

DEPARTMENT OF HEALTH & SOCIAL SERVICES



PROPOSED CHANGES TO REGULATIONS

MEDICAID DENTAL SERVICES COVERAGE AND PAYMENT

- 7 AAC 110. Medicaid Coverage; Professional Services.
- 7 AAC 140. Medicaid Coverage; Facility and Facility-Based Services.
- 7 AAC 145. Medicaid Payment Rates.
- 7 AAC 160. Medicaid Program; General Provisions.



PUBLIC REVIEW DRAFT

February 1, 2021.

COMMENT PERIOD ENDS: March 15, 2021

Please see the public notice for details about how to
comment on these proposed changes.

Notes to reader:

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.
2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.
3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.
4. When the word “including” is used, Alaska Statutes provide that it means “including, but not limited to.”
5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

Title 7 Health and Social Services.**Chapter 110. Medicaid Coverage; Professional Services.**

7 AAC 110.145 is repealed and readopted to read:

7 AAC 110.145. Dental services for adults. (a) Payment for emergent dental services is limited to procedures identified in the Fee Schedule: Emergent Adult Dental Services, adopted by reference in 7 AAC 160.900. Payment for emergent dental services covered under this subsection does not reduce a recipient's annual limit under (b) and (c) of this section. Except as specifically excluded under (g) of this section, the department will pay for the following emergent dental services for recipients 21 years of age or older:

(1) the following dental services for the immediate relief of pain or acute infection:

- (A) limited oral evaluation not more than two times per fiscal year;
- (B) extractions if authorized by the department;
- (C) one intraoral periapical film to determine if an extraction is necessary;
- (D) anesthesia or sedation in accordance with 7 AAC 110.155 and

necessary for dental services covered under this section; a claim submitted to the department for

payment of costs for general anesthesia must be accompanied by written medical justification for the service;

(2) a dental service that exceeds a limit established in (b) and (c) of this section if the department determines, based on medical justification submitted with a prior authorization request, that a delay in the provision of the service will endanger the life of the recipient.

(b) Subject to appropriation under AS 47.07.067, payment for enhanced adult dental services is limited to procedures identified in the Fee Schedule: Enhanced Adult Dental Services, adopted by reference in 7 AAC 160.900. Except as specifically excluded under (g) of this section, the department will pay up to \$1,150 per state fiscal year for the following dental services provided to a recipient 21 years of age or older:

(1) periodic or comprehensive oral evaluation not more than one time per fiscal year, panoramic radiographs not more than one time per a fiscal year and other dental radiographs necessary for dental care;

(2) preventive care, including

(A) prophylaxis, including necessary scaling, polishing, and instructions on oral hygiene and diet, not more than two times per fiscal year; and

(B) topical application of fluoride not more than four times per fiscal year, or topical fluoride varnish not more than four times per fiscal year, or a combination of topical application of fluoride and fluoride varnish not more than four times per fiscal year;

(3) restorative care for the treatment of decayed or fractured teeth, including amalgams and resins, and crowns if the tooth cannot be restored with amalgams or resin;

(A) crowns must be authorized by the department;

(B) all surfaces restored on a single tooth on the same day are considered connected therefore payment is limited to one single or multi surface restoration code per tooth per day;

(C) final restorations are limited to not more than five surfaces per tooth; tooth preparation, temporary restorations, sedative and cement bases, and local anesthesia are considered components of a complete restorative procedure and may not be billed separately;

(D) the department will provide payment for crowns only upon seatment of the permanent crown, and for partials and dentures only upon seatment of the appliance; the department will not provide partial payment for incomplete or in-progress dental services.

(4) endodontics, with the following limitations:

(A) palliative and sedative treatments may not exceed two times per tooth before a definitive treatment;

(B) root canal therapy; tooth preparation, temporary filling of the root canal, and follow-up care are considered components of a complete root canal and may not be billed separately;

(C) a separate claim in addition to a root canal claim may be made for pin retention and restoration, and may not exceed five surfaces per tooth;

(5) periodontics, including treatment of pain or acute infection of supporting tissues of the teeth, including gingivitis, periodontitis, and periodontal abscess;

(6) oral surgery;

(A) extractions must be authorized by the department;

(B) local anesthesia, materials, and routine postoperative care are considered components of a complete surgical procedure and may not be billed separately;

(7) professional consultation, if medically necessary or if requested by the department.

