ALASKA WORKERS' COMPENSATION BOARD

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

TREVOR D. MILLAR, Employee, and PROVIDENCE ALASKA MEDICAL CENTER, Claimant, v. YOUNG LIFE, Employer, and ACE AMERICAN INSURANCE COMPANY, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 201307276 AWCB Decision No. 17-0017 Filed with AWCB Anchorage, Alaska on February 6, 2017

Providence Alaska Medical Center's June 7, 2016, September 20, 2016, and December 13, 2016 claims were heard on January 11, 2017 in Anchorage, Alaska. This hearing date was selected on December 7, 2016. Karen Norton appeared and represented Providence Alaska Medical Center (Claimant). Fred Adorno appeared and represented Young Life and Ace American Insurance Company (Employer). Trevor D. Millar (Employee) did not appear. Ms. Norton and Mr. Adorno testified as witnesses. The record closed at the hearing's conclusion on January 11, 2017.

ISSUE

This case addresses payment to medical providers under the fee schedule adopted in response to the 2014 amendments to AS 23.30.097. The facts are undisputed. The only issue is how outpatient physical or occupational therapy is paid. Claimant contends it should be paid under the outpatient and ambulatory surgical center fee schedule, and Employer contends Claimant should be paid under the fee schedule provisions for physicians or other medical providers.

How are outpatient physical or occupational therapy services paid under the fee schedule?

FINDINGS OF FACT

1. Prior to December 1, 2015, medical fees in workers' compensation cases were established by a medical fee schedule that was updated periodically. Under the version of AS 23.30.097(a) then in effect, the fee schedule provided for payment at 90 percent of the usual, customary, and reasonable (UCR) fee in the geographical area where the services were provided. (Observation; Experience).
2. The most recent fee schedule, effective December 31, 2010, identified medical services by a Healthcare Common Procedure Coding System (HCPCS) code number. The HCPCS incorporates the Current Procedural Terminology (CPT) code numbers developed by the American Medical Association for services by physicians. For other medical providers, HCPCS uses other code numbers. (Alaska 2010 Medical Fee Schedule, Introduction).
3. The CPT codes and maximum fee for selected procedures under the 2010 Medical Fee Schedule are as follows:

Code	Description	Fee
29881	Arthroscopic Knee Surgery with Meniscectomy	$5,158.02
97110	Ther. Px 1+ Areas Each 15 Min. Ther. Exercise	$96.00
97112	Ther. Px 1+ Areas Each 15 Min. Neuromusc. Reeducat.	$93.96
97530	Ther. Activ. Dir. Pt. Contact by Provider Ea. 15 Min.	$77.26
97535	Self-Care/Home Mgmt Training Ea. 15 Min.	$80.78

4. In 2014, HB 316 was introduced and referred to the House Labor and Commerce Committee. (House Journal, Page 1634).
5. 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).

6. 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 [Medical Services Review Committee] will advise the Workers' Compensation Board (WCB) on setting the rates." (House Labor and Commerce Committee Minutes, March 10, 2014).
7. Ms. Latham later explained the intent of HB 316 was to reduce the extremely inflated workers' compensation medical procedure rates to more reasonable rates. (House Labor and Commerce Committee Minutes, March 24, 2014).
8. Ms. Latham 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).
9. On April 19, 2014, Ms. Latham testified before the Senate Finance Committee, explaining that HB 316 introduced a new fee schedule. She responded to a committee member's question about additional reforms to the Workers' Compensation Act stating that while some parties wanted to implement evidence based best practices and utilization review, "[t]he sponsor holds that the process should consist of two parts, lowering fees and implementing utilization and evidence based best practices." (Senate Finance Committee Minutes, April 19, 2009).
10. HB 316 was passed by both chambers of the legislature and approved by the Governor on July 8, 2014. (House Journal, page 2929).

