unit.
- Alaska Workers' Compensation Board.

The DWC maintains offices in Juneau, Anchorage and Fairbanks to serve Alaskan employers and employees. All locations house adjudication and investigate team members with administrative team assistance. Reemployment offices are located in Anchorage and the Benefits Guaranty Fund and Fishermen's Fund are administered in Juneau. The Division of Workers' Compensation has 51 positions and the Alaska Workers' Compensation Board has 18 members made up of an equal amount of labor and management seats.

The DWC also provides administrative assistance to the Alaska Workers' Compensation Appeals Commission with budget, travel and other resources. The AWCAC is operated separately from the AWCB by statute and is located separately from the DWC.

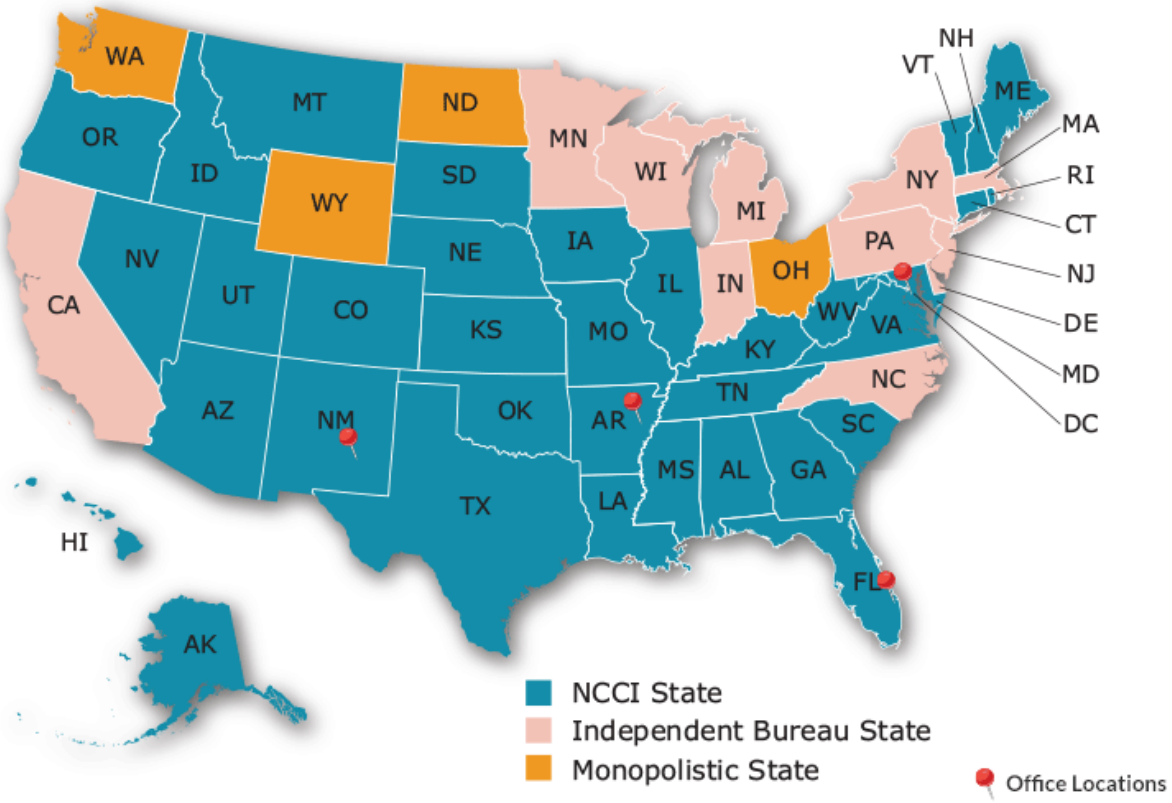
4 COVID IMPACTS

The DWC continues to track COVID related injury claims and the impacts on benefits included in those claims. The National Council on Compensation Insurance, (NCCI), a licensed rating organization retained by the State of Alaska to assist with rate setting for workers' compensation insurance premiums also tracks data on COVID. NCCI's annual loss cost filing does not include COVID-19 claim data, NCCI has concluded the impact on Workers' Compensation is minimal although there may be the potential impact in the future no adjustment was made for the 2020 annual premiums.

Preliminary numbers from across the country:

$260 million of case-incurred losses due to COVID-19 for Accident year 2020, this from NCCI reporting jurisdictions and does not include self-insurer losses. NCCI represents 35 states and the District of Columbia, including Alaska.

Written Workers' Compensation premiums declined 10% in 2020.



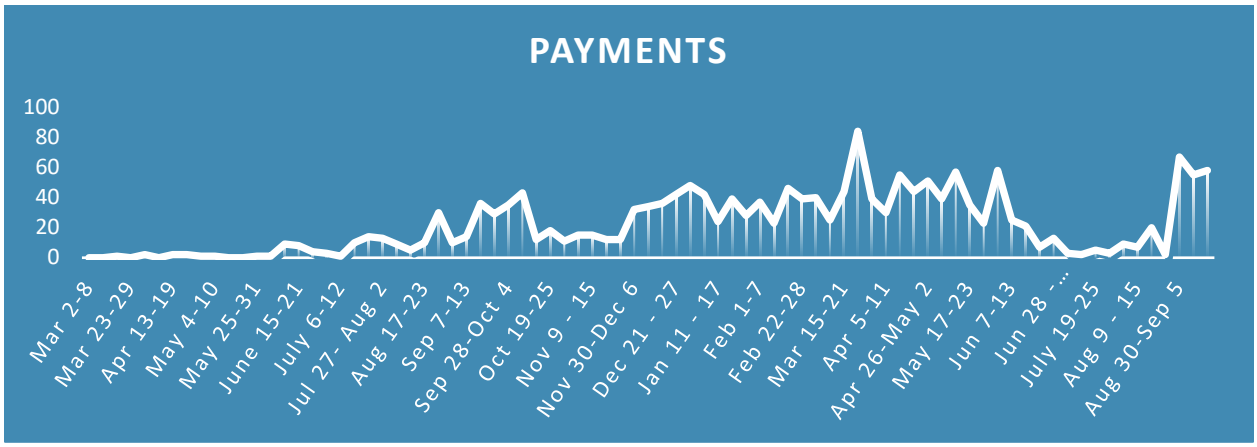
NCCI estimates that COVID-19 claims have the potential of exceeding $500 million in WC losses over the duration of the pandemic in states where NCCI provides ratemaking services.

To put this into perspective, 45,000 claims were reported in 2020, out of 56 million covered workers. Stated in percentage, 0.08% of workers in the states represented by NCCI had a claim for COVID-19 under workers' compensation. How does this compare to Alaska? In 2020 Alaska reported 1,588 accepted COVID-19 WC claims, the Department of Labor shows an average of 282,000 employed in 2020 which works out to 0.56%.

Alaska has realized a growth of claims in the recent months due to the Delta variant. The claim numbers currently show 1483 open and active claims.

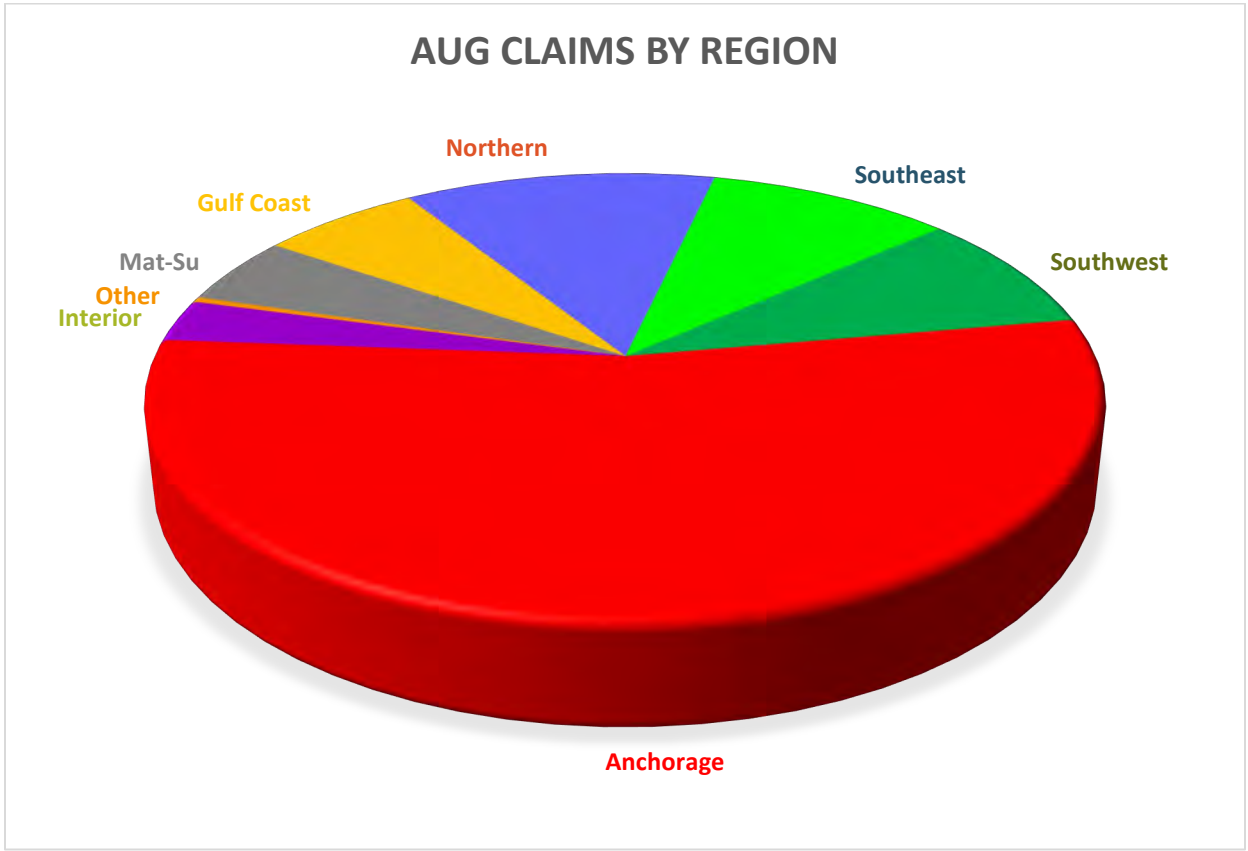
Opened	Closed	Current	Paid	BTC to date	OBT to date	EP to Date	Denials (04)
3413	1930	1483	1571	$1,795,305.80	$1,388,126.35	$618,138.04	306

The Benefit Type Code, BTC, refers to time-loss wages, any impairment charges, vocational rehabilitation, and settlements payments. The Other Benefit Type, OBT, covers medical, transportation, legal fees, and penalties.

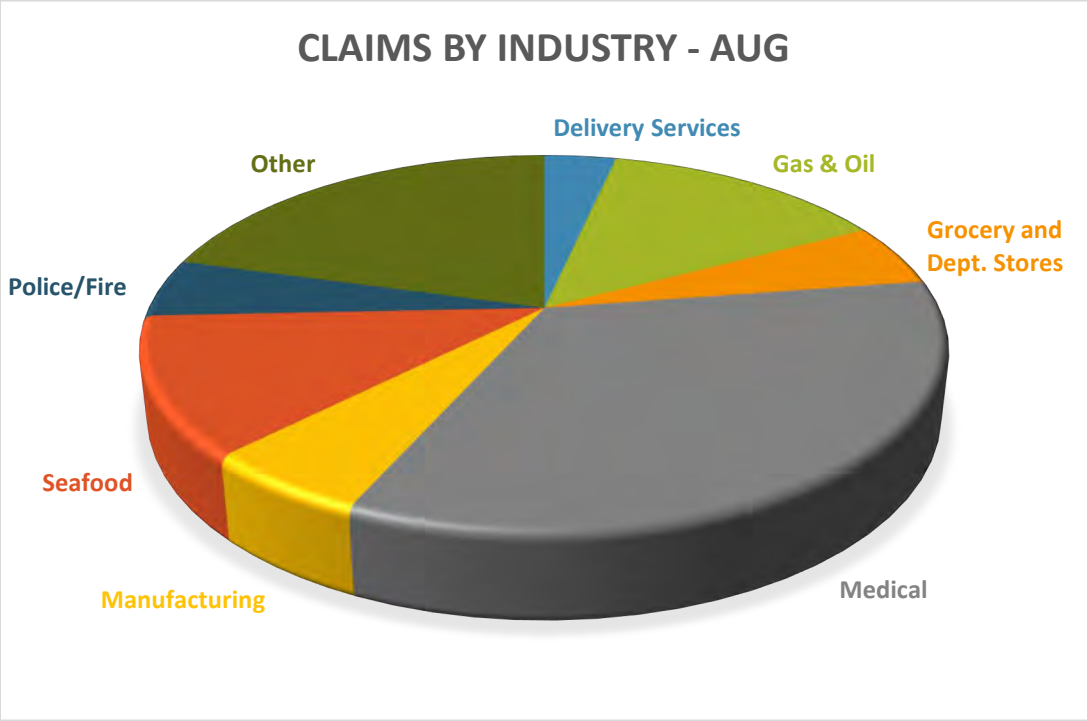


Alaska currently is on an upward trend for claim costs due to COVI-19. After a mild summer decline in claims, the Division has seen a dramatic increase in the past few weeks. This mirrors the overall surge in COVID cases due to the Delta variant.

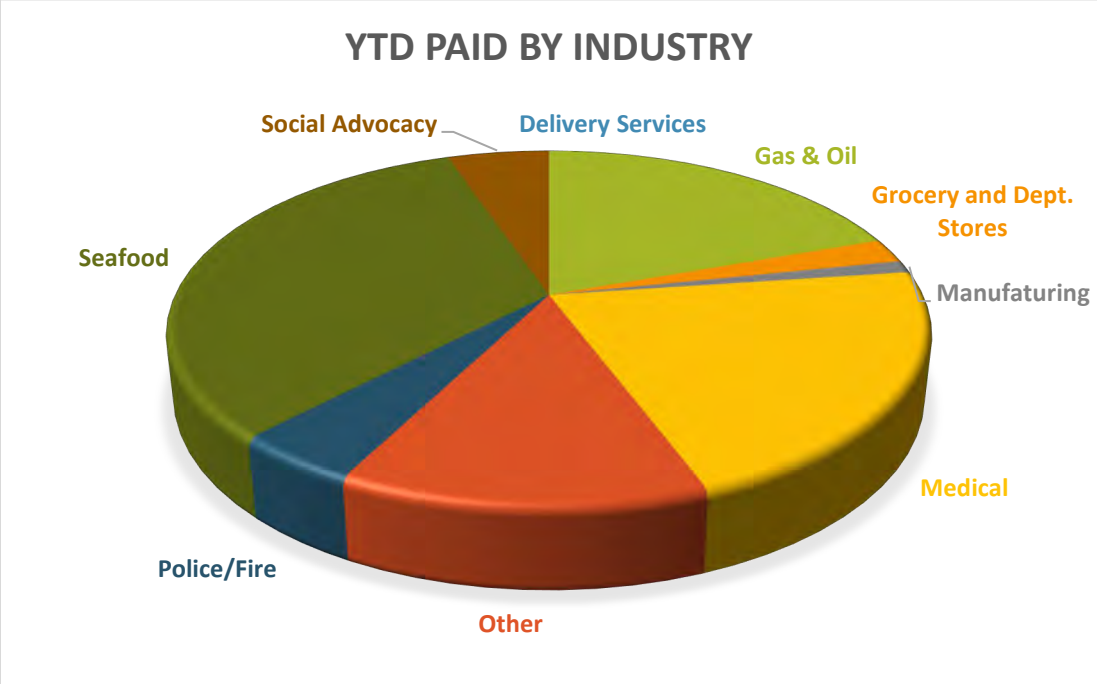
Claims are in line with population as expected, led by Anchorage but with distribution statewide. An interesting aspect of the frequency of COVID at work is that generally the percentage of contagion is considerably less at work than other activity. The only major area where transmission is higher at work is in Southwest Alaska due to the presence of the seafood processing industry.



Claims by industry are led by the medical professions as shown in this chart.



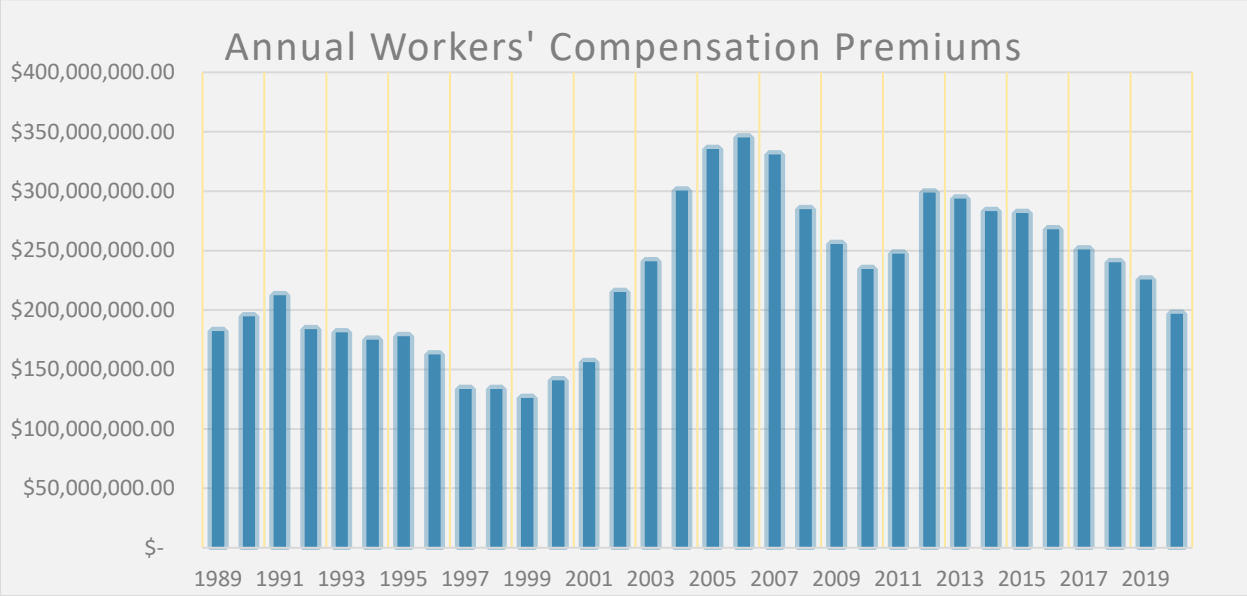
However, the breakout by expenditure points to the expense of procuring medical assistance in Alaska as transportation costs from our remote work sites adds to the expense.



In general, COVID has been a small part of the workers' compensation system expense the past 18 months.

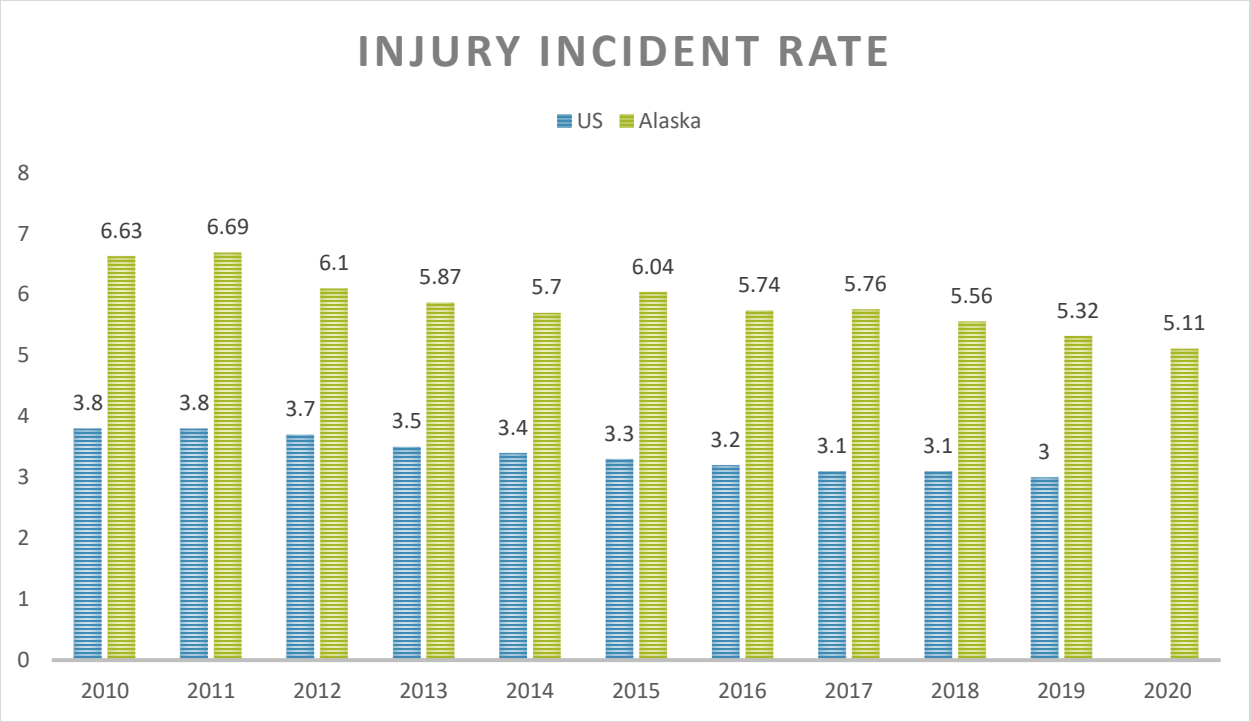
5 WORKERS' COMPENSATION SYSTEM

The last almost two years have been consumed by pandemic issues. However, we must not let that diffuse our focus. The mission of the Division must continue, and services must be provided. DWC is happy to report that the industry is resilient, and work continues. The numbers monitored for workers' compensation insurance show some nice trends.

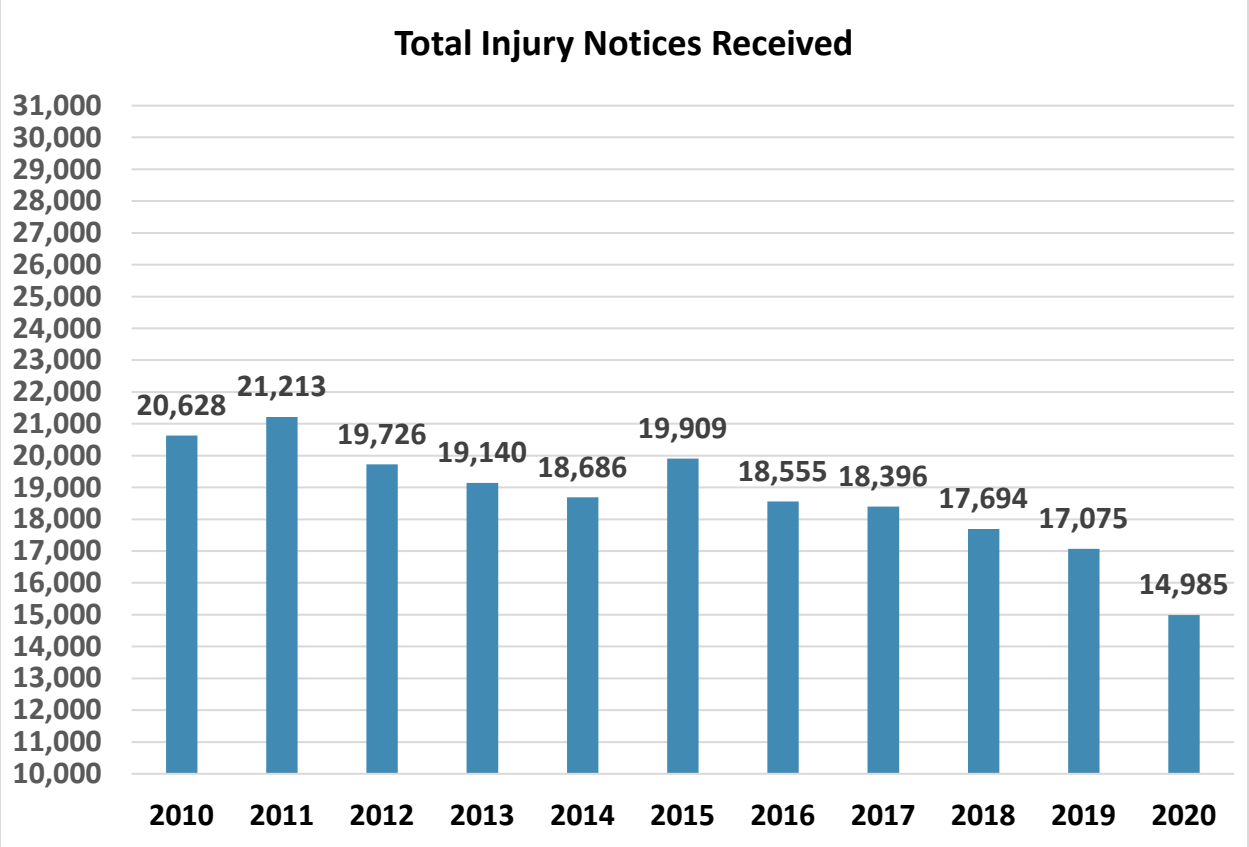


The calendar year of 2020 shows the sixth year of combined premium decline. This overall number shows that our efforts in reducing costs to employers is working. The combination of safer workplaces, changing job structures and fee schedule adherence has assisted Alaskan employers in saving capital and increased the ability for employees to have a safe work environment.

Total injury notices are on a declining trend. Even before the pandemic the numbers show that Alaska is a safer place to work. Compared to the nationwide numbers Alaska still has room for improvement. The rate of incidents per 100 FTE annually in Alaska is 5.11 in 2020. The nationwide number in 2019 was 3.00, unfortunately 2020 numbers have not been released. Alaska number of incidents, based on report of injuries / employee hours worked under the OSHA formula for reporting, in 2019 was 5.32 per 100 FTE. The following chart shows the progress for Alaska and the national number.



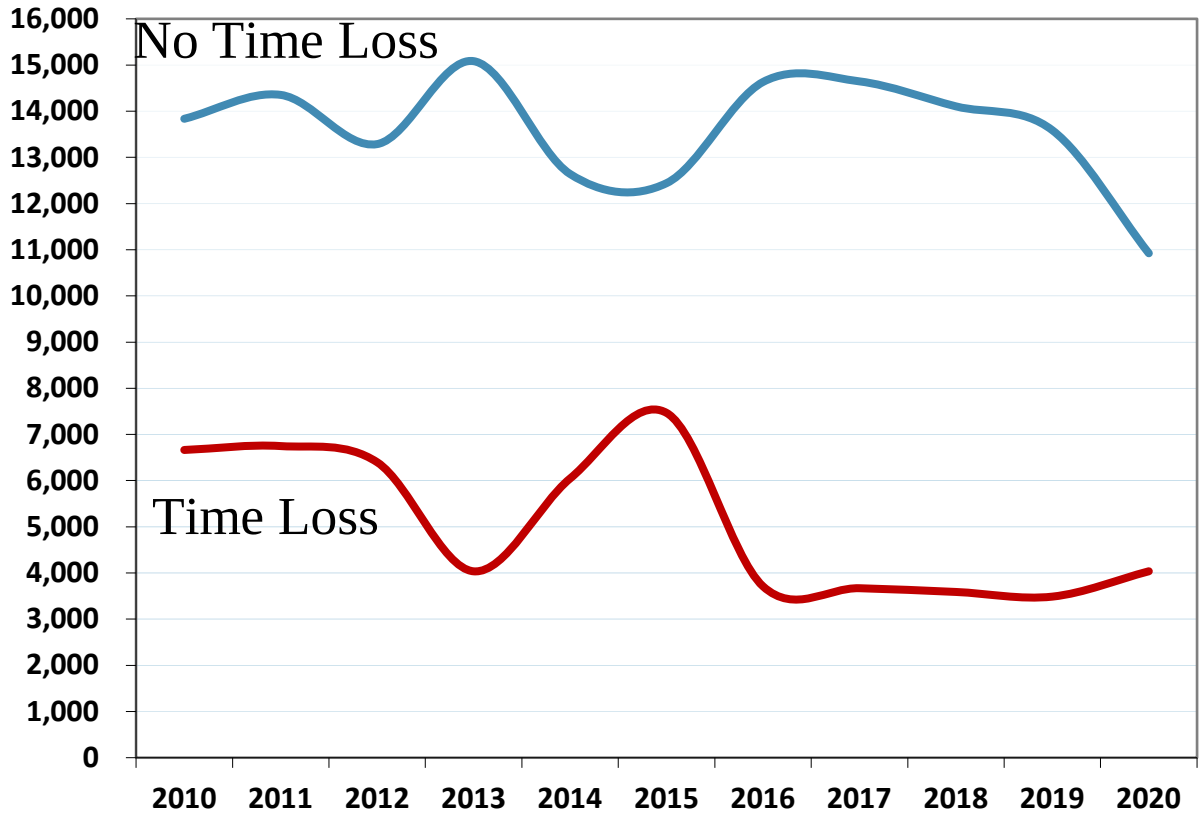
To further punctuate the fact that Alaska's workplace is continually becoming a safer environment DWC charts the number of "Reports of Injury" logged annually.



A look at the claims filed in 2020, there were 14,985 reports of injury and occupational illness filed with the Workers' Compensation Division, a 12.2% decrease from 17,075 reports filed in 2019.

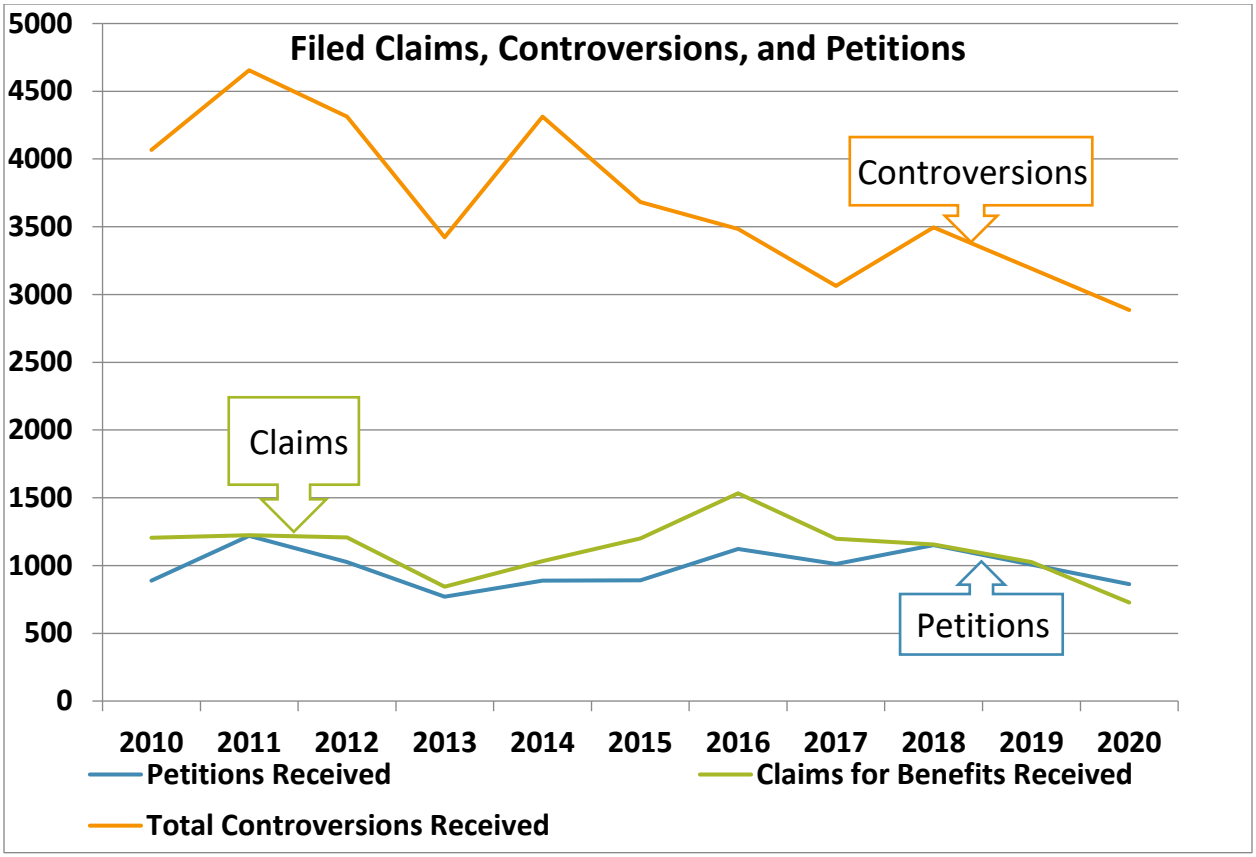
Of the case files established in 2020, claim type filings and distribution to total claims filed were:

- No-time-loss cases: 10,923 cases, 73%.
- Time-loss cases: 4,037 cases, 27%.
- Notification only cases: 4,139 cases, 28%.
- Fatalities: 25 cases, 0.17%.



In 2019, there were 727 claims filed for 610 cases, a 29.1% decrease from 1,025 claims filed in 2019. Also 863 petitions filed for 516 cases in 2020, a 14.2% decrease from 1,006 petitions filed in 2019. Furthermore, 2,886 controversion notices were filed in 2020, a 6.5% decrease from 3,191 in 2019. The number of injury cases controverted in 2020 totaled 2,241, a 6.5% decrease from 2,398 cases in 2019.

A look back ten years shows a decline in controversions compared to claims.



The Alaska Workers' Compensation Board held 188 hearings in 2020. This compares to 225 hearings in 2019 and 231 in 2018. The hearings in 2020 consisted of 152 regular hearings and 36 written record hearings.

Mediations continue to allow parties to resolve issues on claims, in 2020 75 cases were mediated with 72 resolved through the process. This is a 96% success rate.

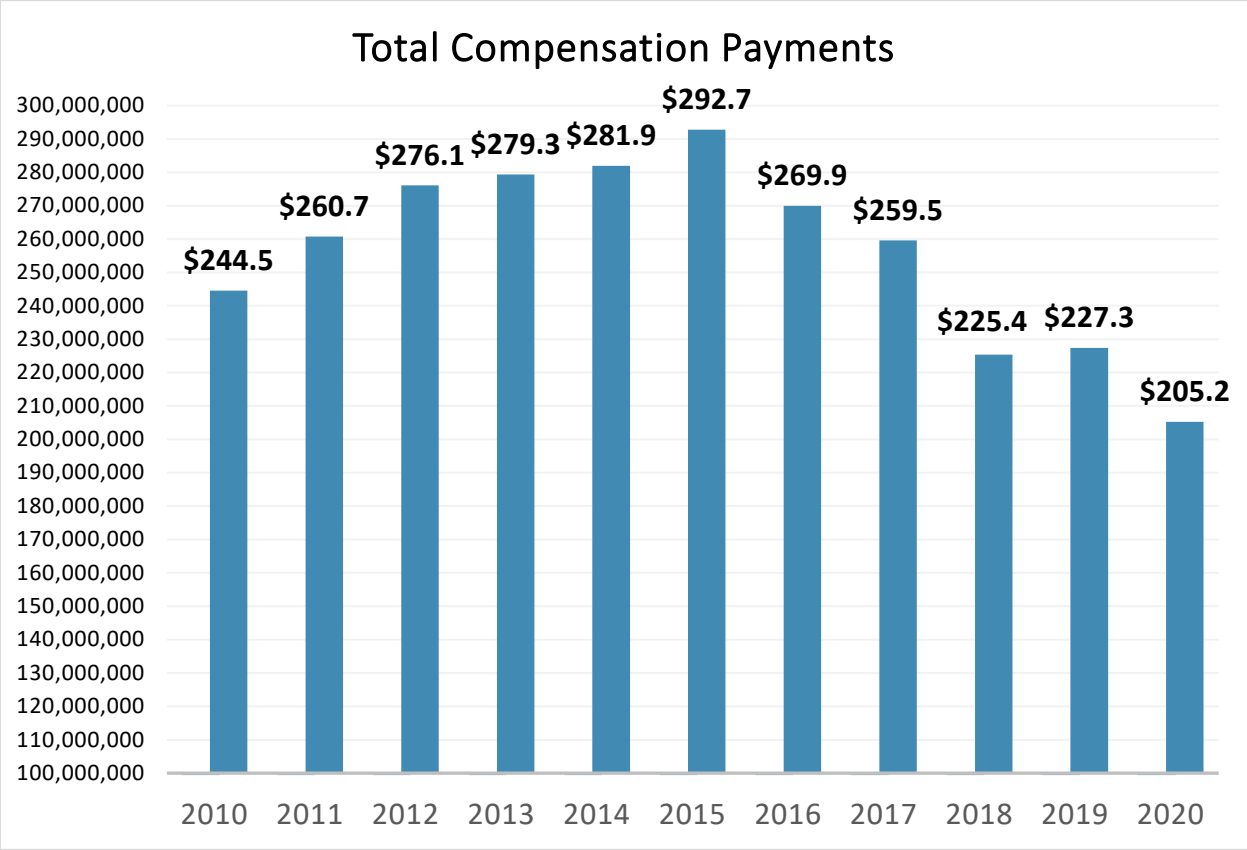
The AWCB also heard 475 Compromise and Release Agreements. AS 23.30.012(b) requires C&Rs to be reviewed by a Board panel if the claimant is not represented by an attorney, is a minor beneficiary or incompetent or is waiving future medical benefits. 8 AAC 45.160(e) states a C&R in which the employee waives medical benefits is presumptively not in the employee's best interest and will only be approved upon a showing by a preponderance of the evidence that the agreement is in the employee's best interest.