(c) Payment for prosthodontic services is limited to procedures identified in the Fee Schedule: Prosthodontic Adult Dental Services, adopted by reference in 7 AAC 160.900. Prosthodontic services must be authorized by the department. Except as specifically excluded under (g) of this section, the department will pay up to \$1,150 per state fiscal year for prosthodontic services provided to a recipient 21 years of age or older, and up to twice the annual limit if one annual limit is not adequate to cover the cost of the provision of upper and lower dentures at the same time. If the department authorizes use of up to twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year limit. In the succeeding fiscal year, the recipient is not authorized a new or additional annual limit. Covered prosthodontic services are limited to:

- (1) complete denture, maxillary;
- (2) complete denture, mandibular;
- (3) partial denture, maxillary;
- (4) partial denture; mandibular;

(5) replacement of a complete or partial dentures only if the existing denture is unusable and only once per five years, unless the department determines, based on medical justification submitted with the prior authorization request, that a delay of dentures will endanger the life of the recipient;

(6) replacement of a partial denture with a complete denture not earlier than five years after payment for the partial denture, unless the department determines, based on

medical justification submitted with the prior authorization request, that a delay of dentures will endanger the life of the recipient;

(7) denture within the same dental arch no more than three times per lifetime, unless the department determines, based on medical justification submitted with the prior authorization request, that a delay of dentures will endanger the life of the recipient;

(8) adjustments to complete or partial dentures not earlier than six months following the seatment date of the denture and not more than four times per fiscal year; and

(9) rebase and reline procedures of a complete or partial denture not earlier than six months following the seatment date of the denture and not more than once per three fiscal years;

(d) The cost of anesthesia or sedation in accordance with 7 AAC 110.155 and necessary for dental services covered under this section does not reduce the recipient's annual limit described in (b) and (c) of this section.

(e) A dental service provided after a recipient's annual limit under (b) and (c) of this section has been exhausted is considered a non-covered service and the department will not provide payment. Notwithstanding 7 AAC 145.015, a provider may bill a recipient for the difference under (b) and (c) of this section if the unused portion of a recipient's annual limit is less than the allowable Medicaid payment rate, or under (b) and (c) of this section if the unused portion of the recipient's combined annual limit is less than the allowable Medicaid payment rate. A provider shall inform a recipient in advance of the recipient's obligation to pay the difference. The provider shall document in the recipient's records that the recipient was informed of and agreed to pay for any balance above the annual limit for the service provided.

(f) The department will assist a provider and recipient to the extent possible in monitoring the recipient's annual limit. However, the department will not assume financial responsibility for dental services provided that exceed the recipient's annual limit.

(g) The department will not pay for the following dental services provided to a recipient 21 years of age or older:

(1) dental services not identified in the Fee Schedule: Emergent Adult Dental Services, the Fee Schedule: Enhanced Adult Dental Services, and the Fee Schedule: Prosthodontic Adult Dental Services, adopted by reference in 7 AAC 160.900;

(2) behavior management;

(3) pulp capping;

(4) endodontic apical surgery and retrograde fillings;

(5) immediate, interim, and temporary dentures;

(6) dental implant and implant-related dental services;

(7) inlays, overlays, and three-fourth crowns;

(8) restoration of etched enamel or deep grooves without obvious dentin involvement;

(9) space maintainers;

(10) tobacco counseling, which is considered a component of periodic and comprehensive evaluations and may not be billed separately;

(11) denture characterization and personalization, and precision attachments;

(12) experimental dental procedures;

(13) local anesthesia, which is considered a component of covered dental procedures and may not be billed separately

(14) anesthesia or sedation in conjunction with a non-covered service or a service for which service limits have been exhausted;

(15) dental sealants;

(16) orthodontic services. (Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 11/1/2010, Register 196; am 5/1/2016, Register 218; am ____/____/____, Register ____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.067

AS 47.07.030

7 AAC 110.150 is repealed and readopted to read:

7 AAC 110.150. Dental services for recipients under 21 years of age. (a) Payment for children's dental services is limited to procedures identified in the Fee Schedule: Dental Services for Children adopted by reference in 7 AAC 160.900. Except as provided in 7 AAC 110.200(3), the department will pay for the following dental services, as described, provided to a recipient under 21 years of age:

(1) periodic oral evaluation not more than two times per calendar year, limited oral evaluation not more than two times per calendar year, and comprehensive oral evaluation not more than two times per calendar year; panoramic radiographs not more than one time per calendar year and other dental radiographs as necessary for dental care;

(2) preventive care, including

(A) prophylaxis, including necessary scaling, polishing, and instructions on oral hygiene and diet, not more than two times per calendar year;