11. HB 316 amended AS 23.30.097 to state:

> **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
> (1) rendered in the state may not exceed the lowest of
> (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
> (i) a physician fee schedule based on the federal Centers for Medicare and Medicaid Services' resource-based relative value scale;
> (ii) an outpatient and ambulatory surgical center fee schedule based on the federal Centers for Medicare and Medicaid Services' ambulatory payment classification; and
> (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;
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> . . . .
> (j) The board shall annually renew and adjust fees on the fee schedules established by the medical services review committee under (a)(1)(A) of this section by a conversion factor established by the medical services review committee and adopted by the board in regulation.
> (k) A fee or other charge for medical treatment or service rendered in another state may not exceed the lowest of
> (1) the fee or charge for a treatment or service set by the workers' compensation statutes of the state where the service is rendered; or
> (2) the fees specified in a fee schedule under (a)(1)(A) of this section.
> (l) A fee or other charge for air ambulance services rendered under this chapter shall be reimbursed at a rate established by the board and adopted in regulation.
> (m) A fee or other charge for durable medical equipment not otherwise included in a covered medical procedure under this section may not exceed the amount of the manufacturer's invoice, plus a markup specified by the board and adopted in regulation.
> (n) Reimbursement for prescription drugs under this chapter may not exceed the amount of the original manufacturer's invoice, plus a dispensing fee and markup specified by the board and adopted in regulation.
> (o) A prescription drug dispensed by a physician under this chapter shall include in a bill or invoice the original manufacturer's code for the drug from the national

> drug code directory published by the United States Food and Drug Administration.
> (p) A fee or other charge for medical treatment or service provided by a hospital licensed by the Department of Health and Social Services to operate as a critical access hospital is exempt from the fee schedules established under (a)(1)(A) of this section.
> (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.[1]

12. The MSRC met on July 7, 2014 to begin its work on the fee schedule. Michael Monagle, then director of the Division of Workers' Compensation, stated that the MSRC's goal was to recommend conversion factors that would be applied to CMS's resource-based relative value units (RBRVUs or RVUs) to arrive at a fee. He explained the intent was not to make draconian cuts to the Workers' Compensation Medical Fee Schedule rates. (MSRC, Minutes, July 7, 2014).
13. CMS periodically revises its fee schedules. The 2016 Physician Fee Schedule Relative Value File released in January 2016 provides the following for the selected CPT codes used in finding of fact number three[2, 3]:

HCPCS	Mod.	Description	Status Code	Not Used for Medicare Payment	Work RVU	Non-Facility Practice Expense RVU	Facility Practice Expense RVU	Mal-practice RVU
29881		Knee Arthoscopy/Surgery	A		7.03	7.17	7.17	1.39
97110		Therapeutic Exercises	A		0.45	0.44	0.44	0.02
97112		Neuromuscular Reeducation	A		0.45	0.48	0.48	0.02
97530		Therapeutic Activities	A		0.44	0.53	0.53	0.01
97535		Self-Care Mgmnt. Training	A		0.45	0.52	0.52	0.02

(CMS 2016 Physician Fee Schedule Relative Value File; PPRRVU16_V0122.xlsx).

14. In general, the Non-Facility Practice Expense RVU is used when the service is performed in the provider's office. The Facility Practice Expense RVU is used when the service is

[1] Sections (l) through (r) were initially to become effective on July 1, 2015. That date was later changed to December 1, 2015. Sec. 1, ch. 31, SLA 2015.
[2] CMS's Relative Value Table has 31 columns and includes 16,289 HCPCS codes. Only the relevant columns are shown here.
[3] Claimant's June 7, 2016 claim included dates of service in 2015, but that dispute has been resolved. Only dates of service in 2016 remain at issue.

provided in a hospital or ambulatory surgery center. (CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2679, MM7631.pdf).

15. CMS also publishes a Geographic Practice Cost Index (GPCI) that is periodically updated. GPCIs are provided for a number of geographic areas, and consist of a Work GCPI, a Practice Expense GCPI, and a Malpractice GCPI, which correspond to the RVU components in the relative value table. For 2016, Alaska 2016 has a Work GPCI of 1.5, a Practice Expense GPCI of 1.107, and a Malpractice GPCI of 0.611. (CMS 2016 Physician Fee Schedule Relative Value File; CY2016_GPCIs.xlsx).
16. Both the 2010 Medical Fee Schedule and the CMS Relative Value Table provide for the use of modifiers in certain situations, none of which are relevant in this case. However, the Relative Value Table includes Status Codes, which were not used in the 2010 Medical Fee Schedule. (2010 Medical Fee Schedule; 2016 Physician Fee Schedule Relative Value File).
17. The CMS Physician Fee Schedule uses a number of status codes. The only code relevant here is Status Code "A," which indicates:

> Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; [Medicare Administrative Contractors] remain responsible for coverage decisions in the absence of a national Medicare policy. (CMS 2016 Physician Fee Schedule Relative Value File, Attachment A; RVUPUF16.pdf).