C&R Type	2016	2017	2018	2019	2020
Approval no required	84	79	57	71	45
Approved	503	432	462	450	374
Denied (required hearing)	174	122	131	85	56

Additionally, 2,400 prehearings were scheduled in 2020 to assist claimants.

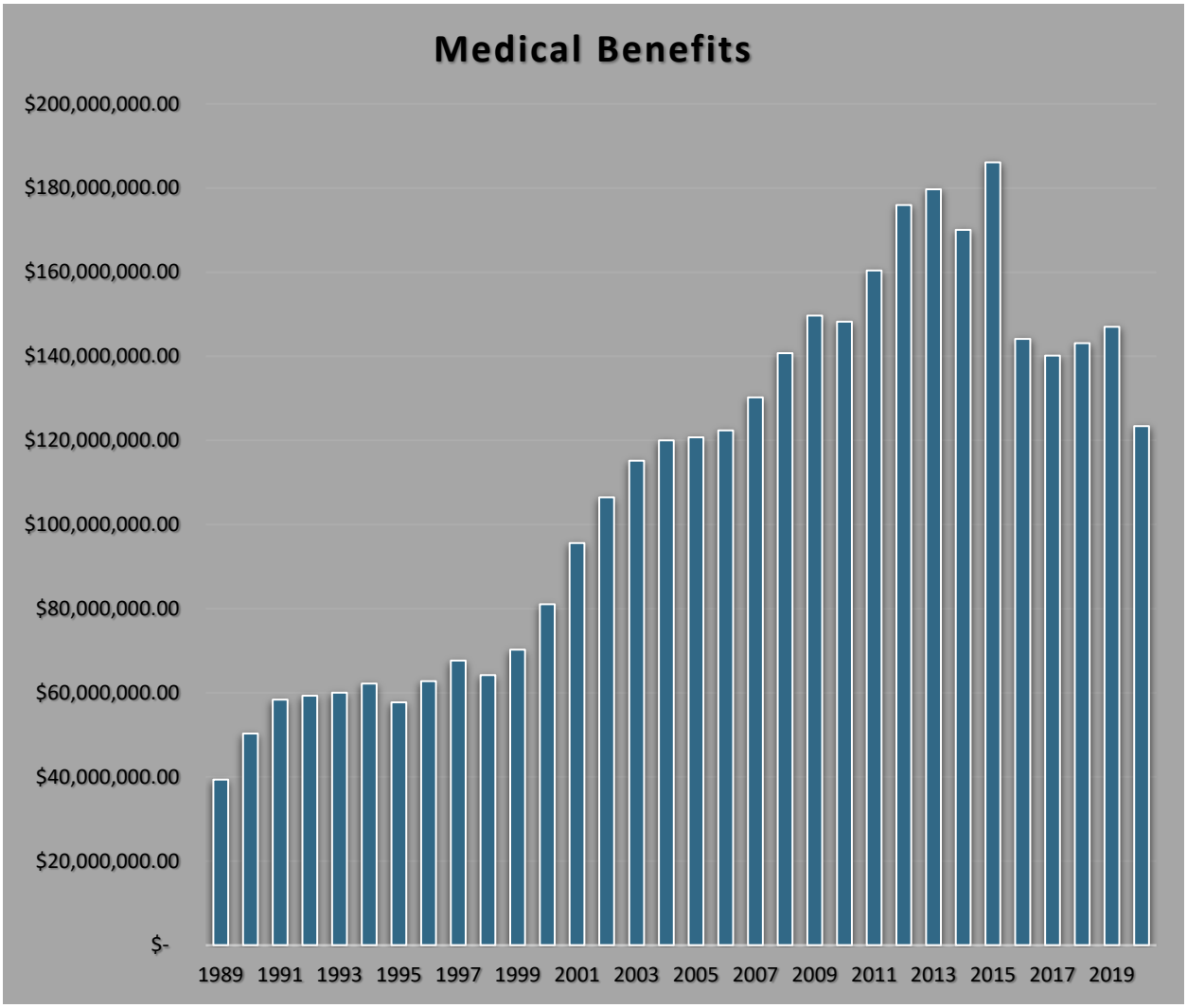
Total compensation benefits paid in 2020 decreased 9.73% over 2019, falling from $227.3 million in 2019 to $205.2 million in 2020.

Benefit payments have continued to trend to the downward side. In Alaska the trend lines are carefully monitored due to the influence of large claims dissolving our average costs for benefits. With a small number of claims the year over year costs can fluctuate widely. In the following graph the effect of Medical Fee Schedule shows up nicely with the implementation of our RSRVB system in 2016.



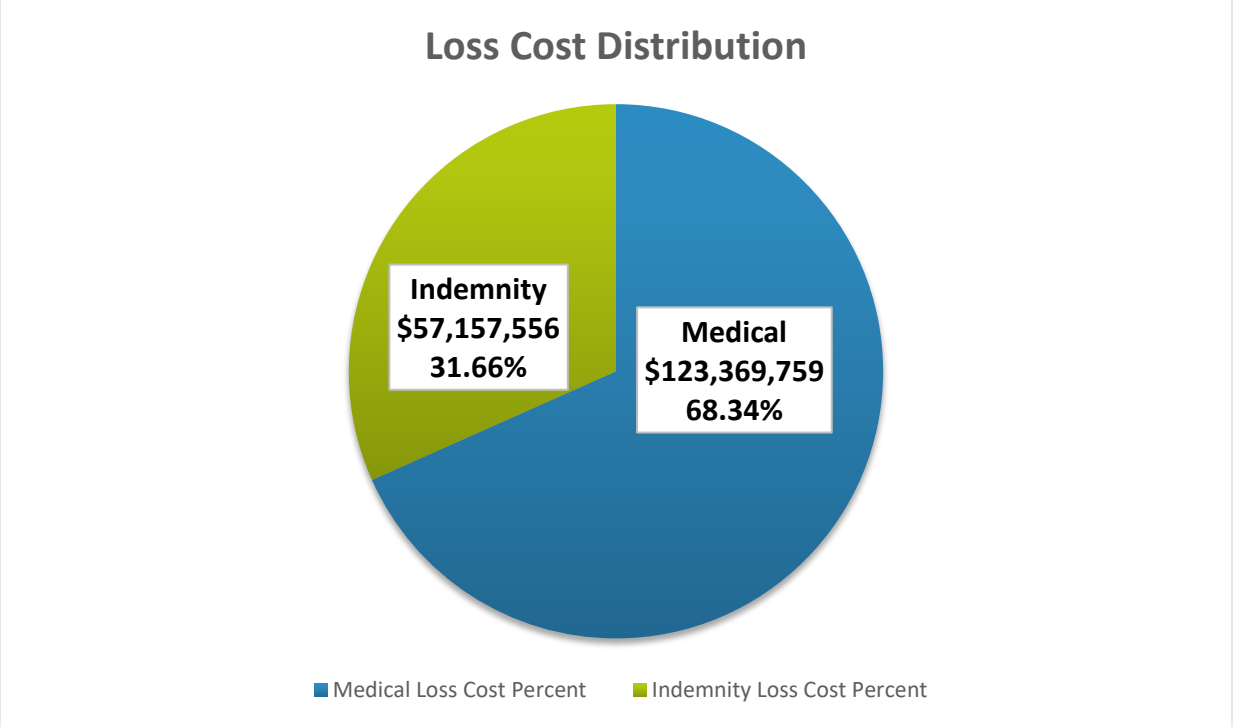
Benefit Type	Amount Paid	% of Cost to Total Cost
Medical	$123,369,759	60.1%
Indemnity	$57,157,556	27.9%
Reemployment	$7,699,606	3.8%
Legal	$13,764,586	6.7%
Other*	$3,228,847	1.6%
Total	$205,220,354	

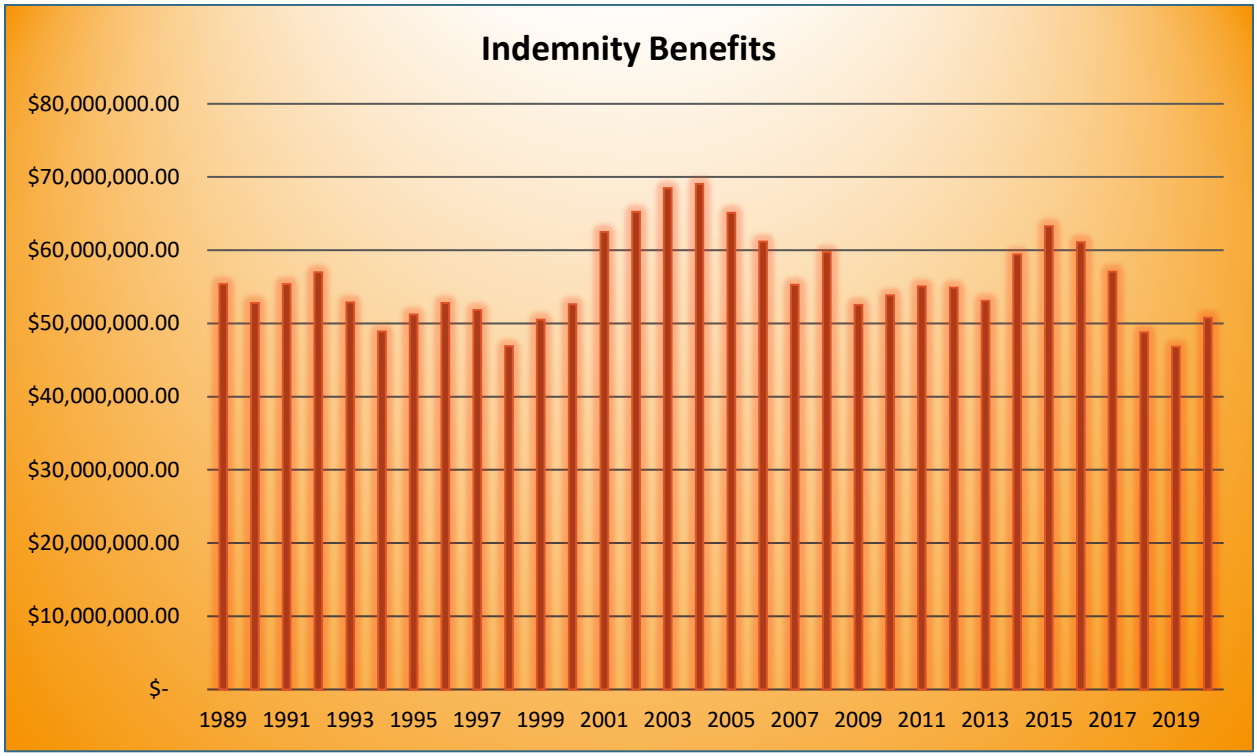
For the first time in over twenty years, the AWCB was able to effect changes in the overall spend for workers' compensation medical benefit payments. These savings have contributed to the decline in workers' compensation premium costs that employers are enjoying currently. Just as important, medical benefits and care access has not been limited to Alaskan employees, the Alaska Workers' Compensation Board and the Medical Services Review Committee have made it a priority to moderate the costs of delivering medical services without impacting delivery of services to injured employees or medical professional businesses.



The trends for indemnity payments are more complicated. As these benefits are reflective of many differing costs, the fluctuation is a product of personal decision by claim parties which cannot be predicted. Large settlements for time-loss due to physical impairments can influence annual costs. Likewise, the pandemic issues of 2020 may have contributed to lengthening the return-to-work time as jobs may have been harder to secure. The DWC also noted more job dislocation settlements in 2020 as we theorize injured employees may have chosen to receive

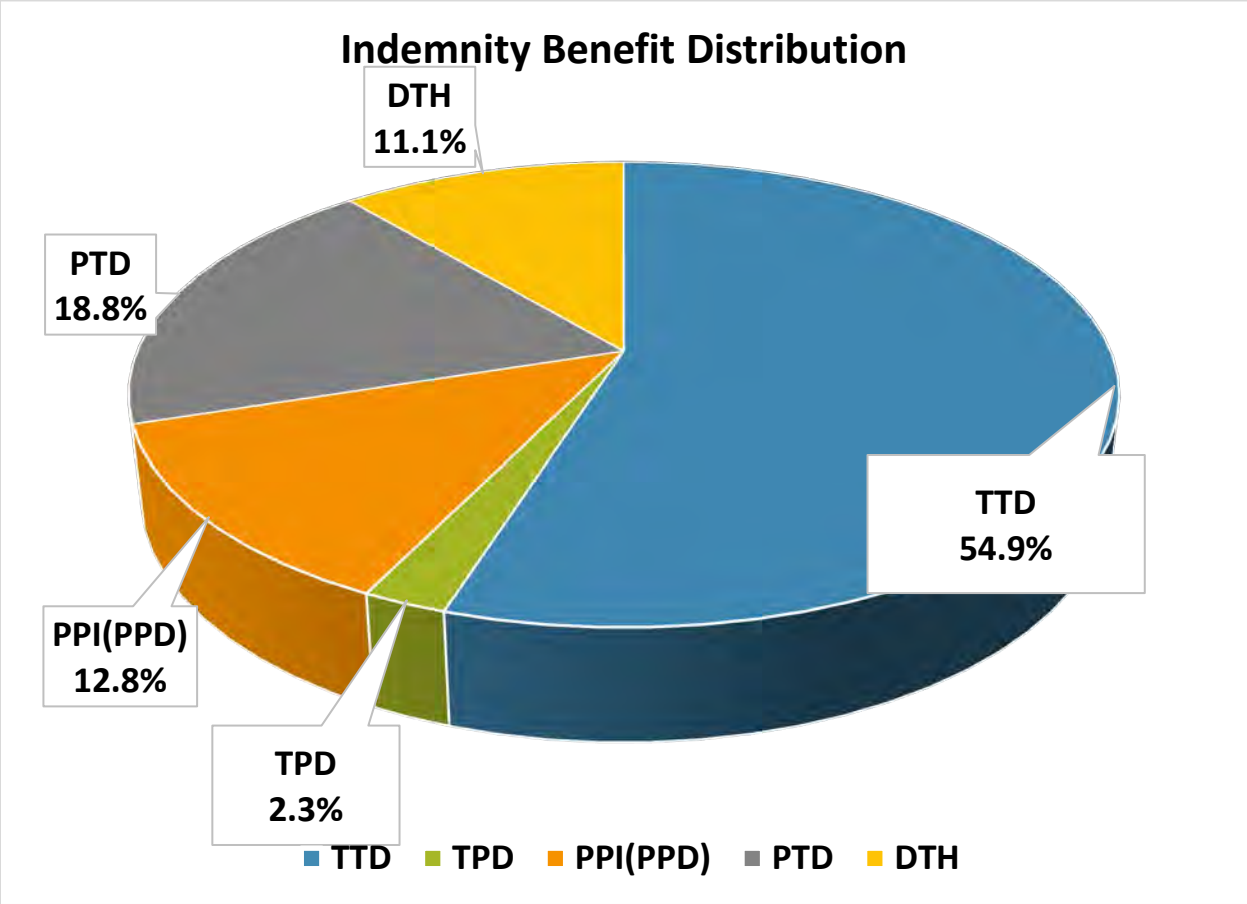
this benefit over a reemployment plan. Indemnity makes up a slightly higher percentage of loss cost in 2020 than 2019, rising to 31.66% of the total compared to 26.31% in 2019.





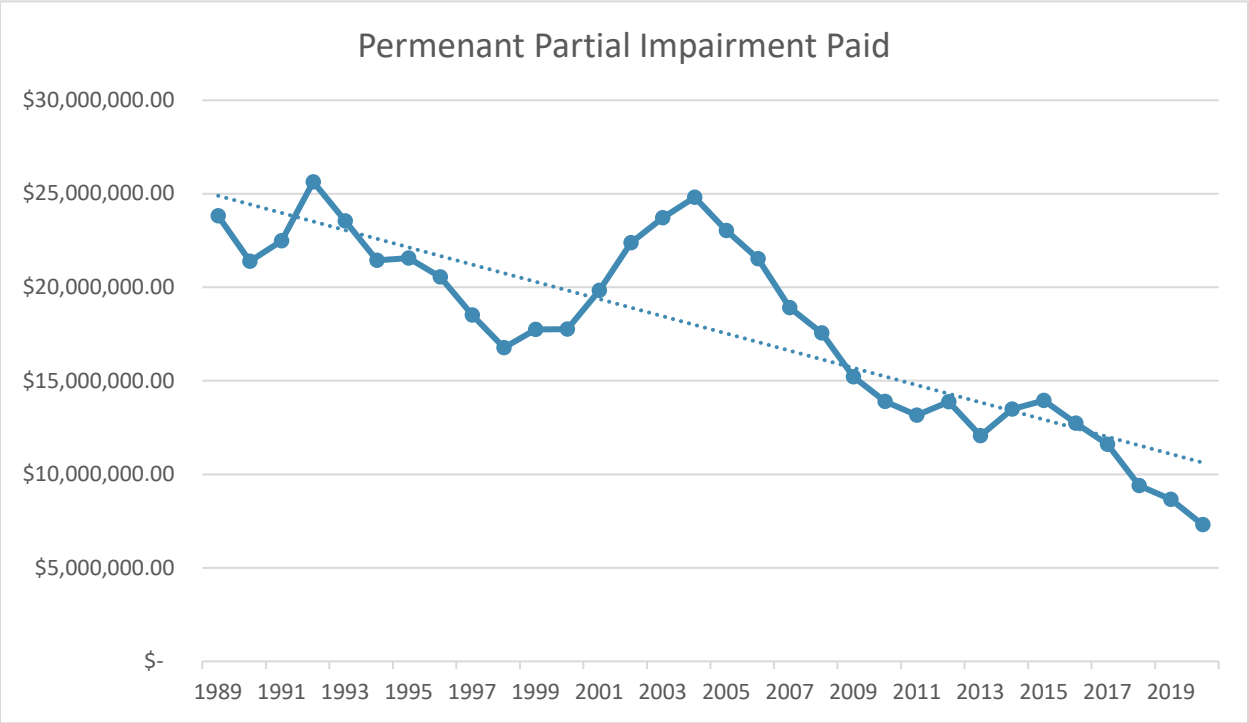
For calendar year 2020 indemnity benefits (TTD, TPD, PPI, PTD & Death Benefits) totaled $57.1 million, an 8.9% increase from $52.4 million in 2019.

- TTD benefits totaled $31.3 million in 2020, a 9.4% increase from $28.6 million in 2018.
- TPD benefits totaled $1.33 million in 2020, a 1.64% decrease from $1.36 in 2019.
- PPI benefits totaled $7.3 million in 2020, a 15.7% decrease from $8.6 million in 2019.
- PTD benefits totaled $10.7 million in 2020, a 33.2% increase from $8.0 million in 2019.
- Death benefits totaled $6.3 million in 2020, a 11.8% increase from $5.6 million in 2020.



Another factor on indemnity benefits is the limitations of out statutes. Impairment and death benefits have been static for many years and the impact of inflation has eroded the benefits over time. This inflationary impact on wage replacement benefits is an economic drag on the State. Injured workers receiving declining benefits for temporary and permanent impairments are forced onto other social insurance programs and those costs are redistributed across our economy. This cost shifting is a concern for all parties as it represents lost growth of our domestic product and rarely results in a successful rehabilitation of clientele. Workers' compensation was envisioned to be a private endeavor with premium and loss costs becoming

a portion of the product costs passed on to the consumer. Social insurance costs of righting wrongs and serving the public are shared by all members of society with no connection to the employee, the employer or the customer served. As a visual to the impact of declining benefit values the payments for permanent partial impairment, (PPI), are charted.

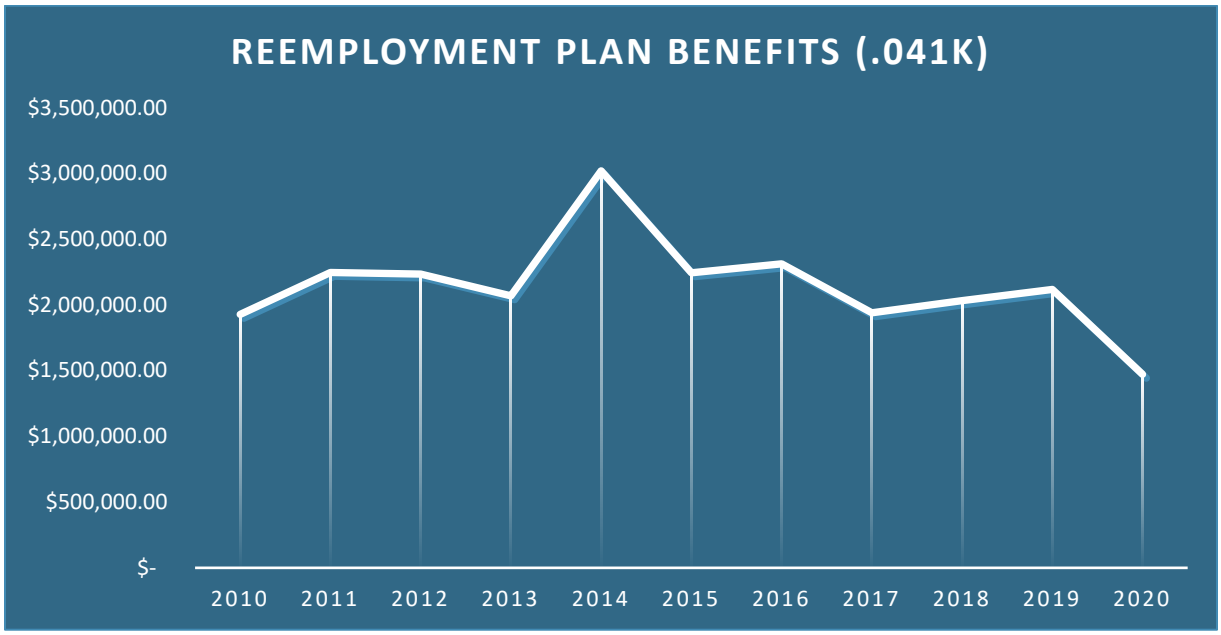


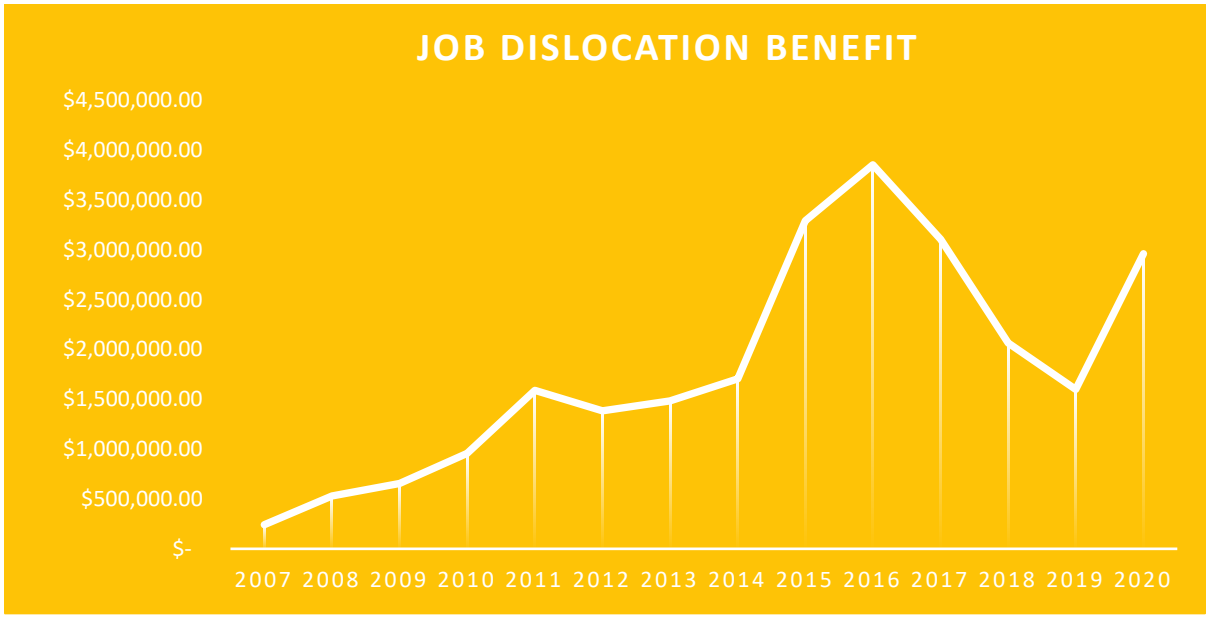
A portion of the decline is due to claim numbers, but the amount per claim has contributed to the payment downturn. Injured employees tend to stay on lost wage benefits if possible as PPI amounts have become insufficient incentive to return to work.

The breakout of total benefits paid has stayed relatively constant the past decade with market-insured and self-insured employers.

INSURER TYPE	Total Benefits Paid	% of Total Costs
Market Insurers	**$154,986,746**	**75.5%**
Self-Insured Employers	**$49,953,724**	**24.3%**
Uninsured Fund	**$279,884**	**0.1%**
Total	**$205,220,354**	

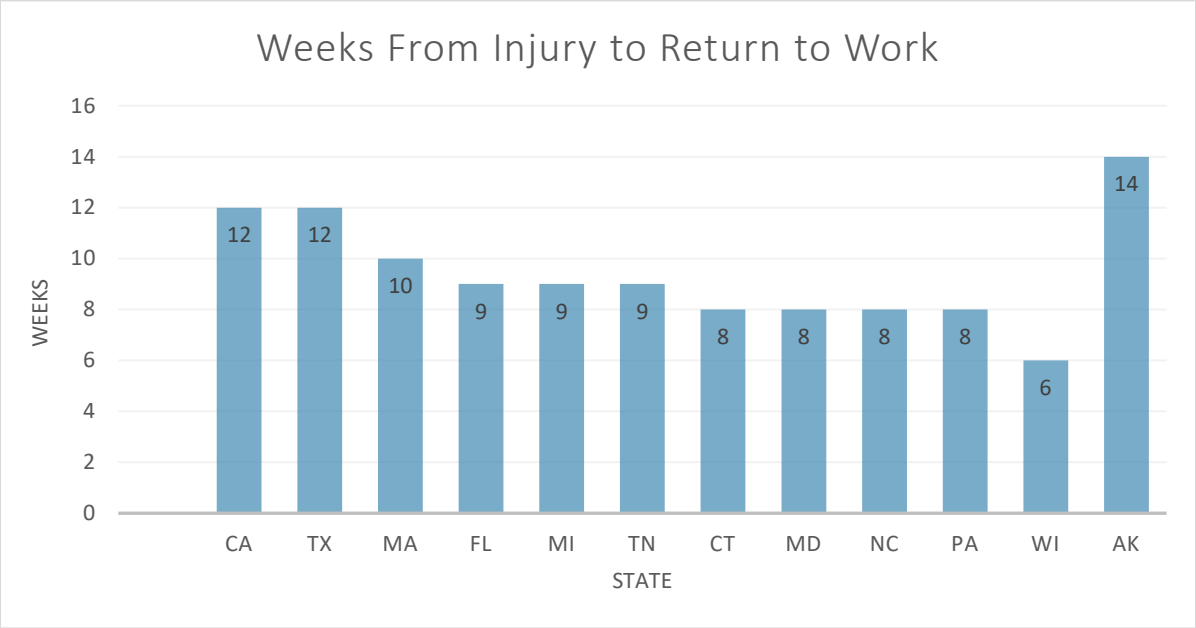
Before the pandemic we chart a steady increase in 041(k) benefits as injured employees were in rehabilitation for continually increasing amounts of time. But in 2020 we notice a shift in job relocation benefits as we theorize settlement was preferable to attempting to work a plan and jobs were increasingly harder to acquire.



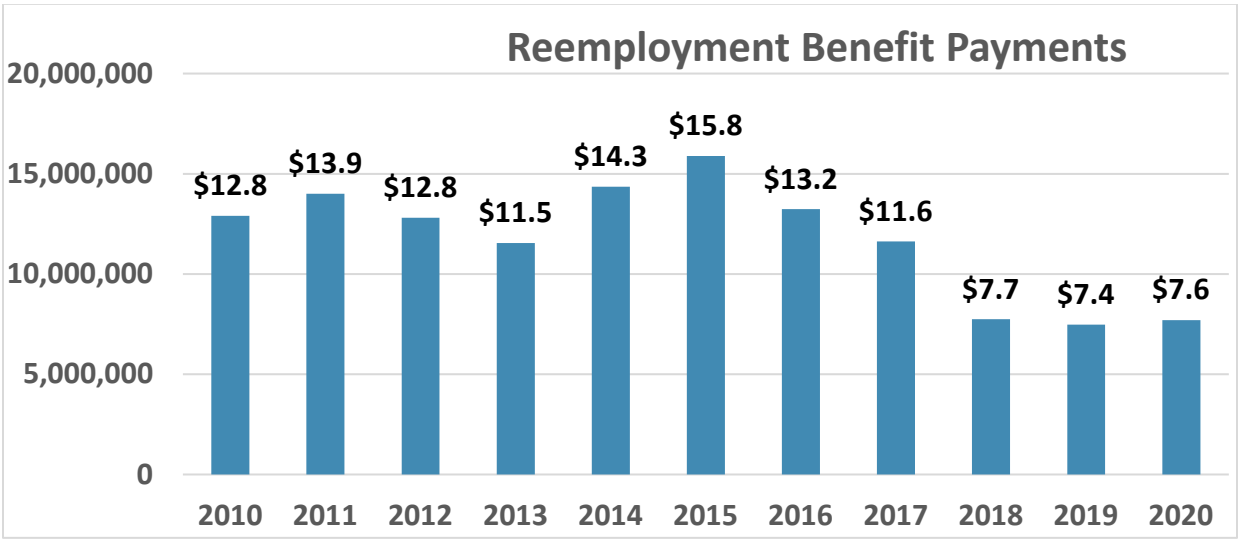


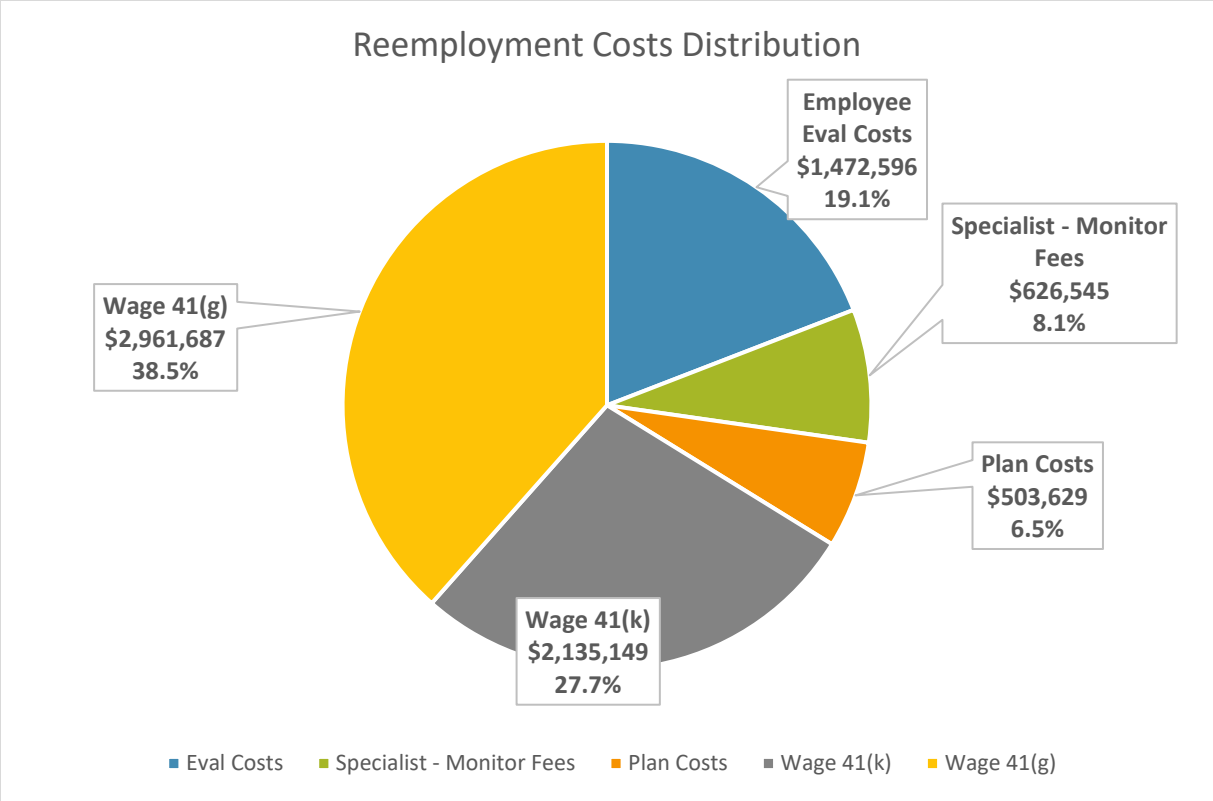
This is dramatically shown in the steep rise of 041(g) benefits. Alaska trails the average time duration between injury and return to work in the nation. In a recent study by Workers' Compensation Research Institute, (WCRI), involving several states, there was a large variation in the length of time for return to work due to several factors. For example, Wisconsin has

developed a plan that involves early communication with injured workers missing more than seven days of work. This plan includes the employee and legal representative, if necessary, employer, and appropriate medical personnel. A determination is made length of temporary total disability, (TTD), and a plan for modified work capability which focuses on clear expectation for the parties in the process of rehabilitation. In Wisconsin's scenario the system has seen an improvement of time loss duration decline by over seven days.

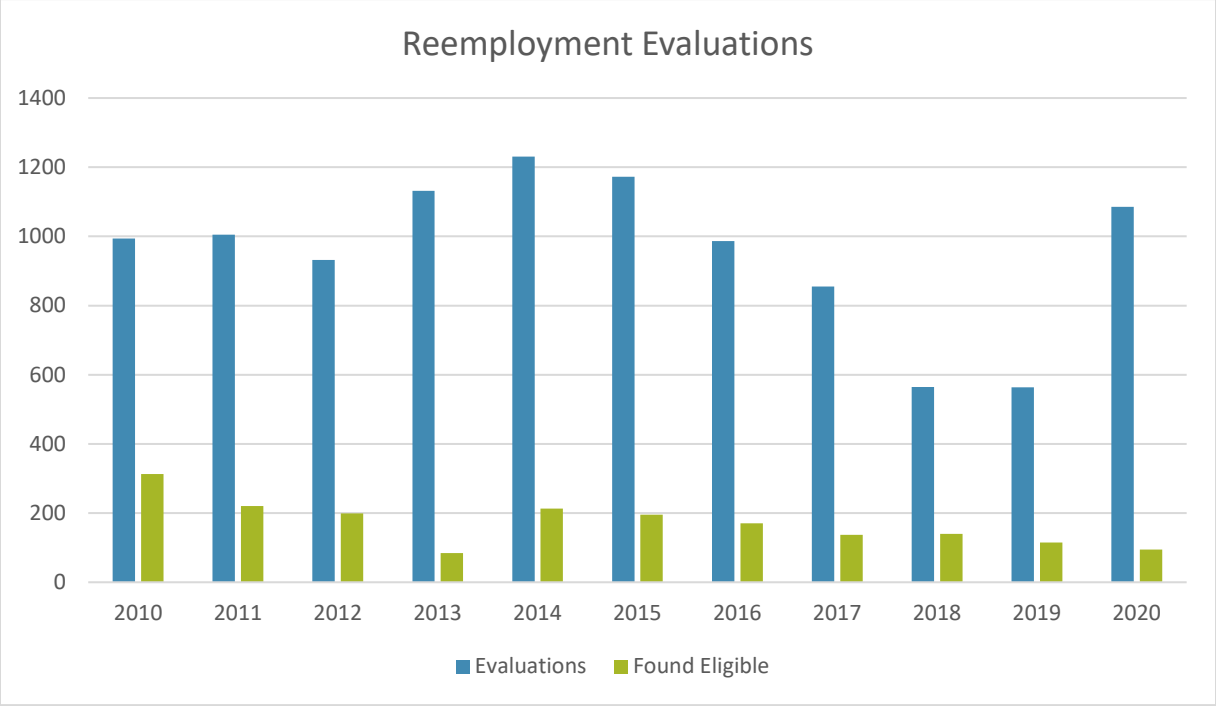


The breakout of costs for reemployment benefits in 2020 show some dramatic changes that occurred in types of benefit payments made. Overall, a 3.1% increase in benefits from 2019 to 2020 occurred.



