ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

CHRISTOPHER HAYNES, Employee, A. NICK WILLIAMS, D.C. Claimant, v. ALASKA HOUSING FINANCE CORP., Employer, and ALASKA NATIONAL INSURANCE COMPANY, Insurer, Defendants.	)	FINAL DECISION AND ORDER ON RECONSIDERATION AWCB Case No. 201517355 AWCB Decision No. 17-0007 Filed with AWCB Anchorage, Alaska on January 12, 2017

Alaska Housing Finance Corp. and Alaska National Insurance Company's (Employer) December 27, 2016 Petition for reconsideration of *Haynes v. Alaska Housing Finance Corp.*, AWCB Decision No. 16-0128 (December 16, 2016) (*Haynes I*) was heard on the written record on January 5, 2017 in Anchorage, Alaska. This hearing date was selected on January 4, 2017. Attorney Martha Tansik represented Employer. No response was received from A. Nick Williams, D.C. (Claimant) or Christopher Haynes (Employee). The record closed at the hearing's conclusion on January 6, 2017.

ISSUE

Employer contends *Haynes I* should be reconsidered as it was a "results driven decision," which was based on material errors of fact and law. Under the law, the time in which the board may

address a petition for reconsideration expires before an opposing party's answer to the petition is due. As a result, neither Claimant nor Employee had yet responded to Employer's petition, but it is assumed they are opposed to reconsideration.

Should Haynes I be reconsidered?

FINDINGS OF FACT

All findings in *Haynes I* are incorporated herein. The following facts are reiterated from *Haynes I* or are established by a preponderance of the evidence:

1. Finding of fact 5 in in *Haynes I* stated:

> The first hearing on the bill was held on March 7, 2014. Anna Latham, legislative staff, testified that for the past decade, Alaska had the highest workers' compensation rates in the nation. The bill proposed a change in the medical fee schedule. The fee schedule in place at that time was based on a percentage of the usual, customary and reasonable fees, but fees had risen significantly. The bill proposed a fee schedule for physicians based on the relative values for various procedures established by the federal Center for Medicare and Medicaid Services (CMS) multiplied by a conversion factor. (House Labor and Commerce Committee Minutes, March 7, 2014).

2. At the March 7, 2014 hearing, Ms. Latham also testified that "this bill proposes to change the fee schedule for workers' compensation claims to a schedule based on the federal Centers for Medicare and Medicaid Services fees with a conversion factor set by the Alaska Workers' Compensation Advisory Board (AWCAB)." (House Labor and Commerce Committee Minutes, March 7, 2014).
3. On March 10, 2014, Ms. Latham again testified before the House Labor and Commerce Committee regarding a revision to HB 316. She explained the changes were due to concerns about the board setting conversion factors given its lack of expertise. The revision was "to make extremely clear in statute that the MSRC will advise the Workers' Compensation Board (WCB) on setting the rates." (House Labor and Commerce Committee Minutes, March 10, 2014).
4. Ms. Latham also testified before the House Finance Committee on April 9, 2014. She explained that the relative value unit accounted for a physician's work, practice expense, and malpractice insurance. The relative value was multiplied by a conversion factor set by the state to determine the amount of the payment. Representative Holmes wanted "to ensure that

the physicians were adequately (sic, paid) and people could get proper care." Ms. Latham replied that "the baseline would be the centers for Medicare and Medicaid," and the board would set the conversion factors. (House Finance Committee Minutes, April 9, 2014).

5. Finding of fact 34 in *Haynes I* stated:

> On July 15, 2016, the MSRC met for the first time since the fee regulation became effective. It was noted that several issues had arisen regarding the application of the fee schedule. One member stated that there had been no blanket opinion at prior MSRC meetings adopting all CMS rules. The committee also discussed a problem that had arisen has arisen because certain codes had an RVU of zero. The example cited was code 99456, related to permanent partial impairment ratings. The Committee stated it was clearly not their intent to value PPI ratings at zero. A member of the public commented that clarification was needed on two of the codes related to chiropractic manipulation, including 98943. However, the Committee needed additional information before commenting on other specific codes, and directed Optum to compile a list of codes with zero value to present the Committee for review. (MSRC, Minutes, July 15, 2016). While the committee discussed modifiers, it did not address status codes. (Observation).