18. CMS's Outpatient Prospective Payment System (OPPS) rule applies to services furnished by ambulatory surgery centers and hospital outpatient departments. Addendum B to the 2016 OPPS final rule 2016 provides payment information by HCPCS code. For those CPT codes used in finding of fact number three, Addendum B provides:

HCPCS Code	Short Descriptor	SI	APC	Relative Weight
29881	Knee Arthoscopy/Surgery	T	5122	32.4936
97110	Therapeutic Exercises	A		
97112	Neuromuscular Reeducation	A		
97530	Therapeutic Activities	A		
97535	Self-Care Mgmnt. Training	A		

(CMS, Addendum B – Final OPPS Payment by HCPCS Code for CY 2016).

19. In Addendum B, "SI" means status indicator and "APC" means ambulatory payment classification. (Adorno). The OPPS status indicator definitions are set out in Addendum D1. Relevant here are status indicators "A" and "T":

Indicator	Item/code/service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, e.g.: ● Ambulance Services ● Clinical Diagnostic Laboratory Services ● Non-Implantable Prosthetic and Orthotic Devices ● EPO for ESRD Patients ● Physical, Occupational, and Speech Therapy ● Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital ● Diagnostic Mammography ● Screening Mammography	Not paid under OPPS. Paid by Intermediaries under a fee schedule or payment system other than OPPS.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.

(CMS, Addendum D1 – Final OPPS Payment by HCPCS Code for CY 2016).

20. At the July 7, 2014 meeting, the MSRC was provided a significant amount of material, including a CMS Payment Formula sheet providing examples of how Medicare payments are calculated for various types of providers. (MSRC, Meeting Materials, July 7, 2014).
21. At the September 5, 2014 MSRC meeting, director Monagle informed the committee that Optum had been retained to provide professional services to the committee. (MSRC, Minutes, September 5, 2014).
22. At its October 24, 2014 meeting during a presentation by Optum, the MSRC discussed whether to adopt rules to incorporate status payment codes and how to address gaps for status codes not covered by CMS. (MSRC, Minutes, October 24, 2014).
23. At the January 15 and 16, 2015 MSRC meeting, a representative of Optum pointed out that the committee needed to make a decision on how to address status codes, particularly when CMS denies payment for a procedure performed on an outpatient basis. Another Optum

representative pointed out that the committee would have to decide how they wanted to handle for unlisted codes or "gaps." (MSRC, Minutes, January 15 and 16, 2015).

24. At the January 29, 2015 MSRC meeting, the committee discussed the need to adopt rules around status codes for outpatient facilities. For procedures CMS indicates should not be performed in an outpatient setting, Optum recommended a rule based on a percentage of billed charges. The committee also discussed the need to recommend rules for modifiers and bill payment, specifically whether CMS payment rules should be adopted with state specific exemptions. (MSRC, Minutes, January 29, 2015).
25. At its February 23, 2015 meeting, the MSRC discussed status codes in the context of medical facilities, particularly status codes C, E. N, P, Q, and T. An Optum representative recommended the committee be very specific when adopting rules because many CMS rules may not apply in the workers' compensation environment. In discussions regarding facility fees, Director Monagle noted that Idaho had determined that Status Code N items, other than implantable hardware, and items with no CPT code or RVU were not payable. Director Monagle stated that the goal was to make the conversion from UCR to RVU "fee schedule neutral." (MSRC, Minutes, February 23, 2015).
26. At the March 16, 2015 meeting, the MSRC considered a draft of its recommendations through the February 23, 2015 meeting. They discussed fees related to status code J and B items, such as implants, prescription drugs, and laboratory fees, for which CMS does not provide a relative value. There was no discussion related to the physician fees schedule, but the committee amended and adopted its draft conversion factors, including those related to physicians' fees. The committee requested information from Optum on how other states have handled status code C, E, and P items as well as items with no CPT codes or relative values and discussed a rule dealing with status codes C, E, and P. The committee noted there may be procedures that CMS does not pay for in an outpatient setting and Optum recommended adopting a rule providing that these procedures be paid under the professional fee schedule, or at a percentage of billed charge. (MSRC, Minutes, March 16, 2015).
27. Under Addendum D1 to the OPPS Rule, status indicator "C" means "Not paid under OPPS. Admit patient. Bill as inpatient." Status indicator "E" means "Not paid under OPPS or any other Medicare payment system." Status indicator "P" means "Paid under OPPS; Per diem APC payment." (CMS, Addendum D1 – Final OPPS Payment by HCPCS Code for CY

2016). Under Attachment A to the CMS Physician Fee Schedule, status code "C" means "[Medicare Administrative Contractors] price the code. [Medicare Administrative 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." Status code "E" means, "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 or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures." Status code "P" means "Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule." (CMS 2016 Physician Fee Schedule Relative Value File, Attachment A; RVUPUF16.pdf).