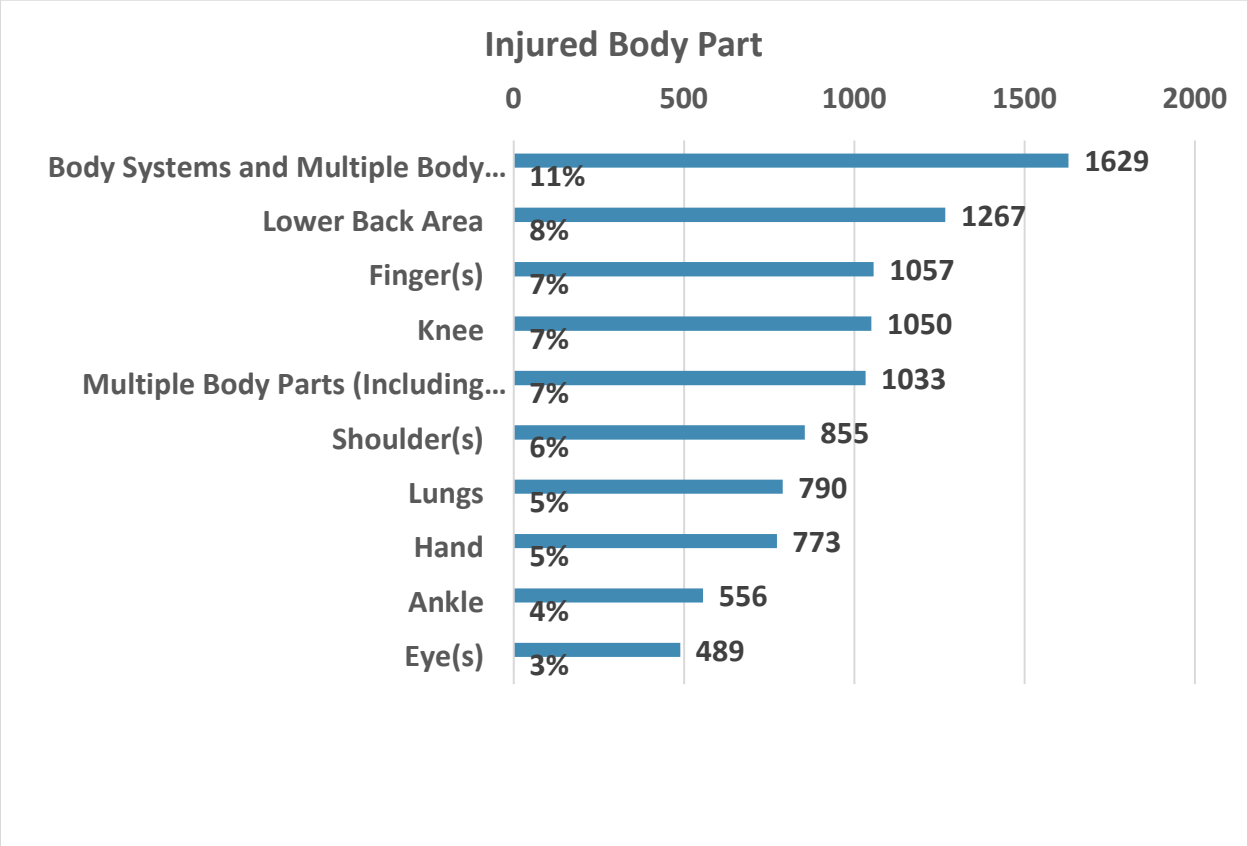


Alaska's struggle to rehabilitate and reemploy injured workers continues to show meager results. Every year we evaluate hundreds of injured employees who have missed ninety days or more and very few of those evaluated become eligible for a reemployment plan.

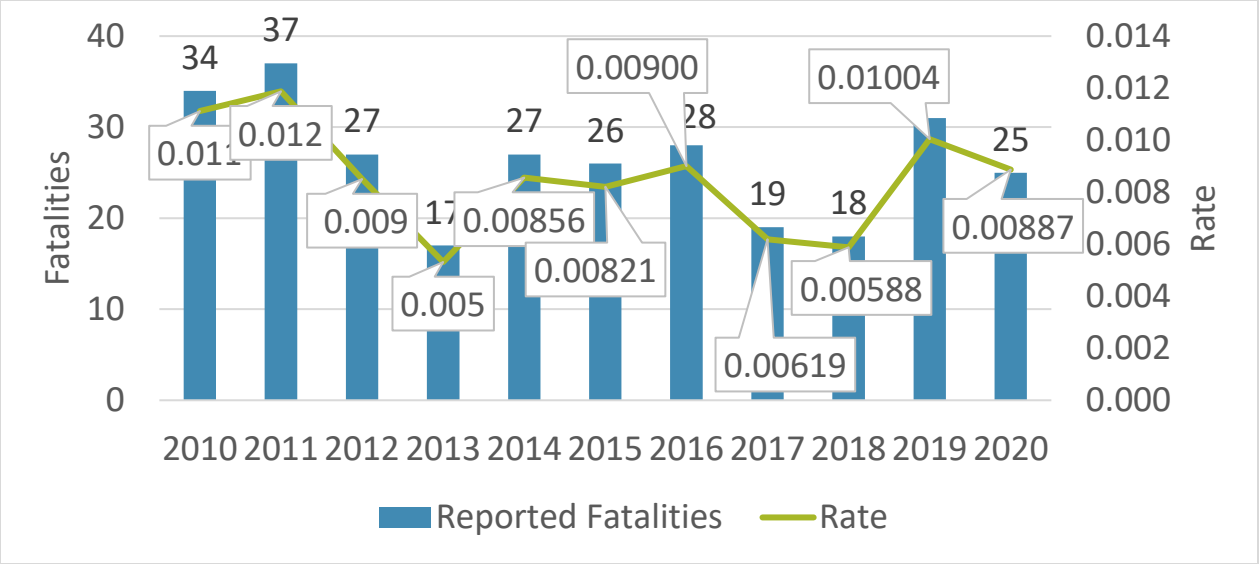


In calendar year 2020, our Reemployment Benefit Administrator, (RBA), and her team reviewed 1,085 evaluations and only 95 injured employee claimants were found eligible. Of these evaluations DWC tracked 414 were due to the ninety, (90), day limit that triggers an evaluation under AS 23.30.041(c), costing employers and their carriers an estimated $561,893. The AWCB is on record asking the Legislature to amend the statute to allow for flexibility in the timing of these evaluations. Currently the Director of DWC has a proposed bill for introduction to modify the wording of AS 23.30.041 to address this concern. I am hopeful we can successfully amend the statute and streamline the process for rehabilitation and reemployment.

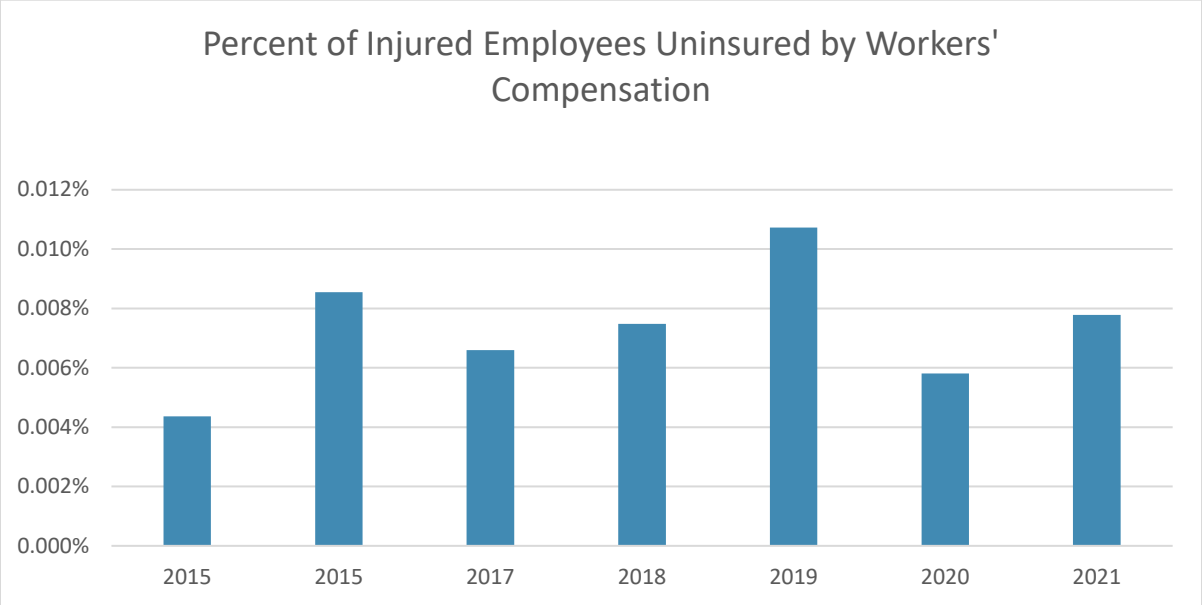
Reports of injuries in Alaska have declined, severity of injuries have also seen a decline as employer safety programs, state and federal mandates and even the type of work performed have all contributed to a safer work environment. In 2020 injured body parts most frequently noted are charted.



With Alaska's vast territory and often harsh work environment, job injuries may happen in remote locations and add a level of complexity to recovery issues. With medical services limited in areas and unpredictable weather events, access to emergency medical can be delayed and injuries escalate due to transportation logistics. Alaska workers suffered fatalities at work also, dropping from a multiyear high in 2019 to the normal range of 25 fatalities in 2020.



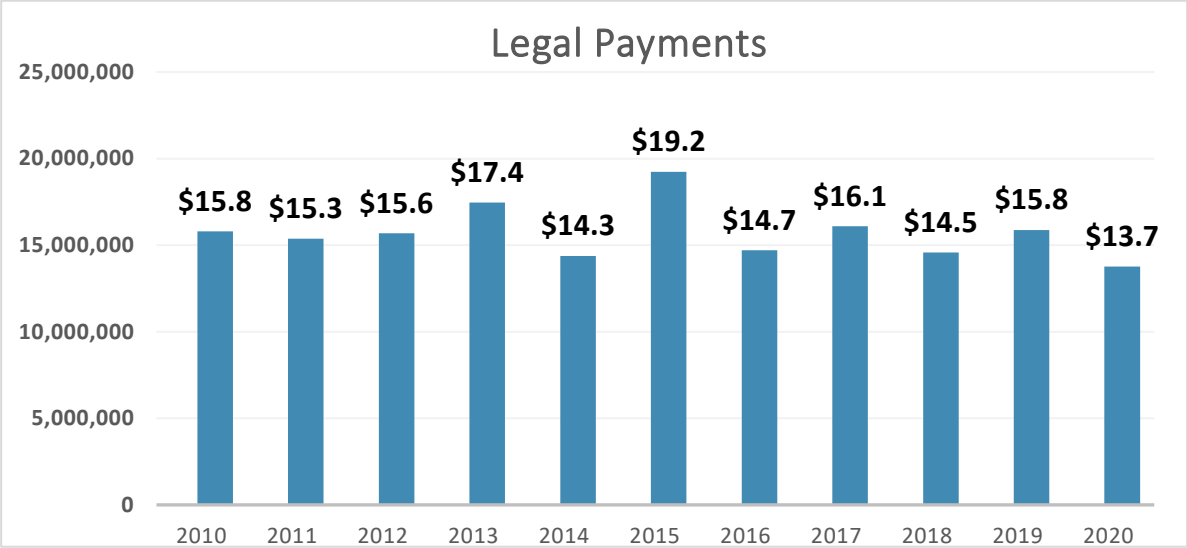
The Division continues to focus on insuring all employees are covered by workers' compensation. Our Special Investigations Unit, (SIU), has continued their excellent run at guaranteeing all employers are properly insured. SIU has in followed up on every allegation of fraud or non-compliance for the last several years. SIU is tasked with not just finding the non-compliant, but also with outreach and education of employers of the tenants of the Act. SIU routinely conducts hundreds of trainings and educational presentations annually. Like all lines of business, COVID influenced SIU operation this past year and we were unable to present SIU educational presentations during this period.



Our goal in Zero but we are tasked with staying under 0.01%.

As our reports of injury have declined so to the number of claims requiring in person adjudication services. DWC Hearing Officers, Workers' Compensation Officers and Board Panel members continued to perform the duties required with the use of technology. Controversion filings were down but more petitions were filed than in 2019. DWC lost a hearing officer due to retirement and a replacement has not been found. The Division also has seen movement on Workers' Compensation Officers and Technicians through retirement and relocation. Currently this attrition is manageable, and recruitment is ongoing.

Workers' Compensation claims continue to generate legal costs which have been consistent for the past decade. Under the Alaska Workers' Compensation Act the vast majority of all costs are borne by the employer.



6 Loss Cost Projections

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

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

an estimated 13.8% reduction in voluntary loss costs and 10.7% decrease in assigned risk rates. The order went into effect on November 5, 2019.

This has moved Alaska forward in comparison with the nation on Workers' Compensation Premiums, allowing businesses in Alaska to compete on a more level surface.

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

7 PENDING LEGISLATION

As previously stated, the DWC has the backing of Commissioner Ledbetter to forward a proposed bill to the Governor's Office. Currently this bill dealing with changes to AS 23.30.041 is being reviewed by the Governor and the Department of Law. There is no Bill number yet as it has not been filed.

House Bill 30, “An Act relating to notice of workers' compensation death benefits; relating to the payment of workers' compensation benefits in the case of permanent partial impairment; relating to the payment of workers' compensation death benefits; and providing for an effective date.” This Bill is still in the House and pending before the House Finance Committee. The Bill sponsor is Representative Andy Josephson who has championed this legislation in the past few legislatures.

House Bill 45, “An Act relating to presumption of compensability for workers' compensation claims related to contagious diseases; and providing for an effective date.” This Bill is also still in the House and pending before the House Finance Committee. The Bill sponsor is Representative Andy Josephson and deals with impacts of pandemic scenarios.

House Bill 204 "An Act relating to the presumption of compensability for a disability resulting from certain cancers in firefighters." The original sponsor was Representative James Kaufman, Representatives Schrage, Shaw and Nelson are now co-sponsors. This Bill is in the House Rules committee.

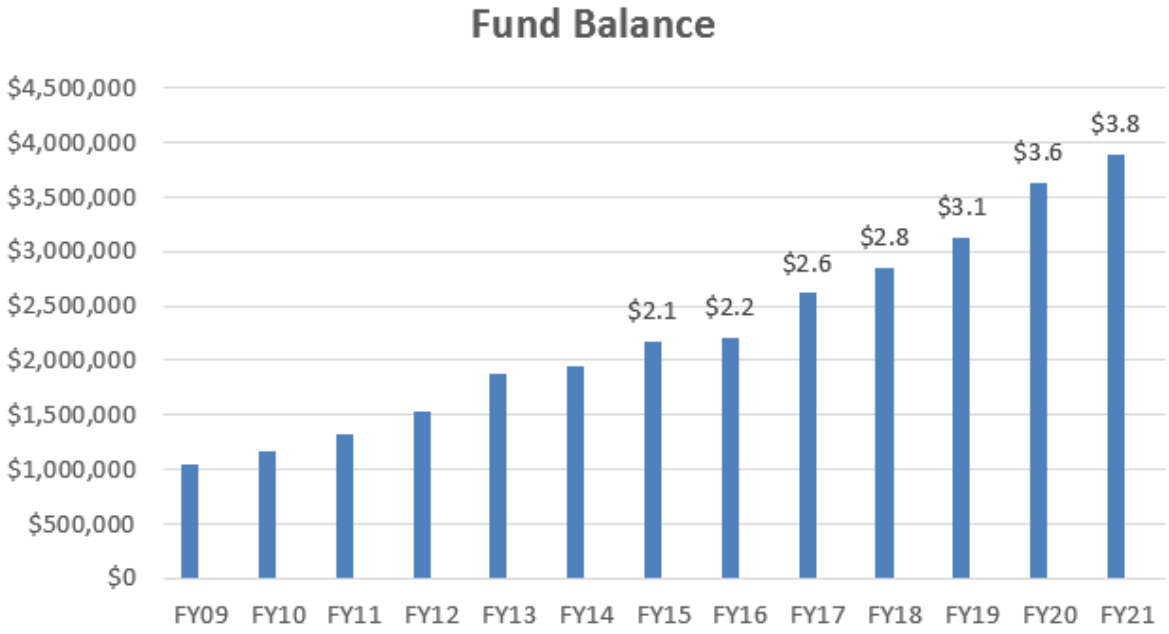
Senate Bill 131, "An Act relating to the presumption of compensability for a disability resulting from certain diseases for firefighters." This Bill, sponsored by Senator Roger Holland and co-sponsored by Senator Gray-Jackson, has passed the Senate. The Bill is now in the House Labor and Commerce committee and has been co-sponsored by Representative Tuck on the House side. AS generally the same makeup as HB 204 I expect this Bill to become the focus of legislation if the committees decide to work on this subject.

Other legislation that has impact on Workers’ Compensation, such as telehealth bills or changes on administrative proceedings under certain conditions are also in process. The Department of Labor and Workforce Development monitor the progress of these Bills and currently we are unaware of any impacts to the Division. With the continuation of special sessions focusing on subjects not pertaining to workers’ compensation I do not expect any movement before the next regular session in January of 2022.

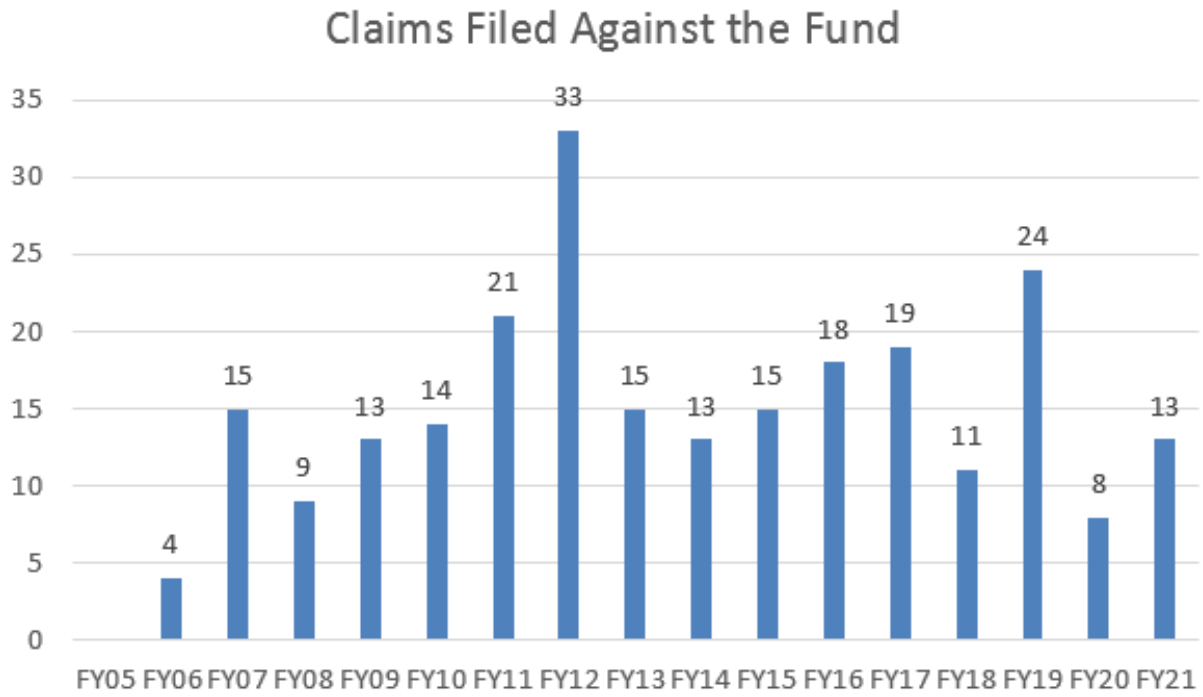
8 Special Funds

Division of Workers’ Compensation oversees a number of funds that pertain to the workers’ compensation system in Alaska. As the Alaska Workers’ Compensation Board these funds and the operation of their procedures also are reportable to you. AS 23.30.040 established the Second Injury Fund to assist rehabilitated workers to find employment by reimbursing costs to employers in the advent of a previously injured worker needing additional benefits. This fund, while closed by the Legislature, continues to collect and pay out benefits for the legacy claims involved. The Second Injury Fund is healthy and has sufficient assets to operate.

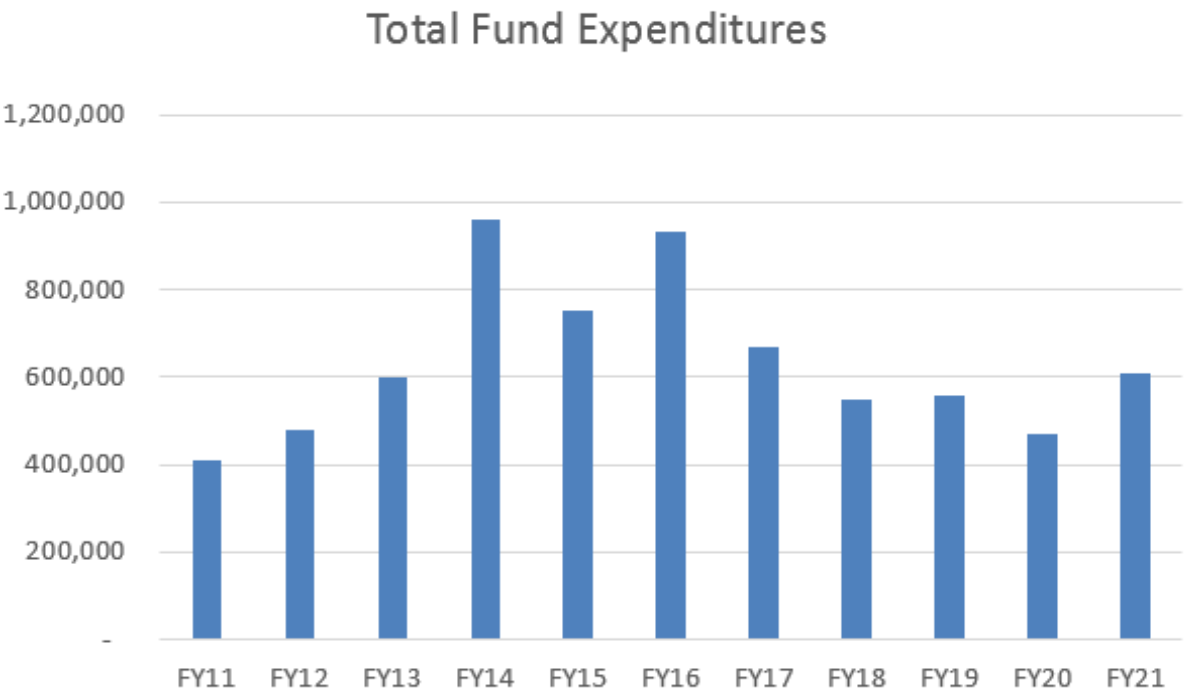
The Workers' Compensation Benefits Guarantee Fund was established with AS 23.30.082 and covers the cost of benefits for injured workers who were employed by non-insured employers. Funds levied under AS 23.30.080 are placed in this fund from collections on uninsured or other non-compliant employers. The health of this fund is of extreme importance as benefits are consistently paid for existing claims. The Division is please to report that this fund continues to operate properly, and the balance is sufficient to meet current needs. Due to the nature of this fund a claim could be levied against this fund that possibly could damage the future solvency.



There were 21 reports of uninsured injuries in 2021 and thirteen employees that were working for an uninsured employer filed claims for benefits.

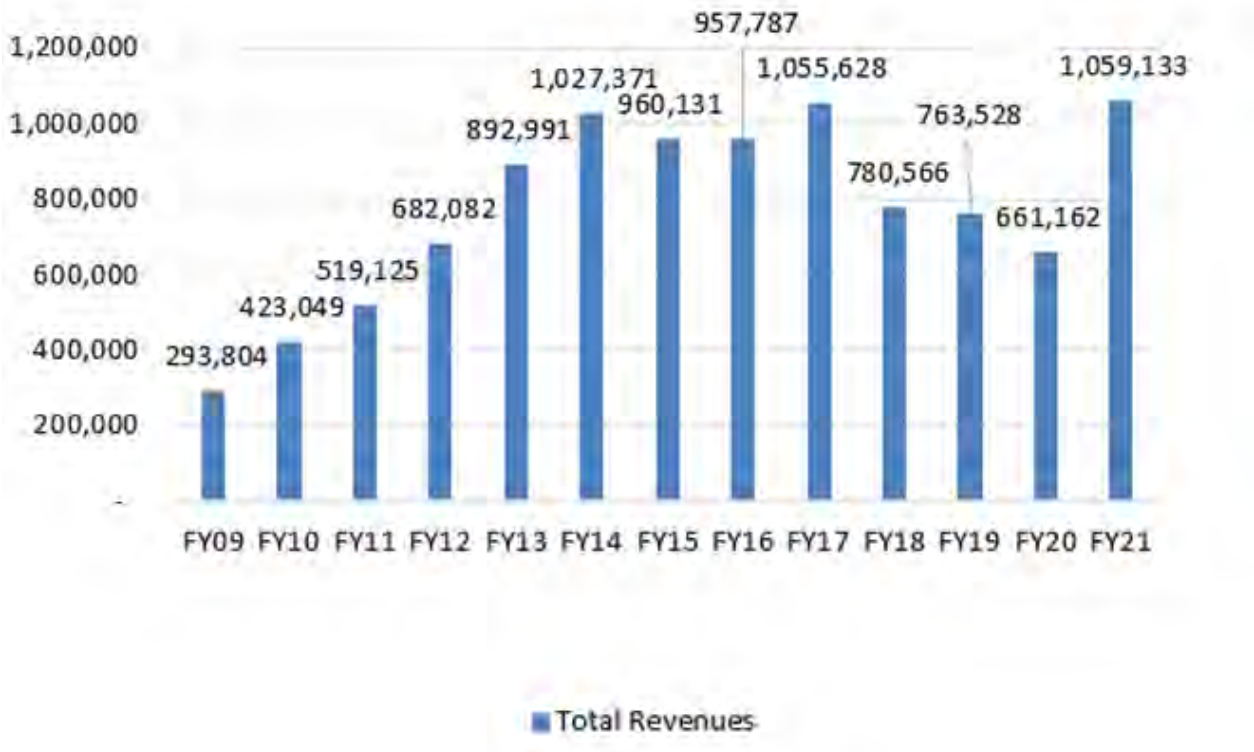


Expenses for the BGF rose slightly in 2020 as legal costs contributed a higher percentage than prior years. Benefits make up 60% of expenses for the BGF.



Expenditure Details	FY2019	FY2020	FY2021
# of Employees Receiving Benefits	6	8	11
Benefit Payments by Type			
Indemnity Costs	$56,525	$40,356	$97,111
Medical Costs	$244,681	$120,066	$169,215
Reemployment Costs	$55,621	$14,089	$4,542
Employee Legal Costs	$9,856	$61,578	$82,343
Total EE Benefits	$336,684	$236,088	$362,257
Administration Costs	$190,214	$235,648	$247,944
Total Expenses	**$556,897**	**$471,736**	**$609,427**
% of Benefit Payments to Total Costs	65.8%	50%	59%
%of Admin. Costs to Total Costs	34.1%	50%	41%

Revenues from penalties increased in 2020 as concentration to detail was enforced.



Fiscal Year	2021	2020	2019
Civil Penalty Stipulation	$179,460	$209,129	$680,178
Civil Penalty Settlement	$464,936	$190,440	
Civil Penalty D&O	$177,231	$137,407	
Uninsured Employer Reimbursement	$70,317	$123,918	$83,349
Judgments	$176,564	$5,950	
Less Adjustments (NSF Checks)	(9,442)	($5,682)	
Total Revenues	**$1,059,133**	**$661,162**	**$763,528**
% from Civil Penalties	61%	84%	89%
% from Employer Reimbursement	7%	16%	11%
% from Judgments	17%	1%	

The final special fund is the Fisherman's Fund. This fund is operated to pay claims for commercial fishermen who do not fall under the Workers' Compensation Act in Alaska. As a portion of the Division, we report to the AWCB, but all accounting and payments are monitored by the Fish Fund Council. The Fisherman's Fund is healthy and has sufficient assets to operate.

9 RECOMMENDATIONS FROM THE DIRECTOR

My number one priority has been the change of philosophy on reemployment and rehabilitation for injured workers. Alaska must concentrate on a stay at work/return to work process that keeps employees engaged in their process of reemployment and assists them in moving to work faster. A RAND study of injured worker return to work programs shows a 38%-42% decrease in the amount of time loss after injury by implementing a plan. The most important aspect of these plans for staying or returning to work is communication. Adjustments to AS 23.30.041 are a step in the direction of a program to engaging in a return-to-work process, but a focus on a program that involves a coaching like criteria for assisting all parties to work together to shorten the amount of time an injured worker spends in a non-working environment.

As it has been over twenty years since adjustments to indemnity benefits pertaining to death and disabilities, the Board should continue to suggest the Alaska Legislature adjust these benefits for inflation. As some action is currently in process, HB 30 by Representative Josephson, action by Board members is appropriate. Letters of support, personal testimony or

Board action all are options. For reference, if AS 23.30.190 was adjusted for cpi, the base amount for compensation would move from $177,000 to $262,228. This is not an increase in benefits, this is merely moving the base multiplier rate back to the original level set in 2000.

Amend the language in Statute to allow our SIU team to prosecute fraud claims. In addition, allow our investigators to write citations to allow for fast and efficient resolution to minor infractions to alleviate Board hearings and legal expense.

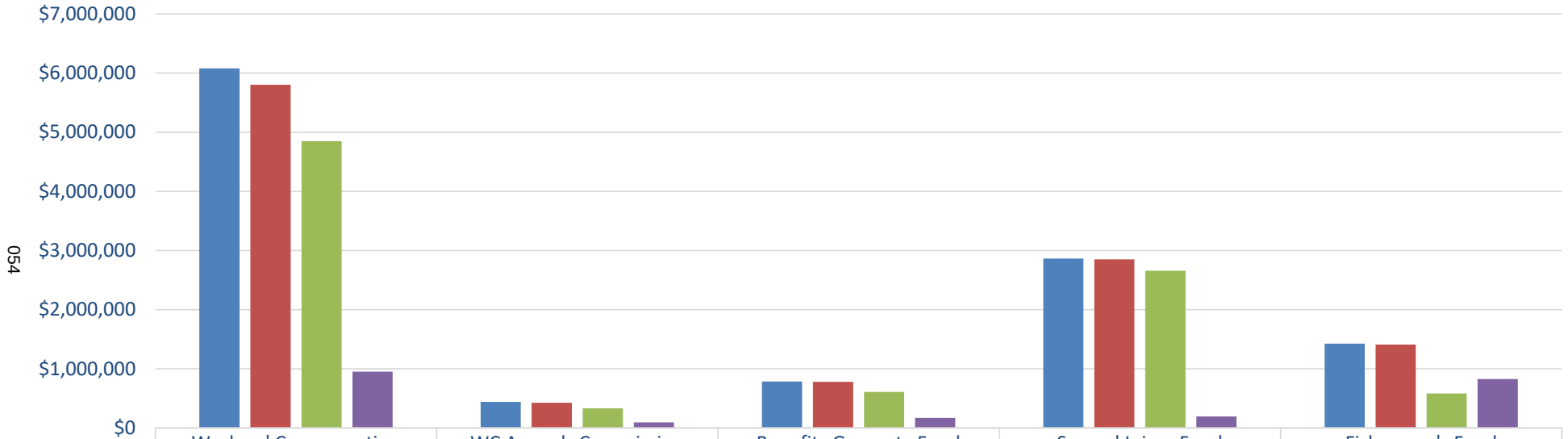
ADMINISTRATIVE SECTION
ANNUAL REPORT

053

Alexis Hildebrand
Administrative Officer II

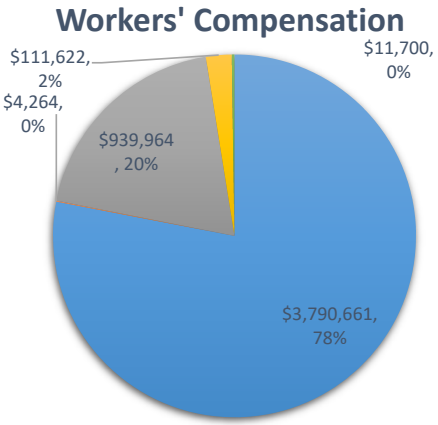
Workers' Compensation Division

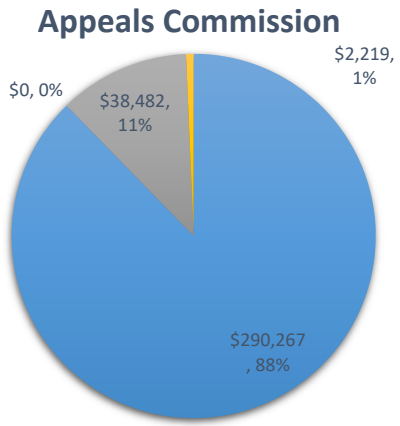
FY2021 Budget
Authority vs Actual Expenditures

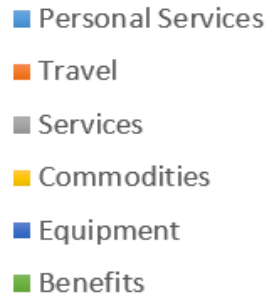


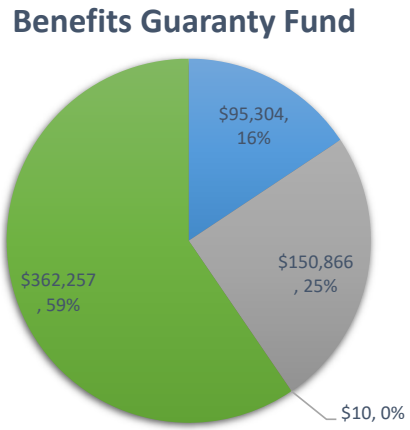
	Workers' Compensation	WC Appeals Commission	Benefits Guaranty Fund	Second Injury Fund	Fishermen's Fund
FY22 Budget	$6,078,900	$440,500	$785,100	$2,864,900	$1,425,200
FY21 Budget	$5,801,500	$425,900	$779,600	$2,852,100	$1,409,900
FY21 Actuals	$4,849,491	$330,968	$608,437	$2,658,044	$583,063
FY21 Balance	$952,009	$94,932	$171,163	$194,056	$826,837

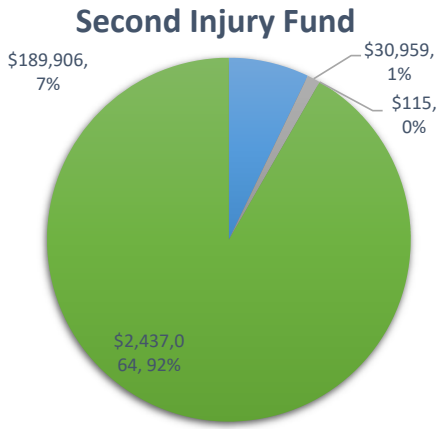
Workers' Compensation Division

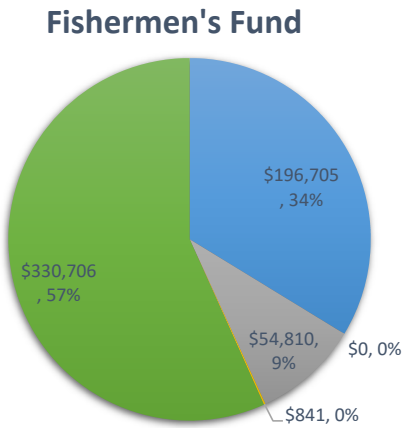












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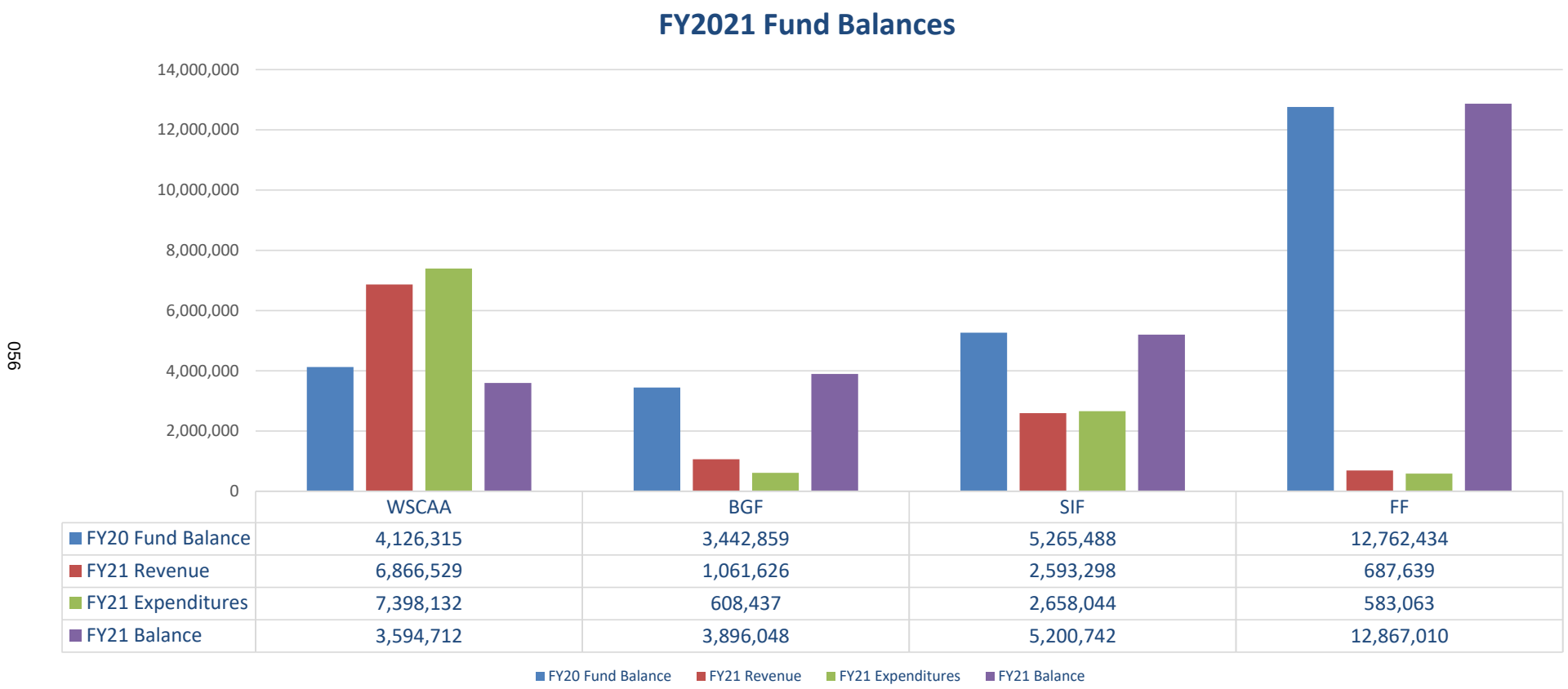
Workers' Compensation Division



