8 AAC 45.020(c) is amended to read:

(c) Papers and documents may [WILL] be filed **in person** at **any of** the division's **offices,** [OFFICE] **by mail, by facsimile transmission, or by electronic mail.** [OR AT ANY OPEN HEARING AS OF THE DATE OF RECEIPT].

8 AAC 45.020 is amended by adding a new subsection to read:

(d) Papers and documents filed by facsimile transmission, or by electronic mail shall be in compliance with Department of Labor and Workforce Development Commissioner's Order No. 001, dated April 23, 2015. (In effect before 7/28/59; am 5/28/83, Register 86; am __/__/____, Register ___)

**Authority:** AS 23.30.005

**Editor's note:** DOLWD Commissioner's Order No. 001 may be found at https://aws.state.ak.us/OnlinePublicNotices/Default.aspx. Filing by electronic mail shall be sent to workerscomp@alaska.gov. Filing in person, by mail and by facsimile should be directed to the respective division offices as follows:

Juneau Office
P.O. Box 115512, Juneau AK 99811-5512
1111 W 8th St, Rm 305, Juneau AK 99801
Fax: (907) 465-2797

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

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

8 AAC 45.032 is amended to read:

**8 AAC 45.032. Files.** Upon receiving written notice of an injury, the division will

(1) **establish an [**SET UP A COMPUTER RECORD OF THE EMPLOYEE'S INJURY WITH A COMPUTER] injury number;

(2) set up a case file **in a format prescribed by the director**, using the [COMPUTER] injury number;

(3) notify the employee or beneficiary, the employer, and the insurer in writing **in a format prescribed by the director** of the injury number;

(4) put the written notice of the injury in the case file together with documents or anything relating to the employee's injury that is filed with the division or board; and

(5) use the [COMPUTER] injury number as the claim number if a claim is filed. (Eff. 7/20/97, Register 143; am 2/27/2000, Register 153; am ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.100 AS 23.30.105
AS 23.30.070

8 AAC 45.060(b) is amended to read:

(b) A party **may** [SHALL] file a document with the board, other than the annual report under AS 23.30.155(m), [EITHER] personally**,** [OR] by mail, **or by electronic filing through facsimile transmission or electronic mail in compliance with Department of Labor and Workforce Development Commissioner's Order No. 001, dated April 23, 2015**[THE BOARD WILL NOT ACCEPT ANY OTHER FORM OF FILING]. Except for a claim, a party shall serve a copy of a document filed with the board upon all parties or, if a party is represented, upon the party's representative. Service must be done[, EITHER] personally, by facsimile, **by**

**electronic mail,** [ELECTRONICALLY,] or by mail, in accordance with due process. Service by mail is complete at the time of deposit in the mail if mailed with sufficient postage and properly addressed to the party at the party's last known address. If a right may be exercised or an act is to be done, three days must be added to the prescribed period when a document is served by mail. (In effect before 7/28/59; am 5/28/83, Register 86; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.100 AS 23.30.135

**Editor's note:** DOLWD Commissioner's Order No. 001 may be found at https://aws.state.ak.us/OnlinePublicNotices/Default.aspx. Filing by electronic mail shall be sent to workerscomp@alaska.gov. Filing in person, by mail and by facsimile should be directed to the respective division offices as follows:

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

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

8 AAC 45.082(*l*)(2) is repealed:

(2) repealed ____/____/_____;

8 AAC 45.082(m) is amended to read:

(m) A fee or other charge for medical treatment or service provided on or after December 31, 2010, **but before December 1, 2015,** may not exceed the board's fees established in the *Official Alaska Workers' Compensation Medical Fee Schedule*, effective December 31, 2010, and adopted by reference. (Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 7/1/88, Register 107; am 10/28/88, Register 108; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 2/3/2001, Register 157; am 7/31/2010, Register 195; am 12/31/2010, Register 196; am 6/27/2011, Register 199; am 7/9/2011, Register 199; am 11/20/2011, Register 200; am 3/28/2012, Register 201; am ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.045 AS 23.30.097
AS 23.30.030 AS 23.30.095

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

**8 AAC 45.083. Fees for medical treatment and services.** (a) A fee or other charge for medical treatment or service provided on or after December 1, 2015, may not exceed the fee schedules set out in this section.

(b) For medical services provided by physicians under the Alaska Workers' Compensation Act, the following conversion factors shall be applied to the total facility or non-facility Relative Value Unit (RVU) in the *Resource-Based Relative Value Scale*, established by the Centers for Medicare and Medicaid Services (CMS), as amended, in effect at the time of treatment or service. Medical service or treatment shall be identified by a code assigned to that treatment or service in the latest edition of the *Current Procedural Terminology* (CPT), published by the American Medical Association (AMA), as amended.

(1) The conversion factor for evaluation & management is 80.

(2) The conversion factor for medicine (excluding anesthesiology) is 80.

(3) The conversion factor for surgery is 205.