(B) topical application of fluoride not more than four times per calendar year, or topical fluoride varnish not more than four times per calendar year, or a combination of topical application of fluoride and fluoride varnish not more than four times per calendar year;

(C) sealants, limited to one time per tooth per calendar year;

(D) space management therapy restricted to posterior teeth; the department will pay for a primary teeth space maintainer only if a significant risk exists of detrimental drifting occurring before the permanent tooth erupts and for a permanent teeth space maintainer only if prosthodontic treatment is not applicable;

(3) restorative care for the treatment of decayed or fractured teeth, including amalgams and resins, and crowns if the tooth cannot be restored with amalgams or resin;

(A) crowns must be authorized by the department;

(B) all surfaces restored on a single tooth on the same day are considered connected therefore payment is limited to one single or multi surface restoration code per tooth per day;

(C) final restorations are limited to not more than five surfaces per tooth; tooth preparation, temporary restorations, sedative and cement bases, and local anesthesia are considered components of a complete restorative procedure and may not be billed separately;

(D) the department will provide payment for crowns only upon seatment of the permanent crown, and for partials and dentures only upon seatment of the appliance; the department will not provide partial payment for incomplete or in-progress dental services.

(4) endodontics, with the following limitations:

(A) palliative and sedative treatments may not exceed two times per tooth before a definitive treatment;

(B) root canal therapy; tooth preparation, filling of the root canal, and follow-up are considered components of a complete root canal and may not be billed separately; and

(C) a separate claim may be made for pin retention and restoration, and may not exceed five surfaces per tooth;

(5) periodontics, including treatment of pain or acute infection of supporting tissues of the teeth, including gingivitis, periodontitis, and periodontal abscess;

(6) prosthodontics including replacement of a complete or partial denture only if the existing denture is unusable and only once per five calendar years;

(7) oral surgery;

(A) extractions must be authorized by the department;

(B) local anesthesia, materials, and routine postoperative care are considered components of a complete surgical procedure and may not be billed separately;

(8) anesthesia and sedation in accordance with 7 AAC 110.155 and necessary for dental services covered under this section;

(9) professional consultation, if medically necessary or if requested by the department;

(b) Except as provided in 7 AAC 110.200(3), the department will not pay for the following dental services for recipients under 21 years of age:

(1) dental services not identified in the Fee Schedule: Dental Services for Children, adopted by reference in 7 AAC 160.900;

(2) behavior management in conjunction with any services covered under 7 AAC 110.155;

- (3) pulp capping;
- (4) endodontic apical surgery and retrograde fillings;
- (5) immediate, interim, and temporary dentures;
- (6) dental implant and implant-related dental services;
- (7) inlays, overlays, and three-fourth crowns;
- (8) restoration of etched enamel or deep grooves without obvious dentin involvement;
- (9) space maintainers for anterior teeth;
- (10) tobacco counseling, which is considered a component of periodic and comprehensive evaluations and may not be billed separately;
- (11) denture characterization and personalization, and precision attachments;
- (12) experimental dental procedures;
- (13) local anesthesia, which is considered a component of covered dental procedures and may not be billed separately
- (14) anesthesia or sedation in conjunction with a non-covered service. (Eff.

2/1/2010, Register 193; am 8/25/2010, Register 195; am 11/1/2010, Register 196; am 5/11/2012, Register 202; am 5/1/2016, Register 218; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 110.153 is repealed and readopted to read:

7 AAC 110.153. Orthodontic services. (a) The department will pay a provider for only those orthodontic dental services identified in the Fee Schedule: Dental Services for Children adopted by reference in 7 AAC 160.900. Orthodontic services provided under this section must

be prior authorized by the department. The department will pay for the following orthodontic services rendered by an orthodontist who is enrolled in accordance with 7 AAC 110.140:

(1) limited orthodontic treatment of the primary dentition for a malocclusion that does not involve the entire dentition. The department will pay for limited orthodontic treatment for recipients under 21 years of age. Treatment may be directed at the existing problem or at one or more aspects of a larger problem when the decision is made to defer or forego more comprehensive therapy. The prior authorization request must be submitted by the orthodontist and must include

(A) a description of the condition;

(B) a description of the orthodontic appliance;

(C) a scored Handicapping Labiolingual Deviation (HLD) Index Report, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic radiograph;

(F) other medical or dental information to support the requested orthodontic treatment, including required extractions or orthognathic surgery; and