28. At its April 20, 2015 meeting, the MSRC proposed the following rules for hospitals, outpatient clinic, and ambulatory surgical centers:

> **Proposed Inpatient Hospital, Outpatient Clinic, and Ambulatory Surgical Center Facility Payment Rules**
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> 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 one-hundred (sic, percent) (100%) of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.
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> 3. (Sic 2) Medical services for which there is no APC weight listed shall be the lower of 85% 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.
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> 4. (Sic 3) Status codes C, E, and P, shall be the lower of 85% 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.
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> 5. (Sic 4) Two (2) or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%).

> 6. (Sic 5) Outpatient clinics and ambulatory surgical centers shall subtract implantable hardware from billed charges and bill separately at invoice cost plus ten percent (10%).
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> 7. (Sic 6) When total charges for a hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars ($30,000) of the inpatient payment calculated for that service (deemed an outlier case), then the total payment for that service shall be calculated using the CMS Inpatient PC Pricer tool as follows:
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> - Implantable charges, if applicable, are subtracted from the total amount charged.
> - The charged amount from (a) is entered into the most recent version of the CMS PC Pricer tool at the time of treatment.
> - The Medicare price returned by the CMS PC Pricer tool is multiplied by 2.5 (250% Medicare price).
> - The allowable implant reimbursement, if applicable, is the invoice cost of the implant(s) plus ten percent (110% of invoice cost).
> - The amounts calculated in (c) and (d) are added together to determine the final reimbursement.
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> (MSRC, Minutes, April 20, 2015).

29. At the April 20, 2105 MSRC meeting, an Optum representative explained that some status codes simply state charges are not paid under the outpatient prospective payment system, and some states refer payers to other fee schedules, such as the professional fee schedule, for payment. She recommended Alaska do the same. (MSRC, Minutes, April 20, 2015).
30. On June 1, 2015, the MSRC sent its recommendations to the Commissioner of the Department of Labor and Workforce Development. The following recommendations are relevant here:

> **FINDINGS OF THE MSRC**
> The MSRC's findings follow in this section. Recommendations are listed separately under the "Recommendations of the MSRC" section.
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>
> ***General***
> . . .
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> CMS does not produce relative values for all medical services, including pathology and clinical labs, durable medical equipment, parenteral and enteral nutrition items and services, some drug and pharmaceutical supplies. In addition, the committee acknowledged there will be some gaps for procedure codes not valued by CMS. The committee finds it needed to recommend payment rules for unvalued services and gaps where no CMS produces no relative values.
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Hospital Outpatient Fee Schedule

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CMS has developed status codes finding that certain procedures should not take place in an outpatient setting. The committee notes that CMS' patient mix trends to elderly patients or retirees whereas workers' compensation trends to younger workers. The committee finds that state specific rules should be recommended to address these status codes, notably status codes C, E, and P.

Billing and Payment Rules

The committee finds that AMA modifiers and CMS payment rules are well established and generally accepted, but notes that certain modifiers, status codes, and NCCI edits require state specific rules.

RECOMMENDATIONS OF THE MSRC

Physician Fee Schedule

The MSRC recommends

- The following conversion factors be multiplied times the CMS relative values established for each CPT code.
  a. Evaluation & Management $80.00
  b. Medicine $80.00
  c. Surgery $205.00
  d. Radiology $257.00
  e. Laboratory $142.00
- The following multipliers be applied to the CMS fee schedules established for each HCPCS code.
  a. Pathology & Clinical Lab CMS x 6.33
  b. Durable Medical Equipment CMS x 1.84
  c. ASP CMS x 3.375
- Using separate CMS physician fee schedule relative values for facilities and non-facilities.
- 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 established shall be the lower of 85% of billed charges, the charge for the treatment or to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

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Hospital Outpatient Fee Schedule

The MSRC recommends

1. An outpatient conversion factor of $221.79 to be applied to the CMS Outpatient Prospective Payment System relative weights established for each APC or CPT code.
2. Implants be paid at invoice plus 10%.