6. The July 15, 2016 MRSC minutes also state: "The Committee clarified its intent that the CMS billing and coding rules will be used and the MSRC can then carve out specific exceptions to those rules by regulation." (MSRC, Minutes, July 15 2016).

7. Finding of fact 35 in *Haynes I* stated:

> At the MSRC's July 29, 2016 meeting, a representative of Optum explained the various status codes, and recommended the Committee address those codes that had a relative value of zero. A member asked for clarification about whether all Medicare rules had been adopted when the Committee agreed to adopt CMS billing and coding rules. *Marie Marx, Director of the Division of Workers' Compensation, clarified that it was not the intent of the Division to use CMS billing and coding rules.* The member stated his belief was that the committee was not adopting all Medicare rules, but only those related to billing and coding. The committee agreed to address chiropractic codes as well as status codes N and I at its next meeting. (Emphasis added).

Due to an editing error, finding of fact 35 is incorrect. It should have stated:

> At the MSRC's July 29, 2016 meeting, a representative of Optum explained the various status codes, and recommended the Committee address those codes that had a relative value of zero. A member asked for clarification about whether all Medicare rules had been adopted when the Committee agreed to adopt CMS billing and coding rules. *Marie Marx, Director of the Division of Workers' Compensation, clarified that it was not the intent of the Division <u>to create its own billing and coding rules. The decision was</u> to use CMS billing and coding rules.*

> The member stated his belief was that the committee was not adopting all Medicare rules, but only those related to billing and coding. The committee agreed to address chiropractic codes as well as status codes N and I at its next meeting. (Emphasis added).

8. At the July 29, 2016 MSRC meeting, Director Marx also suggested the committee focus on carving out specific exceptions to CMS billing and coding rules, giving the examples of work hardening and PPI ratings. She provided a spreadsheet of codes for the Committee to review. (MSRC, Minutes, July 29, 2016).
9. At the November 22, 2016 hearing, Claimant stated Employer had cited 8 AAC 45.083(j) when it controverted his bills. Subsection .083(j) requires providers and payers to follow the CMS and American Medical Association (AMA) billing and coding rules, and he had done so, but there was a discrepancy in the fee schedule. Claimant explained the populations served by Medicare and workers' compensation have significantly different needs and different treatments were appropriate. Even though a code may not be payable under CMS's fee schedule, the AMA has a CPT code for extraspinal manipulation, and under 8 AAC 45.083(j)(7), when there is a discrepancy between CMS and the AMA, the AMA guidance governs. Claimant testified that the treatments here were necessary to treat Employee, and his understanding is that he should be paid for the work performed, but it boils down to what the law says. (Claimant).
10. Sheila Hanson testified she was a branch manager for Corvel Healthcare, Incorporated. As a branch manager, she oversees medical bill review services offered to self-insured employers and insurers in the Pacific Northwest, including Alaska. She is familiar the CMS rules and the Alaska fee schedule. Her understanding of a "carve out" is a state-specific adjustment that is applied to CMS rules; you are using the same rules, but adjusting for differences in geographic costs. She differentiated carve-outs from adjustments in that adjustments apply the CMS rules to arrive at a value for a given service, and then adjusting for the state specific adjustment. As an example, she cited the use of the conversion factors in 8 AAC 45.083 rather that CMS's conversion factors. A carve out is when a line item on a bill is paid differently that the rest of the bill. As an example, the Alaska fee schedule carves-out payment to non-physicians. Ms. Hanson had attended all of the MSRC meetings, and had provided testimony. She explained the process of reviewing a medical bill. The first step is to identify the provider to determine which fee schedule applies; in this case, because