	WSCAA	BGF	SIF	FF
FY20 Fund Balance	4,126,315	3,442,859	5,265,488	12,762,434
FY21 Revenue	6,866,529	1,061,626	2,593,298	687,639
FY21 Expenditures	7,398,132	608,437	2,658,044	583,063
FY21 Balance	3,594,712	3,896,048	5,200,742	12,867,010

FY2021 Division Summary Budget

Department of Labor and Workforce Development

Division of Workers' Compensation — 10/10/21

Monthly Status Report as of: 10/10/2021 | Q4 | FY2021 — 6:50 PM

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 5/30/2021

Summary:

Program	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/10/2021 Expend	10/10/2021 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Workers' Compensation	5,801,500	0	0	0	5,801,500	4,849,491	8,720	943,289	0	0	4,858,211	943,289	83.7%
WC Appeals Commission	425,900	0	0	0	425,900	330,968	0	94,932	0	0	330,968	94,932	77.7%
WC Benefits Guaranty Fund	779,600	0	0	0	779,600	608,437	0	171,163	0	0	608,437	171,163	78.0%
Second Injury Fund	2,852,100	0	0	0	2,852,100	2,658,044	0	194,056	0	0	2,658,044	194,056	93.2%
Fishermen's Fund	1,409,900	0	0	0	1,409,900	583,063	0	826,837	0	0	583,063	826,837	41.4%
Division Total	11,269,000	0	0	0	11,269,000	9,030,002	8,720	2,230,278	0	0	9,038,722	2,230,278	80.2%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
Revenue Type Workers' Safety	6,227,400	0	0	0	6,227,400
Revenue Type: Benefits Guaranty Fund	779,600	0	0	0	779,600
Revenue Type Second Injury Fund	2,852,100	0	0	0	2,852,100
Revenue Type Fishermen's Fund	1,409,900	0	0	0	1,409,900
Total Program Funding	11,269,000	0	0	0	11,269,000

FY2021 Workers' Compensation Budget

Department of Labor and Workforce Development
Division of Workers' Compensation
Monthly Status Report as of: **10/10/2021** | **Q4** | **FY2021**

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2021

Workers' Compensation **AR Unit:073100060**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/10/2021 Expend	10/10/2021 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To Date
Personal Services	4,538,600.00	0.00	0.00	0.00	4,538,600.00	3,790,661.11	0.00	747,938.89	0.00	0.00	3,790,661.11	747,938.89	83.5%
Travel	49,100.00	0.00	0.00	0.00	49,100.00	4,263.78	0.00	44,836.22	0.00	0.00	4,263.78	44,836.22	8.7%
Services	1,114,900.00	-30,721.55	0.00	0.00	1,084,178.45	931,243.63	8,720.00	144,214.82	0.00	0.00	939,963.63	144,214.82	86.7%
Commodities	80,900.00	30,721.55	0.00	0.00	111,621.55	111,621.55	0.00	0.00	0.00	0.00	111,621.55	0.00	100.0%
Equipment	6,000.00	0.00	0.00	0.00	6,000.00	0.00	0.00	6,000.00	0.00	0.00	0.00	6,000.00	0.0%
NPS Subtotal	1,250,900.00	0.00	0.00	0.00	1,250,900.00	1,047,128.96	8,720.00	195,051.04	0.00	0.00	1,055,848.96	195,051.04	84.4%
Grants	12,000.00	0.00	0.00	0.00	12,000.00	11,700.48	0.00	299.52	0.00	0.00	11,700.48	299.52	97.5%
Total Program Expenditures	5,801,500.00	0.00	0.00	0.00	5,801,500.00	4,849,490.55	8,720.00	943,289.45	0.00	0.00	4,858,210.55	943,289.45	83.7%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Revenue Type Workers' Safety	5,801,500.00				5,801,500.00
Total Program Funding	5,801,500.00	0.00	0.00	0.00	5,801,500.00

FY2021 Appeals Commission Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: **10/10/2021** **Q4** **FY2021**

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2021

WC Appeals Commission **AR Unit:073200060**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/10/2021 Expend	10/10/2021 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	281,400.00	8,867.14	0.00	0.00	290,267.14	290,267.14	0.00	0.00	0.00	0.00	290,267.14	0.00	100.0%
Travel	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
Services	139,500.00	-8,867.14	0.00	0.00	130,632.86	38,481.74	0.00	92,151.12	0.00	0.00	38,481.74	92,151.12	29.5%
Commodities	5,000.00	0.00	0.00	0.00	5,000.00	2,218.73	0.00	2,781.27	0.00	0.00	2,218.73	2,781.27	44.4%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	144,500.00	-8,867.14	0.00	0.00	135,632.86	40,700.47	0.00	94,932.39	0.00	0.00	40,700.47	94,932.39	30.0%
Grants	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00			0.0%
Total Program Expenditures	425,900.00	0.00	0.00	0.00	425,900.00	330,967.61	0.00	94,932.39	0.00	0.00	330,967.61	94,932.39	77.7%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Revenue Type: Workers Safety	425,900.00				425,900.00
Total Program Funding	425,900.00	0.00	0.00	0.00	425,900.00

FY2021 Benefits Guaranty Fund Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: **10/10/2021** | **Q4** | **FY2021**

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2021

Benefits Guaranty Fund **AR Unit:073300061**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/10/2021 Expend	10/10/2021 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	95,100.00	204.39	0.00	0.00	95,304.39	95,304.39	0.00	0.00	0.00	0.00	95,304.39	0.00	100.0%
Travel	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
Services	249,800.00	-204.39	0.00	0.00	249,595.61	150,865.99	0.00	98,729.62	0.00	0.00	150,865.99	98,729.62	60.4%
Commodities	2,000.00	0.00	0.00	0.00	2,000.00	10.00	0.00	1,990.00	0.00	0.00	10.00	1,990.00	0.5%
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	251,800.00	-204.39	0.00	0.00	251,595.61	150,875.99	0.00	100,719.62	0.00	0.00	150,875.99	100,719.62	60.0%
Grants	432,700.00	0.00	0.00	0.00	432,700.00	362,257.11	0.00	70,442.89	0.00	0.00	362,257.11	70,442.89	83.7%
Total Program Expenditures	779,600.00	0.00	0.00	0.00	779,600.00	608,437.49	0.00	171,162.51	0.00	0.00	608,437.49	171,162.51	78.0%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Projected Revenue
Revenue Type: Benefits Guaranty Fund	779,600.00				779,600.00
Total Program Funding	779,600.00	0.00	0.00	0.00	779,600.00

FY2021 Second Injury Fund Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: **10/10/2021** | **Q4** | **FY2021**

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2021

Second Injury Fund **AR Unit:073400062**

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/10/2021 Expend	10/10/2021 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	196,400.00	0.00	0.00	0.00	196,400.00	189,905.51	0.00	6,494.49	0.00	0.00	189,905.51	6,494.49	96.7%
Travel	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
Services	83,100.00	0.00	0.00	0.00	83,100.00	30,958.97	0.00	52,141.03	0.00	0.00	30,958.97	52,141.03	37.3%
Commodities	4,300.00	0.00	0.00	0.00	4,300.00	114.99	0.00	4,185.01	0.00	0.00	114.99	4,185.01	2.7%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	87,400.00	0.00	0.00	0.00	87,400.00	31,073.96	0.00	56,326.04	0.00	0.00	31,073.96	56,326.04	35.6%
Grants	2,568,300.00	0.00	0.00	0.00	2,568,300.00	2,437,064.31	0.00	131,235.69	0.00	0.00	2,437,064.31	131,235.69	94.9%
Total Program Expenditures	2,852,100.00	0.00	0.00	0.00	2,852,100.00	2,658,043.78	0.00	194,056.22	0.00	0.00	2,658,043.78	194,056.22	93.2%

061

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
Revenue Type Second Injury Fund	2,852,100.00				2,852,100.00
Total Program Funding	2,852,100.00	0.00	0.00	0.00	2,852,100.00

FY2021 Fishermen's Fund Budget

Department of Labor and Workforce Development

Division of Workers' Compensation

Monthly Status Report as of: **10/10/2021** | **Q4** | **FY2021**

Pay Periods processed	26
Pay Periods Remaining	0
Total	26

PPE: 6/30/2021

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

Program Expenditures	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget	10/10/2021 Expend	10/10/2021 Encumb	Current Balance	Exp Adj Needed	Projected Expend	Total Expend	Projected Balance	% Expend To-date
Personal Services	255,900.00	0.00	0.00	0.00	255,900.00	196,705.32	0.00	59,194.68	0.00	0.00	196,705.32	59,194.68	76.9%
Travel	11,000.00	0.00	0.00	0.00	11,000.00	0.00	0.00	11,000.00	0.00	0.00	0.00	11,000.00	0.0%
Services	217,200.00	0.00	0.00	0.00	217,200.00	54,810.32	0.00	162,389.68	0.00	0.00	54,810.32	162,389.68	25.2%
Commodities	9,700.00	0.00	0.00	0.00	9,700.00	840.81	0.00	8,859.19	0.00	0.00	840.81	8,859.19	8.7%
Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
NPS Subtotal	237,900.00	0.00	0.00	0.00	237,900.00	55,651.13	0.00	182,248.87	0.00	0.00	55,651.13	182,248.87	23.4%
Grants	916,100.00	0.00	0.00	0.00	916,100.00	330,706.24	0.00	585,393.76	0.00	0.00	330,706.24	585,393.76	36.1%
Total Program Expenditures	1,409,900.00	0.00	0.00	0.00	1,409,900.00	583,062.69	0.00	826,837.31	0.00	0.00	583,062.69	826,837.31	41.4%

Program Revenue	Initial Auth	Revised Program	Avail Auth	Adjust Needed	Revised Budget
Revenue Type Fishermen's Fund	1,409,900.00				1,409,900.00
Total Program Funding	1,409,900.00	0.00	0.00	0.00	1,409,900.00

062

QUESTIONS?

063

TAB 7

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

DIVISION OF WORKERS' COMPENSATION

2020 ANNUAL REPORT

October 2021

Annual Reporting of Total Paid Compensation

In 2020, there were 14,985 reports of injury and occupational illness filed with the Workers' Compensation Division, a 12.2% decrease from 17,075 reports filed in 2019.

Of the case files established in 2020, claim type filings and distribution to total claims filed were:

- No-time-loss cases: 10,923 cases, 73%.
- Time-loss cases: 4,037 cases, 27%.
- Notification only cases: 4,139 cases, 28%.
- Fatalities: 25 cases, 0.17%.

The Alaska Workers' Compensation Board held 188 hearings in 2020, compared to 225 hearings in 2019, and 231 in 2018.

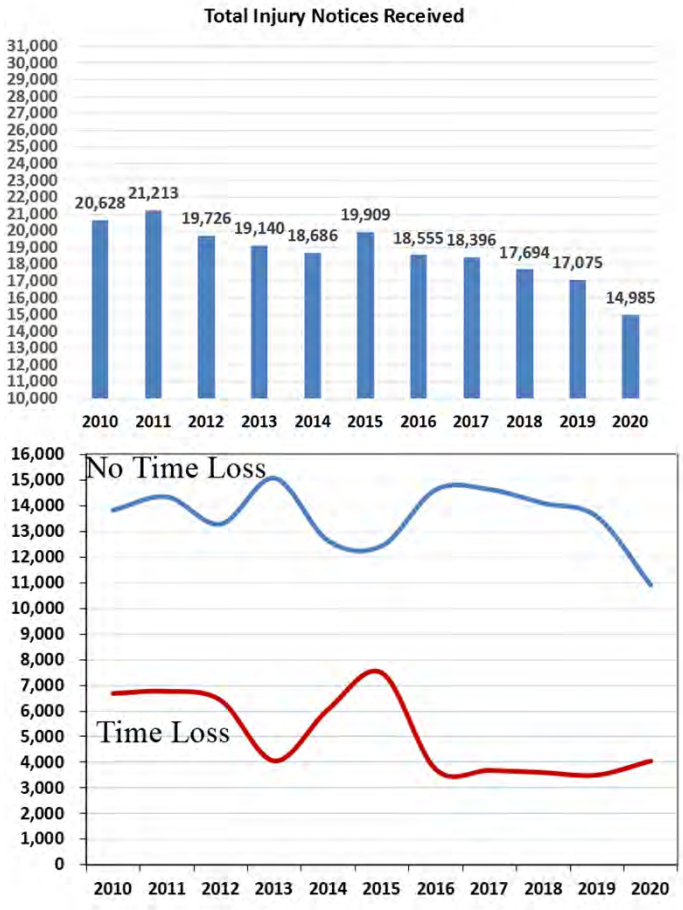
2020

- 152 regular hearings
- 36 written record hearings

The Alaska Workers' Compensation Appeals Commission held 10 hearings and oral arguments in 2020, compared to 14 hearings in 2019 and 10 in 2018.

2020

- 5 merits of appeals
- 4 motions for stay
- 1 show good cause



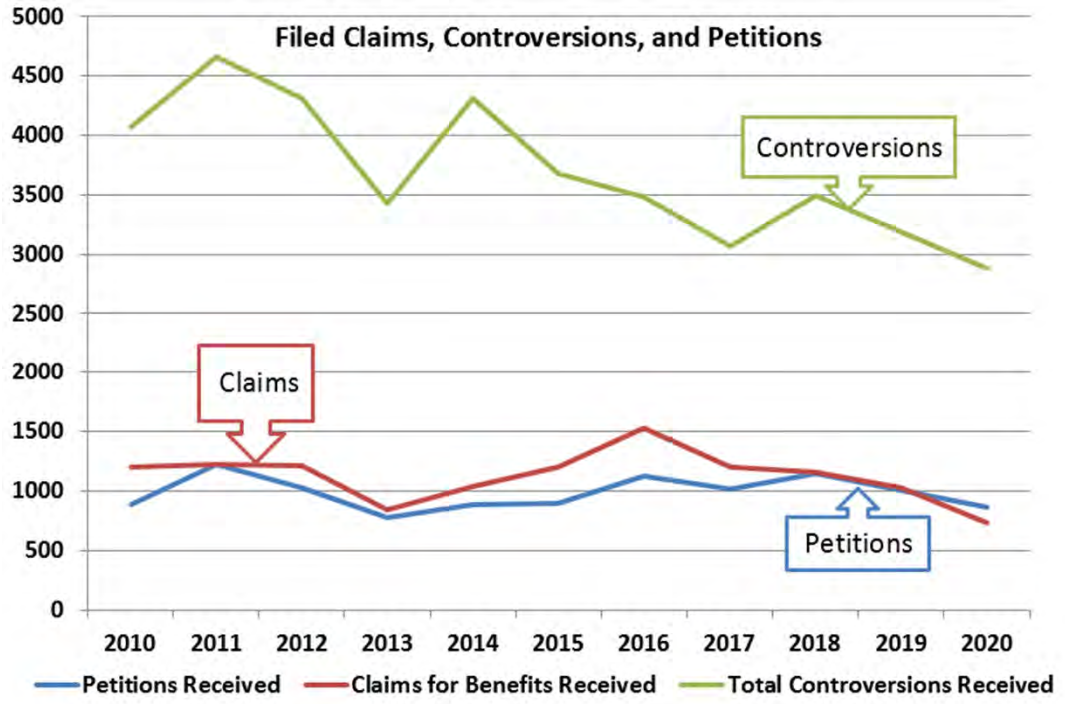
Analysis of Workers' Compensation Claims Data

In 2019, there were 727 claims filed for 610 cases, a 29.1% decrease from 1,025 claims filed in 2019.

There were 863 petitions filed for 516 cases in 2020, a 14.2% decrease from 1,006 petitions filed in 2019.

There were 2,886 controversion notices filed in 2020, a 6.5% decrease from 3,191 in 2019.

The number of injury cases controverted in 2020 totaled 2,241, a 6.5% decrease from 2,398 cases in 2019.



Annual Reporting of Total Paid Compensation

Financial Reports and Audits

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

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

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

- This report covers activity from:
  - CY = Calendar Year Period from January 1, 2020 to December 31, 2020
  - FY = Fiscal Period from July 1, 2020 to June 30, 2021

Notes:

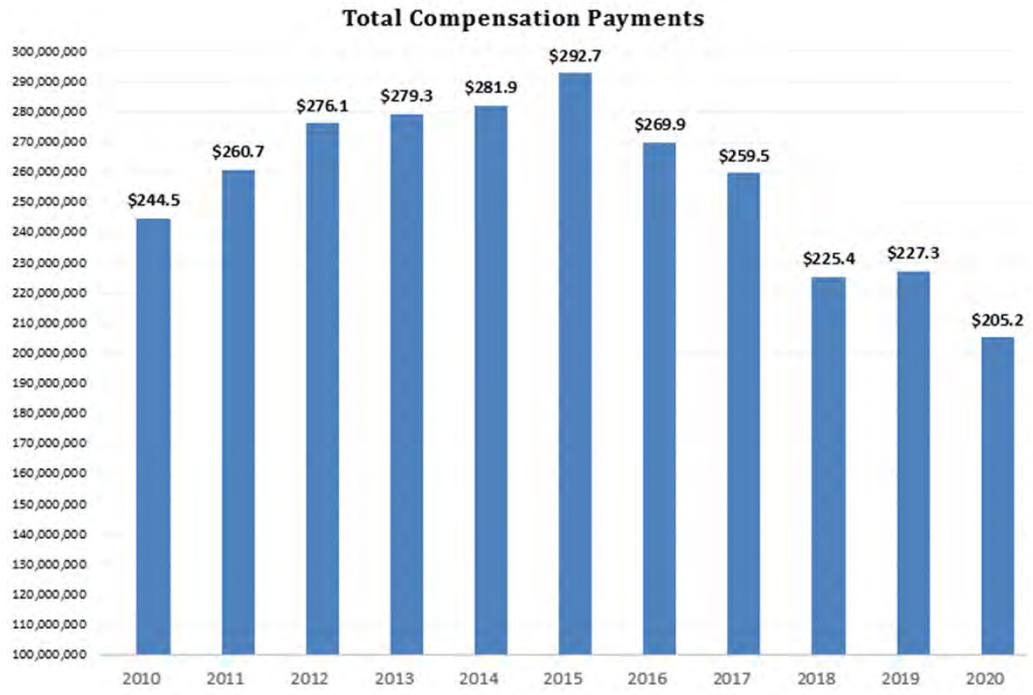
Medical Costs Totals for CY 2020 include the following Medical Costs: Physical Therapy, Chiropractic Fees, Durable Medical expenses, Medical Travel, Employee Medical-Legal Costs. These costs were previously captured in the other category for CY2014, CY2015, CY2016, and CY2017.

Other Costs for CY 2020 include: Unspecified Lump Sum Payment/Settlement, interest, penalty and SIF Contribution Fee.

Total Compensation Payments

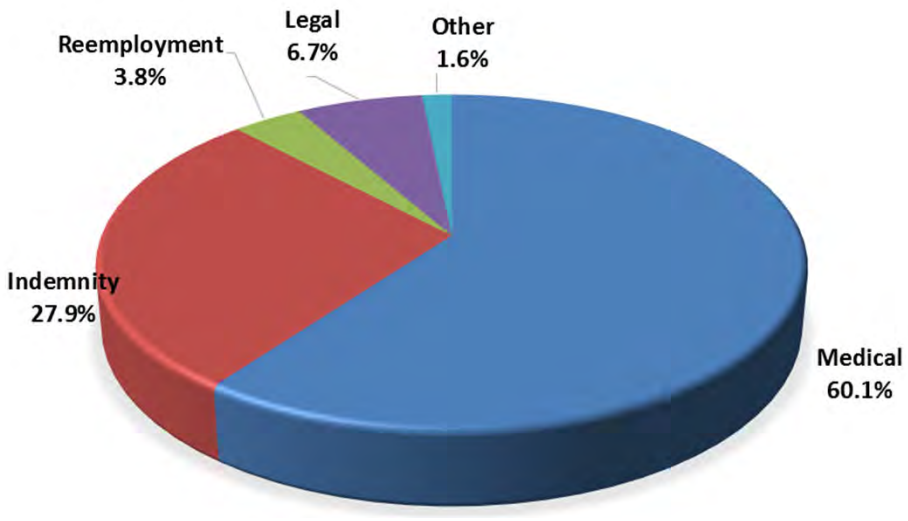
A total of $205.2 million was paid in workers' compensation benefits during calendar year 2020 by market-insured employers and self-insured employers. This is a decrease of 9.73% from $227.3 million in 2019.

690



Total Compensation Payments Distribution

Benefit Type	Amount Paid	% of Cost to Total Cost
Medical	$123,369,759	60.1%
Indemnity	$57,157,556	27.9%
Reemployment	$7,699,606	3.8%
Legal	$13,764,586	6.7%
Other*	$3,228,847	1.6%
Total	$205,220,354	



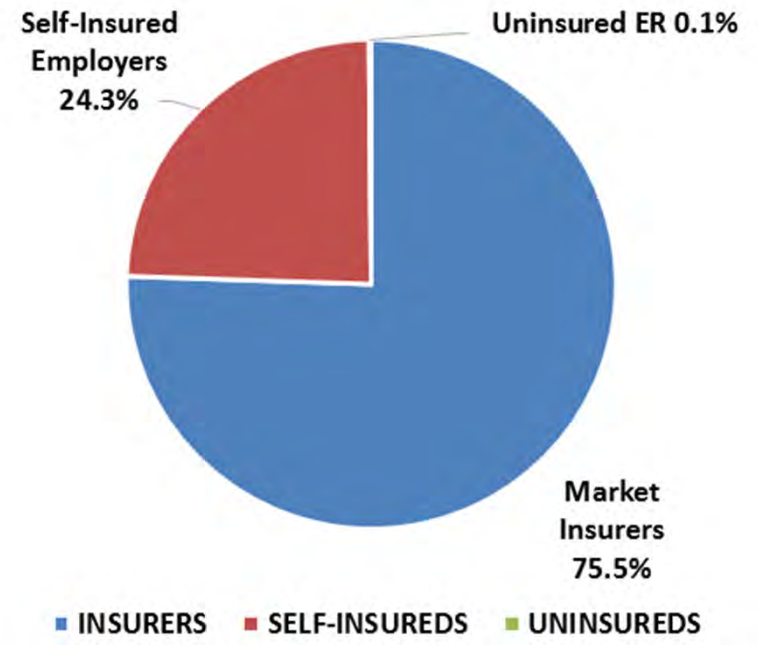
Total Benefits Paid by Top Twenty Insurers/Self-Insured Employers

Of total benefits paid, market-insured employers paid $154.9 million (75.5%), self-insured employers paid $49.9 million (24.3%).

Compared to 2019, market-insured employers paid $174.6 million (76.8%) and self-insured employers paid $52.4 million (23.1%).

INSURER TYPE	Total Benefits Paid	% of Total Costs
Market Insurers	$154,986,746	75.5%
Self-Insured Employers	$49,953,724	24.3%
Uninsured Fund	$279,884	0.1%
Total	$205,220,354	

071



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

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

This compares to $156 million, or 67.8%, in 2019.

072

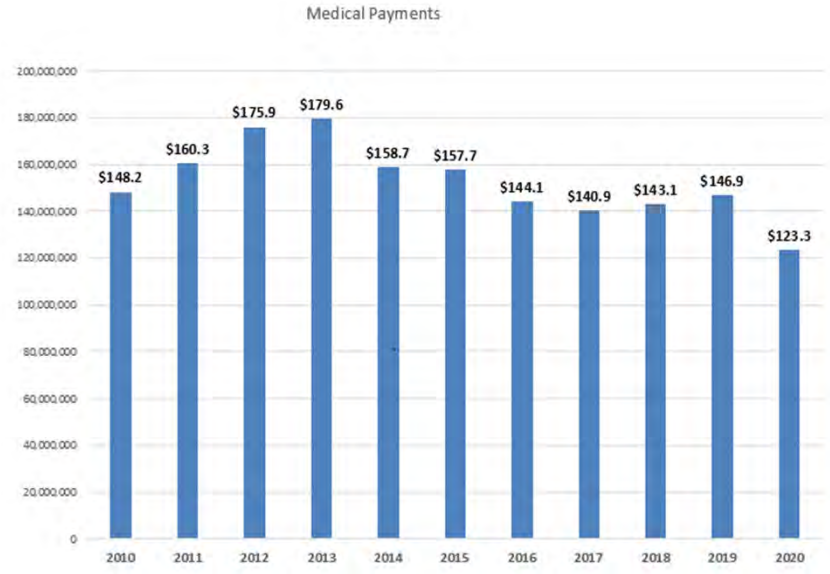
Rank	Insurer	Benefits Paid
1.	ALASKA NATIONAL INS CO	$ 35,972,663.46
2.	STATE OF ALASKA	$ 15,500,944.45
3.	AMERICAN ZURICH INS CO	$ 8,721,326.94
4.	ANCHORAGE, MUNICIPALITY OF	$ 7,604,538.99
5.	COMMERCE AND INDUSTRY INS CO	$ 7,127,488.72
6.	ARCTIC SLOPE REGIONAL CORP	$ 5,388,586.53
7.	LIBERTY INSURANCE CORP	$ 5,380,243.26
8.	LIBERTY NORTHWEST INSURANCE CO	$ 4,999,379.86
9.	ACE AMERICAN INSURANCE COMPANY	$ 4,806,215.25
10.	NEW HAMPSHIRE INSURANCE CO	$ 4,719,783.87
11.	INDEMNITY INS CO OF NORTH AMERICA	$ 4,708,487.18
12.	AMERICAN INTERSTATE INSURANCE CO	$ 4,540,878.84
13.	REPUBLIC INDEMNITY CO OF AMERICA	$ 4,241,101.80
14.	BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY	$ 3,987,215.42
15.	ALASKA AIRLINES, INC.	$ 3,815,419.82
16.	UMIALIK INSURANCE CO	$ 3,788,452.84
17.	ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOC	$ 3,739,780.12
18.	ZURICH AMERICAN INS CO	$ 3,316,233.44
19.	TRAVELERS PROPERTY CASUALTY CO OF AMERICA	$ 3,120,943.77
20.	PROVIDENCE HEALTH SYSTEM – WASHINGTON	$ 2,999,459.78
	TOTAL	138,479,144

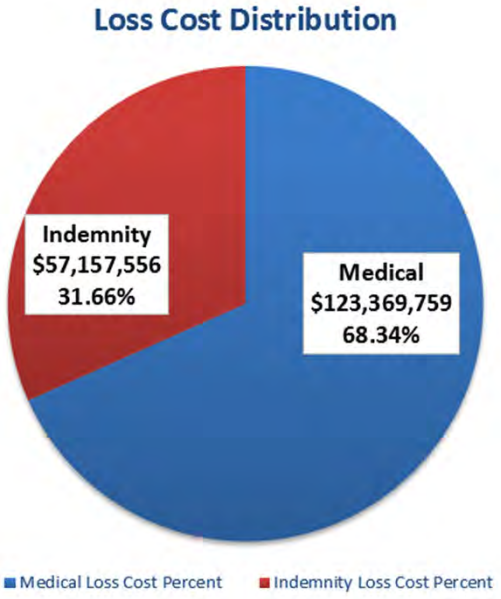
Medical Benefits

In the calendar year 2020, medical benefits totaled $123.3 million, a 16 % decrease from $146.9 million in 2019.

Medical benefits were 60.1% of total benefits paid and 68.34% of loss costs in 2020, compared to 64.6% of total benefits paid and 73.69% of loss costs in 2019.

Total loss costs were $180.5 million in 2020 down from $199.4 million in 2019.

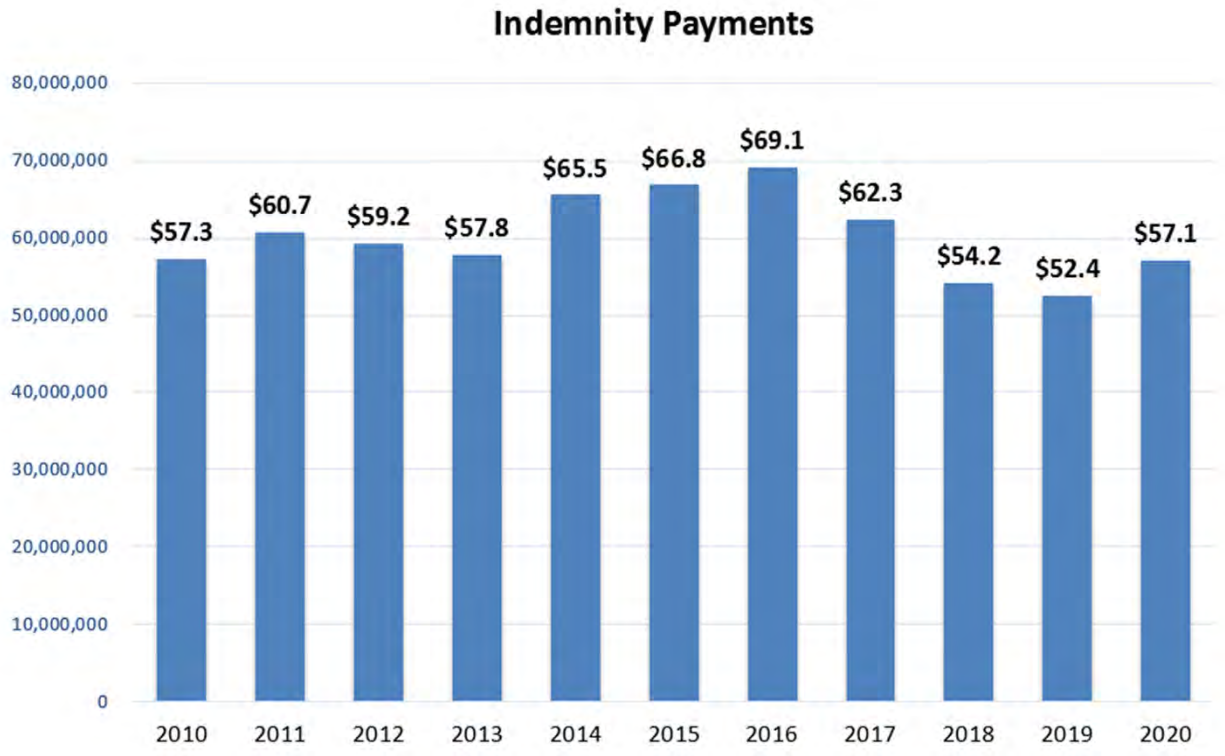




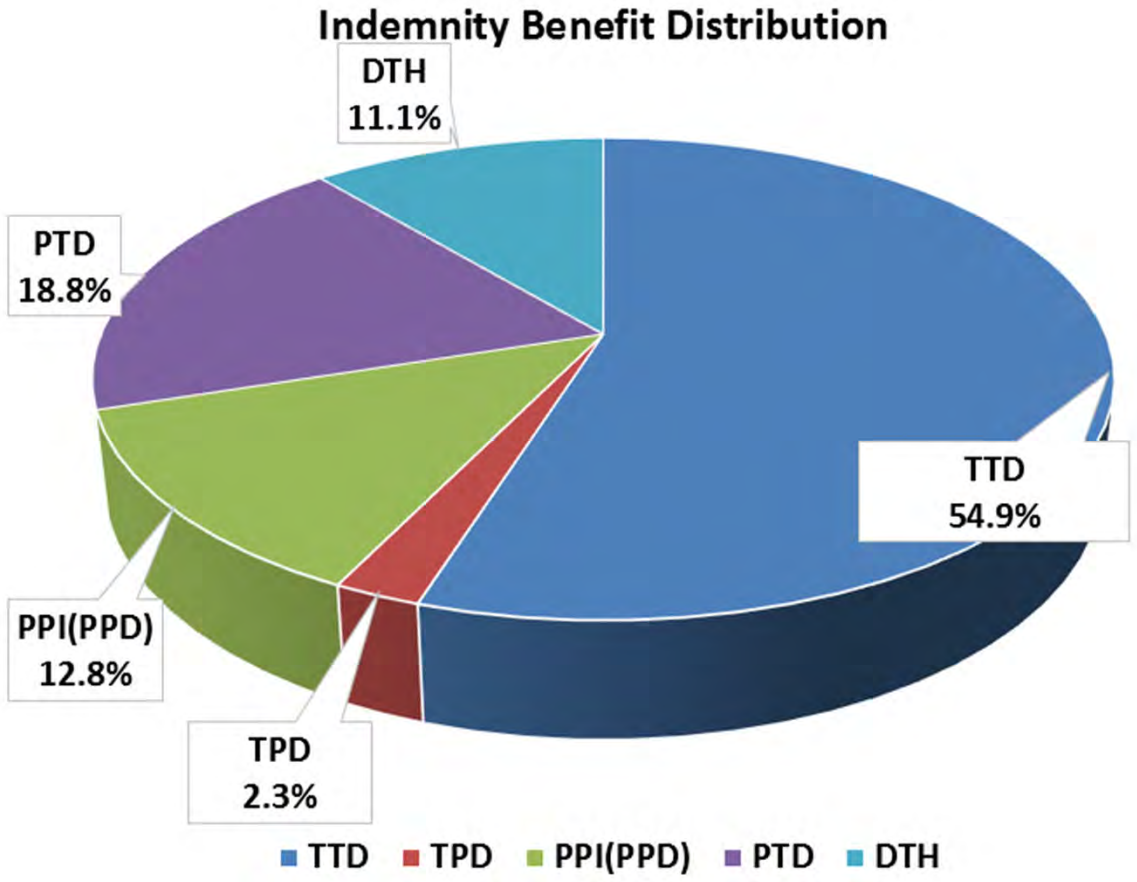
Indemnity Benefits

For calendar year 2020 indemnity benefits (TTD, TPD, PPI, PTD & Death Benefits) totaled $57.1 million, a 8.9% increase from $52.4 million in 2019.

- TTD benefits totaled $31.3 million in 2020, a 9.4% increase from $28.6 million in 2018.
- TPD benefits totaled $1.33 million in 2020, a 1.64% decrease from $1.36 in 2019.
- PPI benefits totaled $7.3 million in 2020, a 15.7% decrease from $8.6 million in 2019.
- PTD benefits totaled $10.7 million in 2020, a 33.2% increase from $8.0 million in 2019.
- Death benefits totaled $6.3 million in 2020, a 11.8% increase from $5.6 million in 2020.