3. State specific payment rules be adopted for status codes C, E, & P.

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Billing and Payment Rules

The MSRC recommends the following billing and payment rules for medical 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 the Centers Medicare and Medicaid Services and by the American Medical Association, 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. Modifiers will be reimbursed as follows:
2. Modifier 50: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU. 50 % 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: 100% 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. 50 % 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 twenty percent (20%) of the surgical procedure.
5. Modifier PE: Reimbursement shall be 85% of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants and an advanced practice registered nurse.
6. Modifier AS: Reimbursement shall be fifteen percent (15%) 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% 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. An exception is when there is a billing rule discrepancy between NCCI edits and AMA CPT Assistant, CPT Assistant guidance governs.
9. The committee recommends establishing relative values of 3.41 for CPT code 97545 and 1.36 for CPT code 97546.

The MSRC recommends the following billing and payment rules for medical services provided by inpatient hospitals, outpatient clinics, and ambulatory surgical centers:

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> 2. Medical services for which there is no APC weight listed shall be the lower of 85% of billed charges, the fee or charge for the treatment or service when provided to the general public, fee or charge for the treatment or service negotiated by the provider and the employer.
> 3. Status codes C, E, and P, shall be the lower of 85% 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.
> 4. Two (2) or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%).
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> . . . .
> (MSRC, Workers' Compensation Medical Fee Schedule Recommendations, June 1, 2015).

31. After approval by the Commissioner, on October 29, 2015, the board adopted an emergency regulation codifying the MRSC's recommendations as 8 AAC 45.083. (Workers' Compensation Board Meeting Minutes, October 25, 2015).
32. At its January 15, 2016 meeting, after approving minor amendments in form and language required by the Department of Law, the board voted to make the emergency regulation permanent. (Workers' Compensation Board Meeting Minutes, January 15, 2016).
33. On May 11, 2016, the Division issued Bulletin 16-01 (Revised), which was the Director's interpretation of issues related to the fee schedule. The bulletin was intended to provide guidance, but is not binding. For medical services provided by an outpatient clinic, the Bulletin states:

> **Medical Services Provided by a Physician**
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> 8 AAC 45.083(b) applies to medical services provided by a 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.
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> . . . .
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> **Medical Services Provided by a Hospital Outpatient Clinic or Ambulatory Surgical Center**
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> For medical services provided by a hospital outpatient clinic or an Ambulatory Surgical Center (ASC), the Alaska MAR payment is calculated as follows:

> *Ambulatory Payment Classifications* Relative Weight for each CPT code x 221.79 = MAR
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> Outpatient Prospective Payment System (OPPS) Addendum B is used to establish the Relative Weight for both hospital outpatient clinic and ASC reimbursement. (Bulletin 16-01, May 11, 2016).

34. Ms. Norton testified that the physical therapy services were billed by Claimant, not the individual therapists. (K. Norton).

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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> . . . .
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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). An adjudicative body 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 an employer to pay 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
> (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;
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> (B) the fee or charge for the treatment or service when provided to the general public; or
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> (C) the fee or charge for the treatment or service negotiated by the provider and the employer under (c) of this section;
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> (f) An employee may not be required to pay a fee or charge for medical treatment or service provided under this chapter.
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> (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.
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> (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 23.30.395. Definitions. In this chapter,

. . . .

(32) "physician" included doctors of medicine, surgeons, chiropractors, osteopaths, dentists, and optometrists;

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 44.62.300. Judicial review of validity.**
> An interested person may get a judicial declaration on the validity of a regulation by bringing an action for declaratory relief in the superior court. In addition to any other ground the court may declare the regulation invalid . . . .

When reviewing a regulation, the Supreme Court looks at three factors:

> We review an agency's regulation for whether it is "consistent with and reasonably necessary to implement the statutes authorizing [its] adoption." Toward this end we consider: (1) whether [the agency] exceeded its statutory authority in promulgating the regulation; (2) whether the regulation is reasonable and not arbitrary; and (3) whether the regulation conflicts with other statutes or constitutional provisions. *Manning v. State*, 355 P.3d 530, 534-35 (Alaska 2015).

Alaska courts apply a sliding-scale approach to statutory interpretation. Under this approach, the plain language of a statute is significant but does not always control; rather, "legislative history can sometimes alter a statute's literal terms." As a general rule, "the plainer the language of the statute, the more convincing contrary legislative history must be." *Hillman v. Alaska*, 382 P.2d 1198, 1199 (Alaska 2016).