Claimant is a chiropractor, the physician fee schedule applies. The second step is to look at the procedure code and determine what status code exists for the bill. The status code is found in CMS's physician's fee schedule. For CPT code 98943, the status code is "N," which represents non-covered. Even though there are relative values for 98943, it remains noncompensable because of the N status code. When a code has a status indicator of "N," the analysis stops there; 8 AAC 45.083(g), which applies when there is no valid CPT code or RVU does not apply because 98943 has both a valid CPT code and relative values. She acknowledged there were codes that were compensable that did not have relative values assigned. As an example, she referred to hearing aids, which she believed were a restricted, or a status code of "R" and would be paid at 85 percent of the bill. To check if something would otherwise be payable in Alaska, they look at the regulations, and in the case of 98943, there are no carve-outs. To the best of her knowledge, there is nothing that alters the non-compensability of 98943. In response to a question asking about the "N" status code, Ms. Hanson stated a status code "N" item would be non-compensable for any provider. In answering a question asking where 8 AAC 45.083(b) incorporates the status codes as part of the fee schedule, Ms. Hanson answered "the status codes are part of the whole table from CMS." Subsection 8 AAC 45.083(j) states that providers and payers shall follow the CMS and AMA billing and coding rules, the status codes are part of the billing and coding rules. (Sheila Hanson).

11. Various types of hearing aids are addressed by a number of HCPCS codes between V5030 and V5261. All are status code N items. (CMS 2016 Physician Fee Schedule Relative Value File; PPRRVU16_V0122.xlsx; Observation).
12. Claimant's bills in this case were reviewed by Corvel. Claimant attached several Explanations of Review from Corvel as exhibits to his claims. (Claims). Prior to December 1, 2015, Claimant billed for 98943 and was paid. (Corvel, Explanation of Review, March 9, 2016). Beginning December 1, 2015, Claimant's charges for 98943 were denied. The explanations for the denial for the December 1, 2015 date of service states: "No additional allowance recommended. Bundled in another procedure/see state regulations," and "Per AK regulations effective 12/1/2015, CPT code 98943 is a non-covered code." (Corvel, Explanation of Review, March 11, 2016). Other billings were denied, and the only

explanation was "Bundled in another procedure/see state regulations." (Corvel, Explanation of Review, February 26, 2016).

13. On May 16, 2016, Employer filed a controversion notice denying all charges for CPT code 98943 stating "Under 8 AAC 45.083(j), CMS billing and coding rules apply to services provided by physicians. According to CMS guidelines, extraspinal manipulation is not reimbursable. Therefore, CPT 98943 is categorized as a non-covered code." (Controversion Notice, May 11, 2016).
14. On December 27, 2016, Employer filed a petition for reconsideration of *Haynes I* and requesting payment of benefits be stayed until *Haynes I* was reconsidered. (Petition, December 27, 2016). (Petition, December 27, 2016). The stay was issued on December 30, 2016. (*Haynes v. Alaska Housing Finance Corp.*, AWCB Decision No. 16-0134 (December 30, 2016)).
15. On January 3, 2016, Employer filed a memorandum explaining why it believed *Haynes I* should be reconsidered. Employer contended finding of fact 35 in *Haynes I* was erroneous, finding of fact 34 was incomplete, no findings were made as to Sheila Hanson's testimony, the findings regarding the legislative history of HB 316 were incomplete, and *Haynes I sua sponte* raised the issue of intent. (Employer's Memorandum, January 3, 2017).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. 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;
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> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;
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> (3) this chapter may not be construed by the courts in favor of a party;
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> (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.

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or

peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987). The board must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson*, 221 P.3d 998 (Alaska 2009).

> **AS 23.30.095. Medical treatments, services, and examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement

In *Bockness v. Brown Jug, Inc.*, 980 P.2d 462. 466 (Alaska 1999), the Court explained that the Act does not require payment for all medical treatment, but only that which is reasonable and necessary.