(4) The conversion factor for radiology is 257.

(5) The conversion factor for pathology and laboratory is 142.

(6) The relative value for CPT code 97545 shall be 3.41, and the relative value for CPT code 97546 shall be 1.36.

(c) The conversion factor for anesthesiology is 121.82, which is to be multiplied by the base and time units for each CPT code established in the *Relative Value Guide,* as amended, published by the American Society of Anesthesiologists.

(d) For supplies, materials, injections, and other services and procedures coded under the *Healthcare Common Procedure Coding System* (HCPCS), the following multipliers shall be applied to the fee schedules established by CMS, as amended, in effect at the time of treatment or service.

(1) Pathology & Clinical Lab CMS x 6.33.

(2) Durable Medical Equipment CMS x 1.84.

(3) Average Sale Price CMS x 3.375.

(e) For medical services provided by inpatient hospitals under the Alaska Workers' Compensation Act, the following conversion factors shall be applied to the *Medicare Severity Diagnosis Related Groups* (MS-DRG) weight established by the Centers for Medicare and Medicaid Services (CMS), as amended, in effect at the time of treatment or service.

(1) The maximum allowable reimbursement for medical services provided by a critical access hospital, rehabilitation hospital, or long term acute care hospital is the lower 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.

(2) The conversion factor for Providence Alaska Medical Center is 17,085.40.

(3) The conversion factor for Mat-Su Regional Medical Center is 15,326.64.

(4) The conversion factor for Bartlett Regional Hospital is 14,615.18.

(5) The conversion factor for Fairbanks Memorial Hospital is 15,972.59.

(6) The conversion factor for Alaska Regional Hospital is 15,413.63.

(7) The conversion factor for Yukon Kuskokwim Delta Regional Hospital is 28,315.11.

(8) The conversion factor for Central Peninsula General Hospital is 14,385.49.

(9) The conversion factor for Alaska Native Medical Center is 22,681.05.

(10) The conversion factor for Mt Edgecumbe Hospital is 19,621.32.

(11) On outlier cases, implants shall be paid at invoice plus 10 percent.

(f) For medical services provided by outpatient clinics or ambulatory surgical centers under the Alaska Workers' Compensation Act, an outpatient conversion factor of 221.79 shall be applied to the relative weights established for each CPT or *Ambulatory Payment Classifications* (APC) code by the Centers for Medicare and Medicaid Services (CMS), as amended, in effect at the time of treatment or service. For procedures performed in an outpatient setting, implants shall be paid at invoice plus 10 percent.

(g) The maximum allowable reimbursement for medical services that do not have current CMS, CPT, or HCPCS codes, a currently assigned CMS relative value, or an established conversion factor shall be the lower 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.

(h) The maximum allowable reimbursement for prescription drugs is as follows:

(1) Brand name drugs shall be reimbursed at the manufacturer's Average Wholesale Price (AWP) plus a $5 dispensing fee.

(2) Generic drugs shall be reimbursed at manufacturer's AWP plus a $10 dispensing fee.

(3) Reimbursement for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's AWP for each drug included in the compound (listed separately by NDC) plus a $10 compounding fee.

(i) The maximum allowable reimbursement for air ambulance services is as follows:

(1) Reimbursement for a fixed wing lift off fee shall not exceed $11,500.

(2) Reimbursement for a fixed wing air mile rate shall not exceed 400 percent of the CMS fee schedule rate, as amended, in effect at the time of service.

(3) Reimbursement for a rotary wing lift off fee shall not exceed $13,500.

(4) Reimbursement for a rotary wing air mile rate shall not exceed 400 percent of the CMS fee schedule rate, as amended, in effect at the time of service.

(j) The following billing and payment rules shall apply for medical treatment or services provided by physicians.

(1) Providers and payers shall follow the billing and coding rules, as amended, in effect at the time of treatment, as established by CMS and the AMA, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Specific modifiers shall be reimbursed as follows:

(2) Modifier 50: Reimbursement shall be 100 percent of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU. Reimbursement shall be 50 percent of the fee schedule amount or the lesser of the billed charge for the procedure for the second and all subsequent procedures.

(3) Modifier 51: Reimbursement shall be 100 percent of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU rendered during the same session as the primary procedure. Reimbursement shall be 50 percent of the fee schedule amount or the lesser of the billed charge for the procedure with the second highest RVU and all subsequent procedures during the same session as the primary procedure.

(4) Modifiers 80, 81, and 82: Reimbursement shall be 20 percent of the surgical procedure.

(5) Modifier PE: Reimbursement shall be 85 percent of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants or an advanced practice registered nurse.

(6) Modifier AS: Reimbursement shall be 15percent of the value of the procedure. State specific modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.

(7) Modifier QZ: Reimbursement shall be 85 percent of the value of the anesthesia procedure. State specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.

(8) Providers and payers shall follow National Correct Coding Initiative edits established by the Centers Medicare and Medicaid Services and the American Medical Association, as amended, in effect at the time of treatment. When there is a billing rule

discrepancy between NCCI edits and AMA CPT Assistant, AMA CPT Assistant guidance governs.