> **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 AS 23.30 (Alaska Workers' Compensation Act), the following conversion factors shall be applied to the total facility or non-facility relative value unit in the Resource-Based Relative Value Scale, adopted by reference in (m) of this section. Medical service or treatment shall be identified by a code assigned to that treatment or service in the Current Procedural Terminology, adopted by reference in (m) of this section:
> (1) the conversion factor for evaluation and 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 Current Procedural Terminology code 97545 is 3.41, and the relative value for Current Procedural Terminology code 97546 is 1.36.

(c) The conversion factor for anesthesiology is $121.82, which is to be multiplied by the base and time units for each Current Procedural Terminology code established in the Relative Value Guide, adopted by reference in (m) of this section.

(d) For supplies, materials, injections, and other services and procedures coded under the Healthcare Common Procedure Coding System, adopted by reference in (m) of this section, the following multipliers shall be applied to the following fee schedules established by the Centers for Medicare and Medicaid Services, and in effect at the time of treatment or service:

(1) Clinical Diagnostic Laboratory services, multiplied by 6.33;

(2) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), multiplied by 1.84;

(3) Payment Allowance Limits for Medicare Part B Drugs, Average Sale Price, multiplied by 3.375.

(e) For medical services provided by inpatient hospitals under AS 23.30 (Alaska Workers' Compensation Act), the conversion factor of 328.2 percent of the hospital specific total base rate shall be applied to the Medicare Severity Diagnosis Related Groups weight adopted by reference in (m) of this section, except that

(1) the maximum allowable reimbursement 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;

(2) the base rate for Providence Alaska Medical Center is $23,383.10;

(3) the base rate for Mat-Su Regional Medical Center is 20,976.66;

(4) the base rate for Bartlett Regional Hospital is $20,002.93;

(5) the base rate for Fairbanks Memorial Hospital is $21,860.73;

(6) the base rate for Alaska Regional Hospital is $21,095.72;

(7) the base rate for Yukon Kuskokwim Delta Regional Hospital is $38,753.21;

(8) the base rate for Central Peninsula General Hospital is $19,688.56;

(9) the base rate for Alaska Native Medical Center is $31,042.20;

(10) the base rate for Mt. Edgecumbe Hospital is $26,854.53; (

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

(f) For medical services provided by hospital outpatient clinics or ambulatory surgical centers under AS 23.30 (Alaska Workers' Compensation Act), an outpatient conversion factor of $221.79 shall be applied to the relative weights established for each Current Procedural Terminology or Ambulatory Payment Classifications code adopted by reference in (m) of this section. 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 Centers for Medicare and Medicaid Services, Current Procedural Terminology, or Healthcare Common Procedure Coding System codes, a currently assigned Centers for Medicare and Medicaid Services 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.

(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 plus a $5 dispensing fee;

(2) generic drugs shall be reimbursed at manufacturer's average wholesale price plus a $10 dispensing fee;

(3) reimbursement for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's average wholesale price for each drug included in the compound, listed separately by National Drug Code, plus a $10 compounding fee.

(i) The maximum allowable reimbursement 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 the billed charges.

(j) The following billing and payment rules apply for medical treatment or services provided by physicians. Providers and payers shall follow the billing and coding rules adopted by reference in (m) of this section as established by the Centers for Medicare and Medicaid Services and the American Medical Association, including the use of modifiers. The procedure with the largest relative value unit is the primary procedure and shall be listed first on the claim form. Specific modifiers shall be reimbursed as follows:

(1) Modifier 50: reimbursement is the lowest of 100 percent of the fee schedule amount or the billed charge for the procedure with the highest relative value unit; reimbursement is the lowest of 50 percent of the fee schedule amount or the billed charge for the procedure for the second and all subsequent procedures;
(2) Modifier 51: reimbursement is the lowest of 100 percent of the fee schedule amount or the billed charge for the procedure with the highest relative value unit rendered during the same session as the primary procedure; reimbursement is the lowest of 50 percent of the fee schedule amount or the billed charge for the procedure with the second highest relative value unit and all subsequent procedures during the same session as the primary procedure;
(3) Modifiers 80, 81, and 82: reimbursement is 20 percent of the surgical procedure;
(4) Modifier PE: reimbursement is 85 percent of the value of the procedure; state specific modifier PE shall be used when services and procedures are provided by a physician assistant or an advanced practice registered nurse;
(5) Modifier AS: reimbursement is 15 percent 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;
(6) Modifier QZ: reimbursement is 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;
(7) providers and payers shall follow National Correct Coding Initiative edits established by the Centers for Medicare and Medicaid Services and the American Medical Association in effect at the time of treatment; if there is a billing rule discrepancy between National Correct Coding Initiative edits and the American Medical Association Current Procedural Terminology Assistant, American Medical Association Current Procedural Terminology Assistant guidance governs.