> **AS 23.30.097. Fees for medical treatment and services.**
> (a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section. A fee or other charge for medical treatment or service
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> (1) rendered in the state may not exceed the lowest of
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> (A) the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, for treatment or service provided on or after December 31, 2010, not to exceed the fees or other charges as specified in the fee schedules established by the medical services review committee and adopted by the board in regulation; the fee schedules must include
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> (i) a physician fee schedule based on the federal Centers for Medicare and Medicaid Services' resource-based relative value scale;
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> (ii) an outpatient and ambulatory surgical center fee schedule based on the federal Centers for Medicare and Medicaid Services' ambulatory payment classification; and
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> (iii) an inpatient hospital fee schedule based on the federal Centers for Medicare and Medicaid Services' Medicare severity diagnosis related group;

(B) the fee or charge for the treatment or service when provided to the general public; or

(C) the fee or charge for the treatment or service negotiated by the provider and the employer under (c) of this section;

. . . .

(f) An employee may not be required to pay a fee or charge for medical treatment or service provided under this chapter.

. . . .

(q) The board may adjust the fee schedules established under (a)(1)(A) of this section to reflect the cost in the geographical area where the services are provided.

(r) The medical services review committee shall formulate a conversion factor and submit the conversion factor to the commissioner of labor and workforce development. If the commissioner does not approve the conversion factor, the medical services review committee shall revise the conversion factor and submit the revised conversion factor to the commissioner for approval.

AS 23.30.098. Regulations. Under AS 44.62.245(a)(2), in adopting or amending regulations under this chapter, the department may incorporate future amended versions of a document or reference material incorporated by reference if the document or reference material is one of the following:

(1) Current Procedural Terminology Codes, produced by the American Medical Association;

(2) Healthcare Common Procedure Coding System, produced by the American Medical Association;

(3) International Classification of Diseases, published by the American Medical Association;

(4) Relative Value Guide, produced by the American Society of Anesthesiologists;

(5) Diagnostic and Statistical Manual of Mental Disorders, produced by the American Psychiatric Association;

(6) Current Dental Terminology, published by the American Dental Association;

(7) Resource-Based Relative Value Scale, produced by the federal Centers for Medicare and Medicaid Services;

(8) Ambulatory Payment Classifications, produced by the federal Centers for Medicare and Medicaid Services; or

(9) Medicare Severity Diagnosis Related Groups, produced by the federal Centers for Medicare and Medicaid Services.

AS 23.30.130. Modification of awards.
(a) Upon its own initiative, or upon the application of any party in interest on the ground of a change in conditions, including, for the purposes of AS 23.30.175, a change in residence, or because of a mistake in its determination of a fact, the board may, before one year after the date of the last payment of compensation benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, whether or not a compensation order has been issued, or before one year after the rejection of a claim, review a compensation case under the procedure prescribed in respect of claims in AS 23.30.110. Under AS 23.30.110 the board may issue a new compensation order which terminates, continues, reinstates, increases, or decreases the compensation, or award compensation.

(b) A new order does not affect compensation previously paid, except that an award increasing the compensation rate may be made effective from the date of the injury, and if part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and payment made earlier in excess of the decreased rate shall be deducted from the unpaid compensation, in the manner the board determines.

AS 44.62.030. Consistency between regulation and statute.
If, by express or implied terms of a statute, a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, a regulation adopted is not valid or effective unless consistent with the statute and reasonably necessary to carry out the purpose of the statute.

AS 44.62.540. Reconsideration.
(a) The agency may order a reconsideration of all or part of the case on its own motion or on petition of a party. To be considered by the agency, a petition for reconsideration must be filed with the agency within 15 days after delivery or mailing of the decision. The power to order a reconsideration expires 30 days after the delivery or mailing of a decision to the respondent. If no action is taken on a petition within the time allowed for ordering reconsideration, the petition is considered denied.