Indemnity Benefits



075

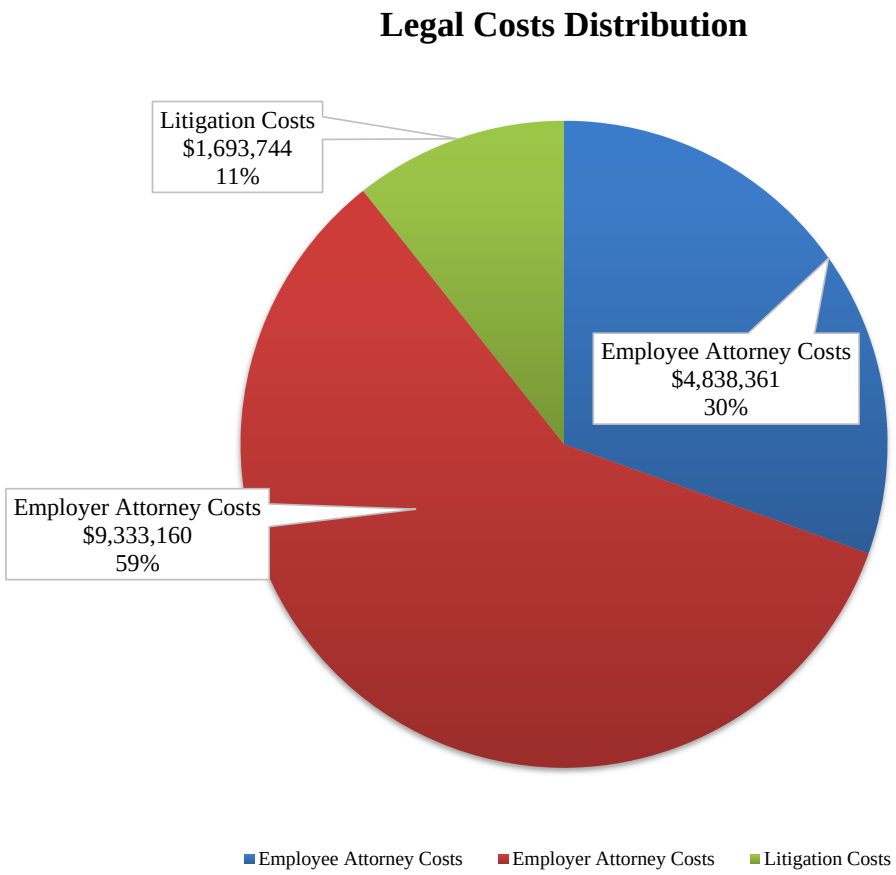
Legal Costs

For calendar year 2020, legal expenses totaled $13.7 million, a 13.2% decrease from $15.8 million in 2019.

- Employee attorney fees were $6.2 million in 2020, a 30.5% increase from $4.8 million in 2019.
- Employer attorney fees were $6.5 million in 2020, a 30.3% decrease from $9.3 million in 2019.
- Litigation costs totaled $946,180 in 2020, a 44.1% decrease from $1.6 million in 2019.
- 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



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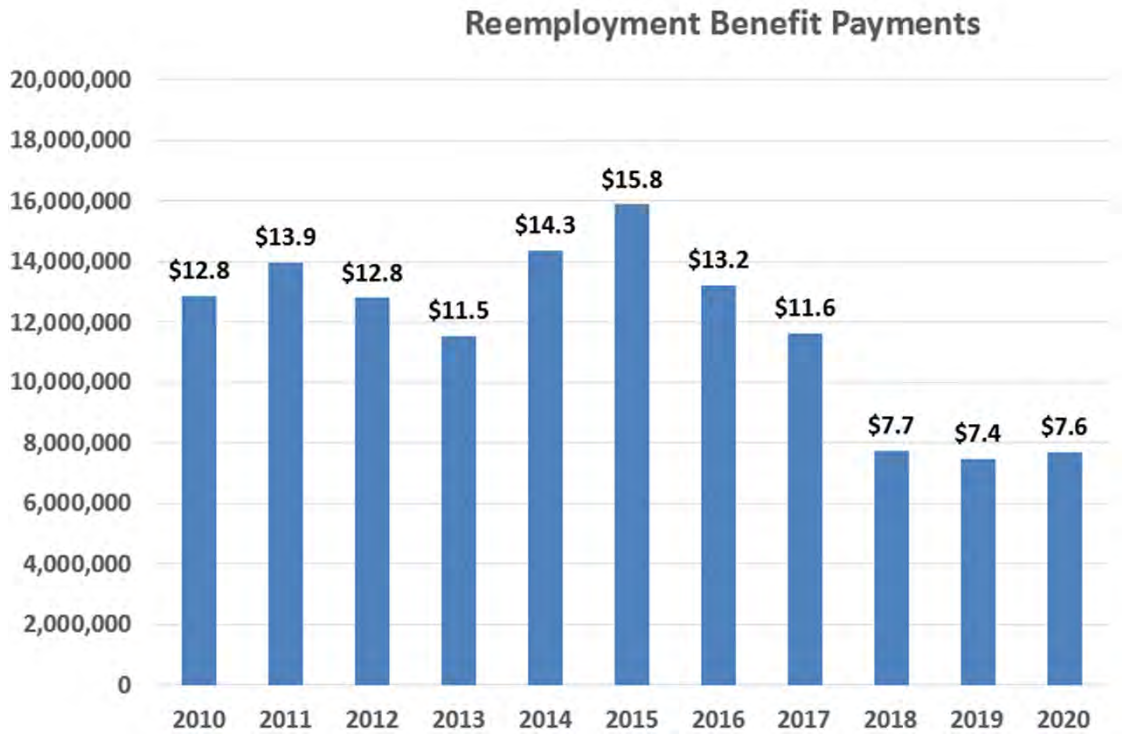
Reemployment Benefits

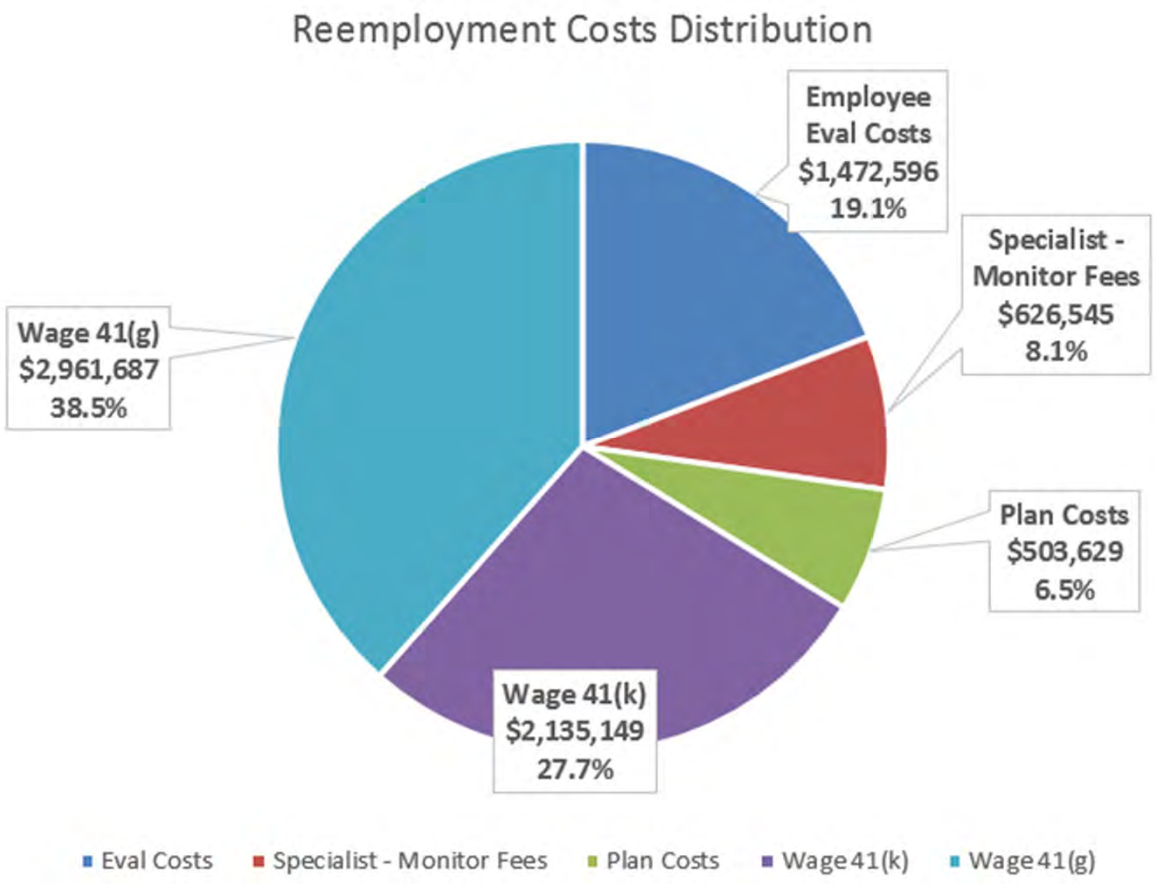
Total reemployment benefit payments totaled $7.6 million in 2020, a 3.1% increase from $7.4 million in 2019.

- Rehabilitation benefit costs under AS 23.30.041(k) totaled $2.1 million in 2020, a 15.8% decrease from $2.5 million in 2019.
- Rehabilitation benefit costs under AS 23.30.041(g) totaled $2.9 million in 2019, a 86.6% increase from $1.5 million in 2020.
- Employee evaluation costs totaled $1.4 million in 2020, a 28.6% decrease from $2.0 million in 2019.
- Rehabilitation specialist fees/plan monitoring fees totaled $626,545 in 2020, a 2.27% decrease from $641,112 in 2019.
- Plan development costs totaled $503,629 in 2020, a 21.4% decrease from $640,734 in 2019.

078



Reemployment Benefits



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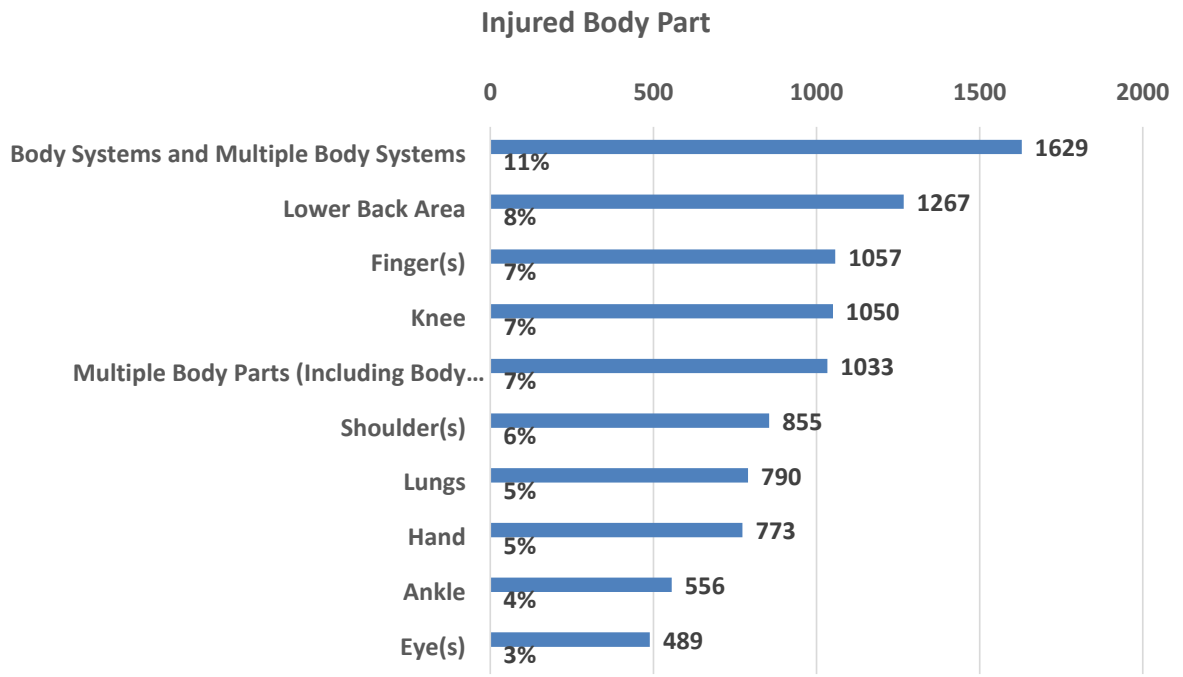
Top Ten Injuries by Body Part Injured

	Body Part Injured	Cases	%*
1.	Body Systems and Multiple Body Systems	1629	11%
2.	Lower Back Area	1267	8%
3.	Finger(s)	1057	7%
4.	Knee	1050	7%
5.	Multiple Body Parts (Including Body Systems & Body Parts)	1033	7%
6.	Shoulder(s)	855	6%
7.	Lungs	790	5%
8.	Hand	773	5%
9.	Ankle	556	4%
10.	Eye(s)	489	3%

080



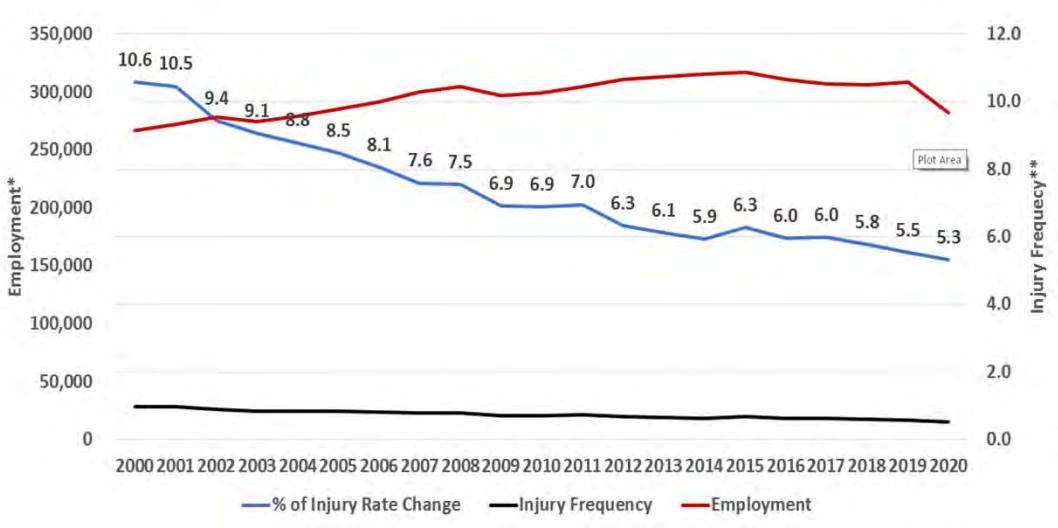
Alaska Injury Frequency

In 2020, 14,985 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.3%.
In 2019, 17,075 injury cases were reported resulting in an Alaska injury frequency rate per 100 employees is 5.5%.

Based on Department of Labor & Workforce Development, Research and Analysis Section data of estimated statewide average monthly employment, employment totaled 297,389 in 2020, an 8.1 decrease from 323,636 in 2019. Excluding 15,413 federal employees, the number of workers covered under the Alaska Workers' Compensation Act in 2020 was approximately 281,976 a 8.69% decrease from 308,796 in 2019.

Year	Injury Frequency	Employment
2020	14,985	281,976
2019	17,075	308,796
2018	17,694	306,211
2017	18,396	312,886
2016	18,555	316,979
2015	19,909	323,619
2014	18,686	321,874
2013	19,140	319,893
2012	19,726	317,562
2011	21,213	311,529
2010	20,628	305,852

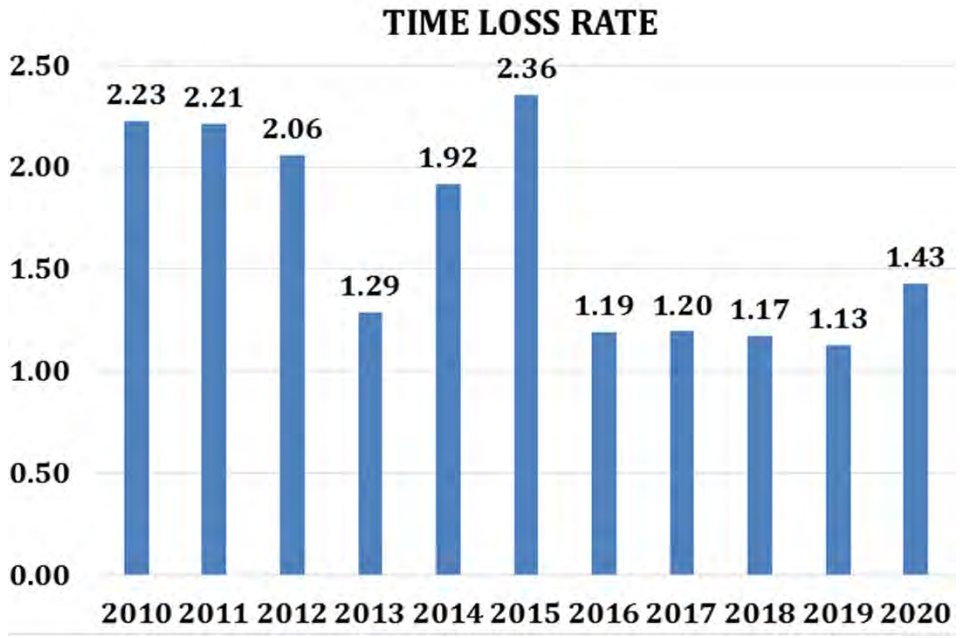
Employment in Alaska ↓ **Alaska Injury Frequency** ↓



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

Time Loss Rate

Using the number of time-loss claims (4,037) established by the Workers' Compensation Division divided by average monthly employment statewide (less Federal Government, $297,389 – 15,413), the time loss rate per 100 employees in 2020 was 1.43, a 26.7% increase from a time loss rate of 1.13 in 2019.

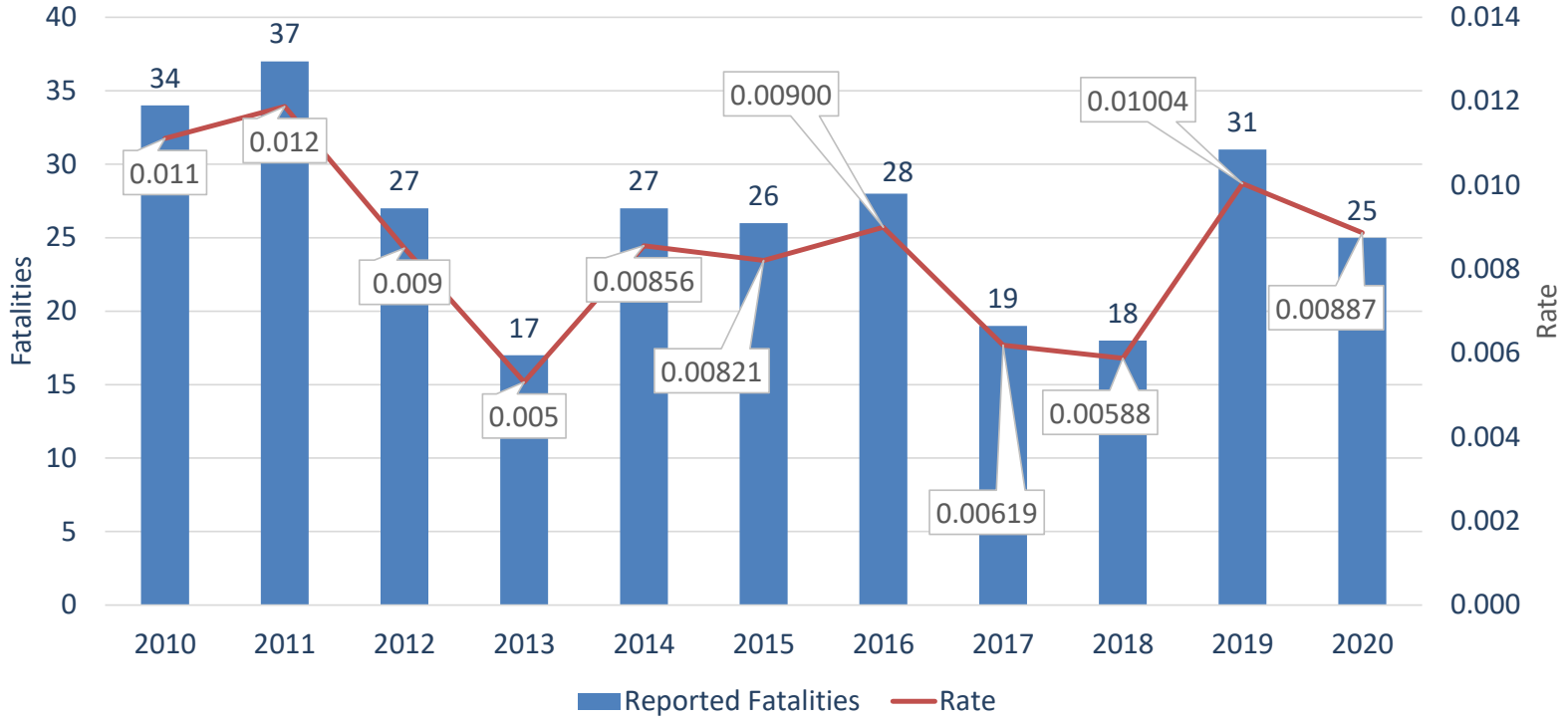


082

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

Fatality Rate

There were 25 fatalities reported in 2020, a 19.4% decrease from 31 fatalities reported in 2019. The fatality rate per 100 employees in 2020 was 0.00887, compared to 0.01004 in 2019.



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

Direct Written Premiums

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

*Estimate based on The Division of Insurance Calendar Year 2020 reconciliation report for Workers' Compensation Service Fee.

Assigned Risk Data Source: Department of Commerce, Community and Economic Development, Alaska Division of Insurance, 2019 Annual Report

Active Self-Insured Employers

There were 23 active self-insured employers in 2020

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

Nabors Alaska Drilling withdrew from self-insurance on August 1, 2020.
PeaceHealth Networks was approved for self-insurance on July 1, 2020.

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Workers' Compensation Premium Rate Ranking

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

Source: Oregon Department of Consumer and Business Services

Supplemental

LOSS COSTS PROJECTIONS

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

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

QUESTIONS?

088

SPECIAL PROGRAMS ANNUAL REPORT

Velma Thomas
Program Coordinator I

680

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
- Vacant, Collections/Loan Officer I
- Nanette Ferrer, Fishermen's Fund WC Technician I
- Evonne Mason, Fishermen's Fund WC Technician I

Benefits Guaranty Fund

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

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

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

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Claim Data

Fiscal Year	2021
Uninsured Injury Reports	21
Total New Claims Filed Against the Fund	13

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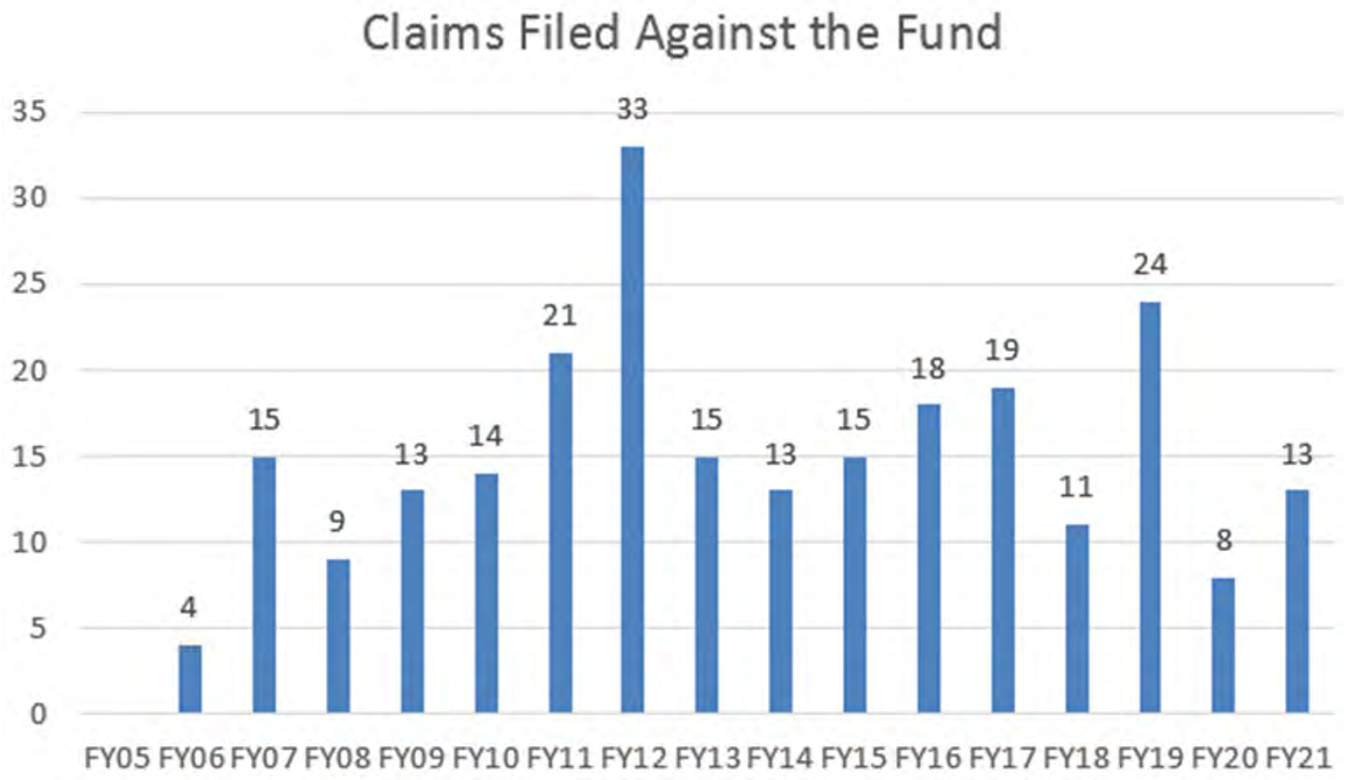
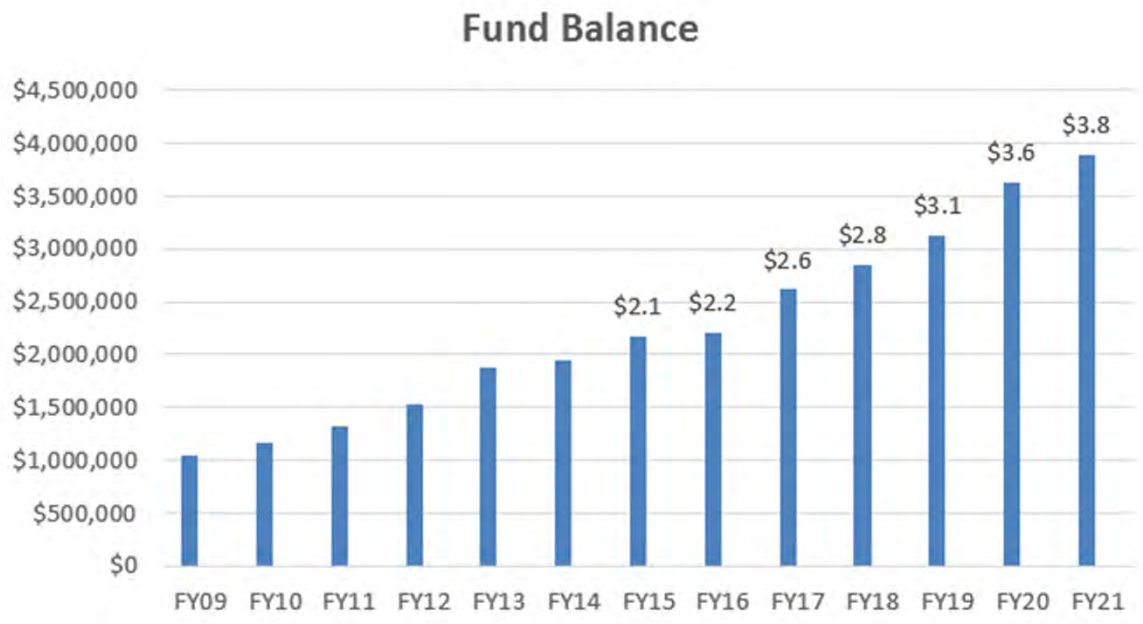
There were 21 reports of uninsured injuries in 2021 and thirteen employees that were working for an uninsured employer filed claims for benefits.



Fund Balance

The fund balance was $3.8 million in FY2021, a 7.2% increase, up $259,351 from FY2020 fund balance of $3.6 million. Increase is attributed to civil penalty settlement agreements and successful execution of judgments against employers who defaulted on civil penalty assessments.

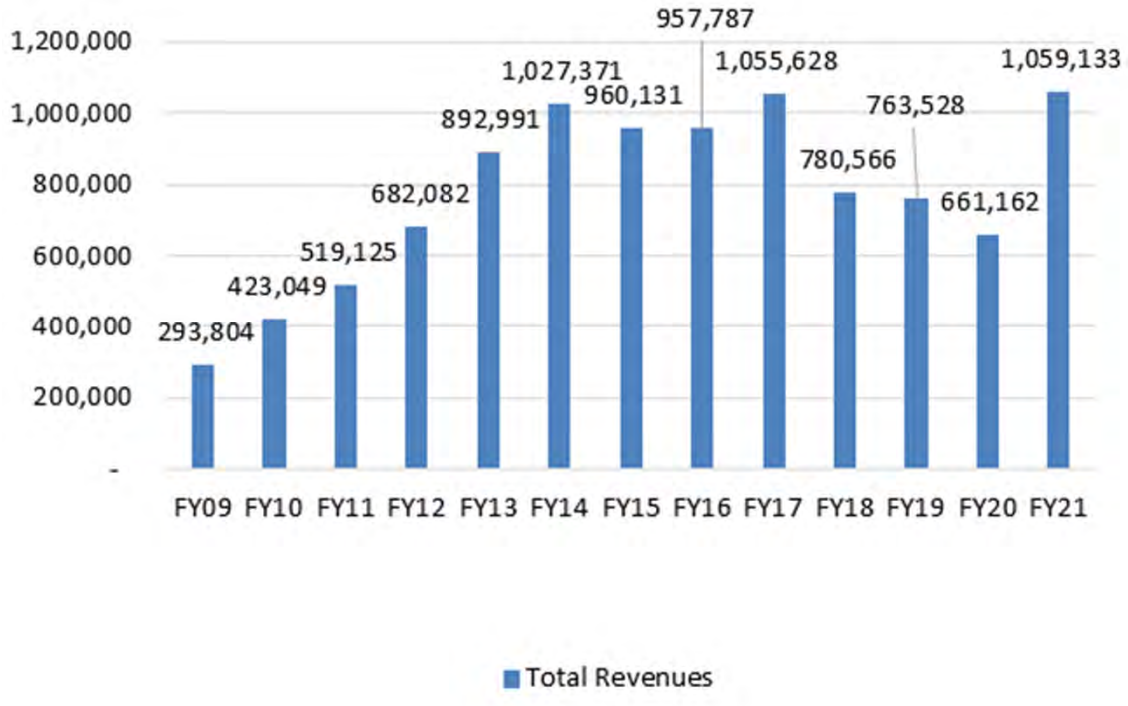


Fiscal Year	2021	2020	2019	2018	2017	2016	2015
Fund Balance	$3,886,050	$3,626,699	$3,130,438	$2,852,200	$2,615,821	$2,208,700	$2,168,594

092

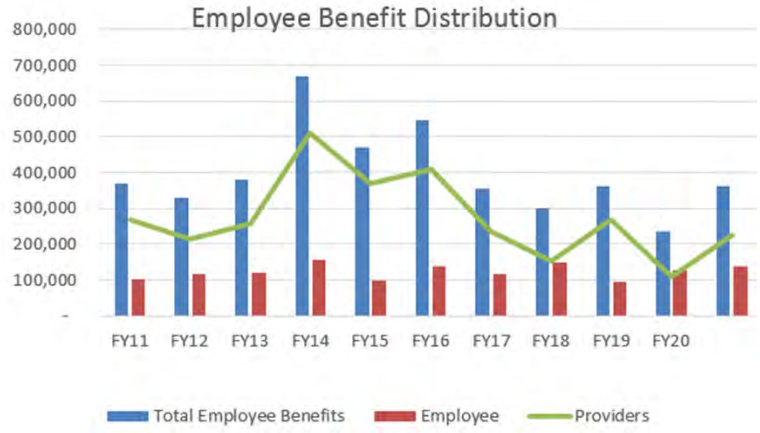
Revenues

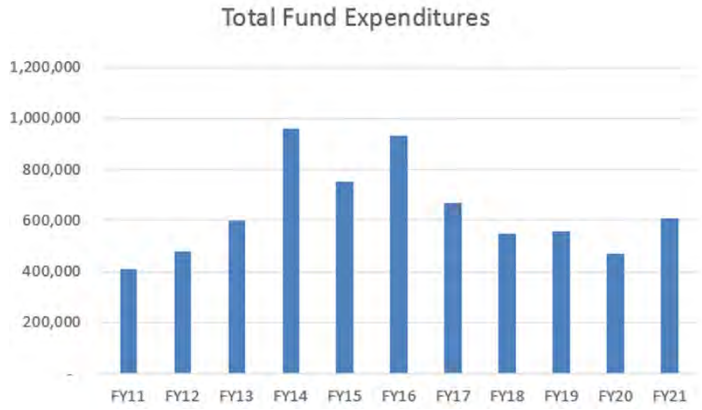
Fiscal Year	2021	2020	2019
Civil Penalty Stipulation	$179,460	$209,129	$680,178
Civil Penalty Settlement	$464,936	$190,440	
Civil Penalty D&O	$177,231	$137,407	
Uninsured Employer Reimbursement	$70,317	$123,918	$83,349
Judgments	$176,564	$5,950	
Less Adjustments (NSF Checks)	(9,442)	($5,682)	
Total Revenues	**$1,059,133**	**$661,162**	**$763,528**
% from Civil Penalties	61%	84%	89%
% from Employer Reimbursement	7%	16%	11%
% from Judgments	17%	1%	



Expenditures

Expenditure Details	FY2019	FY2020	FY2021
# of Employees Receiving Benefits	6	8	11
Benefit Payments by Type			
Indemnity Costs	$56,525	$40,356	$97,111
Medical Costs	$244,681	$120,066	$169,215
Reemployment Costs	$55,621	$14,089	$4,542
Employee Legal Costs	$9,856	$61,578	$82,343
Total EE Benefits	$336,684	$236,088	$362,257
Administration Costs	$190,214	$235,648	$247,944
Total Expenses	**$556,897**	**$471,736**	**$609,427**
% of Benefit Payments to Total Costs	65.8%	50%	59%
%of Admin. Costs to Total Costs	34.1%	50%	41%





Potential Fund Liabilities On Open/Pending Claims

Fiscal Year	Total Claims Filed	No. of Claims (open and pending)	Closed Claims	Potential Liability	Paid Expenses	Balance Due (reserve)
FY2021	13	9	4	$ 826,000.00	$ -	$ 826,000.00
FY2020	8	3	5	$ 848,000.00	$ 304,867.18	$ 213,132.82
FY2019	24	3	21	$ 1,617,212.41	$ 106,986.82	$ 1,510,225.59
FY2018	11	0	11	$ 325,082.88	$ 2,056.00	$ 323,026.88
FY2017	19	1	18	$ 1,735,970.26	$ 806,339.52	$ 929,630.74
FY2016	18	0	18	$ 1,532,960.83	$ 411,101.25	$ 1,121,859.58
FY2015	15	0	15	$ 426,056.00	$ 142,562.96	$ 283,493.04
FY2014	13	0	13	$ 1,266,238.09	$ 921,971.49	$ 344,266.60
FY2013	15	0	15	$ 507,515.82	$ 346,946.05	$ 160,569.77
FY2012	33	1	32	$ 2,123,300.36	$ 821,155.78	$ 1,302,144.58
FY2011	21	0	21	$ 592,946.38	$ 429,583.91	$ 163,362.47
FY2010	15	1	14	$ 1,069,818.89	$ 755,082.04	$ 322,178.83
Total	205	18	187	$ 12,871,101.92	$ 5,048,653.00	$ 7,499,890.90

095

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.**

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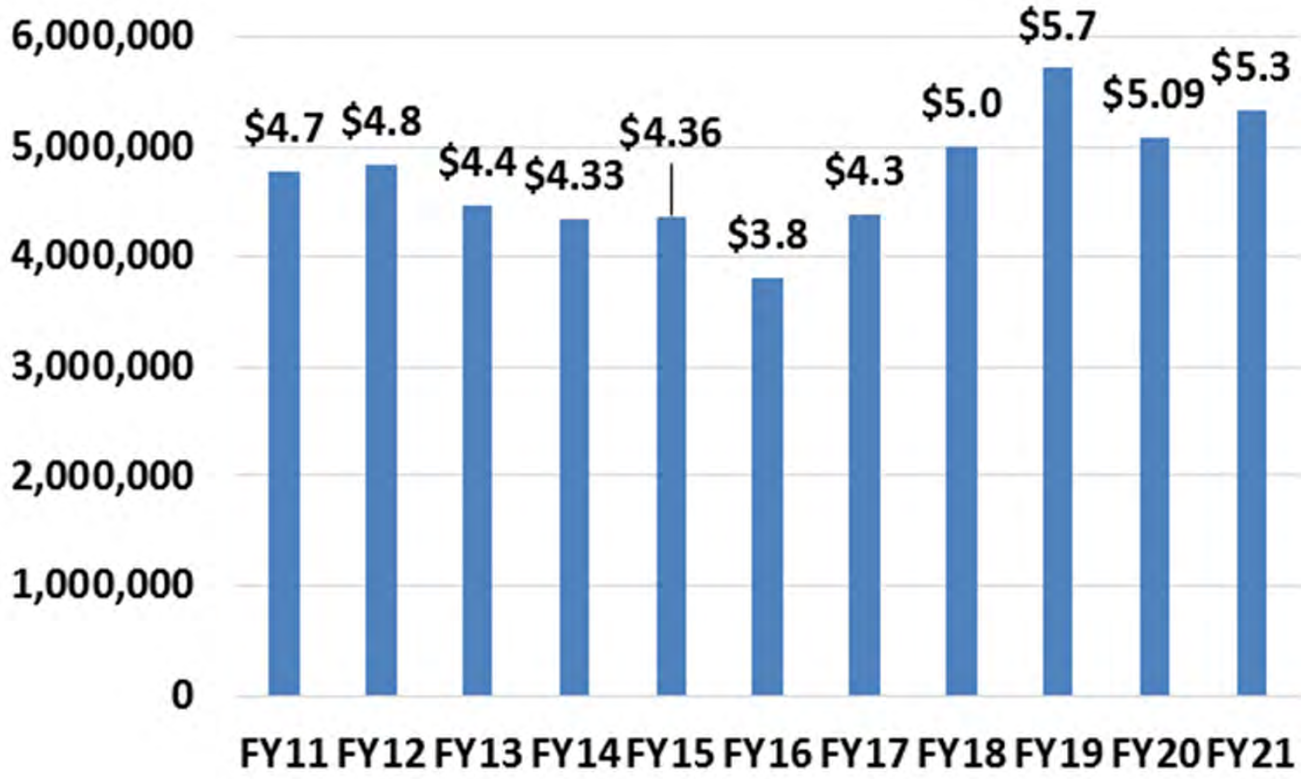
- **The workers' compensation reforms passed by the State of Alaska Legislature on May 11, 2018 (SCS CSHB 79(FIN)) provided for the closure of the Second Injury Fund. The Department of Labor and Workforce Development shall continue to administer the Second Injury Fund and payment of its remaining liabilities.**