(G) an Orthodontic Referral Oral Health and Hygiene Assessment, adopted by reference in 7 AAC 160.900, completed and signed by the referring dentist;

(2) interceptive orthodontic treatment of the primary or transitional dentition to redirect ectopically erupting teeth, correct isolated dental crossbite, or recover minor space loss where overall space for erupting teeth is adequate. The department will pay for interceptive orthodontic treatment for recipients under 13 years of age. The prior authorization request must be submitted by the orthodontist and must include

(A) a description of the condition;

(B) a description of the orthodontic appliance;

(C) a scored Handicapping Labiolingual Deviation (HLD) Index Report, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic radiograph;

(F) other medical or dental information to support the requested orthodontic treatment, including required extractions or orthognathic surgery; and

(G) an Orthodontic Referral Oral Health and Hygiene Assessment, adopted by reference in 7 AAC 160.900, completed and signed by the referring dentist;

(3) comprehensive orthodontic procedures for treatment of cleft palate for treatment in conjunction with orthognathic surgery for a class III skeletal malocclusion, for treatment based on medical necessity due to functional impairment, or based on a score of 28 or greater on the Handicapping Labiolingual Deviation (HLD) Index Report completed by an orthodontist. The department will pay for interceptive orthodontic treatment for recipients under 13 years of age. When requesting approval for orthodontic treatment the provider should consider the recipient's willingness and ability to attend scheduled appointments and ability to maintain an acceptable level of oral hygiene, which is vital to the success of orthodontic treatment. The prior authorization request must be submitted by the orthodontist and must include

(A) a description of the condition including medical information to determine functional impairment;

(B) a description of the orthodontic appliance;

(C) a scored Handicapping Labiolingual Deviation (HLD) Index Report, adopted by reference in 7 AAC 160.900, completed and signed by the orthodontist;

(D) a treatment plan for correcting the condition;

(E) panoramic films;

(F) study models, if requested in the process of reviewing the prior authorization; and

(G) an Orthodontic Referral Oral Health and Hygiene Assessment, adopted by reference in 7 AAC 160.900, completed and signed by the referring dentist.

(b) If comprehensive orthodontic treatment commences less than 18 months after the most recent limited or interceptive orthodontic treatment, reimbursement for the comprehensive orthodontic treatment will be reduced by the amount reimbursed for limited or interceptive orthodontic treatment.

(c) If a recipient's eligibility ends or if the recipient reaches the maximum age for the service before the conclusion of treatment, payment for remaining services is the responsibility of the recipient, or the parent or guardian if the recipient is a minor.

(d) The orthodontist may terminate treatment under (a) of this section prior to completion if the recipient is uncooperative or noncompliant, or if the recipient is no longer eligible for Medicaid or Denali KidCare. Upon early termination of treatment, the orthodontist shall

(1) report early termination of treatment to the department within 30 days of termination of treatment

(2) remove the brackets and, if needed, replace with orthodontic retention.

(e) Except for orthodontic treatment of cleft palate, the department will not pay for services under (a) of this section if the recipient has a history of caries during the six months

before treatment or if the recipient demonstrates oral hygiene inadequate to successfully complete orthodontic services.

(f) Except for orthodontic treatment of cleft palate, the department will not pay for orthodontic treatment under (a)(3) of this section more than one time during the recipient's lifetime. (Eff. 12/1/2010, Register 196; am 5/1/2016, Register 218; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 110.155 is repealed and readopted to read:

7 AAC 110.155. Dentist-administered anesthesia and sedation. (a) The department will pay for nitrous oxide sedation, intramuscular sedation, or non-intravenous conscious sedation required for dental services covered under this article if the dental services provider justifies, in writing, that local anesthesia is inadequate to control pain;

(b) The department will pay for general anesthesia or intravenous sedation required for dental services covered under this article if authorized by the department. A claim submitted to the department for payment of costs for general anesthesia must be accompanied by written medical justification for the service; IV sedation must be authorized by the department. Medical justification and prior authorization requests must include documentation substantiating that local anesthesia and sedation under (a) of this section are inadequate to control pain and that the service is required for a patient who meets one of the following conditions:

- (1) severe intellectual or developmental disability;
- (2) severe physical disability or medically-compromised condition; or
- (3) a prolonged or difficult surgical procedure.

(c) The cost of the supplies necessary for the administration of anesthesia and sedation, including drugs, nitrous oxide masks, tubing, and syringes, are included in the payment made under (a) and (b) of this section. (Eff. 2/1/2010, Register 193; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 110.160 is repealed.