(b) The case may be reconsidered by the agency on all the pertinent parts of the record and the additional evidence and argument that are permitted, or may be assigned to a hearing officer. A reconsideration assigned to a hearing officer is subject to the procedure provided in AS 44.62.500. If oral evidence is introduced

> before the agency, an agency member may not vote unless that member has heard the evidence.

ANALYSIS

Should Haynes I be reconsidered?

Employer alleges *Haynes I* erred in five respects. Each contention will be addressed.

Employer first contends finding of fact 35 in *Haynes I* was erroneous in that it misstates Director Marx' July 29, 2016 statement to the MSRC. As stated above in finding of fact 7, Employer is correct, and the finding will be amended. Employer also contends finding of fact 35 was incomplete in that Director Marx also spoke of carving out specific exceptions to the CMS billing and coding rules. Finding of fact 8 above addresses those statements.

Second, Employer contends finding of fact 34 in *Haynes I*, regarding the July 15, 2016 MSRC meeting, and set out above in finding of fact 5, was incomplete. At its July 15, 2016 meeting, the MSRC clarified its intent that the CMS billing and coding rules will be used and it would then carve out specific exceptions to those rules by regulation as stated in finding of fact 6 above.

Third, Employer contends *Haynes I* made no findings of fact as to Sheila Hanson's testimony. Finding of fact 11 above addresses Ms. Hanson's testimony.

Fourth, Employer contends the findings of fact regarding the legislative history of HB 316 in *Haynes I* were incomplete, particularly regarding Ms. Latham's testimony. Findings of fact 2, 3, and 4 above address additional testimony by Ms. Latham.

Fifth, Employer contends *Haynes I* raised the issue of intent, or the interpretation of 8 AAC 45.083 *sua sponte*. Findings of fact 9 and 10 above clarify that Claimant raised the issues of intent and interpretation.

While finding of fact 35 was incorrect, neither that nor the additional findings Employer argued were necessary, change the result reached in *Haynes I.* Employer's assertion that *Haynes I* raised the issues of intent or interpretation *sua sponte* is incorrect. Although not well stated in

legal terms, the crux of Claimant's argument at hearing was that his treatment was properly coded and billed and should be paid under the fee schedule. Claimant also argued that applying all CMS rules was incompatible with the purpose of workers' compensation.

Employer repeatedly asserts that it was the intention of AS 23.30.097 and 8 AAC 45.083 to adopt CMS's "billing and coding rules," and several of the additional findings of fact it requested address that. However, Claimant did not dispute that the intent of HB 316 and the regulation was to adopt CMS's billing and coding rules. His argument was that, by applying status code N, Employer had created a discrepancy. The dispute in *Haynes I* was whether the CMS billing and coding rules included the payment status codes in CMS's Physician Fee Schedule Relative Value File. Employer contended they were included. While Claimant did not specifically say so, the only conclusion that can be reached from his contention that he should be paid is that Employer is wrong. As Claimant stated "it boils down to what the law says." The issue was not whether the billing and coding rules were adopted, but whether the fee schedule incorporated the payment status codes.

Neither 8 AAC 45.083(b), which provides for calculation of physicians' fees, nor 8 AAC 45.083(j), which provides billing and payment rules for physicians, specifically address status codes. Although 8 AAC 45.083(j) states that "providers and payers shall follow the billing and coding rules" adopted by reference in subsection (m), that does not answer the question of whether billing and coding rules include status codes. The issues of the interpretation of 8 AAC 45.083 and the legislature's intent in amending AS 23.30.097 and in enacting AS 23.30.098 were raised by the parties, and were properly addressed in *Haynes I*.