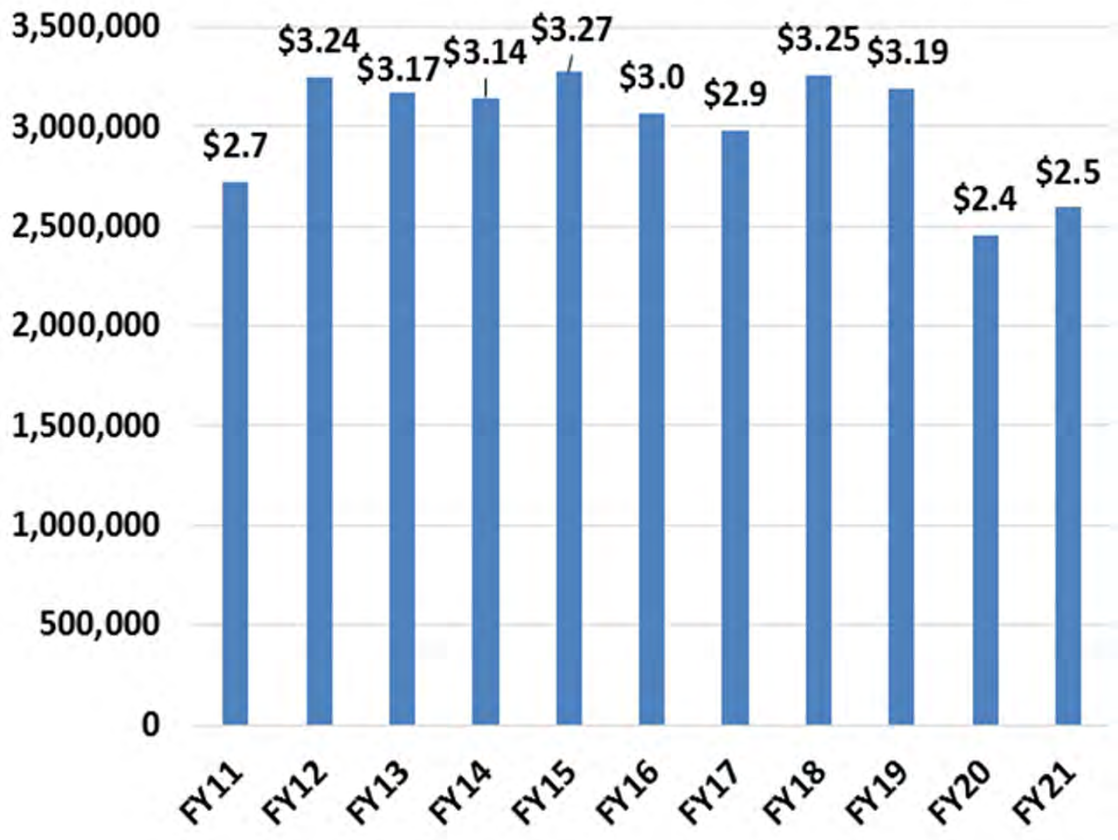
Fiscal Year-End Balance (millions)

Fiscal Year	Balance
2021	$5,328,646
2020	$5,092,860
2019	$5,713,621
2018	$5,003,206
2017	$4,390,500
2016	$3,817,700
2015	$4,369,141
2014	$4,336,000
2013	$4,468,000
2012	$4,847,700
2011	$4,777,200



Revenues (millions)

Fiscal Year	Revenue
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



Contribution Rate History

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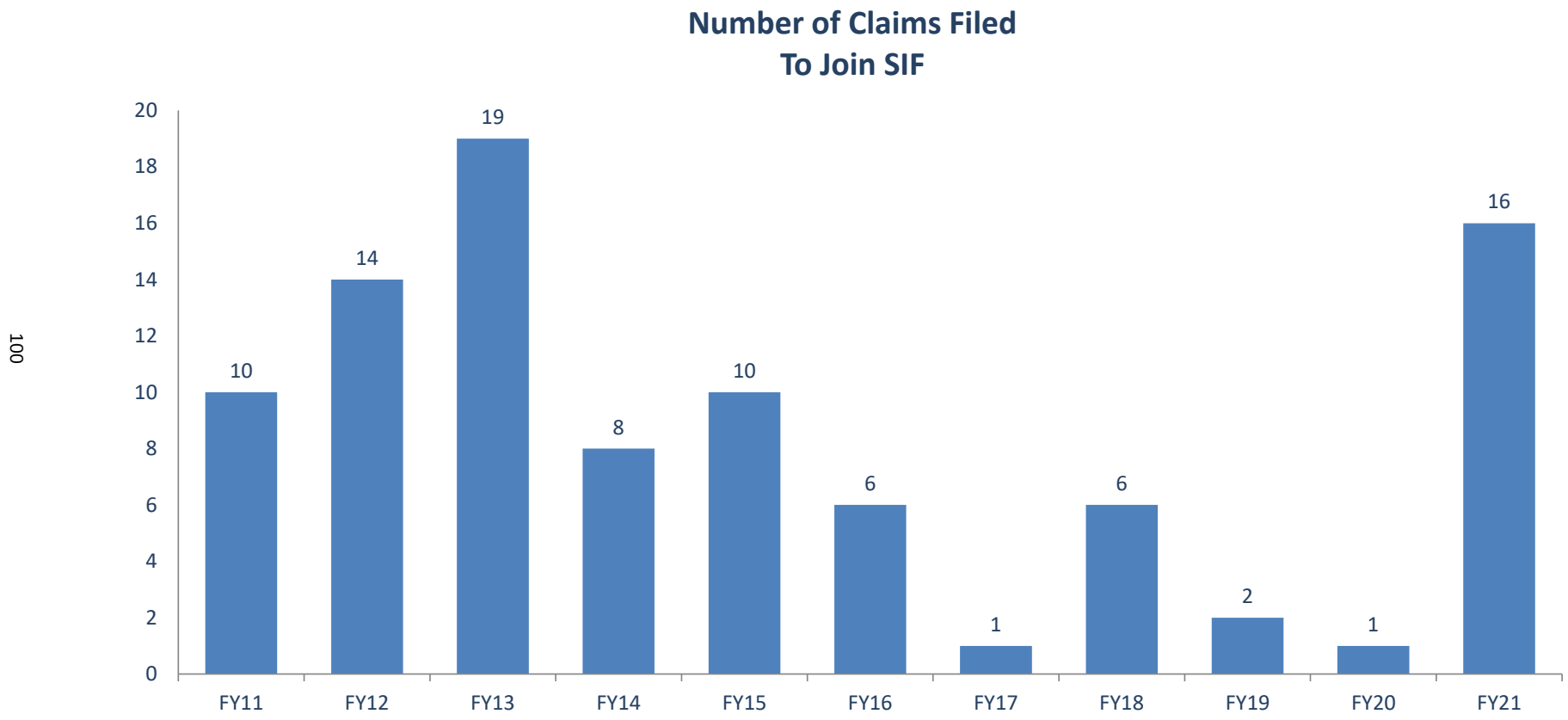
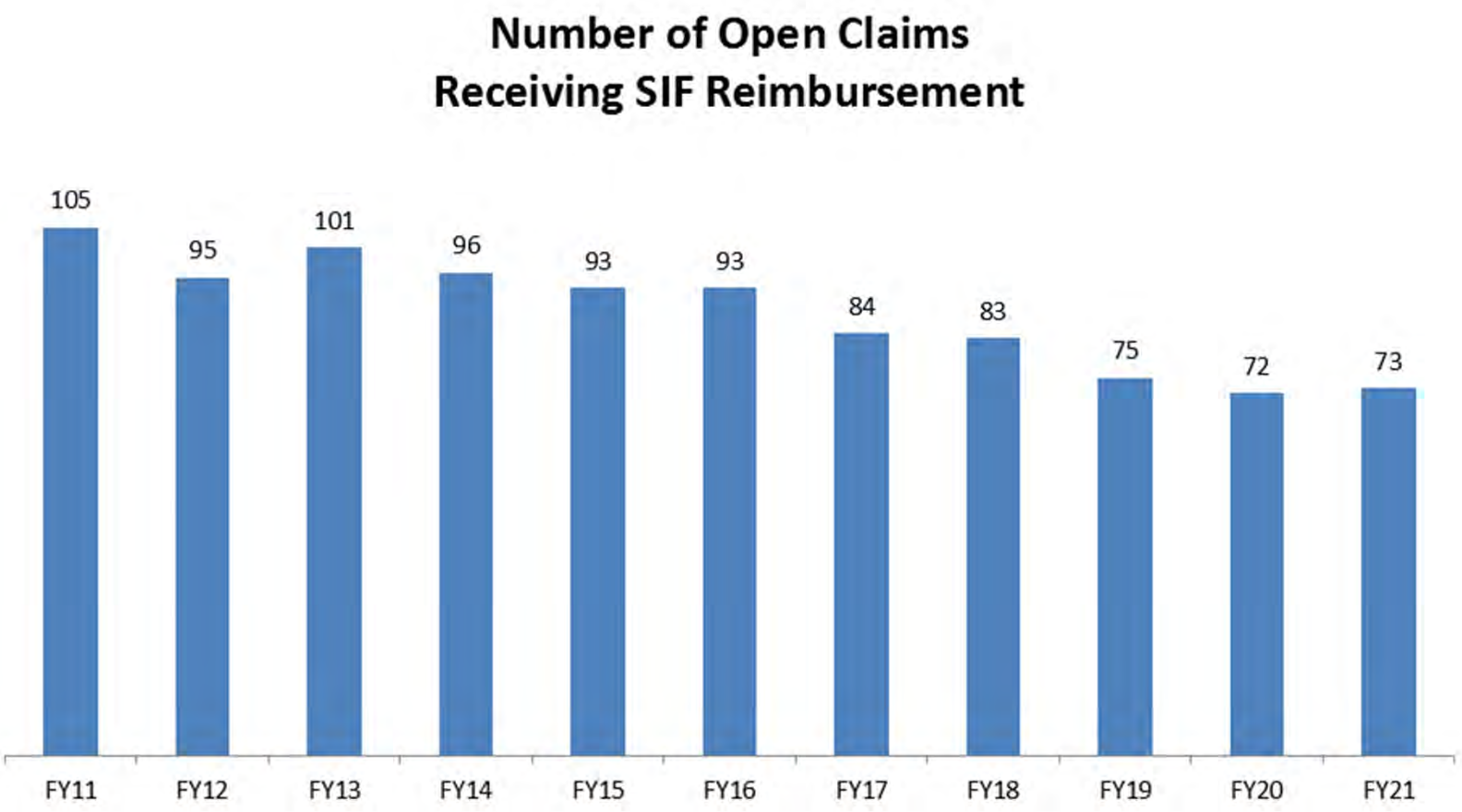
The 2018 reform amendment, effective November 22, 2018, changed revenue stream of SIF penalties for late compensation report filing, under AS 23.30.155(c) from Second Injury Fund to the Workers' Safety and Compensation Administrative Account.

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

Petitions to Join SIF for Reimbursement



Open Claims



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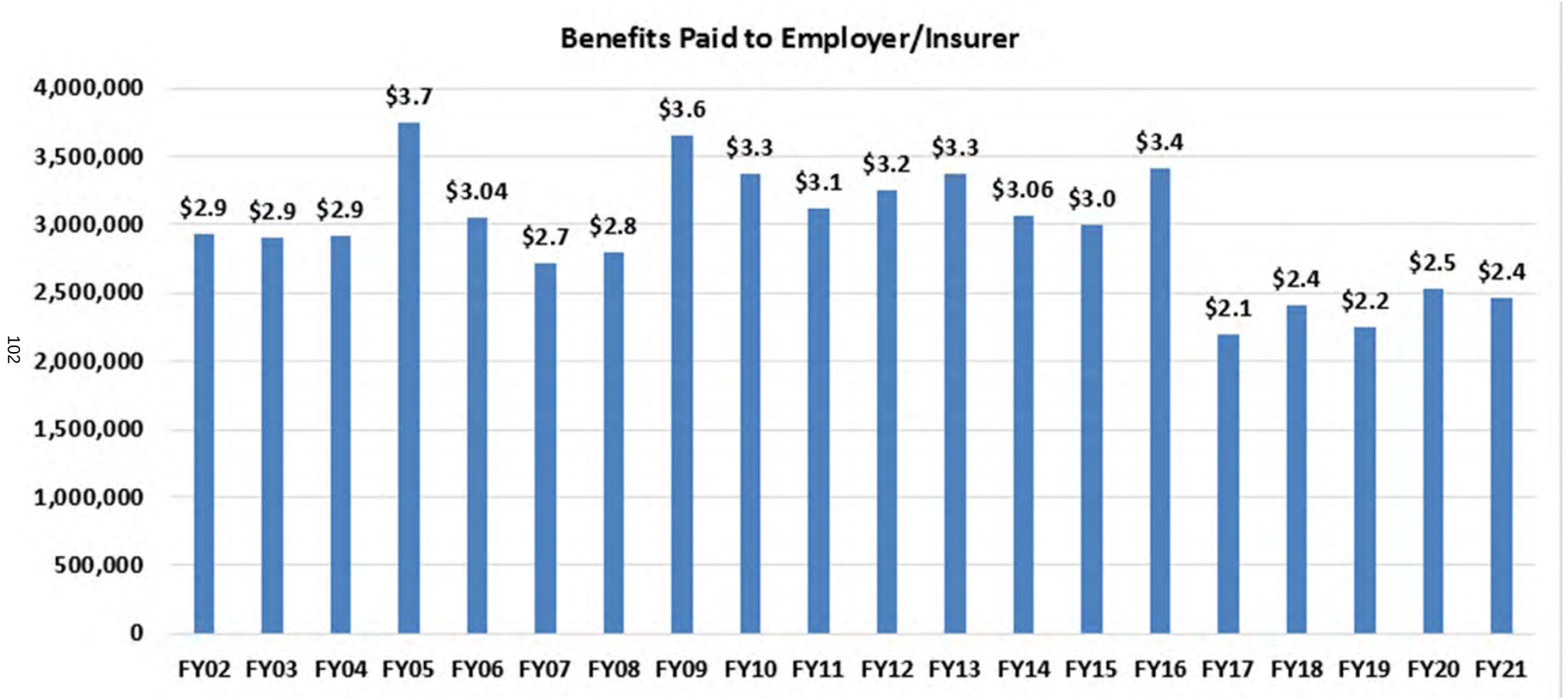
Grant Payments (millions)



Grant Payments by Employer/Type

Top Ten Reimbursement Recipients		
Rank	**Insurer/Self-Insurer**	**Amount**
1.	State of Alaska	$470,021
2.	Commerce & Industry	$236,092
3.	Alaska Airlines	$202,876
4.	Arctic Slope Regional Corp	$167,817
5.	Alaska Timber Ins Ex	$154,248
6.	Municipality of Anchorage	$152,334
7.	National Union Fire Ins	$120,900
8.	Alaska National Insurance	$95,656
9.	Anchorage School District	$92,599
10.	Liberty Mutual Insurance	$91,140

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Reimbursement Recipients by Type		
#	**Type**	**Amount**
18	Market Insurer	$1,158,099
13	Self-Insureds	$1,278,965
31	**Total**	**2,437,064**

QUESTIONS?

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REEMPLOYMENT BENEFITS ANNUAL REPORT
Calendar Year 2020

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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

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2020 By the Numbers

- 478 injured workers were referred for evaluations for eligibility for reemployment benefits.
- 1085 eligibility evaluation reports were reviewed.
- 509 eligibility determinations were made.
- 95 injured workers were found eligible for reemployment benefits.
- 33 injured workers elected to receive a job dislocation benefit.
- 49 elected to pursue reemployment benefits.

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2020 By the Numbers, Cont.

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

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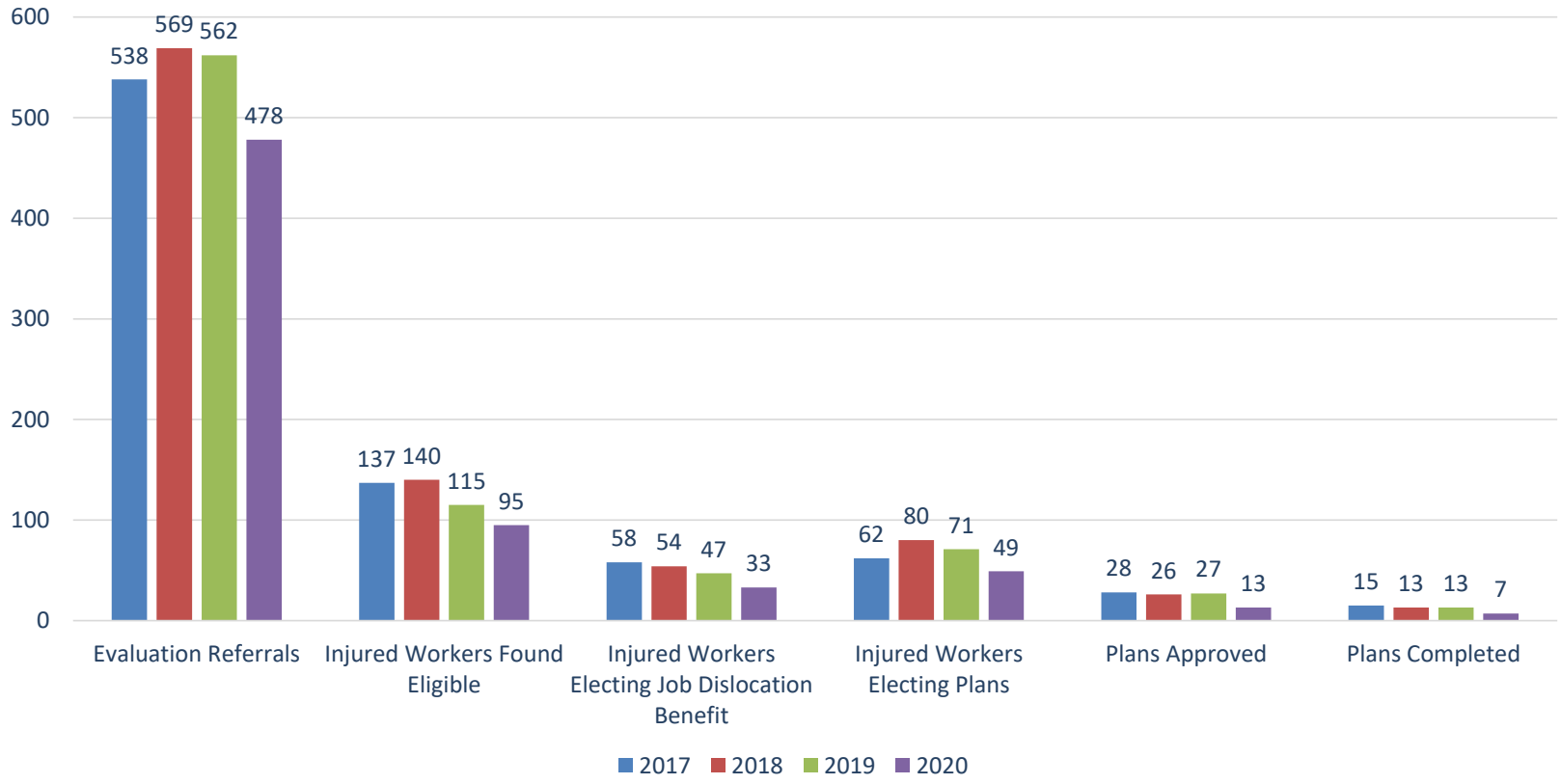
Reemployment Trends



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Reemployment Benefit Plans

- 111 injured workers were in the plan process at some point during 2020.
- 42 injured workers were referred for plan development in 2020.
- 39 injured workers exited the process through a Compromise and Release after plan referral and before plan completion.
- 21 injured workers were in an approved plan at year end.
- 29 injured workers were in plan development and 19 plans were pending approval at year end.
- 8 injured workers successfully completed plans with an average plan length of 31 months from plan approval to plan completion. **One case was delayed due to medical reasons thus causing the average time to be more than the statutorily allowable 24 months for a plan**

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Reemployment Benefit Plans, Cont.

- 34 plans were stalled or exited for various reasons.
  - 5 injured workers' plan process was medically suspended.
  - 1 injured worker changed their election from retraining to a job dislocation benefit.
  - 11 injured workers exited through a Compromise and Release agreement.
  - 12 plans were controverted or a petition to terminate reemployment benefits was filed.
  - 2 plans were unable to be developed to meet statutory requirements.
  - 1 plan process was halted because the injured worker was non-participatory.
  - 2 plans were unsuccessful because the time had expired.

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Outcomes for Workers Completing Plans

- The Reemployment Benefits Section attempted to contact 35 injured workers that had completed plans between 2018 and 2020.
- 20 injured workers responded.
- 11 injured workers had returned to the workforce.
- 6 reported they were working in the plan goal or related.
- 9 injured workers reported they had not returned to work.
  - 1 injured worker is deceased
  - 1 reported they are retired
  - 1 reported they were looking for work in the plan goal
  - 6 stated COVID-19 impacted their ability to work or obtain employment

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Reemployment Benefit Costs

	2018	2019	2020
Evaluation Costs	$2,033,729	$2,118,256	$1,472,595
Reemployment Specialist Plan Fees	$505,711	$755,065	$626,545
Plan Costs	$781,518	$617,835	$503,629
Wage Benefits (AS 23.30.041(k))	$2,359,873	$2,635,051	$2,135,148
Job Dislocation Benefits (AS 23.30.041(g))	$2,065,131	$1,601,142	$2,961,687
TOTALS	$7,745,962	$7,727,349	$7,699,604
% Change	-33.39%	-0.24%	-0.35%

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Reemployment Benefits in Settlements

Impact of settlements on reemployment benefits in 2020

- 149 injured workers exited the reemployment benefits process through Compromise and Release agreements.
- 75 injured workers had funds designated for reemployment benefits included in settlements approved in 2020, increasing reemployment benefit costs.
  - 37 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.
- 78 injured workers exited the reemployment process through a settlement after a determination of eligibility, significantly reducing the number of injured workers available for plan completion.

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Rehabilitation Specialists

- 18 Alaska Rehabilitation Specialists accepted 478 referrals for eligibility evaluations; 92 evaluations were referred to 43 specialists out of state.
- 2 Alaska specialists retired in 2020.
- For Alaska Based Specialists:
  - 330 or 69% of the first reports were submitted within 60 days of the referral.
  - 157 or 33% of the evaluations were completed on the first report submission.
  - 207 or 43% of the evaluations were completed prior to a suspension letter from a Reemployment Benefits Administrator Designee.
  - 333 reports did not meet statutory/regulatory requirements.
- Continued improvements in our process are being made to ensure all work is in compliance with statutory and regulatory requirements through suspension letters, discussions, plans of correction and disqualification from providing services under AS 23.30.041.

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2020 Reemployment Benefit Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1st report	Complete on 1st report or w/o suspension letter	# of late 1st reports	# 60 day gaps in reporting	# reports not meeting stat/reg	Median # days to determ
L. Cortis	15	54	8	1	9	6	60
J. Cranston	34	37	12	16	4	50	62
G Cusack	3	59	1	2	1	2	106
K. Davis	23	35	18	1	1	7	50
J. Doerner	34	31	19	2	1	20	47
P. Harmon	20	36	8	8	2	38	46
R. Hoover	34	32	22	0	0	15	33
T. Hutto	19	43	13	7	2	22	53
S. Krier	6	32	3	1	0	2	41

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2020 Reemployment Benefit Eligibility Evaluations

Rehabilitation Specialist	# of Referrals recv'd	Average # days to 1st report	Complete on 1st report or w/o suspension letter	# of late 1st reports	# 60 day gaps in reporting	# reports not meeting stat/reg	Median # days to determ
D. LaBrosse	22	29	8	1	7	33	53
B. Lees	7	30	7	0	0	0	26
C. Robbins	34	35	30	4	5	10	32
B. Roberts	2	33	0	0	0	4	97
J. Shipman	19	26	15	0	0	0	29
N. Silta	24	31	10	0	1	16	61
T. Torvie	28	31	17	3	0	39	37
P. Vargas	24	45	16	1	7	14	56
A. White	32	26	1	2	1	55	62

QUESTIONS?

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SPECIAL INVESTIGATION UNIT
ANNUAL REPORT

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Rhonda Gerharz
Chief Investigator

Special Investigation Unit

- Established by Alaska Legislature in 2005
- Part of Overall Division Budget
- Staffing:
  - Rhonda Gerharz, Chief Inv. – Anchorage (1/2009)
  - Christine Christensen, Inv. 3 – Anchorage (10/2007)
  - Wayne Harger, Inv. 3 – Fairbanks (4/2011)
  - Michele Wall-Rood, Inv. 3 – Anchorage (10/2021)
  - Dave Price, Inv. 3 – Juneau (3/2014)
  - Brian Suprise, Inv. 2 – Anchorage (05/2021)

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Challenges

- Criminal Fraud Prosecution
- Employers Without Records
- COVID-19 Limitations
  - Business Sustainability
  - Heightened Community Anxiety
  - Suspended In-Person Presentations

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Achievements

- Goal of 80+ Settlements Reached
- Unusual Matters Resolved
- Continued Agency Collaboration
  - FBI Healthcare Fraud Task Force
  - FBI Financial Crimes Task Force
  - Labor Standards & Safety (AKOSH, W&H)
- 255 Public Inquiry Calls
- 368 Compliance Checks (public & other agency)
- 323 Active FTI Investigations – 240 Closed

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Core Values

- SIU In-Person Staff Meeting 6/4/2021 Collaboration:
  - **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

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Fraud Hotline and Email Tips

143	Fraud Calls and Emails
13	Claimant/Injured Worker
64	Employer
58	Agency Assist Requests
4	Both Agency Assist and ER
2	Care Provider
0	Attorneys/Non-Attorney Reps
0	Insurance Companies/Agents
0	Fish Fund Claimant
2	Other

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Failure to Insure

Investigations Opened/Re-Opened	Investigations Closed	Uninsured Injury Referrals Received	Uninsured Injuries Confirmed
235	240	27	21

	Assessed By	Total Assessed	Discounted	Suspended	Ordered to Pay
FY2021	81 Settlements (15 with payment plans)	$1,379,566	$260,930	$502,041	$616,595
	7 Decisions (All Final)	$349,026	N/A	$96,887	$252,139
	TOTALS	**$1,728,592**	**$260,930**	**$598,928**	**$868,734**

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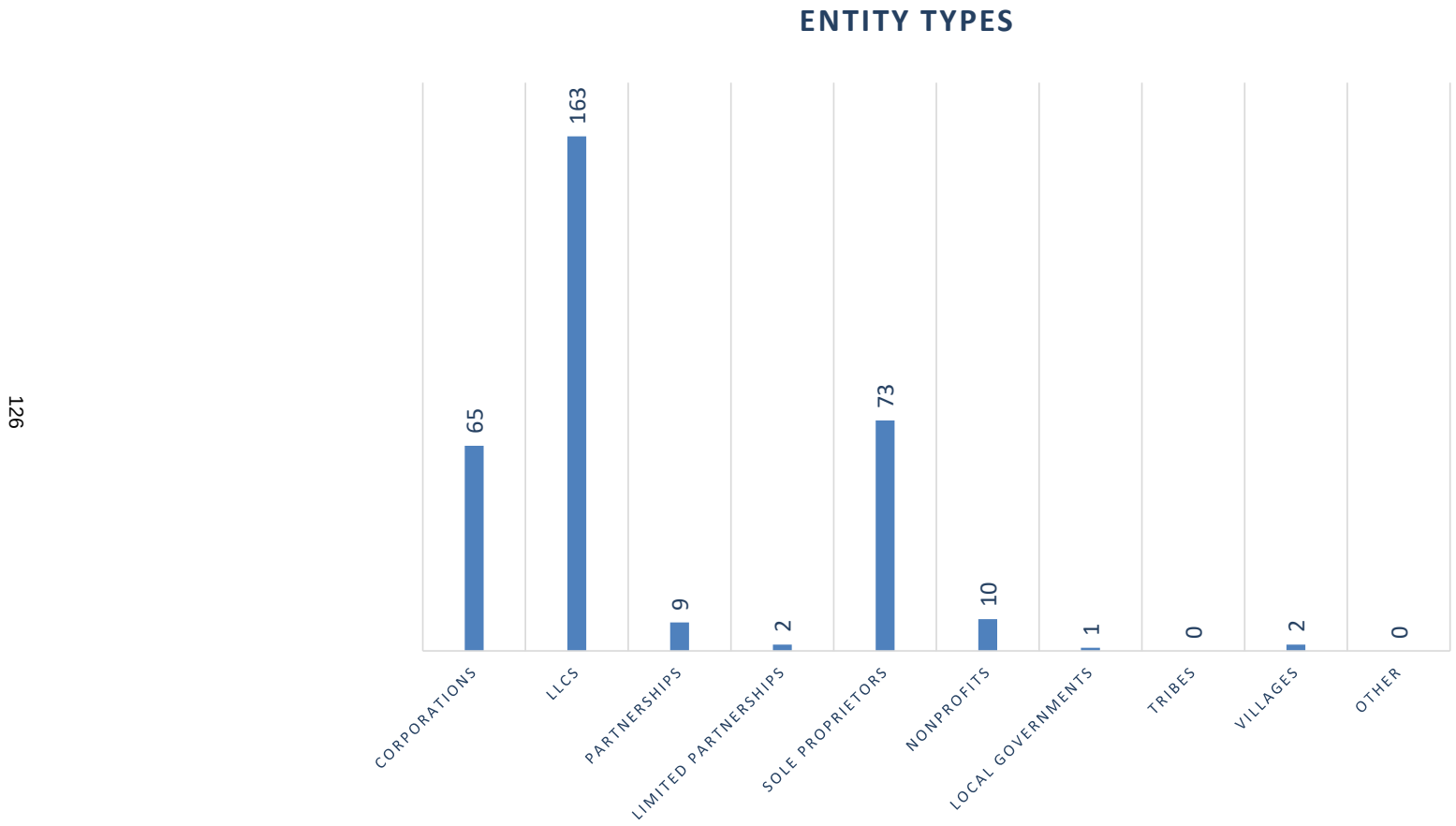
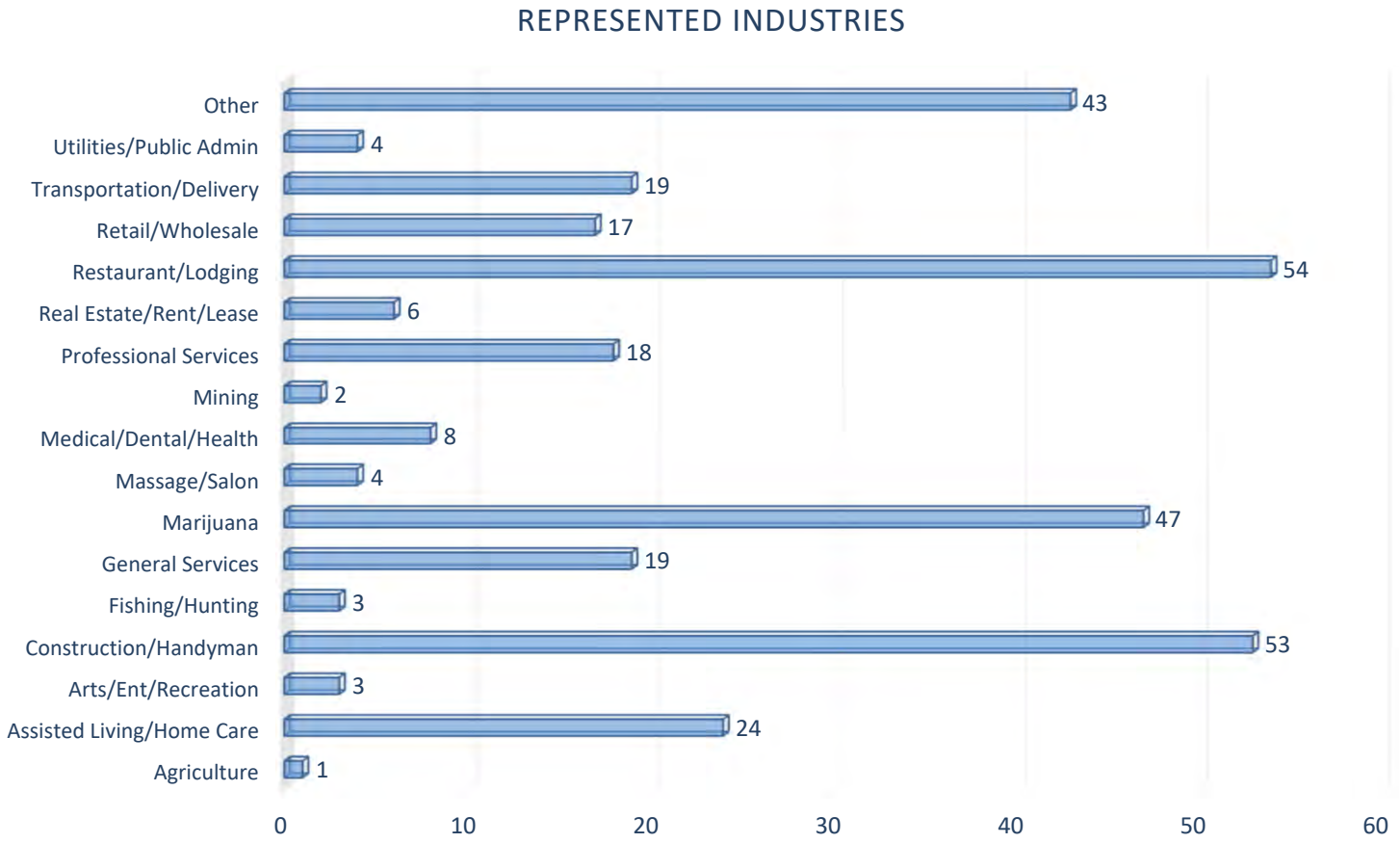
Industry Data for FTI Investigations



Industry Data for FTI Investigations



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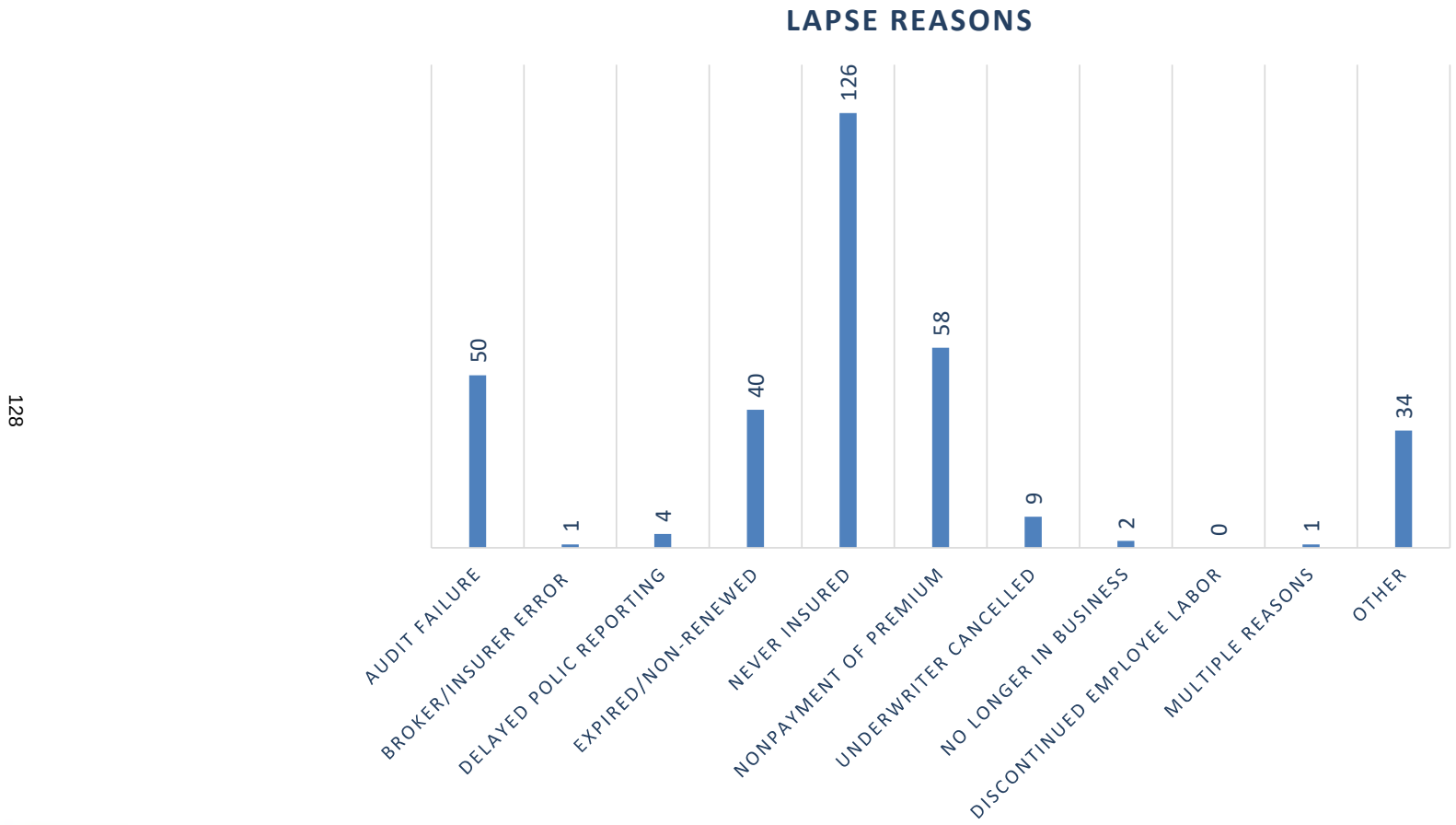
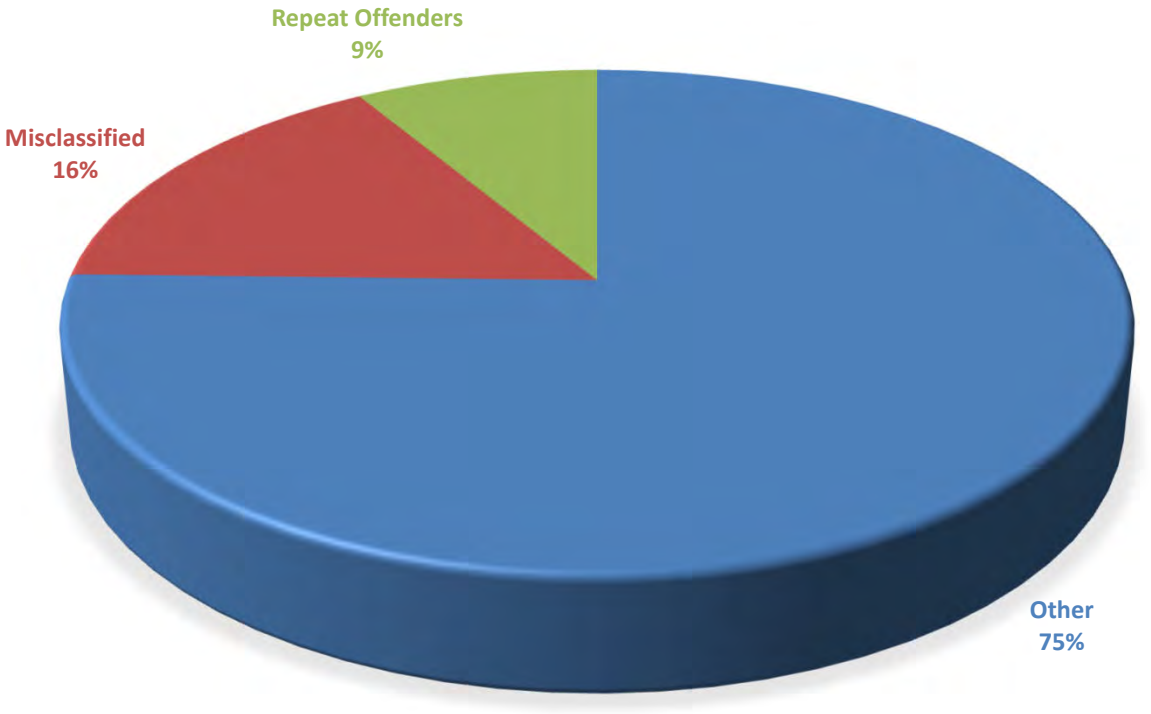


Industry Data for FTI Investigations



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Current Goals/Priorities

- Stronger Criminal Fraud Laws
- Training Budget
- Continued Six Month Case Resolution
- Continued Multiple Agency Joint Investigations
- Resume Targeted Proactive Education

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QUESTIONS?