7 AAC 110.160. Diagnostic x-ray. Repealed. (Eff. 2/1/2010, Register 193; am____/____/____, Register____)

7 AAC 140.105. Ambulatory surgical center services.

7 AAC 140.105(b) is amended to read:

(b) The department will pay for use of the ambulatory surgical center to perform dental services covered by the department under 7 AAC 110.140 - **7 AAC 110.155** [7 AAC 110.160], if use of the center is medically necessary.

Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 140.215. Health clinic services and payment conditions.

7 AAC 140.215(d) is amended to read:

(d) The department will separately pay a health clinic for dental services covered under 7 AAC 110.145 - **7 AAC 110.155** [7 AAC 110.160] provided by a dentist who is enrolled separately under 7 AAC 110.140.

(Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am 4/24/2020, Register 234;
am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.073
AS 47.07.030 AS 47.07.070

Chapter 145. Medicaid Payment Rates.

7 AAC 145.120. Dental services payment rates.

7 AAC 145.120(a) is repealed and readopted to read:

(a) The department will pay a dentist for dental services provided to a recipient 21 years of age or older in accordance with 7 AAC 110.145 and the Fee Schedule: Emergent Adult Dental Services, Fee Schedule: Prosthodontic Adult Dental Services, and Fee Schedule: Enhanced Adult Dental Services, adopted by reference in 7 AAC 160.900.

7 AAC 145.120(b) is repealed and readopted to read:

(b) Except for orthodontic services, the department will pay a dentist for dental services provided to a recipient under 21 years of age in accordance with 7 AAC 110.150 and the Fee Schedule: Dental Services for Children, adopted by reference in 7 AAC 160.900.

7 AAC 145.120(d) is repealed and readopted to read:

(d) The department will pay for orthodontic services in accordance with 7 AAC 110.153 and the Fee Schedule: Dental Services for Children, adopted by reference in 7 AAC 160.900.

7 AAC 145.120(e) is repealed:

(e) Repealed ____/____/____. (Eff. 2/1/2010, Register 193; am 11/1/2010, Register 196; am 1/15/2011, Register 197; am 3/22/2014, Register 209; am 5/1/2016, Register 218; am 7/1/2019, Register 231; am ____/____/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 160.900. Requirements adopted by reference.

7 AAC 160.900(a)(25) is repealed and readopted to read:

(25) the American Academy of Pediatric Dentistry's 2018/2019 *Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling*, as amended from time to time, and appearing in the American Academy of Pediatric Dentistry's *Reference Manual of Pediatric Dentistry*

Editor's note: The American Academy of Pediatric Dentistry's 2018/2019 *Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling* can be accessed on the American Academy of Pediatric Dentistry's website at <https://www.aapd.org/research/oral-health-policies--recommendations/>.

7 AAC 160.900(a)(26) is repealed and readopted to read:

(26) the American Academy of Pediatric Dentistry's 2018 *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents*, as amended from time to time, and appearing in the American Academy of Pediatric Dentistry's *Reference Manual of Pediatric Dentistry*;

Editor's Note: The American Academy of Pediatric Dentistry's 2018 *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents* can be accessed on the American Academy of Pediatric Dentistry's website at https://www.aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf .

7 AAC 160.900(d)(23) is repealed:

(23) repealed____/____/____;

7 AAC 160.900(e)(2) is repealed and readopted to read:

(2) State Fiscal Year 2021 Fee Schedule: Dental Services for Children, revised as of July 1, 2020, State Fiscal Year 2021 Fee Schedule: Emergent Adult Dental Services, revised as of July 1, 2020, State Fiscal Year 2021 Fee Schedule: Prosthodontic Adult Dental Services, revised as of July 1, 2020, and State Fiscal Year 2021 Fee Schedule: Enhanced Adult Dental Services, revised as of July 1, 2020;

Editor's Note: The State Fiscal Year 2021 Fee Schedules can be accessed at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp> .

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013,

Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am 6/16/2016, Register 218; am 7/22/2017, Register 223; am 11/5/2017, Register 224; am 3/1/2018, Register 225; am 10/1/2018, Register 227; am 1/1/2019, Register 228; am 3/24/2019, Register 229; am 6/2/2019, Register 230; am 6/13/2019, Register 230; am 7/1/2019, Register 231; am 10/25/2019, Register 232; am 11/10/2019, Register 232; am 4/24/2020, Register 234; am 6/25/2020, Register 234; am 10/1/2020, Register 235; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.012