Director Marx's July 29, 2016 suggestion that the MSRC focus on carving out exceptions to the CMS billing and coding rules, using work hardening and permanent partial impairment ratings as examples, is not helpful in determining whether status code N items are payable. As finding of fact 11 in *Haynes I* indicates, work hardening and impairment ratings (disability ratings) are status code R items, which have no relative values assigned. Because they have no relative value, those services would, presumably, be paid under the 85 percent rule in 8 AAC 45.083(g). By assigning relative values to those CPT codes in its recommendation, the MSRC would be

electing to treat those items differently, effectively carving them out from the normal treatment under the fee schedule.

Ms. Hanson's testimony was not persuasive. First, she was not a neutral witness; she was a representative of Corvel, which denied Claimant's bills in this case. Not surprisingly, her testimony supported Corvel's denial. Second, her explanation as to why status codes applied was conclusory. Without referring to any authority, she simply stated that "the status codes are part of the billing and coding rules." Third, her testimony that hearing aids would be covered because they have a status code of R was incorrect, and while anyone can make a mistake, her error cast doubt on her expertise. Ms. Hanson's testimony did not help to resolve the issue presented.

Employer contends that because status codes are part of the CMS physician's fee schedule, they are incorporated by reference. However, AS 23.30.097(a)(1)(A)(i) did not direct the board to adopt CMS's physician's fee schedule. It directed the board to adopt "a physician fee schedule based on the federal Centers for Medicare and Medicaid Services' *resource-based relative value scale*." (emphasis added). CMS's relative value scale is only part of its physician's fee schedule. And, as Ms. Hanson noted, "the status codes are part of the whole table from CMS." If the section is construed to require only the inclusion of CMS's relative values, the result is a fee schedule that is consistent with the rest of the Act. And as *Haynes I* noted, construing it as incorporating status code N results in a fee schedule that conflicts with other portions of the Act.

One of basic principles of workers' compensation is that the employer will pay the cost of medical treatment for a work injury. Under AS 23.30.095(a), an employer "shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires." The Supreme Court explained that employers are liable for "reasonable and necessary" medical care. *Bockness*. Claimant's testimony that the treatment was medically necessary was uncontradicted. Nothing in the history of HB 316 suggests the legislature intended to limit medical benefits to injured workers. Rather, the totality of the legislative

history indicates the legislature only intended to replace the fee schedule based on a percentage of usual and customary costs with one based on CMS's relative values.

Employer's contention that *Haynes I* was a "results driven decision" is correct. The panel strove to construe the physician's fee schedule in a manner that was consistent with both the enabling legislation and the entirety of the Act. *Haynes I* will be modified to correct finding of fact 35, and to incorporate other findings in this decision. However, those modifications do not warrant the reconsideration of *Haynes I*'s conclusion.

CONCLUSIONS OF LAW

The findings of fact in *Haynes I* will be modified, but its conclusion will not be reconsidered.

ORDER

1. Finding of fact 35 in *Haynes I* is modified to states:

> At the MSRC's July 29, 2016 meeting, a representative of Optum explained the various status codes, and recommended the Committee address those codes that had a relative value of zero. A member asked for clarification about whether all Medicare rules had been adopted when the Committee agreed to adopt CMS billing and coding rules. Marie Marx, Director of the Division of Workers' Compensation, clarified that it was not the intent of the Division to create its own billing and coding rules. The decision was to use CMS billing and coding rules. The member stated his belief was that the committee was not adopting all Medicare rules, but only those related to billing and coding. The committee agreed to address chiropractic codes as well as status codes N and I at its next meeting.

2. *Haynes I* is also amended to include findings of fact 2, 3, 4, 6, and 8, as set out above.
3. The conclusions and order in *Haynes I* will not be reconsidered.

Dated in Anchorage, Alaska on January 12, 2017

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Mark Talbert, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of CHRISTOPHER HAYNES, employee; A. NICK WILLIAMS, D.C., claimant; v. ALASKA HOUSING FINANCE CORP., employer; ALASKA NATIONAL INSURANCE COMPANY, insurer / defendants; Case No. 201517355; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on January 12, 2017.

/s/
Vera James, Office Assistant I