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ADJUDICATIONS SECTION
ANNUAL REPORT

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William Soule
Acting Chief of Adjudications

Compliance with the Alaska Workers' Compensation Act Relevant Statistics

AS 23.30.110(c) requires decisions and orders (D&O) to be issued within 30 days of hearing record closure. Additionally, the Alaska Workers' Compensation Appeals Commission has stated the Board's failure to issue decisions timely may result in denying a party due process.

	2016	2017	2018	2019	2020
Hearings Held	294	255	231	225	205
* In-person & virtual					152
* Written record					53
D & O's issued	135	148	133	138	121
Average days from record closure to D & O issuance	22	20	23	23	32

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Mediation Statistics

	2016	2017	2018	2019	2020
Hearing Officers Mediating	6	6	6	4	4
Cases Mediated	67	69	52	50	75
Cases Resolved or Partially Resolved	53	59	44	45	72
Percent Resolved	79%	86%	85%	90%	96%

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Compromise and Release Agreement Statistics

C&R Type	2016	2017	2018	2019	2020
Approval Not Required	84	79	57	71	45
Approved	503	432	462	450	374
Denied (required hearing)	174	122	131	85	56

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AS 23.30.012(b) requires C&Rs to be reviewed by a Board panel if the claimant is not represented by an attorney, is a minor beneficiary or incompetent or is waiving future medical benefits.

8 AAC 45.160(e) states a C&R in which the employee waives medical benefits is presumptively not in the employee's best interest and will only be approved upon a showing by a preponderance of the evidence that the agreement is in the employee's best interest.

Alaska Workers' Compensation Appeals Commission

2020 Case Determinations

The AWCAC issued nine Final or Memorandum decisions in 2020:

- Four Board decisions were AFFIRMED
- Two Board decisions were REVERSED (1) or REMANDED (1)
- One decision was an order to the injured worker to SHOW CAUSE for not filing a timely brief, or her appeal would be dismissed.

As of October 5, 2021, there are nine cases pending before the AWCAC and one draft decision circulating.

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Alaska Supreme Court Decisions

Maalah v. Trident Seafoods, Unpublished MOJ (Alaska 2020).

Employee claimed a chronic, outer-ear infection and related hearing loss from working in a wet, noisy fish processing plant. He claimed PPI, TTD, PTD and hearing-related medical benefits. A two-member Board panel initially deadlocked on compensability and enlisted a third panel member to review the record and break the tie. The Board considered Employee's employment records were important evidence as the parties disputed how long he had worked in the plant. The three-member panel eventually denied compensability of Employee's hearing loss claim and related benefits.

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The Court agreed with the Commission and Board that Employee failed to prove entitlement to TTD or PTD benefits because his physicians had released him for full duty. It did not decide other issues related to his employment records because they were not relevant to the disability issue on review. The Court affirmed the Commission's decision that substantial evidence supported the Board's decisions about Employee's entitlement to disability benefits, with exception of a three-day period in 2017. The Court remanded the case to the Commission to either decide Employee's entitlement for TTD benefits for the three-day period or include the issue in its remand to the Board.

Alaska Supreme Court Decisions

Vue v. Walmart Associates, Inc., 475 P.3d 270 (Alaska 2020).

An asset-protection worker was shot in the eye by a shoplifter with a pellet gun. The pellet lodged near his optic nerve and was inoperable. He claimed PTSD-related disability benefits in a "physical-mental" claim. Employer denied pain-related care and stopped paying TTD benefits stating he was not disabled by an injury-related psychological injury. The Board awarded medical care but found Employer's controversion was not unfair or frivolous and denied his request for TTD benefits during periods his doctors said he had physical capacities to return to his normal work. The Commission affirmed. The Court reversed and remanded for the Board to calculate TTD benefits, award a penalty and refer the case to the Insurance Division under AS 23.30.155(o).

The Court held (1) the Board could not ignore Employee's testimony about his ability to work; (2) Employer failed to rebut the presumption of compensability that he continued to be disabled by his mental condition; (3) though medical evidence said Employee was medically stable from the physical injury, none said he was in respect to his mental injury; (4) Employee thus prevailed on the raised but unrebutted presumption; (5) the Court rejected the Commission's *Gurnett* decision and said it was improper to add a subjective "bad faith" requirement before the Board can refer a case to the Division of Insurance under AS 23.30.155(o); (6) Employer had a continuing duty to modify or withdraw a controversion when it received evidence undermining its denial; (7) Employer's controversion of medical care and TTD benefits was "frivolous" under the *Hibdon* two-year standard because Employer had neither evidence the treatment was neither reasonable nor necessary nor within the realm of acceptable medical options; (8) since the EME said he had no expertise to comment on pain management issues, his opinion could not as a matter of law be enough to allow the Board to deny the treatment in question, under *Hibdon*; (9) a controversion stating "all medical benefits that are not reasonable or necessary" is not adequate to inform Employee or his providers what is denied, and why.

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Alaska Supreme Court Decisions

Seal v. Welty, 477 P.3d 613 (Alaska 2020).

This is not a Board or Commission appeal but discusses related issues. A construction worker died when a retaining wall collapsed on him at work. Neither alleged Employer, who claimed the decedent was an independent contractor, nor the property owner who hired alleged Employer had workers' compensation insurance. The decedent's personal representative filed both a workers' compensation claim against the Benefits Guaranty Fund, and a superior court wrongful death action against alleged Employer and the property owner. All but alleged Employer settled in a global settlement that the Board approved. Alleged Employer claimed he could not be sued anymore. The superior court agreed and held the estate had elected a remedy.

In short, relying on the *Rosales* decision, the Court held the contract form in which two matters were resolved in one document was not improper and the Board's approval of it only pertained to that portion of the settlement agreement regarding the estate's workers' compensation claims. The Court reversed the superior court's grant of summary judgment to alleged Employer, vacated the final judgment and remanded for further proceedings.

Alaska Supreme Court Decisions

Espindola v. Peter Pan Seafoods, Inc., 486 P.3d 1116 (Alaska 2021).

A cannery worker claimed a back and shoulder injury, suffered at different times. Employer paid some benefits for both injuries, then controverted. An EME opined arthritic, degenerative changes were the substantial cause of his back condition and stated work had not permanently aggravated either condition. Employer controverted all benefits relying on this opinion. Employee's shoulder got worse, and he eventually filed a claim seeking medical benefits and a finding that Employer's controversion was unfair and frivolous. EME did another exam, which did not change his earlier opinion that Employee's continuing problems were not work-related. Eventually, an SIME concluded Employee's work was not the substantial cause of Employee's back condition but was the substantial cause of his shoulder condition and medical care.

The Court affirmed the Commission's decisions that substantial evidence supported the Board's decision denying Employee's low back condition and that the controversion notices were not unfair or frivolous. It reversed the Commission's decision that substantial evidence supported the Board's decision regarding Employee's shoulder and remanded for further proceedings as to the shoulder.

Alaska Supreme Court Decisions

Alaska State Commission for Human Rights v. United Physical Therapy, 484 P.3d 599 (Alaska 2021).

Employee had a work-related motor vehicle accident. A physical therapist treated him for chronic neck pain and headache. Employee's treating physician endorsed the PT treatment plan, which improved Employee's symptoms. Employer sent scant medical records to its EME panel, which commented on causation but included a disclaimer stating the records were insufficient to fully understand Employee's conditions and complaints. Nevertheless, the EME diagnosed him with a cervical strain and several conditions they considered preexisting or unrelated to the work injury and opined one diagnosis from an attending physician did not even exist. They concluded Employee needed no further treatment and had no PPI. Employee won before the Board.

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The Court (1) found the Board properly interpreted and applied its regulations in determining the issues set for hearing by relying on the prehearing conference summary; (2) reiterated the notion that the Board's duty to advise unrepresented claimants applies to all unrepresented litigants; (3) agreed that the medical summary regulation applies to all litigants and not just Employee and Employer; (4) found, "It is not unreasonable for the Board to consult a reference the legislature adopted for certain medical determinations under the Act" to find the attending doctor's diagnosis was in the AMA *Guides*, because the Board has been required to use the AMA *Guides* since 1988, and the Court had "little doubt the Board panel was familiar with the *Guides*." It affirmed the Commission's holding that the Board did not violate any procedural regulation or abuse his discretion.

Alaska Supreme Court Decisions

State v. Wozniak, 491 P.3d 1081 (Alaska 2021).

This was an attorney fee case. After a hearing, the Board awarded attorney fees under AS 23.30.145(a) in two parts: (1) it awarded actual fees for work up to the time of the hearing, and (2) statutory minimum fees of 10% of ongoing benefits so long as Employee received PTD benefits. The Court concluded, "The Board has discretion to fashion an award as it sees fit so long as it does not abuse that discretion. Even if the Board's award here was somewhat higher than what the State proposed as a reasonable fee and was in a novel format, neither the amount of the fees nor the manner in which they were awarded was manifestly unreasonable under the circumstances presented here." The Court affirmed the Commission's decision affirming the Board.

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Alaska Supreme Court Decisions

Sumpter v. Fairbanks North Star Borough School District, ___ P.3d ___ (Alaska 2021).

Since the Board found Employee not credible, the Court found no problem with its finding because it was supported by specific examples in the record. The Court further found Employee's citation to contradictory medical opinions were not forceful enough to weaken the Board's findings. Employee also contended the Board erred by not considering a possible "repetitive injury over time." But the Court found Employee did not raise this alternate causation theory before the Board. The Court concluded the Board made adequate findings to support its decision, which was supported by substantial evidence in the record as a whole. The Court affirmed the Commission's affirming the board's decisions, in all respects.

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Alaska Supreme Court Decisions

Murphy v. Fairbanks North Star Borough, ___ P.3d ___ (Alaska 2021).

This case is about AS 23.30.105(a). The Board's decision affixed a two-year statute of limitations on claims for PPI benefits; Employee lost his untimely PPI claim. On appeal to the Alaska Supreme Court, Employee relied on *Darrow*, which had distinguished between compensation for "disability" and compensation for "impairment." In short, Employee contended there is no statute of limitations for filing a claim for PPI benefits because PPI is "impairment" and not "disability" benefits. The court disagreed. It considered the statutory text in its entirety, legislative history, and policies underlying the Act and concluded the legislature intended the limitations period in §105 to apply to claims for PPI benefits just as it applies to claims for other "indemnity benefits," which include all cash benefits that compensate employees for losses and expenses other than costs for medical treatment. Because Employee did not file a claim for PPI benefits until over a decade after the statute of limitations began to run, the Court affirmed the Commission's decision affirming the Board's decision.

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QUESTIONS?

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Second Independent Medical Evaluations (SIME) Annual Report for October 2021 Board Meeting

AS 23.30.095
8 AAC 45.092

Dani Byers
Workers' Compensation Officer II, SIME Coordinator

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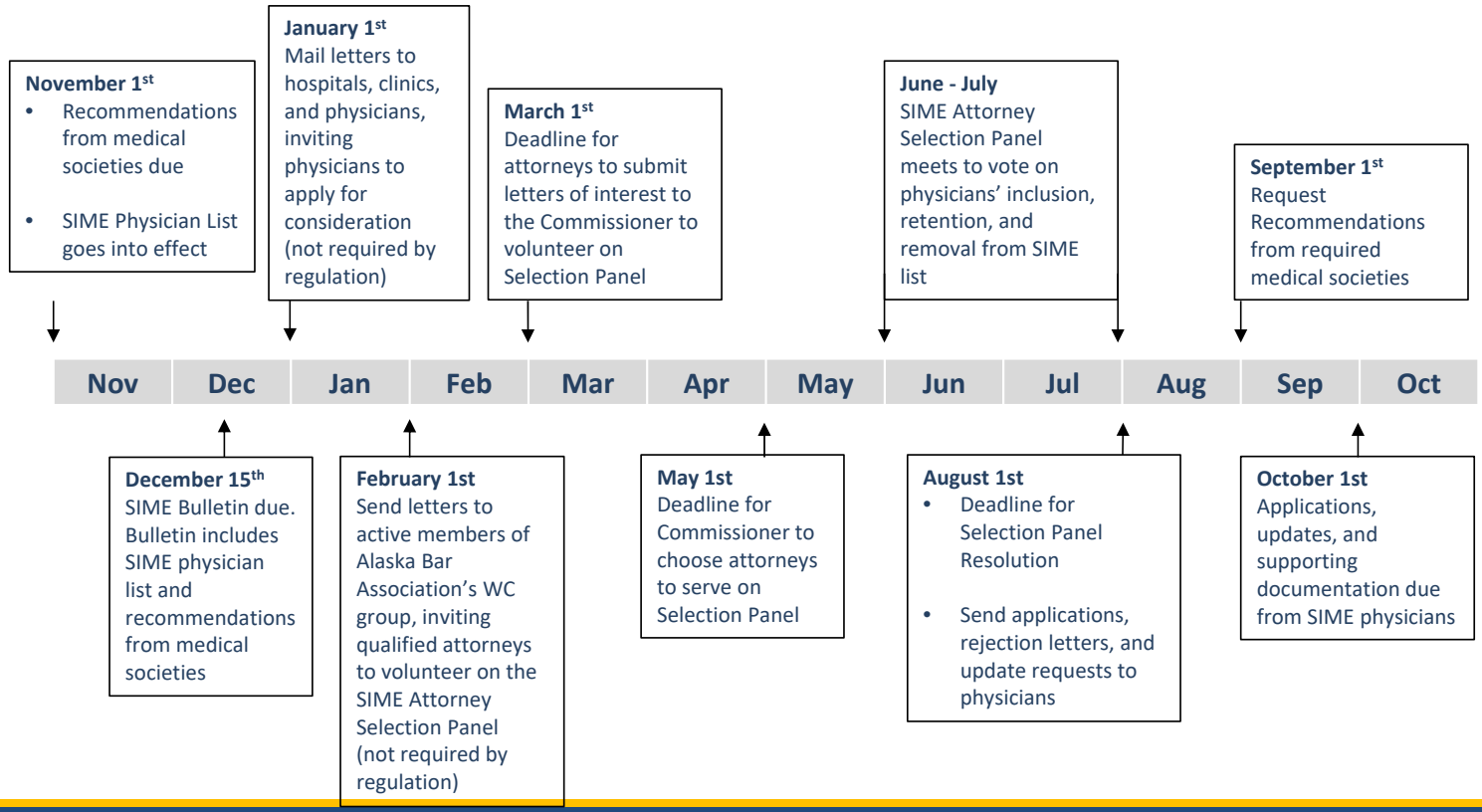
Second Independent Medical Evaluations

SIME ANNUAL PROCESS

November 1st – October 31st



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2021 SIME Selection Panel

<u>2021 Attorney Panel Members:</u>

- JC Croft
- Justin Eppler
- Rebecca Holdiman Miller
- Martha Tansik

<u>New 2021/2022 SIME Physicians Selected:</u>

- Aryeh L. Levenson, MD – Psychiatry
- Stewart Lonky, MD – Pulmonology & Internal Medicine
- Fred F. Naraghi, MD – Orthopedic Surgery (declined invitation)
- G. Charles Roland – Orthopedic Surgery (willing to travel to Alaska for exams!)

<u>2018 SIME Physicians Re-Selected:</u>

- Leon Barkodar, MD – Neurology
- Robert Fisher, MD – Rheumatology (declined to renew)
- John Lane, MD – Orthopedic Surgery
- Wayne Weil, MD – Orthopedic Surgery

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2021 SIME Physician Retirements and Non-Renewals

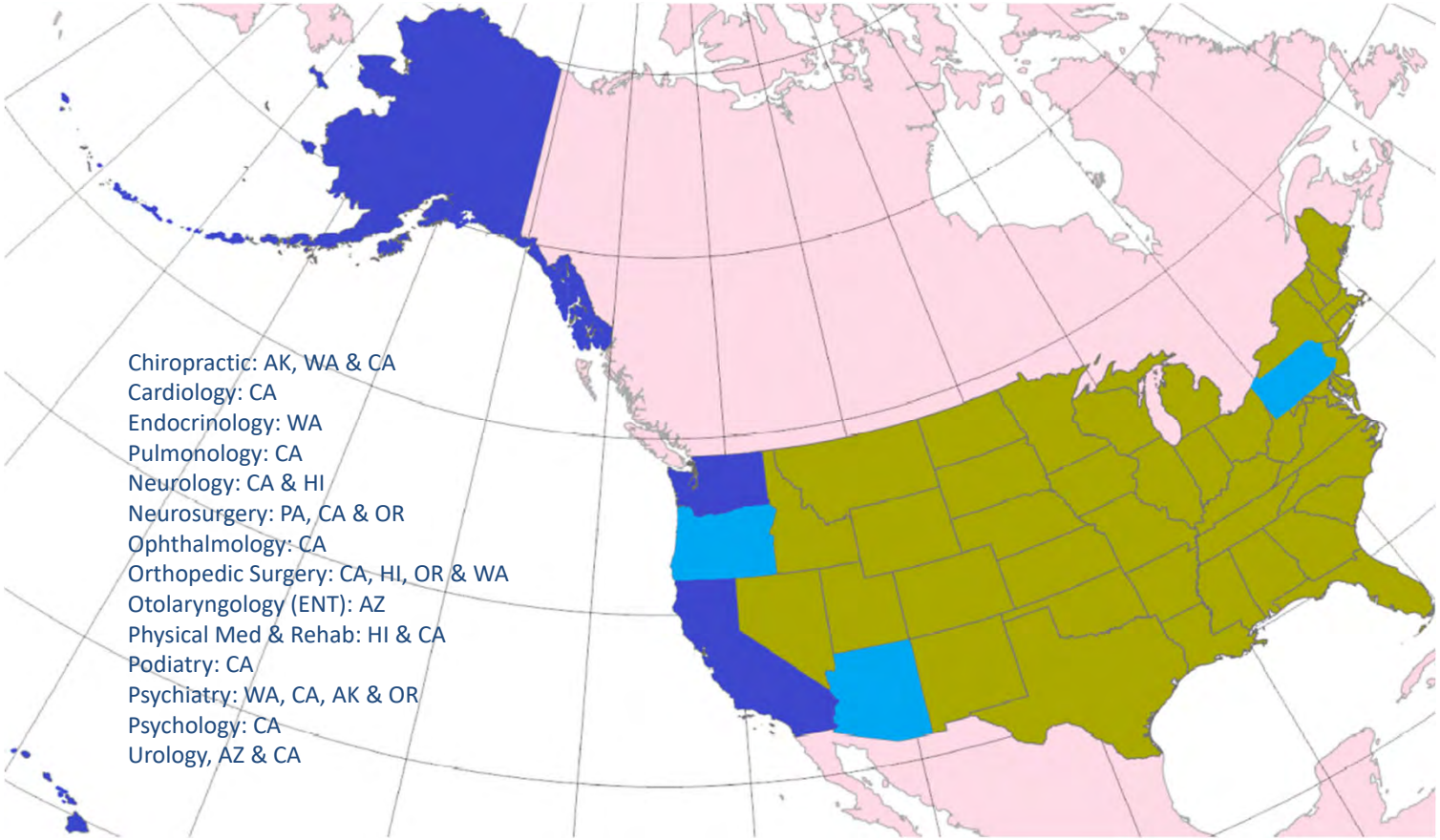
The following SIME physicians did not provide annual updates and/or supporting documentation, and therefore will not appear on the 2021/2022 SIME list:

- Michael Butler, MD – Neurology (2019)
- Robert Fisher, MD – Rheumatology (2018)
- Kenneth Hammerman, MD – Gastroenterology (2001)
- Edward Holmes, MD – Toxicology & Occupational Medicine (2002)
- Jeffrey Light, DDS – Dentistry, Prosthodontics & TMJ (2008)
- Daniel Raybin, MD – Pulmonology (2001)
- Benjamin Simon, MD – Cardiology (2020)
- Alan Weingarden, MD – Ophthalmology (2020)

Some of these physicians are retiring, some are too busy with their practice, and some simply did not respond to the board's annual update request despite multiple written follow-ups and phone calls by the board's designee.

2021-2022 SIME Primary Practice

Locations by Specialty



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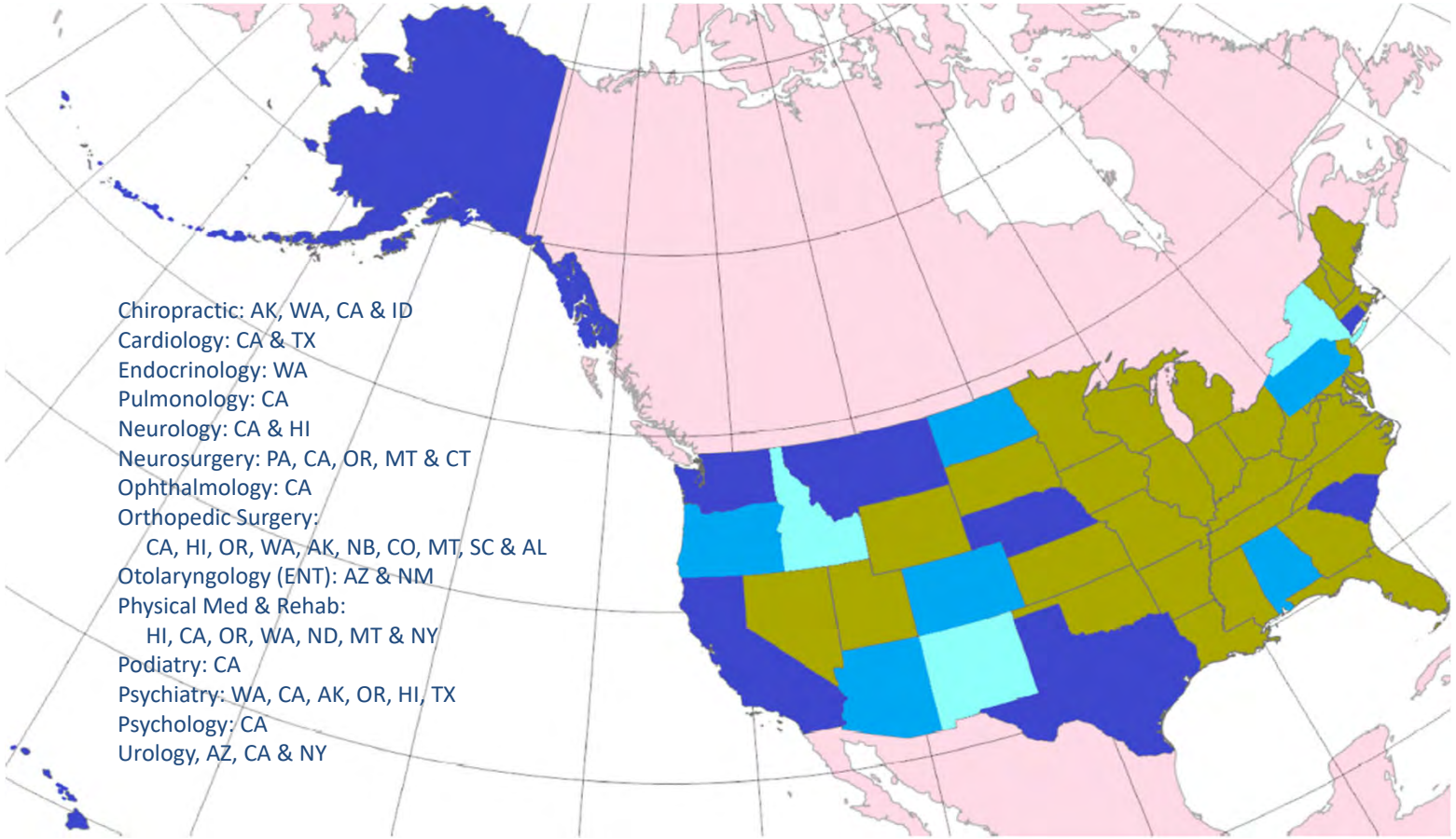
2021-2022 SIME Medical Licenses by State & Specialty



Chiropractic: AK, WA, CA & ID
Cardiology: CA & TX
Endocrinology: WA
Pulmonology: CA
Neurology: CA & HI
Neurosurgery: PA, CA, OR, MT & CT
Ophthalmology: CA
Orthopedic Surgery:
CA, HI, OR, WA, AK, NB, CO, MT, SC & AL
Otolaryngology (ENT): AZ & NM
Physical Med & Rehab:
HI, CA, OR, WA, ND, MT & NY
Podiatry: CA
Psychiatry: WA, CA, AK, OR, HI, TX
Psychology: CA
Urology, AZ, CA & NY

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2020-2021 SIMEs by Specialty

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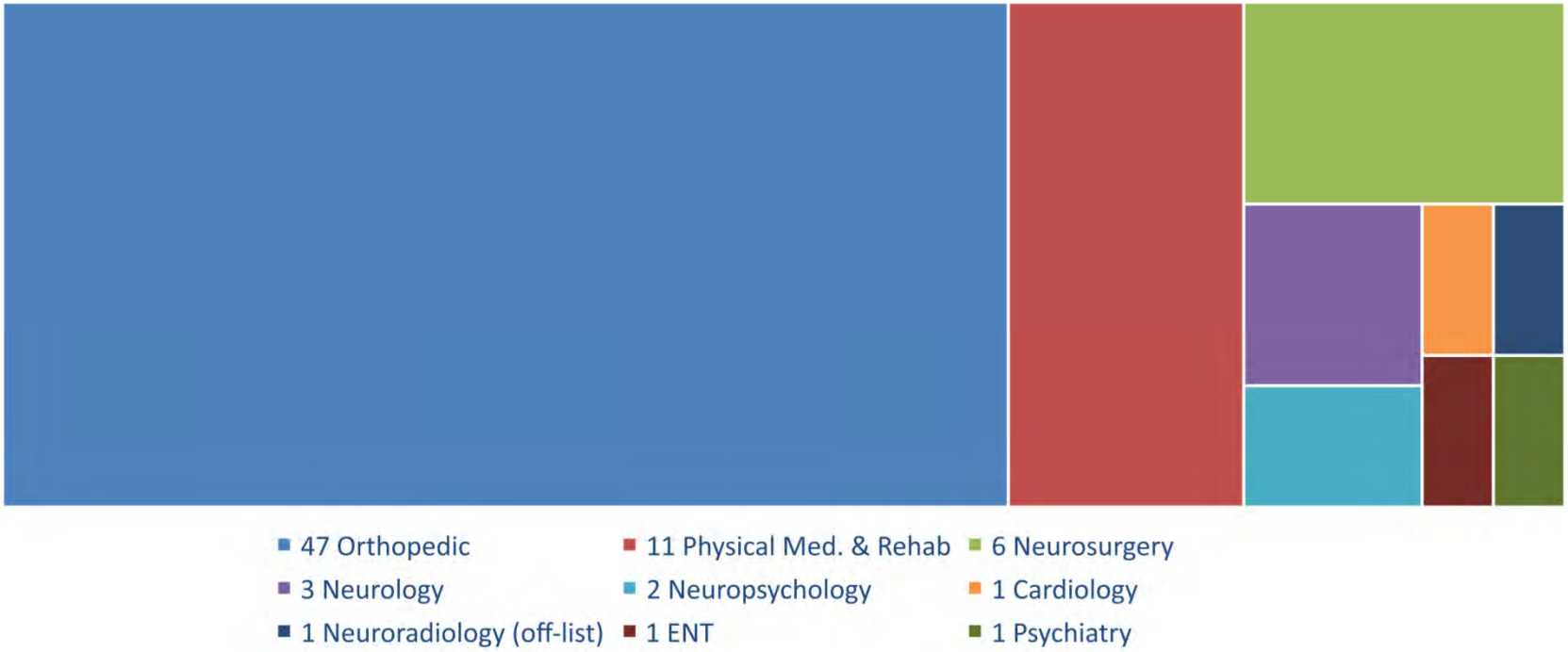
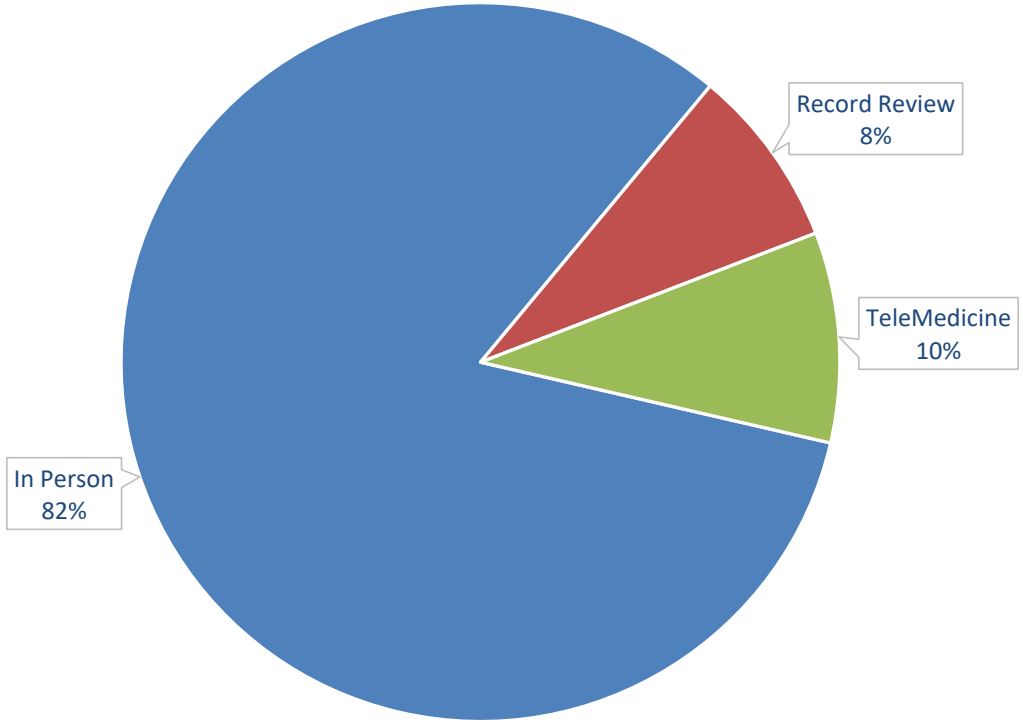


2020-2021 SIME Methods



Total AWCB Cases with SIMES: 72

Panel SIMES (multiple physicians): 2

SIME Assignments: 74

- In-Person: 61 (82%)
- Record Review: 6 (8%)
- Video/ TeleMedicine: 7 (10%)

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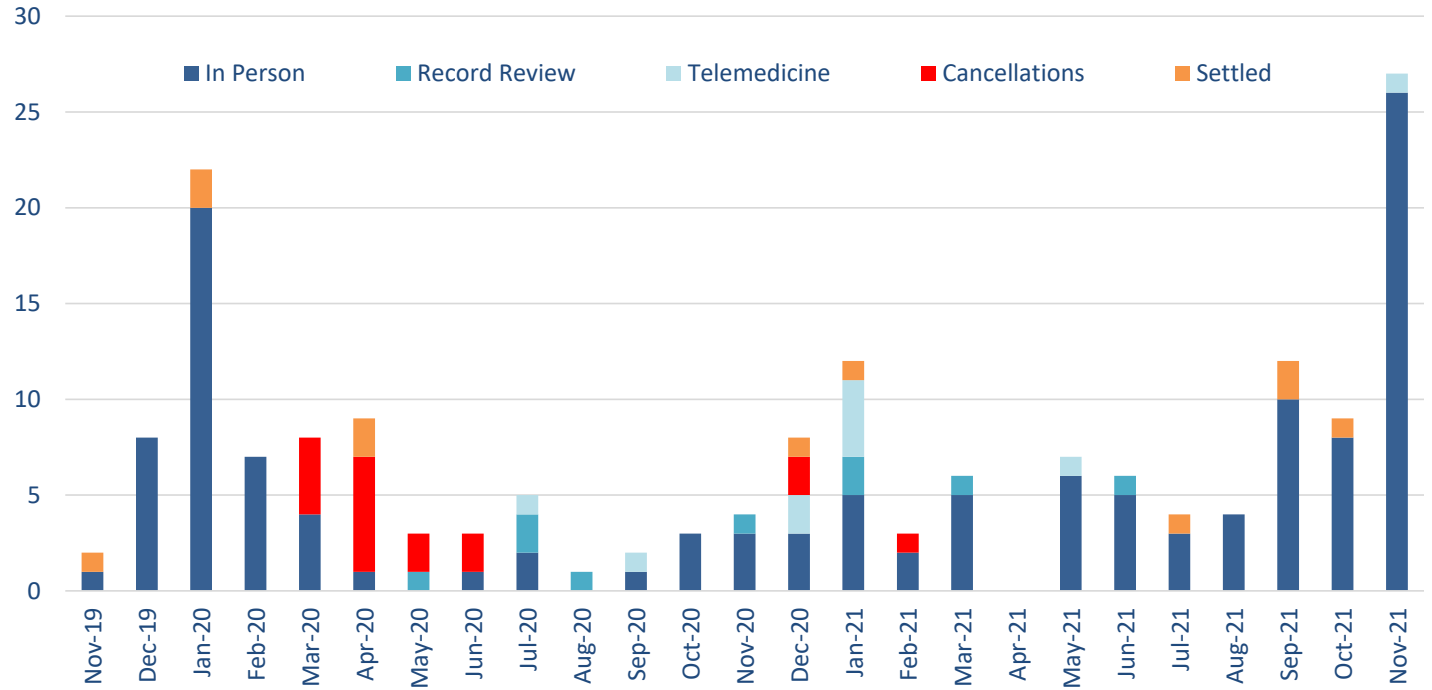
SIMEs and COVID-19

The Covid pandemic has delayed many SIMEs, due to parties' concern about traveling during the pandemic. Most previously delayed cases are now moving forward with SIMEs, and as a result, the board is likely to see an increase in hearing requests in 2022.