(k) The following billing and payment rules shall apply for medical treatment or services provided by inpatient hospitals, outpatient clinics, and ambulatory surgical centers.

(1) Medical services for which there is no APC weight listed shall be the lower 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 codes C, E, and P shall be the lower 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 code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the APC calculated amount and all other status code T items paid at 50 percent.

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

(5) When total costs for a hospital inpatient MS-DRG coded service exceeds the CMS outlier threshold established at the time of service plus Medicare's MS-DRG payment, then the total payment for that service shall be calculated using the CMS Inpatient PC Pricer tool as follows:

(A) Implantable charges, if applicable, are subtracted from the total amount charged.

(B) The charged amount from (a) is entered into the most recent version of the CMS PC Pricer tool at the time of treatment.

(C) The Medicare price returned by the CMS PC Pricer tool is multiplied by 2.5, or 250 percent of the Medicare price.

(D) The allowable implant reimbursement, if applicable, is the invoice cost of the implant(s) plus 10 percent, or 110 percent of invoice cost.

(E) The amounts calculated in (c) and (d) are added together to determine the final reimbursement.

(*l*) For medical treatment or services provided by other providers, the maximum allowable reimbursement for medical services provided by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers, shall be the lower 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.

(m) The following material is incorporated by reference:

(1) *Current Procedural Terminology Codes*, produced by the American Medical Association, as may be amended.

(2) *Healthcare Common Procedure Coding System*, produced by the American Medical Association, as may be amended.

(3) *International Classification of Diseases*, published by the American Medical Association, as may be amended.

(4) *Relative Value Guide*, produced by the American Society of Anesthesiologists, as may be amended.

(5) *Diagnostic and Statistical Manual of Mental Disorders*, produced by the American Psychiatric Association, as may be amended.

(6) *Current Dental Terminology*, published by the American Dental Association, as may be amended.

(7) *Resource-Based Relative Value Scale*, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(8) *Ambulatory Payment Classifications*, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(9) *Medicare Severity Diagnosis Related Groups*, produced by the federal Centers for Medicare and Medicaid Services, as may be amended.

(n) In this section, "maximum allowable reimbursement" means the charge for medical treatment or services calculated in accordance with the fee schedule. (Eff. ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.097 AS 23.30.098

**Editor's note:** The above-referenced materials may be found at: Department of Labor and Workforce Development, Division of Workers' Compensation at 1111 W 8th St., Suite 305 Juneau, Alaska 99811

8 AAC 45.530(a) is amended to read:

(a) Within 14 days after receiving a rehabilitation specialist's eligibility evaluation report for an employee injured on or after July 1, 1988, the administrator will determine whether the employee is eligible or ineligible for reemployment benefits, or that insufficient information exists to make a determination on the employee's eligibility for reemployment benefits. The

administrator will give the parties written notice by **first class** [CERTIFIED] mail of the determination, the reason for the determination, and how to request review by the board of the determination. (Eff. 7/20/97, Register 143; am 7/2/98, Register 146; am 7/9/2011, Register 199; am ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.041

8 AAC 45.550(c) is amended to read:

(c) If the employee and the employer fail to agree to the reemployment plan written under (a)(8) of this section, either party may request the administrator to review and approve the plan. Within 14 days after the administrator receives the plan for review, the administrator will

(1) approve the plan and notify the parties by **first class** [CERTIFIED] mail;

(2) deny the plan and notify the parties by **first class** [CERTIFIED] mail; or

(3) notify the parties that the plan is incomplete and request additional information from the parties before making a decision on the plan.

8 AAC 45.550(d) is amended to read:

(d) If the administrator requests additional information, the administrator will make a decision within 14 days after the additional information is received, and notify the parties by **first class** [CERTIFIED] mail. (Eff. 7/2/98, Register 146; am 7/9/2011, Register 199; am ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.041

8 AAC 45.900(a) is amended by adding a new section to read:

(15) Unless the statutory context requires otherwise, "provider" means any physician, pharmacist, dentist, or other health service worker or any hospital, clinic, or other facility licensed under AS 08 to furnish medical or dental services, including chiropractic, physical therapy, and mental health services, and includes an out-of-state person or facility that meets the requirements of this section and is otherwise qualified to be licensed under AS 08.

(Eff. 5/28/83, Register 86; am 12/14/86, Register 100; am 7/1/88, Register 107; am 3/16/90, Register 113; am 7/20/97, Register 143; am 7/2/98, Register 146; am 4/16/2010, Register 194; am 12/22/2011, Register 200; am ____/____/_____, Register _____)

**Authority:** AS 23.30.005 AS 23.30.090 AS 23.30.230
AS 23.30.030 AS 23.30.175 AS 23.30.240
AS 23.30.041 AS 23.30.220 AS 23.30.395
AS 23.30.097