(k) The following billing and payment rules apply for medical treatment or services provided by inpatient hospitals, hospital outpatient clinics, and ambulatory surgical centers:
(1) medical services for which there is no Ambulatory Payment Classifications 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 codes C, E, 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 code T on the same claim shall be reimbursed with the highest weighted code paid at 100 percent of the Ambulatory Payment Classifications calculated amount and all other status 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) if total costs for a hospital inpatient Medicare Severity Diagnosis Related Groups coded service exceeds the Centers for Medicare and Medicaid Services outlier threshold established at the time of service plus the Medicare Severity Diagnosis Related Groups payment, then the total payment for that service shall be calculated using the Centers for Medicare and Medicaid Services Inpatient PC Pricer tool as follows:
(A) implantable charges, if applicable, are subtracted from the total amount charged;
(B) the charged amount from (A) of this paragraph is entered into the most recent version of the Centers for Medicare and Medicaid Services PC Pricer tool at the time of treatment;
(C) the Medicare price returned by the Centers for Medicare and Medicaid Services 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 plus 10 percent, or 110 percent of invoice cost;
(E) the amounts calculated in (C) and (D) of this paragraph 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 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.

(m) The following material is adopted by reference:
(1) Current Procedural Terminology Codes, 2015 edition, produced by the American Medical Association, as may be amended;
(2) Healthcare Common Procedure Coding System, 2015 edition, produced by the American Medical Association, as may be amended;
(3) International Classification of Diseases, 2016 edition, valid October 1, 2015 through September 30, 2016, published by the American Medical Association, as may be amended;
(4) Relative Value Guide, 2015 edition, produced by the American Society of Anesthesiologists, as may be amended;
(5) Diagnostic and Statistical Manual of Mental Disorders, 5th edition, produced by the American Psychiatric Association, as may be amended;
(6) Current Dental Terminology, 2015 edition, published by the American Dental Association, as may be amended;

> (7) Resource-Based Relative Value Scale, effective January 1, 2015, produced by the federal Centers for Medicare and Medicaid Services, as may be amended;
> (8) Ambulatory Payment Classifications, effective January 1, 2015, produced by the federal Centers for Medicare and Medicaid Services, as may be amended;
> (9) Medicare Severity Diagnosis Related Groups, effective January 1, 2015, 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.

ANALYSIS

How are outpatient physical or occupational therapy services paid under the fee schedule?

There are no factual disputes; the parties' sole disagreement is how the fee schedule applies to the outpatient physical therapy services provided to Employee. Employer contends the services are not compensable under the outpatient fee schedule because they have an OPPS status indicator of "A." Rather, Employer contends the services should be paid under the fee schedule provisions for physicians or other medical providers. Claimant contends the physician's fee schedule is inapplicable because the physical therapists are not physicians under the Act, and because it, rather than the individual physical therapists, billed for the services, the provision for other medical providers is inapplicable. Claimant contends CMS's status indicator "A" was not incorporated as part 8 AAC 45.083(f), and it should be paid under that section.

The MSRC's intent as to OPPS status indicator "A" is not clear. Prior to its recommendations to the Commissioner, the MSRC heard a variety of relevant testimony. At its first meeting on July 7, 2014, the MSRC was presented with an example of how Medicare calculates fees under the OPPS, but the example did not refer to status indicators. At the October 24, 2014 Meeting the MSRC discussed whether status payment codes should be incorporated, but reached no decision. On January 15 and 16, 2015, an Optum representative noted the committee needed to make a decision on how to address status codes, and at the February 23, 2015 meeting they discussed status codes in the context of medical facilities. In its June 1, 2015 report to the Commissioner, the committee found that it needed to make payment rules for unvalued services and gaps where CMS did not produce relative values. It also found that while CMS payment rules were well

established, for outpatient clinics, status indicators "C," "E," and "P" required state specific rules, and it adopted a rule addressing those indicators. The MRSC's recommendation was adopted by the board as 8 AAC 45.083.