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QUESTIONS?

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TAB 8

8 AAC 45.083(a)(6) is amended to read:

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

8 AAC 45.083 is amended by adding a new subsection to read:

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

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

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

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

(10) *Hospital Outpatient Prospective Payment System*, effective January 1, **2022** [2021], produced by the federal Centers for Medicare and Medicaid Services;

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

Authority: AS 23.30.005 AS 23.30.097 AS 23.30.098

8 AAC 45.185(a)(1) is amended to read:

(1) a beneficiary of a [REVOCABLE] trust that owns a corporation or limited liability company; **or**

(Eff. 1/10/2021, Register 237; am ___/___/____, Register ____)

Authority: AS 23.30.005 AS 23.30.240

Official

ALASKA

WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective January 1, 2022

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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Contents

Introduction

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

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

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

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

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

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

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

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

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

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

SCOPE OF PRACTICE LIMITS

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

ORGANIZATION OF THE FEE SCHEDULE

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

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

- Medicine
  - Physical Medicine
- Category II
- Category III
- HCPCS Level II
- Outpatient Facility
- Inpatient Hospital

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

Changes to the Evaluation and Management (E/M) section of codes effective January 1, 2021 are discussed in more detail in the Evaluation and Management section of this fee schedule.

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

PROVIDER SCHEDULE

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

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

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

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

SERVICES BY OUT-OF-STATE PROVIDERS

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

DRUGS AND PHARMACEUTICALS

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

The maximum allowable reimbursement for prescription drugs is as follows:

1. Brand name drugs shall be reimbursed at the manufacturer's average wholesale price plus a $5 dispensing fee;
2. Generic drugs shall be reimbursed at the manufacturer's average wholesale price plus a $10 dispensing fee;
3. Compounded and/or mixed drugs shall be limited

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

HCPCS LEVEL II

Durable Medical Equipment

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

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

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

Ambulance Services

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

OUTPATIENT FACILITY

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

INPATIENT HOSPITAL

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

DEFINITIONS

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

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

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

Board — the Alaska Workers' Compensation Board.

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

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

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

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

Day — a continuous 24-hour period.

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

Drugs — a controlled substance as defined by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Optometrist — an individual licensed to practice optometry.

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

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

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

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

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

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

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

Procedure — a unit of health service.

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

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

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

Prosthesis — an artificial substitute for a missing body part.

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

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

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

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

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

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	1.85	1.118	2.0683
Malpractice RVU x Malpractice GPCI	0.14	0.614	0.08596
Total RVU			3.69926

Data for the purpose of example only

Calculation using example data:

1.03 x 1.500 = 1.545

+ 1.85 x 1.118 = 2.0683

+ 0.14 x 0.614 = 0.08596

= 3.69926

3.69926 x $119.00 (CF) = 440.21194

Payment is rounded to $440.21

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

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

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

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

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

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

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

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

RBRVS Status Codes

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

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

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

Add-on Procedures

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

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

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

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

Exempt from Modifier 51 Codes

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

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

Professional and Technical Components

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

Global Days

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

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

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

XXX Designates services where the global concept does not apply.

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

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

Telehealth Services

Telehealth services are covered and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star ★ icon and in CPT Appendix P. 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 appropriate telephone codes (99441–99443). Telehealth services should be reported with modifier 95 appended.

Supplies and Materials

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

Medical Reports

A medical provider may not charge any fee for completing a medical report form required by the Workers' Compensation Division. A medical provider may not charge a separate fee for medical reports that are required to substantiate the medical necessity of a service. CPT code 99080 is not to be used to complete required workers' compensation insurance forms or to complete required documentation to substantiate medical necessity. CPT code 99080 is not to be used for signing affidavits or certifying medical records forms. CPT code 99080 is appropriate for billing only after receiving a request for a special report from the employer or payer.

In all cases of accepted compensable injury or illness, the injured worker is not liable for payment for any services for the injury or illness.

Off-label Use of Medical Services

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

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

Payment of Medical Bills

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

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

Scope of Practice Limits

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

Board Forms

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

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

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

Applicable HCPCS Modifiers

Modifier AS—Physician Assistant or Nurse Practitioner Assistant at Surgery Services

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

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

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

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

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

Data for the purpose of example only

Modifier TC—Technical Component

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

Modifier QZ—CRNA without medical direction by a physician

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

State-Specific Modifiers

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

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

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

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

Data for the purpose of example only

Evaluation and Management

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

When exact text of the AMA 2021 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 MAR. Telehealth services are identified in CPT with a star ★ icon and in CPT Appendix P. In addition, the Centers for Medicare and Medicaid Services (CMS) has a designated list of covered telehealth services. CPT and CMS guidelines will also be adopted in this fee schedule. Note that many of the services identified by CMS for telehealth have temporary approval during the calendar year of the public health emergency (PHE) and may not be approved services in the next calendar year. Telehealth services should be performed using approved audio/visual methods where available. Telehealth services utilizing telephone only should be reported using the appropriate telephone codes (99441–99443). Telehealth services should be reported with modifier 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 99202-99215

CMS has announced that the CPT E/M code changes and guidelines developed by the American Medical Association (AMA) effective January 1, 2021 will be adopted. This includes deletion of CPT code 99201, changes to the code descriptions of codes 99202–99215 to place emphasis on code selection based on time or a revised medical decision making (MDM) table. History and exam should still be documented but will be commensurate with the level required by the practitioner to evaluate and treat the patient. Prolonged E/M visit will be a covered service with new CPT code 99417 or HCPCS code G2212.

The MDM for codes 99202-99215 is determined using a modified MDM table that includes meeting or exceeding two of the three levels of the elements. The elements in the 2021 MDM table are:

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

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

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

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

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

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

Note that the 2021 E/M MDM table found on CPT pages 16-17 is to be used only for codes 99202-99215. All other E/M codes use the table found on CPT page 12.

Time Element for Codes 99202-99215. CPT codes 99202-99205 and 99212-99215 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 99202-99205 and 99212-99215. Documentation should include notation of the times spent on the date of service.

When time is utilized to select a level of E/M (for codes other than 99202–99215), only the face-to-face time is considered, and the counseling coordination of care must be documented.

E/M Component Guidelines for E/M Services 99217-99350

The changes described for CPT codes 99202–99215 are not applicable to the other E/M services. History, exam, and MDM are the key elements and should be documented.

The first three components (history, examination, and medical decision making) are the keys to selecting the correct level of E/M codes, and all three components must be addressed in the documentation. However, in established, subsequent, and followup categories, only two of the three must be met or exceeded for a given code. CPT guidelines define the following:

1. The history component is categorized by four levels:

   Problem Focused — chief complaint; brief history of present illness or problem.

   Expanded Problem Focused — chief complaint; brief history of present illness; problem-pertinent system review.

   Detailed — chief complaint; extended history of present illness; problem-pertinent system review extended to indicate a review of a limited number of additional systems; pertinent past, family medical, and/or social history directly related to the patient's problems.

   Comprehensive — chief complaint; extended history of present illness; review of systems that is directly related to the problems identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

2. The physical exam component is similarly divided into four levels of complexity:

   Problem Focused — an exam limited to the affected body area or organ system.

   Expanded Problem Focused — a limited examination of the affected body area or organ system and of other symptomatic or related organ system(s).

   Detailed — an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

   Comprehensive — A general multisystem examination or a complete examination of a single organ system.

The CPT book identifies the following body areas:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

The CPT book identifies the following organ systems:

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

3. Medical decision making is the final piece of the E/M coding process, and is somewhat more complicated to determine than are the history and exam components. Three subcomponents must be evaluated to determine the overall complexity level of the medical decision.

   a. The number of possible diagnoses and/or the number of management options to be considered.

   b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed.

   c. The risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

Contributory Components

Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than 50 percent of the time spent). In these cases, time determines the proper code. Document the exact amount of time spent to substantiate the selected code. Also, set forth clearly what was discussed during the encounter. If a physician coordinates care with an interdisciplinary team of physicians or health professionals/agencies without a patient encounter, report it as a case management service.

Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. Per CPT guidelines for office encounters, count only the time spent face-to-face with the patient and/or family; for hospital or other inpatient encounters, count the time spent in the patient's unit or on the patient's floor. The time assigned to each code is an average and varies by physician. **Note**: Time is not a factor when reporting emergency room visits (99281–99285) like it is with other E/M services.

According to the CPT book, "a presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason" for the patient encounter. The CPT book defines five types of presenting problems. These definitions should be reviewed frequently, but remember, this information merely contributes to code selection—the presenting problem is not a key factor. For a complete explanation of evaluation and management services refer to the CPT book.

Subcategories of Evaluation and Management

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

Office or Other Outpatient Services (99202–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary. Support the claim with documentation. The description and requirements for office and other outpatient services were revised beginning in 2021 see detailed information above.

Hospital Observation Services (99218–99220, 99224–99226)

CPT codes 99218-99220 and 99224-99226 report E/M services provided to patients designated or admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The CPT instructional notes for Initial Hospital Observation Care include the following instructions:

- Use these codes to report the encounter(s) by the supervising physician or other qualified health care professional when the patient is designated as outpatient hospital "observation status."
- These codes include initiation of observation status, supervision of the health care plan for observation, and performance of periodic reassessments. To report observation encounters by other physicians, see Office or Other Outpatient Consultation codes (99241–99245) or Subsequent Observation Care (99224–99226).

When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for postrecovery of a procedure that is considered a global surgical service.

Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving observation services, is admitted to the hospital on the same date—the observation service is not reported separately.

Observation Care Discharge Services (99217)

This code reports observation care discharge services. Use this code only if discharge from observation status occurs on a date other than the initial date of observation status. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. If a patient is admitted to, and subsequently discharged from, observation status on the same date, see codes 99234–99236.

Hospital Inpatient Services (99221–99223, 99231–99239)

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

If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.

Codes 99238 and 99239 report hospital discharge day management but exclude discharge of a patient from observation status (see 99217). When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital 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 (99241–99255)

Consultations in the CPT book fall under two subcategories: Office or Other Outpatient Consultations and Initial Inpatient Consultations. For Follow-up

Inpatient Consultations, see Subsequent Hospital Care codes 99231–99233 and Subsequent Nursing Facility Care codes 99307–99310. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both subcategories. The general rules and requirements of a consultation are defined by the CPT book as follows:

- A consultation is "a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem."
- Most requests for consultation come from an attending physician or other appropriate source, and the necessity for this service must be documented in the patient's record. Include the name of the requesting physician on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. A confirmatory consultation requested by the patient and/or family is not reported with consultation codes but should instead be reported using the appropriate office visit codes (99202–99215). A confirmatory consultation requested by the attending physician, the employer, an attorney, or other appropriate source should be reported using the consultation code for the appropriate site of service (Office/Other Outpatient Consultations 99241–99245 or Initial Inpatient Consultations 99251–99255). If counseling dominates the encounter, time determines the correct code in both consultation subcategories.
- 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.

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 (99304–99318)
Nursing facility E/M services have been grouped into three subcategories: Comprehensive Nursing Facility Assessments, Subsequent Nursing Facility Care, and Nursing Facility Discharge Services. Included in these codes are E/M services provided to patients in psychiatric residential treatment centers. These facilities must provide a "24-hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (99324–99337)
These codes report care given to patients residing in a long-term care facility that provides room and board, as well as other personal assistance services. The facility's services do not include a medical component.

Home Services (99341–99350)
Services and care provided at the patient's home are coded from this subcategory. Code selection is based upon new or established patient status and the level of history, exam, and MDM provided. Time may be used to select a level of E/M when counseling or coordination of care dominate the service.

Prolonged Services (99354–99360)
This section of E/M codes includes the three service categories:

Prolonged Physician Service with Direct (Face-to-Face) Patient Contact
These codes report services involving direct (face-to-face) patient contact beyond the usual service, with separate codes for office and outpatient encounters (99354 and 99355) and for inpatient encounters (99356 and 99357). Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

Code 99354 or 99356 reports the first hour of prolonged service on a given date, depending on the place of service, with 99355 or 99357 used to report each additional 30 minutes for that date. 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 example, services lasting one hour and twelve minutes are reported by 99354 or 99356 alone. Services lasting one hour and seventeen minutes are reported by the code for the first hour plus the code for an additional 30 minutes. For codes 99205 and 99215 prolonged services are reported with CPT code 99417 or HCPCS code G2212.

Prolonged Physician Service without Direct (Face-to-Face) Patient Contact
These prolonged physician services without direct (face-to-face) patient contact may include review of extensive records and tests, and communication (other than telephone calls) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service. Use 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

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

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

Case Management Services (99366–99368)
Physician case management is the process of physician-directed care. This includes coordinating and controlling access to the patient or initiating and/or supervising other necessary health care services.

Care Plan Oversight Services (99374–99380)
These codes report the services of a physician providing ongoing review and revision of a patient's care plan involving complex or multidisciplinary care modalities. Only one physician may report this code per patient per 30-day period, and only if more than 30 minutes is spent during the 30 days. Do not use this code for supervision of patients in nursing facilities or under the care of home health agencies unless the patient requires recurrent supervision of therapy. Also, low intensity and infrequent supervision services are not reported separately.

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

Special Evaluation and Management Services (99450, 99455–99456)
This series of codes reports physician evaluations in order to establish baseline information for insurance certification and/or work related or medical disability.

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

99455	10.63
99456	21.25

Other Evaluation and Management Services (99499)
This is an unlisted code to report services not specifically defined in the CPT book.

MODIFIERS

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

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

State-Specific Modifier

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

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

Anesthesia

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

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

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

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

Time for Anesthesia Procedures

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

Calculating Anesthesia Charges

The following scenario is for the purpose of example only:

01382 Anesthesia for arthroscopic procedure of knee joint

Dollar Conversion Unit = $100.00

Base Unit Value = 3

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

Physical Status Modifier Value = 0

Qualifying Circumstances Value = 0

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

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

Anesthesia Supervision

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

Anesthesia Monitoring

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

Other Anesthesia

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

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

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

ANESTHESIA MODIFIERS

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

Physical Status Modifiers

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

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

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

Qualifying Circumstances

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

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

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

Modifiers

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

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

Applicable HCPCS Modifiers

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

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

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

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

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

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

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

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

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

Surgery

GENERAL INFORMATION AND GUIDELINES

Definitions of Surgical Repair

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

BILLING AND PAYMENT GUIDELINES

Global Reimbursement

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

In addition to the surgical procedure, global reimbursement includes:

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

Follow-up Care for Diagnostic Procedures

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

Follow-up Care for Therapeutic Surgical Procedures

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

Additional Surgical Procedure(s)

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

Incidental Procedure(s)

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

Suture Removal

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

Aspirations and Injections

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

Surgical Assistants

For the purpose of reimbursement, physicians who assist at surgery may be reimbursed as a surgical assistant. The surgical assistant must bill separately from the primary physician. Assistant surgeons should use modifier 80, 81,

or 82 and are allowed the lower of the billed charge or 20 percent of the MAR.

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

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

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

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

Data for the purpose of example only

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

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

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

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

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

Data for the purpose of example only

Anesthesia by Surgeon

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

Multiple or Bilateral Procedures

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

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

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

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

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

Example:

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

Data for the purpose of example only

Endoscopic Procedures

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

Example:

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

Data for the purpose of example only

Arthroscopy

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

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific modifiers shall be reimbursed as follows:

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

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

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

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

Applicable HCPCS Modifiers

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

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

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

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

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

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

Data for the purpose of example only

State-specific Modifiers

Modifier PE—Physician Assistants and Advanced Practice Registered Nurses

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

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

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

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

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

Data for the purpose of example only

Radiology

GENERAL INFORMATION AND GUIDELINES

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

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Review of Diagnostic Studies

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

Written Reports

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

Multiple Radiology Procedures

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

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

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

See example below under Reimbursement Guidelines for CPT Modifiers.

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

Specific CPT modifiers shall be reimbursed as follows:

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

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

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

Alaska MAR:

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

Data for the purpose of example only

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

Technical Component:

72142-TC	$998.14	100% of the TC
72147-TC	$495.13	(50% of the TC for the second procedure)
Total	$1,493.27	

Professional Component:

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

Global Reimbursement:

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

Applicable HCPCS Modifiers

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

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

Pathology and Laboratory

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

Example data for CPT code 80500 in the RBRVS with the Alaska GPCI using the non-facility RVUs:

	RVUS	GPCI	SUBTOTAL
Work RVU x Work GPCI	0.37	1.500	0.555
Practice Expense RVU x Practice Expense GPCI	0.25	1.118	0.2795
Malpractice RVU x Malpractice GPCI	0.02	0.614	0.01228
Total RVU			0.84678

Data for the purpose of example only

Calculation using example data:

0.37 x 1.500 = 0.555

+ .25 x 1.118 = 0.2795

+ 0.02 x 0.614 =0.01228

= 0.84678

0.84678 x $122.00 (CF) = 103.30716

Payment is rounded to $103.31

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

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

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

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

BILLING AND PAYMENT GUIDELINES

Professional Component

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

Technical Component

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

Organ or Disease Oriented Panels

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

Drug Screening

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

MODIFIERS

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

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

Specific CPT modifiers shall be reimbursed as follows:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

Medicine

GENERAL INFORMATION AND GUIDELINES

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

BILLING AND PAYMENT GUIDELINES

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

Multiple Procedures

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

See modifier section below for examples of the reduction calculations.

Separate Procedures

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

Materials Supplied by Physician

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

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

Telehealth Services

Telehealth services are covered and reimbursed at the lower of the billed amount or MAR. Telehealth services are identified in CPT with a star ★ icon and in CPT Appendix P. 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 appropriate telephone codes (99441–99443). Telehealth services should be reported with modifier 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

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.

CPT code 64550 has been deleted. There is no replacement other than physical therapy codes.

Publications, Books, and Videos

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

Functional Capacity Evaluation

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

Work Hardening

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

97545	3.41
97546	1.36

Osteopathic Manipulative Treatment

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

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

Chiropractic Manipulative Treatment

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

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

upper extremities; rib cage (excluding costotransverse and costovertebral joints); and abdomen.

- Chiropractors may report codes 97014, 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943.

MODIFIERS

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

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

Reimbursement Guidelines for CPT Modifiers

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

Specific modifiers shall be reimbursed as follows:

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

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

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

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

Alaska MAR:

93303	$647.29
93303-TC	$448.18
93303-26	$199.11
93351	$673.25
93351-TC	$405.34
93351-26	$267.91

Data for the purpose of example only

Technical Component:

93303-TC	$448.18	100% of the TC
93351-TC	$304.01	(75% of the TC for the second procedure)
Total	$752.19	

Global Reimbursement:

93303	$647.29	100%
93351	$571.92	(75% of the TC for the second procedure + 100% of the 26) ($304.01 + $267.91 = $571.92)
Total	$1,219.21	

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

Alaska MAR:

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

Data for the purpose of example only

Technical Component:

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

Global Reimbursement:

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

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

Alaska MAR:

97016	$36.40
[(.18 x 1.5) + (.16 x 1.118) + (0.01 x .0.614)] x 80	
97024	$20.21
[(.06 x 1.5) + (.14 x 1.118) + (0.01 x .0.614)] x 80	

Data for the purpose of example only

The reduced MAR for multiple procedure rule:

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

Example:

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

Applicable HCPCS Modifiers

TC Technical Component

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

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

Category II

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

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

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

Category III

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

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

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

CATEGORY III MODIFIERS

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

HCPCS Level II

GENERAL INFORMATION AND GUIDELINES

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

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

MEDICARE PART B DRUGS

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

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

DURABLE MEDICAL EQUIPMENT

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

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

Hearing Aids

The patient must be referred by a physician for evaluation and dispensing of hearing aids. Initial or replacement dispensing of hearing aids includes one year of follow-up care including all evaluations, tests, adjustments, repairs, or reprogramming of the hearing aids. New hearing aids may be dispensed 1) once every four years or 2) when new medical evaluation by a physician and testing documents changes necessitate a new device prescription as related to the work-related injury or 3) replacement of a nonworking device that is no longer covered by warranty. Repairs will not be paid when a device is still under the manufacturer's warranty. An evaluation and management service shall not be billed at the time of any hearing aid evaluations or testing. The dispensing of hearing aids is reported with the appropriate HCPCS Level II codes and a copy of the manufacturer/supplier's invoice. Reimbursement for hearing aids is the lower of the manufacturer/supplier's invoice cost plus 30 percent or billed charges including testing, dispensing and fitting cost. CPT/HCPCS codes 92630, 92633, V5011, V5090, V5110, V5160, V5240, and V5241 are not separately reimbursed services.

Hearing Aid Services

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

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

MODIFIERS

Applicable HCPCS modifiers found in the DMEPOS fee schedule include:

NU New equipment

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

UE Used durable medical equipment

AMBULANCE SERVICES

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

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

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

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

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

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

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

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

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

Outpatient Facility

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

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

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

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

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

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance services • Separately payable clinical diagnostic laboratory services • Separately payable non-implantable prosthetic and orthotic devices • Physical, occupational, and speech therapy • Diagnostic mammography • Screening mammography	Not paid under OPPS. See the appropriate section under the provider fee schedule.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. *Alaska Specific Guideline: May be performed in the outpatient or ASC setting if beneficial to the patient and as negotiated by the payer and providers. Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
D	Discontinued codes	Not paid under OPPS.
E1	Items, codes and services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary	Not paid under OPPS. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.* *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
E2	Items and services for which pricing information and claims data are not available	Not paid under OPPS. Status may change as data is received by CMS. *Alaska Specific Guideline: Payment is the lowest of 85 percent of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.*
F	Corneal tissue acquisition; certain CRNA services, and hepatitis B vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through drugs and biologicals	Paid under OPPS; separate APC payment includes pass-through amount.
H	Pass-through device categories	Separate cost-based pass-through payment. *Alaska Specific Guideline: A payer shall subtract implantable hardware from a hospital outpatient clinic's or ambulatory surgical center's billed charges and pay separately at manufacturer or supplier invoice cost plus 10 percent.*
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPSI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
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. (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.

INDICATOR	ITEM/CODE/SERVICE	OP PAYMENT STATUS/ ALASKA SPECIFIC GUIDELINE
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radio pharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza vaccine; pneumococcal pneumonia vaccine; Covid-19 Vaccine, Monoclonal Antibody Therapy Product	Not paid under OPPS. Paid at reasonable cost.
M	Items and services not billable to the Medicare Administrative Contractor (MAC)	Not paid under OPPS.
N	Items and services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services, including outliers. 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 date of service as a HCPCS code assigned OPSI of S, T, or V. (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
Q2	T packaged codes	Paid under OPPS; addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned OPSI T. (2) In other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS; addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments. (1) Composite APC payment on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS or Clinical Laboratory Fee Schedule (CLFS). (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published OPSI J1, J2, S, T, V, Q1, Q2, or Q3. (2) In other circumstances, laboratory tests should have an OPSI = A and payment is made under the CLFS.
R	Blood and blood products	Paid under OPPS; separate APC payment.
S	Procedure or service, not discounted when multiple	Paid under OPPS; separate APC payment.
T	Procedure or service, multiple reduction applies	Paid under OPPS; separate APC payment. *Alaska Specific Guideline: Two or more medical procedures with a status indicator code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classification's calculated amount and all other status indicator code T items paid at 50 percent.*
U	Brachytherapy sources	Paid under OPPS; separate APC payment.
V	Clinic or emergency department visit	Paid under OPPS; separate APC payment.
Y	Non-implantable durable medical equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to a DME MAC.

SURGICAL SERVICES

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

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

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

DRUGS AND BIOLOGICALS

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

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

EQUIPMENT, DEVICES, APPLIANCES, AND SUPPLIES

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

Example:

- Syringe for drug administration
- Patient gown
- IV pump

SPECIALTY AND LIMITED-SUPPLY ITEMS

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

Example:

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

USE OF OUTPATIENT FACILITY AND ANCILLARY SERVICES

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

NURSING AND RELATED TECHNICAL PERSONNEL SERVICES

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

SURGICAL DRESSINGS, SPLINTING, AND CASTING MATERIALS

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

Inpatient Hospital

GENERAL INFORMATION AND GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

Example of Implant Outlier:

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

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

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

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

EXEMPT FROM THE MS-DRG

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

SERVICES AND SUPPLIES IN THE FACILITY SETTING

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

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

PREPARING TO DETERMINE A PAYMENT

The CMS IPPS Web Pricer is normally available on the CMS web site one to two months after the Inpatient Prospective Payment System rule goes into effect each October 1. The version that is available on January 1, 2022 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

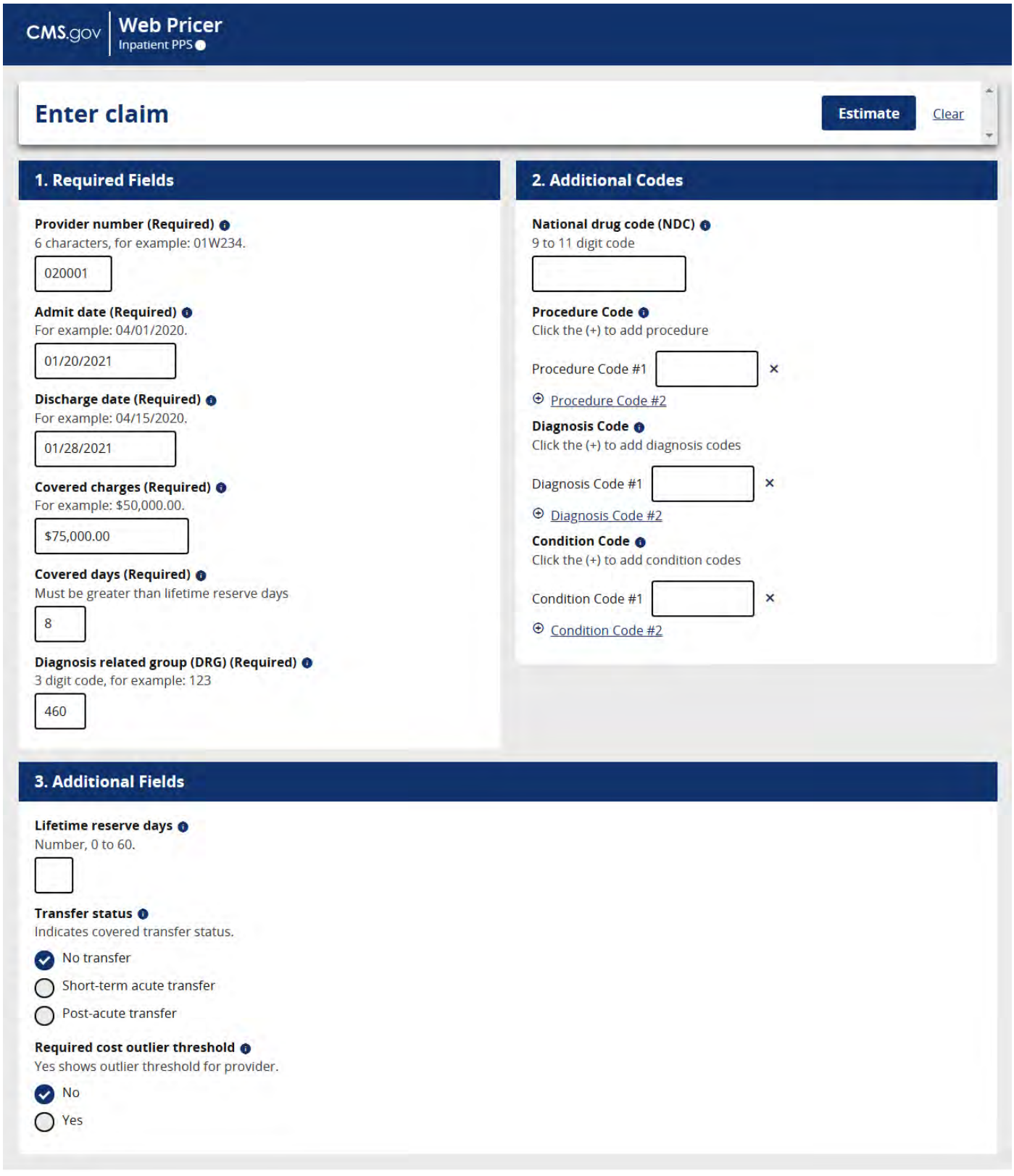
Third-party vendors such as Optum, 3M, and others also have software available which will assign the MS-DRG to the claim.

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

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

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

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


CMS.gov
Web Pricer
Inpatient PPS
Enter claim
Estimate
Clear
1. Required Fields
Provider number (Required)
6 characters, for example: 01W234.
020001
Admit date (Required)
For example: 04/01/2020.
01/20/2021
Discharge date (Required)
For example: 04/15/2020.
01/28/2021
Covered charges (Required)
For example: $50,000.00.
$75,000.00
Covered days (Required)
Must be greater than lifetime reserve days
8
Diagnosis related group (DRG) (Required)
3 digit code, for example: 123
460
2. Additional Codes
National drug code (NDC)
9 to 11 digit code
Procedure Code
Click the (+) to add procedure
Procedure Code #1
Procedure Code #2
Diagnosis Code
Click the (+) to add diagnosis codes
Diagnosis Code #1
Diagnosis Code #2
Condition Code
Click the (+) to add condition codes
Condition Code #1
Condition Code #2
3. Additional Fields
Lifetime reserve days
Number, 0 to 60.
Transfer status
Indicates covered transfer status.
No transfer
Short-term acute transfer
Post-acute transfer
Required cost outlier threshold
Yes shows outlier threshold for provider.
No
Yes

The IPPS Web Pricer instructions are included below:

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

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

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

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

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

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

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

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

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

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

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

CONDITION CODE – Enter the condition code when required

LIFETIME RESERVE DAYS – not required to be entered.

TRANSFER STATUS – Select the correct option from

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

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

REQUIRED COST OUTLIER THRESHOLD – Enter 'N' (or tab) if the cost outlier threshold is not applicable for the claim. For the cost outlier threshold, enter 'Y.'

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

Review results

Edit Claim Clear

Summary

Return code	**14**
Key claim information	
Provider number	020001
Effective date	12/02/2020
Diagnosis related group (DRG)	460
Claim estimate	
Claim estimate with provider adjustments	$35,534.13
Outlier calculation	$0.00
Grand total amount	**$35,534.13**

The estimate is based on submitted claim info

↓ Download CSV

Provider details

Provider type	00
Geographic CBSA	11260
Reclass CBSA	

Capital amounts

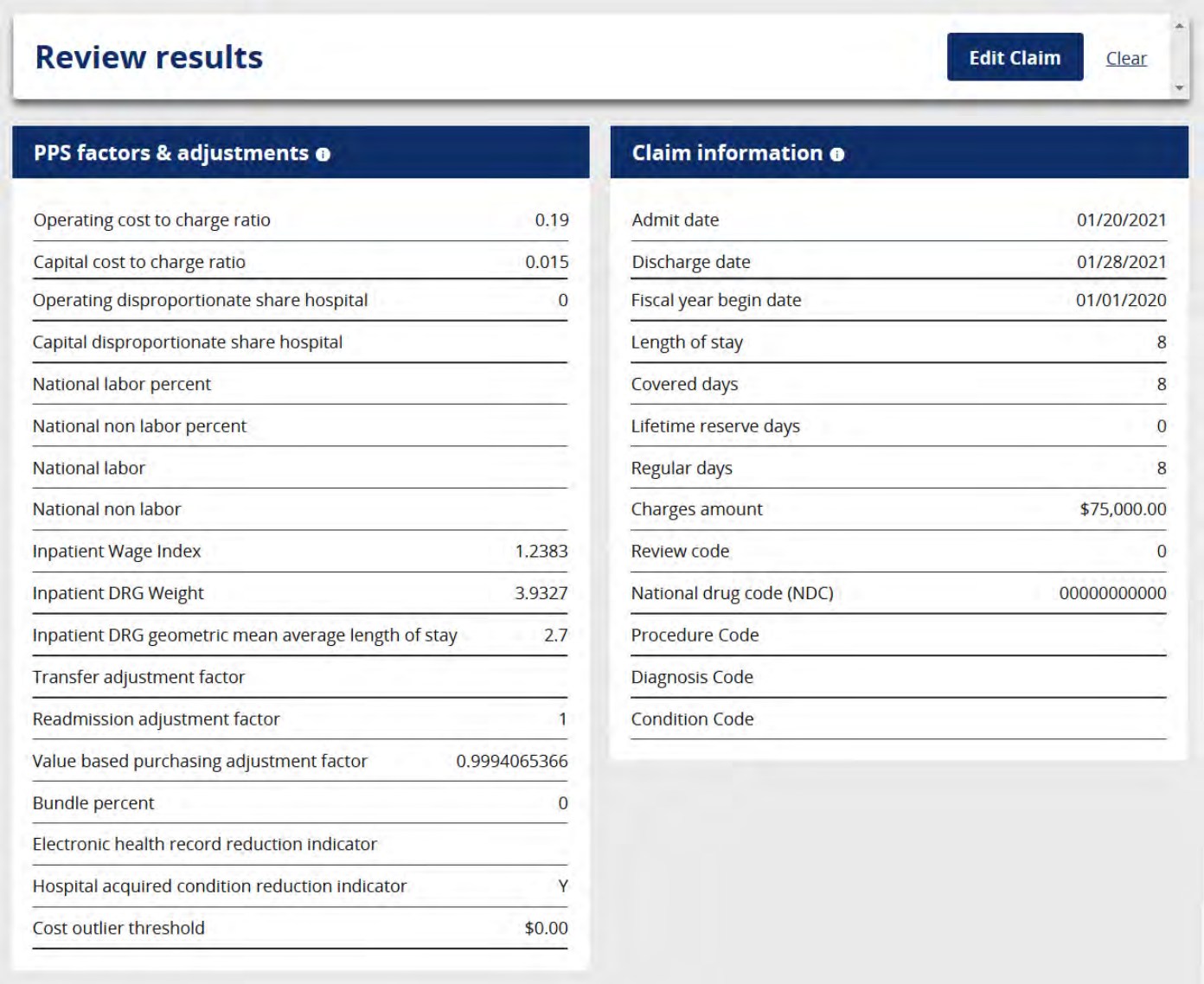
Capital federal specific portion	$2,290.07
Capital outlier	$0.00
Capital disproportionate share hospital	$225.34
Capital indirect medical education	$51.43

Operating amounts

Operating federal specific portion	$29,117.71
Operating hospital specific payment	$0.00
Operating outlier	$0.00
Operating disproportionate share hospital	$1,998.20
Operating indirect medical education	$844.72
Uncompensated care	$1,382.87
Readmission adjustment	$0.00
Value based purchasing adjustment	$-17.28
New technology	$0.00

Other PPS amounts

Hospital acquired condition adjustment	$-358.93
Low volume	$0.00
Islet add on	$0.00
Electronic health record adjustment	$0.00
Bundle adjustment	$0.00
Medicare Advantage hospital specific payment	
Total pass through & miscellaneous	**$16.07**
Pass through amount capital	$0.00
Pass through amount direct	$16.07
Pass through amount organ	$0.00



A Note on Pass-through Payments in the IPPS Web Pricer

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

Pass-through estimates should be included when determining the Alaska workers' compensation payment.

Determining the Final Maximum Allowable Reimbursement (MAR)

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

CMS IPPS Web Pricer Grand Total Amount	$35,534.13
Multiplied by Providence Alaska Medical Center multiplier	x 2.38
Alaska Workers' Compensation Payment	$84,571.23

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.