The MSRC's minutes after the adoption of 8 AAC 45.083 also raise questions as to its intent. On July 15, 2016, one member stated it had not been the committee's intent to adopt all CMS rules, and the committee discussed the problem of CPT codes with a relative value of zero. A member of the public testified clarification was needed on chiropractic codes, including 98943; however the committee made no decision but asked Optum to provide more evidence for review. Again on July 29 2016, a different member stated it was his belief that the committee was not adopting all Medicare rules, only those related to billing and coding.

The legislative history of HB 316 provides some guidance, however. Committee testimony indicates the intent of the bill was to reduce worker's compensation medical costs by enacting a new fee schedule. Certainly, nothing suggests the bill was intended to reduce the benefits available to injured workers or change or override other provisions of the act.

A hearing panel does not have jurisdiction to find a regulation conflicts with the Act; under AS 44.62.300, only the courts have that authority. This case does not require a determination as to the validity of 8 AAC 45.083, but when faced with two conflicting interpretations of the regulation, the same factors considered by the courts in determining whether a regulation is valid come into play in determining which interpretation is more appropriate. It must be assumed that the MSRC was aware of the bill's intent, and that it did not intend to exceed its statutory authority or to make recommendations that conflict with other sections of the Act.

Employer contends the physical therapy fees here should be paid under the physician fee schedule rather than the outpatient fee schedule. However, the definition of "physician" in AS 23.30.395(32) does not include physical therapists, and nothing in HB 316 or its legislative history suggests the legislature intended to amend that definition. The fact that 8 AAC 45.083 includes a subsection (l), specifically addressing "other providers" strongly suggests that neither the MSRC nor the board intended non-physicians to be paid under the physician fee schedule.

Employer next contends that physical and occupational therapists could be paid under the "other provider" provision of 8 AAC 45.083(l). In this case, however, the therapists did not bill for their services, it was Claimant that billed for services at its outpatient clinic. Claimant, not the individual therapists, is the medical provider in this case, and 8 AAC 45.083(l) is inapplicable.

Employer contends that because status indicators are part of the CMS's OPPS schedule, they are incorporated by reference. Employer points to the fact that 8 AAC 45.083(k)(2) and (3) provide special rules for status indicators "C," "E," "P," and "T," and suggests the inclusion of those status indicators shows the MSRC intended all status indicators to be incorporated. However, AS 23.30.097(a)(1)(A)(ii) did not direct the board to adopt the entirety of CMS's OPPS schedule. It directed the board to adopt "an outpatient and ambulatory surgical center fee schedule based on the federal Centers for Medicare and Medicaid Services' *ambulatory payment classification*." (emphasis added). CMS's ambulatory payment classifications are only one part of the OPPS schedule. The MSRC could reasonably use specific status indicators to provide special payment rules for a large number of HCPCS codes without referring to each individual code. The fact that the MSRC referred to some status indicators does not mean that all other status indicators, together with CMS's payment rules, were adopted as part of the regulation.

If the 8 AAC 45.083 is construed to include only CMS's ambulatory payment classifications and relative weights, as well as those status indicators specifically referenced in 8 AAC 45.083(k), the result is a fee schedule consistent with the rest of the Act. To construe 8 AAC 45.083 as incorporating status codes that indicate an item is nonpayable conflicts with other portions of the Act. A basic principle of the workers' compensation system 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*. Employer did not allege the treatment here was not reasonable or medically necessary. 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 old fee schedule with one based on CMS's ambulatory patient classifications. The outpatient fee schedule is best harmonized with the Act if it is not construed as incorporating status indicator "A."

CONCLUSION OF LAW

Physical or occupational therapy services billed through an outpatient clinic are payable under 8 AAC 45.083(f).

ORDER

Claimant's June 7, 2016, September 20, 2016, and December 13, 2016 claims are granted.

Dated in Anchorage, Alaska on February 6, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Pamela Cline, Member

/s/
David Ellis, Member

If compensation is payable under terms of this decision, it is due on the date of issue. A penalty of 25 percent will accrue if not paid within 14 days of the due date, unless an interlocutory order staying payment is obtained in the Alaska Workers' Compensation Appeals Commission.
If compensation awarded is not paid within 30 days of this decision, the person to whom the awarded compensation is payable may, within one year after the default of payment, request from the board a supplementary order declaring the amount of the default.

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 TREVOR D. MILLAR, employee, and PROVIDENCE ALASKA MEDICAL CENTER, claimant; v. YOUNG LIFE, employer; ACE AMERICAN INSURANCE COMPANY, insurer / defendants; Case No. 201307276; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on February 6, 2017.

/s/

Nenita Farmer, Office Assistant